Coverage Determinations, Appeals and Grievances

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Filing a grievance (making a complaint) about your prescription coverage

A grievance is a complaint other than one that involves a request for a coverage determination. The complaint process is used for certain types of problems only. This includes problems related to quality of care, waiting times, and the customer service you receive. Grievances do not involve problems related to approving or paying for Medicare Part D drugs.

Some types of problems that might lead to filing a grievance include:
- Issues with the service you receive from Customer Service.
- If you feel that you are being encouraged to leave (disenroll from) the plan.
- If you disagree with our decision not to give you a “fast” decision or a “fast” appeal.
- We don’t give you a decision within the required time frame.
- We don’t give you required notices.
- You believe our notices and other written materials are hard to understand.
- Waiting too long for prescriptions to be filled.
- Rude behavior by network pharmacists or other staff.
- We don’t forward your case to the Independent Review Entity if we do not give you a decision on time.

If you have any of these problems and want to make a complaint, it is called “filing a grievance.”

Who may file a grievance
You or someone you name may file a grievance. The person you name would be your “representative.” You may name a relative, friend, lawyer, advocate, doctor or anyone else to act for you. Other persons may already be authorized by the Court or in accordance with State law to act for you.

If you want someone to act for you who is not already authorized by the Court or under State law, you and that person must sign and date a statement granting the person legal
permission to be your representative. To learn how to name your representative, call UnitedHealthcare® Customer Service.

**Filing a grievance with our plan**
The process for making a complaint is different from the process for coverage decisions and appeals. If you have a complaint, you or your representative may call the phone number for Medicare Part D Grievances (for complaints about Medicare Part D drugs) listed on the back of your member ID card. We will try to resolve your complaint over the phone.

If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.

- Submit a written request for a grievance by completing the Medicare Plan Appeals & Grievances Form (PDF) and mailing it to the Medicare Part D Appeals & Grievance Dept. at PO Box 6106, M/S CA 124-0197, Cypress CA 90630-9948; or
- You may fax your written request toll-free to 1-866-308-6294.

If you ask for a written response, file a written grievance, or your complaint is related to quality of care, we will respond in writing.

If you are making a complaint because we denied your request for a “fast coverage decision” or a “fast appeal,” we will automatically give you a “fast” complaint. If you have a “fast” complaint, it means we will give you an answer within 24 hours.

- You may submit a written request for a Fast Grievance to the Medicare Part D Appeals & Grievance Dept. at PO Box 6106, M/S CA 124-0197, Cypress CA 90630-9948; or
- You may fax your written request toll-free to 1-866-308-6296; or
- You may contact UnitedHealthcare at 1-866-314-8188, TTY: 711 from 8:00 a.m.–8:00 p.m. local time, 7 days a week to file an expedited Grievance.

Please be sure to include the words “fast”, “expedited” or “24-hour review” on your request.

Whether you call or write, you should contact Customer Service right away. The complaint must be made within 60 calendar days after you had the problem you want to complain about. If possible, we will answer you right away. If your health condition requires us to answer quickly, we will do that. Most complaints are answered in 30 calendar days.
If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we do not agree with some or all of your complaint or don’t take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

Go to View plans and pricing to view the Evidence of Coverage. For prescription drug plans, view chapter 7 of the Evidence of Coverage. For Medicare Advantage plans, view Chapter 9.

60-day formulary change notice

Notice of Formulary Changes will be posted 60 days prior to the removal or change in the preferred or tiered cost-sharing status of a Medicare Part D drug. The posting will include:

- The name of the affected covered Medicare Part D drug.
- Information on whether the covered Medicare Part D drug is being removed from the formulary, or changing its preferred or tiered cost-sharing status.
- The reason the covered Medicare Part D drug is being removed from the formulary, or changing its preferred or tiered cost-sharing status.
- Alternative drugs in the same therapeutic category, class or cost-sharing tier, and the expected cost sharing for that drug.
- The means by which members may obtain an updated coverage determination or an exception to a coverage determination.

Asking for a coverage determination (coverage decision)

An initial coverage determination is also called a coverage decision. A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your prescription drugs covered under the Part D benefit included in your plan. We are making a coverage decision for you whenever we decide what is covered for you and how much we pay. In some cases we might decide a drug is not covered or is no longer covered by Medicare for you. If you (or your doctor) don’t agree with our coverage decision, you (or your doctor) may file an appeal.

In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn’t covered under your plan, that isn’t a coverage determination. You need to call or write to us to ask for a formal decision about the coverage.
Drug requirements and limitations
For certain prescription drugs, special rules restrict how and when the plan covers them. A team of doctors and pharmacists developed these rules to help our members use drugs in the most effective ways. These special rules also help control overall drug costs, which keeps your drug coverage more affordable. Some covered drugs may have restrictions that help ensure safe, effective and affordable drug use. If there is a restriction for your drug, it usually means that you (or your doctor) will have to use the coverage decision process and ask us to make an exception. We may or may not agree to waive the restriction for you.

