SilverScript Claims and Appeals Process

Prior Authorization Review

SilverScript will implement the prescription drug cost containment programs requested by the plan sponsor by comparing member requests for certain medicines and/or other prescription benefits against pre-defined medical criteria specifically related to use of those medicines or prescription benefits before those prescriptions are filled.

If SilverScript determines that the member's request for prior authorization cannot be approved, that determination will constitute an Adverse Benefit Determination. SilverScript will send a denial letter to the member and the member's physician.

Initial Coverage Determination

A member's request for a particular drug or benefit will be reviewed and processed according to current plan rules, including that the drug or benefit is covered by the plan at the time of service.

If SilverScript determines that the member's request for a drug or benefit cannot be approved based on the terms of the Plan that determination will constitute an adverse benefit determination.

SilverScript Appeals Process

If an adverse benefit determination of the Initial Coverage Determination is rendered on the member's claim, the member may file an appeal of that determination. The appeals process has five (5) levels:

- Level 1: Redetermination by SilverScript
- Level 2: Reconsideration by an Independent Review Entity (IRE)
- Level 3: Hearing before an Administrative Law Judge (ALJ) or attorney adjudicator
- Level 4: Review by the Medicare Appeals Council (the Council)
- Level 5: Judicial review by a federal district court

Level 1 Appeal

You, your representative, your doctor, or other prescriber can request a standard or expedited redetermination of the Initial Coverage Determination. A Level 1 Appeal is handled by a SilverScript individual not involved in the Initial Coverage Determination.

A Level 1 Appeal should be filed within 60 calendar days from the date of the adverse benefit determination of the Initial Coverage Determination. The member's appeal should include the following information:

- Name of the person the appeal is being filed for
- Medicare and SilverScript Identification Number

- Date of birth
- Written statement of the issue(s) being appealed
- Drug name(s) being requested
- Written comments, documents, records or other information relating to the claim
- If you have appointed a representative, include the name of your representative and proof of representation.

The member's appeal and supporting documentation may be mailed or faxed to SilverScript at:

SilverScript Insurance Company
Prescription Drug Plans
Coverage Decisions and Appeals Department
P.O. Box 52000, MC 109
Phoenix, AZ 85072-2000

If you need help right away:
Call: 1-844-757-0448
TTY Users Call: 711
Fax: 1-855-633-7673
Hours of Operation: 24 hours a day, 7 days a week

Physicians may submit urgent appeal requests by calling the physician-only toll-free number 1-866-693-4620.

Members will receive an appeal notice with the determination of their claim. A standard appeal for a drug you have not received yet will result in a response within 7 days (or 14 days, if you are requesting repayment for a drug you have already purchased) and an expedited appeal will have a response as quickly as your health condition requires, but no later than 72 hours.

Level 2 Appeal

If we say no to all or part of your Level 1 Appeal, you can ask for a Level 2 Appeal. The Level 2 Appeal is conducted by an Independent Review Organization that is not connected to us. If you are not satisfied with the decision at the Level 2 Appeal, you may be able to continue through additional levels of appeal.

- Would you like some help? Here are resources you may wish to use if you decide to ask for any kind of coverage decision or appeal a decision:
- You **can call us at Customer Care** (phone numbers are printed on the back cover of this booklet).
- You can **get free help from** your State Health Insurance Assistance Program (see Section 2 of this chapter).
- **Your doctor or other prescriber can make a request for you.** For Part D prescription

drugs, your doctor or other prescriber can request a coverage decision or a Level 1 or Level 2 Appeal on your behalf. To request any appeal after Level 2, your doctor or other prescriber must be appointed as your representative.

- **You can ask someone to act on your behalf**. If you want to, you can name another person to act for you as your "representative" to ask for a coverage decision or make an appeal.
    - There may be someone who is already legally authorized to act as your representative under state law.
    - If you want a friend, relative, your doctor or other prescriber, or other person to be your representative, call Customer Care (phone numbers are printed on the back cover of this booklet) and ask for the "Appointment of Representative" form. (The form is also available on Medicare's website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf.) The form gives that person permission to act on your behalf. It must be signed by you and by the person whom you would like to act on your behalf. You must give us a copy of the signed form.
- **You also have the right to hire a lawyer to act for you**. You may contact your own lawyer or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Level 3 Appeal

If you disagree with the determination of the IRE and the value of the drug meets a minimum dollar amount, you can request a standard or expedited reconsideration by an Administrative Law Judge (ALJ) or attorney adjudicator within 60 days from the date of the Level 2 Appeal determination notice. This gives you the opportunity to present your appeal to a new person who will independently review the facts of your appeal and listen to your testimony before making a new and impartial decision in accordance with the applicable law.

If the Level 2 Appeal issues an unfavorable determination, you may submit a written request with the information listed below. Note that if any of the described information is missing from your request for an ALJ or attorney adjudicator hearing, it can cause delays in the processing of your appeal.

- The beneficiary's name, address and Medicare health insurance claim number;
- The name and address of the appellant, when the appellant is not the beneficiary;
- The name and address of the designated representative, if any;
- The document control number assigned by the IRE, if any;
- The dates of service being appealed;

- The reasons you disagree with the IRE's reconsideration or other determination being appealed, and

- A statement of any additional evidence to be submitted and the date it will be submitted.

Send your written request for ALJ or attorney adjudicator hearing to the office specified in the Level 2 Appeal determination notice.

