

# Express Scripts Medicare® (PDP) for the State of Delaware

## Appeals Guide

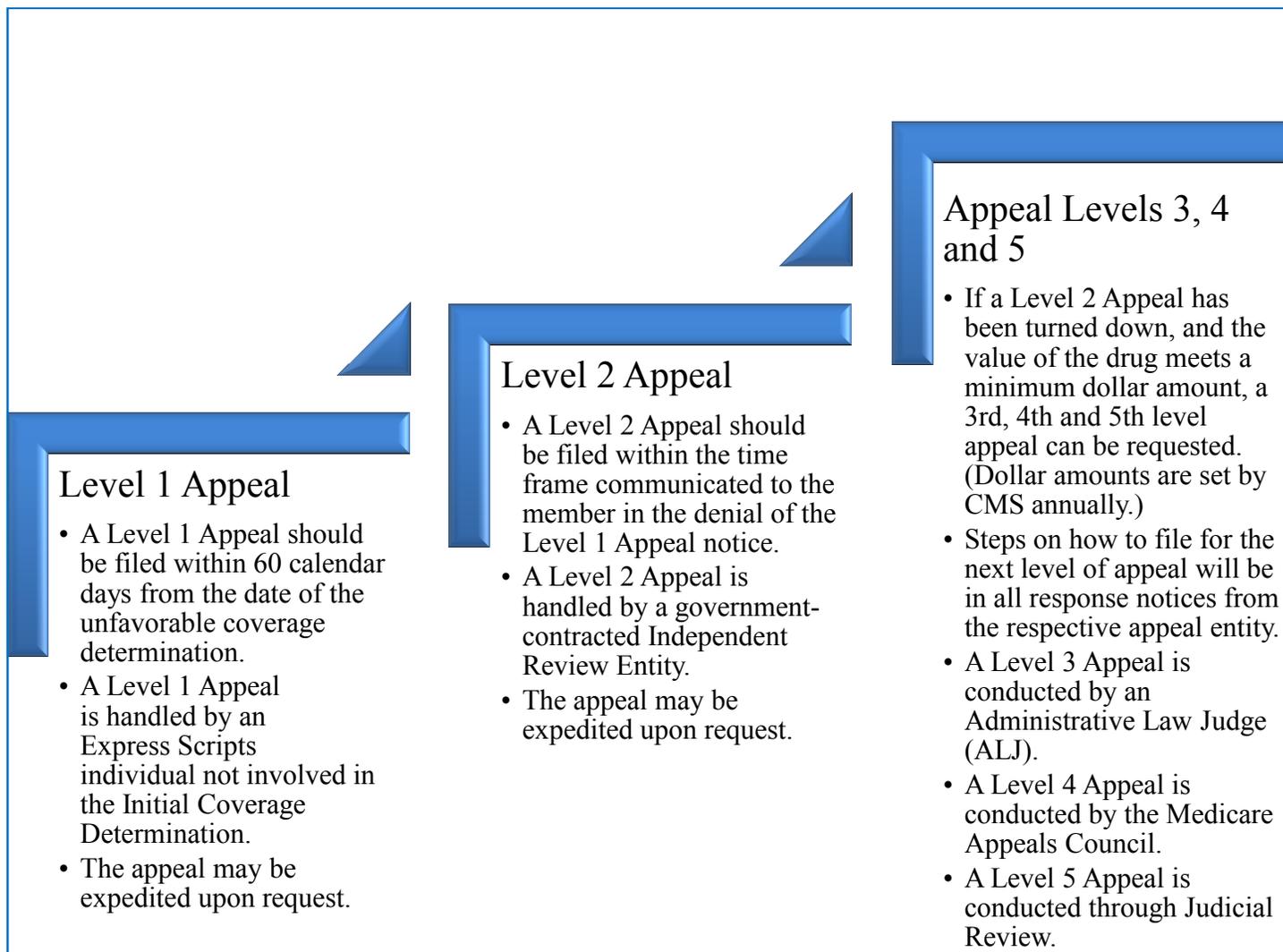
The appeals process deals with problems related to your benefits and coverage for prescription drugs, including problems related to payment. This is the process you would use for issues such as whether a drug is covered and in what way (for example, what tier the drug is on and if the drug has any restrictions or limitations).

### How do I request an appeal?

If we make a coverage decision and you are not satisfied with this decision, you can “appeal” the decision. An appeal is a formal way of asking **Express Scripts Medicare® (PDP)** to review and change a coverage decision we have made. To start an appeal, you, your doctor or your representative must contact us.

When you make an appeal, we review the coverage decision we have made to check to see if we were following all of the rules properly. Your appeal is handled by different reviewers than those who made the original unfavorable decision. When we have completed the review, we give you our decision.

The graphic below outlines the different levels of the appeal process, each of which follows in succession dependent on the factors noted below. Different entities are responsible for handling the different levels of appeal.



The chart below outlines the timing associated with making an initial decision and a Level 1 Appeal based on whether the appeal request is non-urgent (standard) or urgent (expedited).

Types of Process		Review Time Frames for Level 1 Appeals	
		Initial Decision	Level 1 Appeal (Redetermination Decision)
Non-Urgent (Standard) Appeal	Exceptions	No later than 72 hours from receipt of physician supporting information*	No later than 7 days from receipt of request
	Other Coverage Determinations	No later than 72 hours from receipt of request*	
Urgent (Expedited) Appeal	Exceptions	No later than 24 hours from receipt of physician supporting information*	No later than 72 hours from receipt of request
	Other Coverage Determinations	No later than 24 hours from receipt of request*	
Initial Request for Payment (submission of direct claim)		No later than 14 days from receipt of request	
Appeals Involving Requests for Payment (submission of direct claim)		No later than 7 days from receipt of request. If approved, payment must be issued no later than 30 days from receipt of request.	
*Notifications are made verbally within the time frame noted. Written notifications are then sent within 3 days from the date of verbal notification.			

