

# Appeals – Part D Prescription Drugs

## *What is an Appeal*

An “**appeal**” is the type of complaint you make **when you want us to reconsider and change a decision we have made about what Part D prescription drug we will cover for you, including whether we will pay for a Part D prescription drug that you have already received, or how much we will pay.**

## *Who May Request an Appeal*

You can make an appeal yourself, or someone you name may do it for you. The person you name would be your *appointed representative*. You can name a relative, friend, advocate, doctor, or anyone else to act for you. Some other persons may already be authorized under State law to act for you. If you want someone to act for you, then you and the representative accepting the appointment must sign, date, and complete an Appointment Of Representative form or similar written statement.

**An Appointment of Representative form is attached following these pages.**

## *There Are Two Kinds of Appeals You Can Request*

**Standard (7 days)** - You can request a standard appeal for a case that involves coverage or payment. AvMed Health Plans must give you a decision no later than 7 days after receiving your appeal.

**Expedited (72 hours)** - You can request an expedited (fast) appeal for cases that involve coverage, if you or your doctor believes that your health could be seriously harmed by waiting up to 7 days for a decision. If your request to expedite is granted, AvMed Health Plans must make a decision no later than 72 hours after receiving your appeal.

- If the doctor who prescribed the drug(s) asks for an expedited appeal for you, or supports you in asking for one, and the doctor indicates that waiting for 7 days could seriously harm your health, AvMed Health Plans will automatically expedite the appeal
- If you ask for an expedited appeal without support from a doctor, AvMed Health Plans will decide if your health requires an expedited appeal. If you do not get an expedited appeal, your appeal will be decided within 7 days.

## *How Do I Request an Appeal?*

You need to file your appeal within 60 calendar days from the date included on the notice of our coverage determination. We can give you more time if you have a good reason for missing the deadline.

### **For a Standard Appeal:**

You or your appointed representative should mail your written appeal to:

AvMed Health Plans  
Member Relations Department  
P.O. Box 749  
Gainesville, Fl 32602

### **For an Expedited Appeal:**

You or your appointed representative should contact us by telephone at 1-800-782-8633, 24-hours a day, 7 days a week. TTY/TDD users should call 1-877-442-8633. You may also send us a fax to: (305) 671-4936.

*AvMed is a Medicare Advantage organization with a Medicare contract*

### ***What Do I Include with My Appeal?***

You should include your name, address, Member ID number, the reasons for appealing, and any evidence you wish to attach. If your appeal relates to a decision by us not to cover a drug that is not on our list of covered drugs (formulary), your prescribing physician must indicate that all of the drugs on any tier of our formulary would not be as effective to treat your condition as the requested off-formulary drug or would harm your health. If your appointed representative is appealing for you, the signed, dated, and completed Appointment Of Representative form must be included with the appeal.

### ***What Happens Next?***

When we receive your request to reconsider the coverage determination, we give the request to people at our organization who were not involved in making the coverage determination. This helps ensure that we will give your request a fresh look.

We must gather all the information we need to make a decision about your appeal. If we need your assistance in gathering this information, we will contact you. You have the right to obtain and include additional information as part of your appeal.

**If we decide completely in your favor:** For a Part D drug you already paid for and received, we must send payment to you no later than 30 calendar days after we receive your request. For a Part D drug you have not received, we must authorize or provide you with the Part D drug as quickly as your health requires, but no later than 7 calendar days for a standard decision, and 72-hours or sooner, if your health would be affected by waiting this long for a fast decision.

**If we deny your appeal:** If we deny any part of your appeal, you or your appointed representative have the right to ask an independent organization, to review your case. This independent review organization contracts with the federal government and is not part of AvMed Health Plans.

### **Contact Information:**

If you need information or help, call us at:  
1-800-782-8633, 24-hours a day, 7 days a week  
TTY/TDD users should call 1-877-442-8633.

### **Other Resources To Help You:**

**1-800-MEDICARE (1-800-633-4227)**  
(24-hours a day/7 days a week)  
TTY/TTD: 1-877-486-2048

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APPOINTMENT OF REPRESENTATIVE

NAME OF BENEFICIARY	MEDICARE NUMBER
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**SECTION I: APPOINTMENT OF REPRESENTATIVE**

**To be completed by the beneficiary:**

I appoint this individual: \_\_\_\_\_ to act as my representative in connection with my claim or asserted right under Title XVIII of the Social Security Act (the "Act") and related provisions of Title XI of the Act. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my appeal, wholly in my stead. I understand that personal medical information related to my appeal may be disclosed to the representative indicated below.

