Appeals, Coverage Determinations and Grievances

Medicare Complaint Form

Appeals

Who can file an Appeal?

An appeal may be filed by any of the following:

- You may file an appeal.
- Someone else may file the appeal for you on your behalf. You may appoint an individual to act as your representative to file the appeal for you by following the steps below:
    - Provide your Medicare Advantage health plan with your name, your Medicare number and a statement, which appoints an individual as your representative. (Note: you may appoint a physician or a Provider.) For example: "I [your name] appoint [name of representative] to act as my representative in requesting an appeal from your Medicare Advantage health plan regarding the denial or discontinuation of medical services."
    - You must sign and date the statement.
    - Your representative must also sign and date this statement.
    - You must include this signed statement with your appeal.
    - **Click here** to find and download the CMS Appointment of Representation form.
    - Please refer to your plan's Appeals and Grievance process located in Chapter 9: What to do if you have a problem or complaint (coverage decisions, appeals, complaints) of the Evidence of Coverage Document or your plan's member handbook.

Medicare Complaint Form

What is an Appeal?

An appeal is a type of complaint you make when you want a reconsideration of a decision (determination) that was made regarding a service, or the amount of payment your Medicare Advantage health plan pays or will pay for a service or the amount you must pay for a service.

When can an Appeal be filed?

You may file an appeal within sixty (60) calendar days of the date of the notice of the initial coverage decision. For example, you may file an appeal for any of the following reasons:

- your Medicare Advantage health plan refuses to cover or pay for services you think your Medicare Advantage health plan should cover.

- your Medicare Advantage health plan or one of the Contracting Medical Providers refuses to give you a service you think should be covered.
- your Medicare Advantage health plan or one of the Contracting Medical Providers reduces or cuts back on services you have been receiving.
- if you think that your Medicare Advantage health plan is stopping your coverage too soon.

Note: The sixty (60) day limit may be extended for good cause. Include in your written request the reason why you could not file within the sixty (60) day timeframe.

Where can an Appeal be filed?

An appeal may be filed in writing directly to us, calling us or submitting a form electronically.

How do I start an Appeal?

To start your appeal, you, your doctor or other provider, or your representative must contact us.

You can call us at **1-866-842-4968** (TTY 7-1-1), 8 a.m. – 8 p.m. local time, 7 days a week.

Customer Service also has free language interpreter services available for non-English speakers.

You can submit a Part C request to the following address:

UnitedHealthcare Community Plan
Attn: Part D Standard Complaint and Appeals Department
P.O. Box 6106 MS CA 124-0157
Cypress, CA 90630-0016
Fax: 1-888-517-7113 Expedited Fax: 1-866-373-1081
8 a.m. – 8 p.m. local time, 7 days a week.

For an Expedited Part C Appeal: You, your prescriber, or your representative should contact us by telephone **1-877-262-9203** TTY 711, or expedited fax at Expedited Fax: 1-866-373-1081, TTY 711, 8 a.m. – 8 p.m. local time, 7 days a week. Monday through Friday.

You can submit a Part D request to the following address:

UnitedHealthcare Community Plan
Attn: Part D Standard Complaint and Appeals Department
P.O. Box 6106 Cypress, CA 90630-9948
Fax: 1-866-308-6294 Expedited Fax: 1-866-308-6296

Or you can call us at: **1-888-867-5511**TTY 711.
Available 8 a.m. - 8 p.m. local time, 7 days a week

Why file an Appeal?

You may use the appeal procedure when you want a reconsideration of a decision (organization determination) that was made regarding a service or the amount of payment your Medicare Advantage health plan paid for a service.

Fast Decisions/Expedited Appeals

You have the right to request and receive expedited decisions affecting your medical treatment in "Time-Sensitive" situations. A Time-Sensitive situation is a situation where waiting for a decision to be made within the timeframe of the standard decision-making process could seriously jeopardize:

- your life or health, or
- your ability to regain maximum function.

If your Medicare Advantage health plan or your Primary Care Provider decides, based on medical criteria, that your situation is Time-Sensitive or if any physician calls or writes in support of your request for an expedited review, your Medicare Advantage health plan will issue a decision as expeditiously as possible, but no later than seventy-two (72) hours plus (14) calendar days, if an extension is taken, after receiving the request.

Medicare Complaint Form

Coverage Determination

Asking for a coverage determination (coverage decision)

The process for coverage decisions and making appeals deals with problems related to your benefits and coverage for prescription drugs, including problems related to payment. This is the process you use for issues such as whether a drug is covered or not and the way in which the drug is covered.

An initial coverage decision about your Part D drugs is called a "coverage determination.", or simply put, 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. 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 disagree with this coverage decision, you can make an appeal.

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 additional requirements or limits that help ensure safe, effective and affordable drug use. And some drugs may require a coverage determination to verify whether they are covered by the Medicare Part D plan. The coverage determination process allows you or your prescriber to request coverage of drugs with additional requirements or ask for exceptions to your benefits.

You can find out if your drug has any additional requirements or limits 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 "Find a Drug" and download your plan's Formulary.

Some drugs covered by the Medicare Part D plan have "limited access" at network pharmacies because:

- The FDA says the drug can be given out only by certain facilities or doctors
- These drugs may require extra handling, provider coordination or patient education that can't be done at a network pharmacy

Requirements and limits 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 for one co-pay 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 are 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 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 co-pay will apply.