You can find out if your drug has any restrictions by looking for the abbreviations next to the drug names in the plan’s Drug List. To find the plan’s drug list go to View plans and pricing and enter your ZIP code Choose one of the available plans in your area and view the plan details. You’ll find the form you need in the Helpful Resources section.

Restrictions on your drug apply to retail and mail service. These may include:

**Prior Authorization (PA)**
The plan requires you or your doctor to get prior authorization for certain drugs. This means the plan needs more information from your doctor to make sure the drug is being used correctly for a medical condition covered by Medicare. If you don't get approval, the plan may not cover the drug.

**Quantity Limits (QL)**
The plan will cover only a certain amount of this drug, or a cumulative amount across a category of drugs (such as opioids), for one copay or over a certain number of days. These limits may be in place to ensure safe and effective use of the drug. If your doctor prescribes more than this amount or thinks the limit is not right for your situation, you and your doctor can ask the plan to cover the additional quantity.

**Step Therapy (ST)**
There may be effective, lower-cost drugs that treat the same medical condition as this drug. You may be required to try one or more of these other drugs before the plan will cover your drug. If you have already tried other drugs or your doctor thinks they are not right for you, you and your doctor can ask the plan to cover this drug.

**Medicare Part B or Medicare Part D Coverage Determination (B/D)**
Depending on how this drug is used, it may be covered by either Medicare Part B (doctor and outpatient health care) or Medicare Part D (prescription drugs). Your doctor may need to provide the plan with more information about how this drug will be used to make sure it’s correctly covered by Medicare.

NOTE: If you do not get approval from the plan for a drug with a requirement or limit before using it, you may be responsible for paying the full cost of the drug.
IN ADDITION TO THE ABOVE, YOU CAN ASK THE PLAN TO MAKE THE FOLLOWING EXCEPTIONS TO THE PLAN’S COVERAGE RULES

You (and your doctor) can ask the plan to make an exception to the coverage rules. There are several types of exceptions that you can ask the plan to make.

Formulary Exceptions

- You can ask the plan to cover your drug even if it is not on the plan’s drug list (formulary). If a formulary exception is approved, the non-preferred brand copay will apply. You cannot ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.

Cost-Sharing Exceptions

- If your drug is in a cost-sharing tier you think is too high, you and your doctor can ask the plan to make an exception in the cost-sharing tier so that you pay less for it.
- Drugs in some of our cost-sharing tiers are not eligible for this type of exception. For example, if we grant your request to cover a drug that is not in the plan’s Drug List, we cannot lower the cost-sharing amount for that drug. In addition:
  - Tier exceptions are not available for drugs in the Specialty Tier.
  - Tier exceptions are not available for drugs in the Preferred Generic Tier.
  - Tier exceptions are not available for branded drugs in the higher tiers if you ask for an exception for reduction to the generic-only tier level.
  - Tier exceptions may be granted only if there are alternatives in the lower tiers used to treat the same condition as your drug.

Generally, the plan will only approve your request for an exception if your doctor provides information that the alternative drugs included in the plan’s formulary, the lower-tiered drug or additional utilization restrictions would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

An exception is a type of coverage decision. Similar to other types of coverage decisions, if we turn down your request for an exception, you can appeal our decision.

How to request a coverage determination (including benefit exceptions)

Call the UnitedHealthcare Customer Service number to request a coverage determination (coverage decision). When requesting a formulary or cost-sharing exception, or asking for the plan to cover an additional amount of a drug with a quantity limit or asking for the plan to waive a step therapy requirement, a statement from your doctor supporting your request is required. Usually, the coverage decision will be made within 72 hours after we receive the request or your doctor’s supporting statement (if required).

You can request an expedited (fast) coverage decision if you or your doctor believe that your health could be seriously harmed by waiting up to 72 hours for a decision. If your request to expedite is granted, we must give you a decision no later than 24 hours after we receive your request or prescribing doctor’s supporting statement (if required).
If you are a continuing member in the plan, you may notice that a formulary medication which you are currently taking is either not on the 2018 Drug List or its cost sharing or coverage is limited in the upcoming year. If you are affected by a change in drug coverage you can:

- Work with your doctor (or other prescriber) and ask the plan to make an exception to cover the drug. If we approve your request before the new plan year, you’ll be able to get your drug at the start of the new plan year.
- Find a different drug that we cover. You can call Customer Service to ask for a list of covered drugs that treat the same medical condition. You should discuss that list with your doctor, who can tell you which drugs may work for you.

In some situations, we will cover a **one-time**, temporary supply. During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug.

