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## **Section 8(a). Medicare PDP EGWP Disputed Claims Process**

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When a claim is denied in whole or in part, you may appeal the denial.

### **Part D Prescription Drugs**

#### **How to ask for a coverage decision or make an appeal**

**This section tells you what to do if you have problems getting a Part D drug or you want Express Scripts Medicare to pay you back for a Part D drug**

Your benefits include coverage for many prescription drugs. To be covered, the drug must be used for a medically accepted indication.

#### **This section is about your Part D drugs only.**

- If you do not know if a drug is covered or if you meet the rules, you can ask Express Scripts Medicare. Some drugs require that you get approval from Express Scripts Medicare before we will cover them.
- If your pharmacy tells you that your prescription cannot be filled as written, the pharmacy will give you a written notice explaining how to contact Express Scripts Medicare to ask for a coverage decision.
- For more information on asking for coverage decisions or appeals about your Part D prescription drugs, see **Express Scripts Medicare Evidence of Coverage, Chapter 7 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints))**.

#### **How to contact us when you are asking for a coverage decision or appeal**

A coverage decision is a decision we make about your coverage or about the amount we will pay for your Part D prescription drugs. An appeal is a formal way of asking us to review and change a coverage decision we have made.

#### **Initial Coverage Reviews for Part D Prescription Drugs and Appeals for Part D Prescription Drugs - Contact Information**

##### **Call:**

1-844-374-7377

Calls to this number are free. Our business hours are 24 hours a day, 7 days a week.

##### **TTY:**

1-800-716-3231

This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Our business hours are 24 hours a day, 7 days a week.

##### **Fax:**

1-877-251-5896

##### **Write:**

##### **For Medicare Reviews:**

Express Scripts  
Attn: Medicare Reviews  
P.O. Box 66571  
St. Louis, MO 63166-6571

##### **For Medicare Appeals:**

Express Scripts  
Attn: Medicare Appeals  
P.O. Box 66588  
St. Louis, MO 63166-6588

##### **Website:**

<https://www.express-scripts.com>

## **Step-by-step: How to ask for a coverage decision, including an exception:**

**Legal Term:** A "fast coverage decision" is called an "**expedited coverage determination.**"

### **Step 1: Decide if you need a "standard coverage decision" or a "fast coverage decision."**

"**Standard coverage decisions**" are made within **72 hours** after we receive your doctor's statement. "**Fast coverage decisions**" are made within **24 hours** after we receive your doctor's statement.

***If your health requires it, ask Express Scripts Medicare to give you a "fast coverage decision." To get a fast coverage decision, you must meet two requirements:***

- You must be asking for a *drug you have not yet received*. (You cannot ask for fast coverage decision to be paid back for a drug you have already bought.)
- Using the standard deadlines could *cause serious harm to your health or hurt your ability to function*.
- **If your doctor or other prescriber tells Express Scripts Medicare that your health requires a "fast coverage decision," we will automatically give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor or prescriber's support, we will decide whether your health requires that we give you a fast coverage** If we do not approve a fast coverage decision, we will send you a letter that:
  - Explains that we will use the standard deadlines.
  - Explains if your doctor or other prescriber asks for the fast coverage decision, we will automatically give you a fast coverage decision.
  - Tells you how you can file a "fast complaint" about our decision to give you a standard coverage decision instead of the fast coverage decision you We will answer your complaint within 24 hours of receipt of the complaint.

### **Step 2: Request a "standard coverage decision" or a "fast coverage decision."**

Start by calling, writing, or faxing our plan to make your request for Express Scripts Medicare to authorize or provide coverage for the prescription you want. You can also access the coverage decision process through our website. We must accept any written request, including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website at <https://www.express-scripts.com>. To assist Express Scripts Medicare in processing your request, please be sure to include your name, contact information, and information identifying which denied claim is being appealed.

You, your doctor, (or other prescriber) or your representative can do this. You can also have a lawyer act on your behalf.