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 a tier that does not contain branded drugs used for your condition.
    - Tier exceptions are not available for biological (injectable) drugs if you ask for an exception for reduction to a tier that does not contain other biological (injectable) drugs.
    - 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 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 tiering 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 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 2020 formulary 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, 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.

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 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 the Health Tools Menu. Once your request has been submitted, we will attempt to contact your prescriber 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)(54.6 KB) – 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.

To have your doctor make a request

Your doctor or provider can contact UnitedHealthcare at **1-800-711-4555** for the Prior Authorization department to submit a request, or fax toll-free to 1-844-403-1028. The plan's decision on your exception request will be provided to you by telephone or mail. In addition, the initiator of the request will be notified by telephone or fax.

Your doctor can also request a coverage decision by going to **www.professionals.optumrx.com**.

To inquire about the status of a coverage decision, contact UnitedHealthcare.

Please refer to your plan's Appeals and Grievance process located in Chapter 9: What to do if you have a problem or complaint (coverage decisions, appeals, complaints) of the Evidence of Coverage document or your plan's member handbook.

Note: Existing plan members who have already completed the coverage determination process for their medications in 2020 may not be required to complete this process again.

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. **Click here** to find and download the CMS Appointment of Representation form.

Both you and the person you have named as an authorized representative must sign the representative form.

For Coverage Determinations

OptumRX Prior Authorization Department
P.O. Box 25183
Santa Ana, CA 92799
Fax: 1-844-403-1028

For Appeals

Medicare Part D Appeals and Grievance Department
PO Box 6103, M/S CA 124-0197
Cypress, CA 90630-9948
Fax: 1-866-308-6294

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 FormOpens in a new tab** or by secure email.
- Send the letter or the **Redetermination Request FormOpens in a new tab** to the Medicare Part D Appeals and Grievance Department at:

P.O. Box 6106
M/S CA 124-0197
Cypress CA 90630-9948

- Or you can fax it to the UnitedHealthcare Medicare Plans - AOR toll-free at 1-866-308-6294. Or you can call 1-800-595-9532 TTY 711 8 a.m. - 5 p.m. local time, Monday – Friday.
- You must mail your letter within 60 days of the date of adverse determination was issued, or within 60 days from the date 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.
- The 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.

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 and 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.

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.

Medicare Complaint Form

Grievances

Who can file a Grievance?

A grievance may be filed by any of the following:

- You may file a grievance.
- Someone else may file the grievance for you on your behalf. You may appoint an individual to act as your representative to file the grievance for you by following the steps below:
    - Provide your Medicare Advantage health plan with your name, your Medicare number and a statement, which appoints an individual as your representative. (Note: you may appoint a physician or a Provider.) For example: "I [*your name*] appoint [*name of representative*] to act as my representative in requesting a grievance from your Medicare Advantage health plan regarding the denial or discontinuation of medical services."
    - You must sign and date the statement.
    - Your representative must also sign and date this statement.
    - You must include this signed statement with your grievance.

What is a Grievance?

A grievance is a type of complaint you make if you have a complaint or problem that does not involve payment or services by your Medicare Advantage health plan or a Contracting Medical Provider. For example, you would file a grievance: if you have a problem with things such as the quality of your care during a hospital stay; you feel you are being encouraged to leave your plan; waiting times on the phone, at a network pharmacy, in the waiting room, or in the exam room; waiting too long for prescriptions to be filled; the way your doctors, network pharmacists or others behave; not being able to reach someone by phone or obtain the information you need; or lack of cleanliness or the condition of the doctor's office.

When can a Grievance be filed?

You may file a grievance within sixty (60) calendar days of the date of the circumstance giving rise to the grievance.

Note: The sixty (60) day limit may be extended for good cause. Include in your written request the reason why you could not file within the sixty (60) day timeframe.

Expedited Grievance

You have the right to request an expedited grievance if you disagree with your Medicare Advantage health plan's decision to invoke an extension on your request for an organization determination or reconsideration, or your Medicare Advantage health plan's decision to process your expedited reconsideration request as a standard request. In such cases, your Medicare Advantage health plan will respond to your grievance within twenty-four (24) hours of receipt.

Where can a Grievance be filed?

A grievance may be filed in writing directly to us.

Why file a Grievance?

You are encouraged to use the grievance procedure when you have any type of complaint (other than an appeal) with your Medicare Advantage health plan or a Contracting Medical Provider, especially if such complaints result from misinformation, misunderstanding or lack of information.

Grievance, Coverage Determinations and Appeals

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.

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 Grievances listed on the back of your member ID card. We will try to resolve your complaint over the phone.

You can call us at **1-866-842-4968** (TTY 7-1-1), 8 a.m. – 8 p.m. local time, 7 days a week.

Customer Service also has free language interpreter services available for non-English speakers.

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 to Part C & D Grievances:

UnitedHealthcare Community Plan
Attn: Complaint and Appeals Department
P.O. Box 6106,
Cypress CA 90630-9948

Or

Expedited Fax: 1-**866-308-6296**
Standard Fax: 1-**866-308-6294**

If you ask for a written response, file a written grievance, or if 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 "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.

1. You may submit a written request for a Fast Grievance to the Medicare Part D Appeals & Grievance Dept. at:

P.O. Box 6106
Cypress, CA 90630-9948

2. You may fax your written request toll-free to **1-866-308-6296**; or

3. You may contact UnitedHealthcare 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.

- Please refer to your plan’s Appeals and Grievance process located in Chapter 9: What to do if you have a problem or complaint (coverage decisions, appeals, complaints) of the Evidence of Coverage document or your plan’s member handbook.

Medicare Complaint Form