**Compass - Appeals**

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**Description:** Instructions for when an Appeal is requested. An Appeal is a request for the plan to re-review a decision made regarding the coverage of a drug.

**Note:** Applies to **Commercial clients ONLY**, not MED D or EGWP. For Medicare Part D beneficiaries, review the Med D CIF for the client. Once you have confirmed that our PBM handles the Appeals process, refer to [Compass MED D - CCR - Coverage Determinations and Redeterminations (Appeals) (064997)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=a23bc09d-37f7-4105-ba57-d4e9d7f512ff).

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| Requesting an Appeal |

An Appeal is a request to reprocess a denied review. Plan specific steps to request an Appeal are provided to the member and provider within the denial letter.

 **Reminders for PBO managed Appeals:**

* Appeals should not be offered until all other alternatives have been explored. Run a Test Claim and explore alternatives listed.
* To request an Appeal, there must be at least one denial of a request for coverage on file. If there is no denial on file, an Appeal cannot be requested. Refer to [Compass - Prior Authorization, Exceptions, Appeals Guide (063978)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=657ddfe3-27d1-4a21-8f51-8cbd3961001c).Typically, an Appeal must be submitted within 180 calendar days of the denial.
* Do **not** transfer the member to the Appeal Department.
* Do **not** provide Appeal Department phone number to the member; the member should contact their Provider for all Appeal updates regarding denial reasons or pending statuses if not viewable in Compass.
* A **fully authorized** Third-Party caller may initiate an Appeal. Third Party callers must provide the information for the Appeal process and written consent from the member for Provider’s office to file an appeal on member’s behalf.

**Notes:**

* Any letter after the PA number identifies this as an appeal. Letters may vary based on the specifics of the appeal.
* **Specialty Medications** warm transfer the member to Specialty Customer Care (**1-800-237-2767**). If the Provider’s office is calling about Specialty medication for Prior Authorization/Appeal, warm transfer to Specialty PA Department (**1-866-814-5506**).

Perform the steps below:

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| **Step** | **Action** | |
| **1** | Review the CIF to determine if our PBM handles Appeals for the member.   * If we do not handle Appeals, follow the instructions listed in the **CIF**.   + If there is no information after clicking on the Appeal Process tab in the **CIF**, call the Senior Team for assistance. * If we handle Appeals, proceed to the **next step.** | |
| **2** | From the **Claims Landing Page,** click **Create Test Claim**, to check coverage on the medication and determine the reject reason. Refer to [Compass - Test Claims (050041)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=60c20ea0-1d07-46e3-809a-b54734b80fbe) as needed to clarify coverage for that drug.  **Notes:**   * If Test Claim is accepted, educate the member, and clarify coverage for the drug. * If test claim rejects, educate member on rejection, and proceed to **next step.** * If member advises the coverage is incorrect or a request for coverage has already been submitted, proceed to **next step.** * For **Reject Examples**, refer to the [Scenario Guide](#_Scenario_Guide).   A screenshot of a computer  Description automatically generated | |
| **3** | From the **Quick Actions** panel on the Claims Landing Page, click the **Override/PA History** hyperlink.    **Result:** Override History, PA Status, and ePA sections will display.  A screenshot of a computer  AI-generated content may be incorrect. | |
| **4** | Navigate to the **PA Status** section and click on the **ID #** hyperlink to review the **Member Facing Information** section of the PA Status pop-up and verify there is at least one denied request for coverage on file and it has **not** been more than 180 calendar days since the original denial.  c A screenshot of a computer  AI-generated content may be incorrect. | |
| **If there is…** | **Then…** |
| A denied request for coverage on file and it has **not** been more than 180 calendar days since the original denial | Proceed to the **next step**. |
| **No** denied request for coverage on file or it has been more than 180 calendar days since the original denial | Submit an ePA request. Refer to [Compass - Prior Authorization, Exceptions, Appeals Guide (063978)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=657ddfe3-27d1-4a21-8f51-8cbd3961001c) and [Compass - Initiating an ePA Request (055814)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=18bb86b7-af5b-4f25-af23-9c635e8a0aa4). |
| **5** | Advise the member of the **Denial** reason in the PA Status pop-up.    **Notes:** Advise a copy of the denial letter will be mailed to them.  You may choose to pay out of pocket for the medication or discuss alternative medications with your provider.  If you would like, I will be happy to search for potentially cost-saving alternatives that may not require an approval request. | |
| **If the member…** | **Then…** |
| Agrees | Offer alternatives. Refer to [Compass - Viewing and Running Test Claims for Alternative Rxs (056849)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=b3dbfb44-1c9e-47a6-b8f4-6010f553731b). |
| Requests an Appeal | Proceed to the **next step**.  **Note:** Some clients allow for a 2nd Prior Authorization attempt before an Appeal is required. Review CIF for client-specific guidelines. If the client allows for a second Prior Authorization attempt before an Appeal is needed, send a second ePA request and advise member. |
| **6** | I understand that obtaining your medication is important to you.  You do have an appeal process under your plan.  Please keep in mind that an appeal does not guarantee coverage.    Inform the member verbally of the appeal process:   To file an appeal, ask your provider to fax a [Letter of Medical Necessity (LOMN)](#_Process_for_Handling) to the Appeal Department at **1-866-443-1172**. Your provider may also send the request by mail if they prefer. The Appeals process may take up to 30 calendar days to complete, after which time you will receive a letter informing you of the results.     * If the appeal does not involve a provider, then the member can complete the appeal themselves via:     Fax to **1-866-443-1172**    Or  Mail to:  CVS/Caremark Appeals Department MC109  P.O. Box 52084  Phoenix, AZ 85072-2084   * If Request is for an **Urgent Appeal**:  Have your provider clearly mark ‘Urgent’ on the Letter of Medical Necessity, not the lead fax page, and have it faxed to **1-866-443-1172**. The turnaround time is 72 hours. | |