SIGNATURE OF BENEFICIARY		DATE
STREET ADDRESS		PHONE NUMBER (AREA CODE)
CITY	STATE	ZIP

**SECTION II: ACCEPTANCE OF APPOINTMENT**

**To be completed by the representative:**

I, \_\_\_\_\_, hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services; that I am not, as a current or former employee of the United States, disqualified from acting as the beneficiary's representative; and that I recognize that any fee may be subject to review and approval by the Secretary.

I am a / an \_\_\_\_\_  
(PROFESSIONAL STATUS OR RELATIONSHIP TO THE PARTY, E.G. ATTORNEY, RELATIVE, ETC.)

SIGNATURE		DATE
STREET ADDRESS		PHONE NUMBER (AREA CODE)
CITY	STATE	ZIP

**SECTION III: WAIVER OF FEE FOR REPRESENTATION**

**Instructions: This form should be filled out if the representative waives a fee for such representation.**

(Note that providers or suppliers may not charge a fee for representation and thus, all providers or suppliers that furnished the items or services at issue **must** complete this section.)

I waive my right to charge and collect a fee for representing \_\_\_\_\_  
before the Secretary of the Department of Health and Human Services.

SIGNATURE	DATE
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**SECTION IV: WAIVER OF PAYMENT FOR ITEMS OR SERVICES AT ISSUE**

**Instructions: Providers or suppliers that furnished the items or services at issue must complete this section if the appeal involves a question of liability under section 1879(a)(2) of the Act.** (Section 1879(a)(2) generally addresses whether a provider/supplier or beneficiary did not know, and could not reasonably be expected to know, that the items or services at issue would not be covered by Medicare.)

I waive my right to collect payment from the beneficiary for furnished items or services at issue involving 1879(a)(2) of the Act.

SIGNATURE	DATE
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## **CHARGING OF FEES FOR REPRESENTING BENEFICIARIES BEFORE THE SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES**

An attorney, or other representative for a beneficiary, who wishes to charge a fee for services rendered in connection with an appeal before the Department of Health and Human Services (DHHS) at the Administrative Law Judge (ALJ) or Medicare Appeals Council (MAC) level is required by law to obtain approval of the fee in accordance with 42 CFR §405.910(f). A claim that has been remanded by a court to the Secretary for further administrative proceedings is considered to be before the Secretary after the remand by the court.

The form, "Petition to Obtain Representative Fee" elicits the information required for a fee petition. It should be completed by the representative and filed with DHHS. Where a representative has rendered services in a claim before DHHS, the regulations require that the amount of the fee to be charged, if any, for services performed before the Secretary of DHHS be specified. If any fee is to be charged for such services, a petition for approval of that amount must be submitted.

An approval of a fee is not required where the appellant is a provider or supplier or where the fee is for services (1) rendered in an official capacity such as that of legal guardian, committee, or similar court-appointed office and the court has approved the fee in question; (2) in representing the beneficiary before the federal district court of above, or (3) in representing the beneficiary in appeals below the ALJ level. If the representative wishes to waive a fee, he or she may do so. Section III on the front of this form can be used for that purpose. In some instances, as indicated on the form, the fee must be waived for representation.

### **AUTHORIZATION OF FEE**

The requirement for the approval of fees ensures that representative will receive fair value for the services performed before DHHS on behalf of a claimant while at the same time giving a measure of security to the beneficiaries. In approving a requested fee, the ALJ or MAC considers the nature and type of services performed, the complexity of the case, the level of skill and competence required in rendition of the services, the amount of time spent on the case, the results achieved, the level of administrative review to which the representative carried the appeal and the amount of the fee requested by the representative.

### **CONFLICT OF INTEREST**

Sections 203, 205 and 207 of Title XVIII of the United States Code make it a criminal offense for certain officers, employees and former officers and employees of the United States to render certain services in matters affecting the Government or to aid or assist in the prosecution of claims against the United States. Individuals with a conflict of interest are excluded from being representatives of beneficiaries before DHHS.

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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0950. The time required to prepare and distribute this collection is 15 minutes per notice, including the time to select the preprinted form, complete it and deliver it to the beneficiary. If you have comments concerning the accuracy of the time estimates or suggestions for improving the form, please write to CMS, PRA Clearing Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

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