To initiate a coverage determination request, please contact UnitedHealthcare at **1-866-314-8188, TTY:711** from 8:00 a.m.–8:00 p.m. local time, 7 days a week. Have the following information ready when you call:

- Member name
- Member date of birth
- Medicare Part D Member ID number
- Name of the medication
- Physician’s name
- Physician's phone number
- Physician fax number (if available)

You may also request a coverage decision/exception by logging on to www.optumrx.com and submitting a request. If you are a new user with www.optumrx.com, you will need to register before you can access the Prior Authorization request tool. Once you have registered, you will find the Prior Authorization tool under Health Care Professionals > Healthcare Provider Tools > Prior Authorizations. Once your request has been submitted, we will attempt to contact your doctor to get a supporting statement and/or additional clinical information needed to make a decision.

Download this form to request an exception:

- [Medicare Part D Coverage Determination Request Form (PDF)](link to www.optumrx.com) – for use by members and providers
This is a CMS-model exception and prior authorization request form developed specifically for use by all Medicare Part D prescribing physicians or members. You may use this form or the Prior Authorization Request Forms listed below. The Prior Authorization Department will accept both request forms.

- Medication Prior Authorization Request Form (PDF)
  Note: PDF (Portable Document Format) files can be viewed with Adobe® Reader®. If you don’t already have this viewer on your computer, download it free from the Adobe website.

To initiate a request, providers may contact UnitedHealthcare at 1-866-314-8188, TTY:711 from 8:00 a.m.–8:00 p.m. local time, 7 days a week or fax toll-free to 1-800-527-0531 for Standard Prior Authorization or 1-800-853-3844 for Specialty Prior Authorization. The plan’s decision on your exception request will be provided to you by telephone and/or mail. In addition, the initiator of the request will be notified by telephone or and/fax.

To inquire about the status of a coverage decision, contact UnitedHealthcare at 1-866-314-8188, TTY:711 from 8:00 a.m.–8:00 p.m. local time, 7 days a week.

Go to View plans and pricing to view the Evidence of Coverage. For prescription drug plans, view Chapter 7 of the Evidence of Coverage. For Medicare Advantage plans, view Chapter 9.

Note: Existing plan members who have already completed the coverage determination process for their medications in 2017 may not be required to complete this process again. If you have obtained approval this year, please refer to the approved through date provided on your approval letter to determine when your approval expires. After the date of expiration on your approval letter, you will need to obtain a new approval in order for the plan to continue to cover the drug, if the drug still requires review and you and your doctor feel it is needed.

What happens if we deny your request?
If we deny your request, we will send you a written reply explaining the reasons for denial. If an initial decision does not give you all that you requested, you have the right to appeal the decision. See How to appeal a decision about your prescription coverage.

How to appoint a representative to help you with a coverage determination or an appeal
The representative can be a permanent one, such as a Power of Attorney, or it can be someone you name to help you only during the coverage determination case. Download the representative form.

Both you and the person you have named as an authorized representative must sign the representative form. This statement must be sent to UnitedHealthcare, PO Box 6106, M/S
CA 124-0197, Cypress CA 90630-9948. If your prescribing doctor calls on your behalf, no representative form is required.

Making 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 us to review and change a coverage decision we have made.

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.

How to appeal a decision about your prescription coverage

Appeal Level 1 - You may ask us to review an adverse coverage decision we’ve issued to you, even if only part of our decision is not what you requested. An appeal to the plan about a Medicare Part D drug is also called a plan "redetermination."

Appeal Level 2 – If we reviewed your appeal at “Appeal Level 1” and did not decide in your favor, you have the right to appeal to the Independent Review Entity (IRE).

When we receive your request to review the adverse coverage determination, we give the request to people at our organization not involved in making the initial determination. This helps ensure that we give your request a fresh look.

To file an appeal:

- Write a letter describing your appeal, and include any paperwork that may help in the research of your case. Provide your name, your member identification number, your date of birth, and the drug you need. You may also request an appeal by downloading and mailing in the Redetermination Request Form (PDF)

- Send the letter or the Redetermination Request Form to the Medicare Part D Appeals and Grievance Department PO Box 6106, M/S CA 124-0197, Cypress CA 90630-9948. You may also fax your letter of appeal to the Medicare Part D Appeals and Grievances Department toll-free at 1-866-308-6294. You must mail your letter within 60 days of the date the adverse determination was issues, or within 60 days from the date of the denial of reimbursement request. If you missed the 60-day deadline, you may still file your appeal if you provide a valid reason for missing the deadline.

Note: if you are requesting an expedited (fast) appeal, you may also call UnitedHealthcare at 1-866-314-8188, TTY:711 from 8:00 a.m.–8:00 p.m. local time, 7 days a week
• The Medicare Part D Appeals and Grievance Department will look into your case and respond with a letter within 7 calendar days of receiving your request. You'll receive a letter with detailed information about the coverage denial.