**If you are requesting an exception, provide the "supporting statement,"** which is the medical reasons for the exception. Your doctor or other prescriber can fax or mail the statement to Express Scripts Medicare. Or your doctor or other prescriber can tell Express Scripts Medicare on the phone and follow up by faxing or mailing a written statement if necessary.

### **Step 3: We consider your request and give you our answer.**

#### ***Deadlines for a "fast coverage decision"***

- We must generally give you our answer within **24 hours** after we receive your request.
  - For exceptions, we will give you our answer within 24 hours after we receive your doctor's supporting statement. We will give you our answer sooner if your health requires Express Scripts Medicare to.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

#### ***Deadlines for a "standard" coverage decision about a drug you have not yet received***

- We must generally give you our answer **within 72 hours** after we receive your request.
  - For exceptions, we will give you our answer within 72 hours after we receive your doctor’s supporting statement. We will give you our answer sooner if your health requires Express Scripts Medicare to.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested**, we must **provide the coverage** we have agreed to provide **within 72 hours** after we receive your request or doctor’s statement supporting your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

#### **Deadlines for a “standard” coverage decision about payment for a drug you have already bought**

- We must give you our answer **within 14 calendar days** after we receive your request.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested**, we are also required to make payment to you within 14 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

#### **Step 4: If we say no to your coverage request, you can make an appeal.**

- If we say no, you have the right to ask Express Scripts Medicare to reconsider this decision by making an appeal. This means asking again to get the drug coverage you want. If you make an appeal, it means you are going on to Level 1 of the appeals process.

#### **Step-by-step: How to make a Level 1 appeal**

##### **Legal Term**

An appeal to the plan about a Part D drug coverage decision is called a plan "**redetermination.**"

A "fast appeal" is also called an "**expedited redetermination.**"

##### **Step 1: Decide if you need a “standard appeal” or a “fast appeal.”**

*A “standard appeal” is usually made within 7 days. A “fast appeal” is generally made within 72 hours. If your health requires it, ask for a “fast appeal”.*

- If you are appealing a decision we made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a “fast appeal.”
- The requirements for getting a “fast appeal” are the same as those for getting a “fast coverage decision.”

##### **Step 2: You, your representative, doctor, or other prescriber must contact Express Scripts Medicare and make your Level 1 appeal.** If your health requires a quick response, you must ask for a “fast appeal.”

- **For standard appeals, submit a written request or call Express Scripts Medicare.**
- **For fast appeals, either submit your appeal in writing or call Express Scripts Medicare.**
- **We must accept any written request**, including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website. Please be sure to include your name, contact information, and information regarding your claim to assist Express Scripts Medicare in processing your request.

- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting Express Scripts Medicare or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information in your appeal and add more information.** You and your doctor may add more information to support your appeal.

**Step 3: We consider your appeal and we give you our answer.**

- When we are reviewing your appeal, we take another careful look at all of the information about your coverage. We check to see if we were following all the rules when we said no to your request.
- We may contact you or your doctor or other prescriber to get more information.

***Deadlines for a “fast appeal”***

- For fast appeals, we must give you our answer **within 72 hours after we receive your appeal.** We will give you our answer sooner if your health requires it.
  - If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no and how you can appeal our decision.

***Deadlines for a “standard” appeal for a drug you have not yet received***

- For standard appeals, we must give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if you have not received the drug yet and your health condition requires Express Scripts Medicare to do so.
  - If we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage as quickly as your health requires, but no later than **7 calendar days** after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no and how you can appeal our decision.

***Deadlines for a “standard appeal” about payment for a drug you have already bought***

- We must give you our answer **within 14 calendar days** after we receive your request.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested,** we are also required to make payment to you within 30 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

**Step 4: If we say no to your appeal, you decide if you want to continue with the appeals process and make another appeal.**

- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process.

## Step-by-step: How to make a Level 2 appeal

### Legal Term

The formal name for the "independent review organization" is the "**Independent Review Entity**." It is sometimes called the "IRE."