If you are requesting an expedited hearing, you can make an oral request. Follow the instructions in the IRE's determination notice. An expeditious decision will be decided if your doctor or other prescriber indicates, or the ALJ or attorney adjudicator determines, that waiting 90 days for a decision may seriously jeopardize your life, health, or ability to regain maximum function.

You will be sent a Notice of Hearing with the date, time, and location of your hearing at least twenty (20) days before the hearing. Once you receive the "Notice of Hearing", fill out Response to Notice of Hearing Form (HHS-729) - PDF and return it to the ALJ or attorney adjudicator listed on the Notice of Hearing within 5 days of receiving it.

A hearing will generally be held by video-teleconference (VTC). However, an in-person hearing may be held if the ALJ or attorney adjudicator determines the circumstances of the appeal warrant an in-person hearing. Telephone hearings may also be arranged in certain circumstances for the convenience of the parties. Your hearing may take longer to schedule if the ALJ or attorney adjudicator needs to schedule a medical or non-medical expert to testify.

Members will receive a decision with the determination of their claim. A standard appeal will result in a response within 90 days and an expedited appeal will have a response as quickly as your health condition requires, but no later than 10 days. For additional information, please go to the Office of Medicare Hearings and Appeals (OMHA) website at https://www.hhs.gov/ or call (844) 419-3358.

Level 4 Appeal

If you disagree with the ALJ's or attorney adjudicator's decision, you can request a standard or expedited reconsideration by the Medicare Appeals Council (the Council) within 60 days from the date of the Level 3 Appeal decision.

If the ALJ or attorney adjudicator Level 3 Appeal issues an unfavorable determination, you may submit a written request with the information listed below.

- Beneficiary's name;

- Name of the health services provider;

- Date and type of service;

- Medicare contractor or managed care organization that issued the initial determination in your case;

- Health Insurance Claim Number (HICN);

- OMHA appeal number;
- Date of the Administrative Law Judge (ALJ) or attorney adjudicator decision or dismissal;
- An appointment of representative, such as CMS Form 1696 - PDF (PDF, 66.4 KB) (if applicable);
- Any additional evidence, clearly marked as new or duplicate; and
- Proof that you provided copies of your request to all other parties.

You may fax your request for review to (202) 565-0227 or mail your request to:

> Department of Health and Human Services Departmental Appeals Board, MS 6127 Medicare Operations Division – Cohen Building 330 Independence Avenue, SW, Room G-644 Washington DC 20201

If you are requesting an expedited hearing, you can make an oral request. Follow the instructions in the ALJ's or attorney adjudicator's determination notice. An expeditious decision will be decided if your doctor or other prescriber indicates, or the ALJ or attorney adjudicator determines, that waiting 90 days for a decision may seriously jeopardize your life, health, or ability to regain maximum function.

Members will receive a decision with the determination of their claim. A standard appeal will result in a response within 90 days and an expedited appeal will have a response as quickly as your health condition requires, but no later than 10 days.

For additional information, please go to the Medicare Appeals Council (the Council) website at https://www.hhs.gov/ or call 1-800-MEDICARE.

Level 5 Appeal

If you disagree with the Council's decision, and the value of your claim meets a minimum dollar amount, you can request a judicial review by a federal district court within 60 days from the date of the Level 4 Medicare Council decision. You should contact the clerk's office of the federal district court for instructions on how to file the appeal. The court location will be on the Council's decision notice.

For more information on the appeals process:

- The State of Delaware Statewide Benefits Office website at https://dhr.delaware.gov/benefits/prescription/medicare/appeals.shtml.
- Visit https://www.medicare.gov/claims-and-appeals/file-an-appeal/appeals.html
- Call 1-800-MEDICARE (1-800-633-4227)

- Visit https://www.medicare.gov/forms-help-and-resources/forms/medicare-forms.html

- Call your State Health Insurance Assistance Program (SHIP) for free, personalized health insurance counseling, including help with appeals. Please visit https://www.medicare.gov/contacts/ or call 1-800-MEDICARE for the SHIP phone number in your state.

Filing a Grievance or Complaint

If you have an issue or concern with this plan that is not a request for coverage or reimbursement for a drug, you have the right to file a complaint or grievance.

If your complaint involves the quality of care you received, you can file a grievance with SilverScript Customer Care by calling 1-844-757-0448 (TTY users only: 711) or your Beneficiary and Family Centered Quality Improvement Organization (BFCC-QIO). Visit https://www.medicare.gov/contacts/ or call 1-800-MEDICARE for the phone number of your local BFCC-QIO.

If you want to file a complaint:

- You must file your complaint within 60 days from the date of the event that led to the complaint.

- You can file your complaint and any supporting documentation with SilverScript at the following address:

  SilverScript Insurance Company
  Prescription Drug Plans
  Grievance Department
  P.O. Box 14834
  Lexington, KY 40512
  If you need help right away:
  Call: 1-844-757-0448
  TTY Users Call:
  711
  Fax: 1-724-741-4956
  Hours of Operation: 24 hours a day, 7 days a week

- You must be notified of the plan's decision generally no later than 44 days after the plan receives the complaint.

- If the complaint relates to a plans' refusal to make an expedited coverage determination or redetermination and you have not yet purchased or received the drug, the plan must notify you of its decision within 24 hours after it receives the complaint.

If the plan does not address your complaint, call 1-800-MEDICARE.

For more information on filing a complaint:

- Visit https://www.medicare.gov/claims-and-appeals/file-an-appeal/appeals.html.

- Call your SHIP for free, personalized counseling and help filing a complaint. Call 1-800- MEDICARE or visit https://www.medicare.gov/contacts/ for the phone number of your local SHIP office.