• The information on how to file a Level 1 Appeal can also be found in the adverse coverage decision letter.

To inquire about the status of an appeal, contact UnitedHealthcare at 1-866-314-8188, TTY:711 from 8:00 a.m.–8:00 p.m. local time, 7 days a week

**Who may file your appeal of the coverage determination?**
If you are appealing a coverage decision about a Medicare Part D drug, you, your authorized representative, or a prescriber (or his or her office staff) may file a standard appeal request or a fast appeal request.

**How soon must you file your appeal?**
You must file the appeal request within 60 calendar days from the date included on the notice of our initial determination. We may give you more time if you have a good reason for missing the deadline.

**How soon will we decide on your appeal?**

• For a standard decision regarding reimbursement for a Medicare Part D drug you have paid for and received and for standard appeal review requests for drugs you have not yet received:

  We will give you our decision within 7 calendar days of receiving the appeal request. If we do not give you our decision within 7 calendar days, your request will automatically go to Appeal Level 2 (Independent Review Entity).

• For a fast decision about a Medicare Part D drug that you have not yet received.

  We will give you our decision within 72 hours after receiving the appeal request. If we do not give you our decision within 72 hours, your request will automatically go to Appeal Level 2.

**Next steps if the plan says "no"**
If you asked for Medicare Part D drugs or payment for Medicare Part D drugs and we did not rule completely in your favor at Appeal Level 1, you may file an appeal with the Independent Review Entity (Appeal Level 2).

If you choose to appeal, you must send the appeal request to the Independent Review Entity (IRE). The decision you receive from the plan (Appeal Level 1) will tell you how to file the appeal, including who can file the appeal and how soon it must be filed. You must file your appeal within 60 days from the date on the letter you receive.
To obtain an aggregate number of the plan's grievances, appeals and exceptions please contact UnitedHealthcare at 1-866-314-8188, TTY: 711 from 8:00 a.m.–8:00 p.m. local time, 7 days a week.

The following information about your Medicare Part D Drug Benefit is available upon request:

- Information on the procedures used to control utilization of services and expenditures.
- Information on the number and disposition in the aggregate of appeals and quality of care grievances filed by those enrolled in the plan.
- A summary of the compensation method used for physicians and other health care providers.
- A description of our financial condition, including a summary of the most recently audited statement.

**Quality assurance policies and procedures**
The Utilization Management/Quality Assurance (UM/QA) program is designed to help ensure safe and appropriate use of prescription drugs covered under Medicare Part D. This program focuses on reducing adverse drug events and drug interactions, optimizing medication utilization, and providing incentives to reduce costs when medically appropriate. UnitedHealthcare offers the UM/QA program at no additional cost to its members and their providers.

**Utilization management**
The UM/QA program incorporates utilization management tools to encourage appropriate and cost-effective use of Medicare Part D prescription drugs. These tools include, but are not limited to: prior authorization, clinical edits, quantity limits and step therapy.

**Quality assurance**
As part of the UM/QA program, all prescriptions are screened by drug utilization review systems developed to detect and address the following clinical issues:

- Clinically significant drug interactions
- Therapeutic duplication
- Inappropriate or incorrect drug therapy
- Patient-specific drug contraindications
- Over-utilization and under-utilization
- Abuse or misuse

The UM/QA program helps ensure that a review of prescribed therapy is performed before each prescription is dispensed. These concurrent drug reviews are implemented as clinical edits at the point-of-sale or point-of-distribution.
In addition, retrospective drug utilization reviews identify inappropriate or medically unnecessary care. We perform ongoing, periodic review of claims data to evaluate prescribing patterns and drug utilization that may suggest potentially inappropriate use.

Carefully weigh the differences in drug lists against the plan costs and other features when choosing a plan that may be a good fit for you. The Drug List may change at any time. You will receive notice when necessary.

**Tier 2: Generic. Low Copay**
This tier includes most generic drugs. Use Tier 2 drugs, instead of drugs in Tiers 3 or 4 to help reduce your out-of-pocket costs.

**Tier 3: Preferred Brand. Medium Copay.**
This tier includes many common brand name drugs, called preferred brands, and some higher-cost generic drugs. Many Tier 3 drugs have lower-cost options in Tier 1 or 2. Ask your doctor if they could work for you.

**Tier 4: Non-Preferred Drug. Highest Copay.**
This tier includes higher cost generic and brand name drugs. Many Tier 4 drugs have lower-cost options in Tier 1, 2 or 3. Ask your doctor if you can switch to one of these drugs to help reduce your out-of-pocket costs.

**Tier 5: Specialty Tier. Coinsurance.**
This tier includes unique and/or very high-cost drugs. You pay a percentage of the total drug cost, called coinsurance.