The **independent review organization is an independent organization hired by Medicare**. It is not connected with Express Scripts Medicare and is not a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

### **Step 1: You (or your representative or your doctor or other prescriber) must contact the independent review organization and ask for a review of your case.**

- If we say no to your Level 1 appeal, the written notice we send you will include **instructions on how to make a Level 2 appeal** with the independent review organization. These instructions will tell who can make this Level 2 appeal, what deadlines you must follow, and how to reach the review organization. If, however, we did not complete our review within the applicable time frame, or make an unfavorable decision regarding "at-risk" determination under our drug management program, we will automatically forward your claim to the IRE.
- We will send the information we have about your appeal to this This information is called your "case file." **You have the right to ask Express Scripts Medicare for a copy of your case file.**
- You have a right to give the independent review organization additional information to support your appeal.

### **Step 2: The independent review organization reviews your appeal.**

- Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.

#### **Deadlines for "fast appeal"**

- If your health requires it, ask the independent review organization for a "fast "
- If the organization agrees to give you a "fast appeal," the organization must give you an answer to your Level 2 appeal **within 72 hours** after it receives your appeal request.

#### **Deadlines for "standard appeal"**

- For standard appeals, the review organization must give you an answer to your Level 2 appeal **within 7 calendar days** after it receives your appeal if it is for a drug you have not yet received. If you are requesting that we pay you back for a drug you have already bought, the review organization must give you an answer to your Level 2 appeal **within 14 calendar days** after it receives your

### **Step 3: The independent review organization gives you their answer.**

#### *For "fast appeals":*

- **If the independent review organization says yes to part or all of what you requested, we must provide the drug coverage that was approved by the review organization within 24 hours after we receive the decision from the review organization.**

#### *For "standard appeals":*

- **If the independent review organization says yes to part or all of your request for coverage, we must provide the drug coverage that was approved by the review organization within 72 hours after we receive the decision from the review organization.**
- **If the independent review organization says yes to part or all of your request to pay you back for a drug you already bought, we are required to send payment to you within 30 calendar days after we receive the decision from the review organization.**

### **What if the review organization says no to your appeal?**

**If this organization says no to part or all of your appeal**, it means they agree with our decision not to approve your request (or part of your request). (This is called “upholding the decision.” It is also called “turning down your appeal.”) In this case, the independent review organization will send you a letter:

- Explaining its decision.
- Notifying you of the right to a Level 3 appeal if the dollar value of the drug coverage you are requesting meets a certain amount. If the dollar value of the drug coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final.
- Telling you the dollar value that must be in dispute to continue with the appeals process.

**Step 4: If your case meets the requirements, you choose whether you want to take your appeal further.**

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator.

**Taking your appeal to Level 3 and beyond**

**Appeal Levels 3, 4 and 5 for Part D Drug Requests**

This section may be appropriate for you if you have made a Level 1 appeal and a Level 2 appeal, and both of your appeals have been turned down.

If the value of the drug you have appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. If the dollar amount is less, you cannot appeal any further. The written response you receive to your Level 2 appeal will explain who to contact and what to do to ask for a Level 3 appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

**Level 3 appeal**

**An Administrative Law Judge or an attorney adjudicator who works for the Federal government** will review your appeal and give you an answer.

- **If the answer is yes, the appeals process is over.** We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge or attorney adjudicator **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process *may or may not* be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

**Level 4 appeal**

The **Medicare Appeals Council (Council)** will review your appeal and give you an answer. The Council is part of the Federal government.

- **If the answer is yes, the appeals process is over.** We must **authorize or provide the drug coverage** that was approved by the Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, the appeals process *may or may not* be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.

- If you do not want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal or denies your request to review the appeal, the notice will tell you whether the rules allow you to go on to a Level 5 appeal. It will also tell you who to contact and what to do next if you choose to continue with your appeal.

**Level 5 appeal**

A judge at the **Federal District Court** will review your appeal

A judge will review all of the information and decide *yes* or *no* to your This is a final answer. There are no more appeal levels after the Federal District Court