For more information about the appeals process, including the time frames associated with appeal levels 2 – 5, contact Customer Service at **1.877.680.4883**, 24 hours a day, 7 days a week. TTY users should call **1.800.716.3231**. The steps for the process are also outlined in your *Evidence of Coverage* in **Chapter 7, What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**.

Below is additional contact information for coverage reviews and appeals.

<b>Administrative Coverage Reviews and Appeals Contact Information</b>	<b>Initial Clinical Coverage Reviews (Including Prior Authorization Requests) Contact Information</b>		
<p>If you need a decision about whether a medication is covered:  <b>Write to:</b>            Express Scripts            Attn: Medicare Administrative Appeals            P.O. Box 66587            St. Louis, MO 63166-6587</p> <p>If you need help right away:  <b>Call:</b> 1.800.413.1328  <b>TTY Users Call:</b> 1.800.716.3231  <b>Fax:</b> 1.877.328.9660  <b>Hours of Operation:</b> Monday through Friday, 8:00 a.m. to 6:00 p.m., Central Time</p>	<p>To request a Prior Authorization:  <b>Write to:</b>            Express Scripts            Attn: Medicare Reviews            P.O. Box 66571            St. Louis, MO 63166-6571</p> <p>If you need help right away:  <b>Call:</b> 1.844.374.7377 (1.844.ESI.PDPS)  <b>TTY Users Call:</b> 1.800.716.3231  <b>Fax:</b> 1.877.328.9799  <b>Hours of Operation:</b> 24 hours a day, 7 days a week</p> <tr> <th data-bbox="683 743 1292 785"><b>Clinical Appeals Contact Information</b></th> </tr> <tr> <td data-bbox="683 785 1292 1276"> <p>If you need to appeal an adverse determination:  <b>Write to:</b>            Express Scripts            Attn: Medicare Clinical Appeals            P.O. Box 66588            St. Louis, MO 63166-6588</p> <p>If you need help right away:  <b>Call:</b> 1.844.374.7377 (1.844.ESI.PDPS)  <b>TTY Users Call:</b> 1.800.716.3231  <b>Fax:</b> 1.877.852.4070  <b>Hours of Operation:</b> Monday through Friday, 8:00 a.m. to 8:00 p.m., Central Time</p> </td> </tr>	<b>Clinical Appeals Contact Information</b>	<p>If you need to appeal an adverse determination:  <b>Write to:</b>            Express Scripts            Attn: Medicare Clinical Appeals            P.O. Box 66588            St. Louis, MO 63166-6588</p> <p>If you need help right away:  <b>Call:</b> 1.844.374.7377 (1.844.ESI.PDPS)  <b>TTY Users Call:</b> 1.800.716.3231  <b>Fax:</b> 1.877.852.4070  <b>Hours of Operation:</b> Monday through Friday, 8:00 a.m. to 8:00 p.m., Central Time</p>
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**Can I get a temporary transition supply while I wait for an exception decision?**

As a new or continuing member in our plan, you may be taking drugs that are not covered from one year to the next. Or, you may be taking a drug that is covered but your ability to get it is limited. For example, you may need a prior authorization from us before you can fill your prescription. You should talk to your doctor to decide if you should switch to an appropriate drug that we cover or request an exception so that we will cover the drug you take. While you talk to your doctor to determine the right course of action for you, or while you wait for a coverage decision from us, we may cover a temporary transition supply of your drug in certain cases during the first 90 days that you are enrolled in the plan or at the start of a new coverage year.

For each of your drugs that has restrictions or limitations, we will cover a temporary transition supply when you go to a network pharmacy within the first 90 days of coverage. This temporary transition supply will be for at least 30 days, or less if your prescription is written for fewer days. In that case, you will be allowed multiple fills to provide up to a total of at least a 30-day supply of the medication.

If you are a resident of a long-term care facility, we will allow you to refill your prescription until we have provided you with a 98-day transition supply, consistent with the dispensing increment (unless you have a prescription written for fewer days). We will cover more than one refill of these drugs for the first 90 days you are a member of our plan. If you need a drug that has restrictions or limitations but you are past the first 90 days

of membership in our plan, we will cover a 31-day emergency transition supply of that drug (unless you have a prescription written for fewer days) while you pursue an exception.

Other times when we will cover at least a temporary 30-day transition supply (or less, if you have a prescription written for fewer days) include:

- When you enter a long-term care facility
- When you leave a long-term care facility
- When you are discharged from a hospital
- When you leave a skilled nursing facility
- When you cancel hospice care
- When you are discharged from a psychiatric hospital with a medication regimen that is highly individualized

Express Scripts Medicare will send you a letter within 3 business days after you receive a temporary transition supply to notify you that the prescription was provided as a temporary supply and to explain your options.

### **Some additional notes about rights to appeal**

The Centers for Medicare & Medicaid Services (CMS) requires pharmacies to advise members of their rights when a prescription cannot be filled under the Part D benefit and the issue cannot be resolved at the point of sale. Pharmacies are required to distribute notices instructing members to contact their plan in order to obtain a coverage determination if they disagree with the information provided by the pharmacist. If the plan denies your request for a coverage determination, information about your appeal rights and instructions for filing an appeal are included in the notice of denial. All Medicare beneficiaries have the right to appeal the plan's coverage decision.