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| Checking the Status of an Appeal |

Perform the steps below:

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| **Step** | **Action** | | |
| **1** | Review the Client Information Form (CIF) to determine if our Prescription Benefit Manager (PBM) handles Appeals for the member.   * If we do not handle Appeals, follow the instructions listed in the **CIF**.   + If there is no information after clicking on the Appeal Process tab in the **CIF**, call the Senior Team for assistance. * If we handle Appeals, proceed to the **next step.** | | |
| **2** | From the **Quick Actions** Panel on the Claims Landing Page, click on the **Override/PA History** hyperlink.    **Result:** Override History, PA Status, and ePA sections will display. | | |
| **3** | Navigate to the **PA Status** section and click the **ID #** hyperlink and review the status of the Appeal in the **Member Facing Information** section of the PA Status pop-up.  **Notes:**   * Look for a letter at the end of the Prior Authorization (PA) number to identify an Appeal. The letter can vary based on specifics of the appeal. * Advise the member of the **Approval/Denial** reason by clicking the ID number hyperlink to review notes on the PA Status pop-up. Advise of the effective and expiration dates.   A screenshot of a computer  AI-generated content may be incorrect.  **Example:** An Appeal for Tysabri was received on 09/11/2024 and was Approved on 09/12/2024 for an effective date of 08/11/2024 through 09/11/2025. | | |
| **If the Status is…** | **Then…** | |
| Not listed, Appeal has not been initiated | * Our PBM handles the Appeal: Refer to [Requesting an Appeal](#_Requesting_an_Appeal_1) section. * Our **PBM does not handle the Appeal:** Advise of any client specific processes listed in the CIF. | |
| Pending Appeal | Advise the member of the status.  **Example:**  I see that an Appeal request has been started for your medication. The Appeals process may take up to 30 calendar days to complete, after which time you will receive a letter informing you of the results.  **Note:** Urgent Appeals have up to a 72-hour turnaround time from the time the Appeal information was received. The only way to verify an Appeal was submitted as “urgent” is to contact the Prior Authorization department (**1-800-294-5979**). | |
| Status Closed | Review the **Resolution** column: | |
| **If…** | **Then…** |
| Approved | Advise the member of the approval and next steps.  **Example:**  Your Appeal request for <medication name> has been approved for <number of months>. Your medication will now process through your prescription benefit coverage. Please remember to ask your Provider to renew your coverage request again before <expiration date>.  A screenshot of a computer  AI-generated content may be incorrect. |
| Denied | Advise the member of the **Denial** reason, by clicking the ID number hyperlink to review notes on the PA Status pop-up.  A screenshot of a computer  AI-generated content may be incorrect.   * After reviewing the denial reason, to check if more information is available, in the **Documents** column of the PA Status section, click **View** to see if more information is provided in documents attached to the PA/Appeal/Clinical Exception.   **Note:** If “Not Available” displays in the **Documents** column, documents are not viewable through Compass. This does not mean there are no documents attached to the PA/Appeal/Clinical Exception, contact Prior Authorization dept if needed for more information.  A screenshot of a computer  AI-generated content may be incorrect.   * If no documents are available, a message will display “No Documents available.” * If only one document is associated with the PA/Appeal/Clinical Exception, the document displays in a new window. * If more than one document is associated with the PA/Appeal/Clinical Exception, a **View Documents** pop-up displays with hyperlinks to the documents associated with the request.   A screenshot of a computer  AI-generated content may be incorrect.  **Note:** 2nd level Appeal process details are provided in the denial letter and must be filed within 180 days (6 months) of the 1st Appeal denial date. Review the CIF and 1st Level Appeal denial letter for client-specific timeframe. Member must follow the process outlined in the denial letter as these requests are not handled by our appeals Department.  **Note:** You can advise the member of the options to pay out of pocket or discuss alternatives with their doctor if they have not already done so.  **Example:**  I understand that obtaining your medication is important to you. The Appeal has been denied due to <see notes column>. You may choose to pay out of pocket for the medication or discuss alternative medications with your Provider. If you would like, I will be happy to search for potentially cost-saving alternatives that may not require prior authorization. |

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| Provider Calls |

Refer to the table below:

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| **If…** | **Then…** |
| Provider is calling, our PBM handles Appeals, and is asking for a more thorough explanation as to why the request was denied  The IRO will fax the provider with the medical necessity decision. Compass will be updated after the decision. | Review the reason for denial with the Provider by clicking the **ID** hyperlink in Compass.  A screenshot of a computer  AI-generated content may be incorrect.  **Result:** The PA Status pop-up displays.  A screenshot of a computer  AI-generated content may be incorrect.  After reviewing denial reason, if more information is required, **warm transfer** the provider to the PA department using the number from the reject; if there is no phone number in the reject, you may call **1-800-294-5979**. If we do not handle Prior Authorizations or Exceptions for the client, direct them to the appropriate place listed in the CIF.  **Notes:**   * Appeals can be started as soon as a denial is received; however, in most cases they must be requested within 180 calendar days of the original denial. The caller may refer to the denial letter for more specific information for the specific plan. * If a Prior Authorization is denied due to information provided being incomplete or inaccurate, the provider may be warm transferred to the PA department at 1-800-294-5979 to initiate a 2nd Prior Authorization without moving forward into the Appeal process * Advise the provider of the Appeals RxClaim fax: **1-866-443-1172** to send a Letter of Medical Necessity (LOMN). * Refer to the [Letter of Medical Necessity (LOMN)](#_Process_for_Handling) section for additional information. If **urgent**, advise the provider to add the word “Urgent” on the lead page of the LOMN, NOT the fax lead page. * If the fax is not working, warm transfer the provider to: Commercial Urgent Appeals: **1-866-443-1183**, Option **1** (do not disclose number to callers). |

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| Letter of Medical Necessity (LOMN) |

A Letter of Medical Necessity (LOMN) is a letter written by the provider stating why the medication should be considered for coverage or additional coverage. While a LOMN from a provider is the best option for a thorough review, the member has the right to submit their own. The letter of Medical Necessity must include:

* Member’s name, Date of Birth (DOB) and Member ID#.
* Name of requested drug.
* Statement of why the Appeal should be approved or the Provider’s disagreement with the denial reason.
* Reason medication is medically necessary.
* Include any office chart, labs, or other clinical notes.
* Additional information to support the Appeal.
* If the request is an **Urgent** request, advise Provider to add the word “Urgent” on the **lead page** of the LOMN, **not** the fax lead page.

Advise provider to fax Letter of Medical Necessity (LOMN) to Appeals RxClaim fax: **1-866-443-1172**.

**Notes:**

* If the fax is not working,**warm transfer**the provider **to 1-866-443-1183**, Option **1**, to leave a message (do not disclose number to members).
* Ensure the member is informed about the options to pay out of pocket and is aware of any formulary alternatives.

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| Urgent (Life Threatening) Appeals Support Task |

**Urgent (life threatening) Appeals should not be proactively offered.**

A LOMN from Provider is the best option for a thorough review.

An urgent (life threatening) situation is one in which the member’s health may be in serious jeopardy or, in the opinion of a Provider; the member may experience pain that cannot be adequately controlled while waiting for a decision on the review of a claim. If the member or Provider believes the situation is urgent as defined by law, the member or Provider may request an expedited Appeal.

 This task is **ONLY** used if an urgent (life threatening) review is requested and follows the urgent indicator.

Urgent Appeals are processed within 72 hours once information is received from the Provider. The only way to verify an Appeal was submitted as “urgent” is to contact the Prior Authorization department (**1-800-294-5979**).

**Note:** Inform the member of the options to discuss formulary alternatives and the ability to purchase the product out of pocket.

Perform the steps below for an Urgent (life threatening) Appeal:

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| --- | --- | --- |
| **Step** | **Action** | |
| **1** | Review CIF to determine who handles the Appeals for the client. | |
| **If our PBM…** | **Then…** |
| Handles Appeals | Proceed to the **next step**. |
| Does not handle the Appeals or there is no information after clicking on the Appeals tab | Inform the member that our Prescription Benefit Manager does not handle their Appeals, apologize, and refer the member to their Benefits Office. |
| **2** | Educate the caller:   * **If the caller is the member**, educate the member that a letter of medical necessity from the Provider should be submitted via fax to **1-866-443-1172.** The Provider should indicate “Urgent” on the lead page of the LOMN (not on the fax lead page). Urgent Appeals are processed within 72 hours once information is received from the Provider. * **If caller is the Provider’s office,** educate the caller to fax a Letter of Medical Necessity to **1-866-443-1172** and clearly indicate “Urgent” on the LOMN (not on the fax lead page). The turnaround time is 72 hours once information is received from the Provider.   Refer to[Letter of Medical Necessity (LOMN)](#_Process_for_Handling) section.   * If the request follows the urgent indicator and the member would like us to contact their Provider, follow the information below:   From the **Case Data** section that appears on all Compass screens, click the **Create Support Task** button. Refer to [Compass - Create a Support Task (050031)](https://thesource.cvshealth.com/nuxeo/thesource/" \l "!/view?docid=64f18e5a-4d56-4175-ba8e-e7d094e501d6) and [Compass - Support Task Types and Uses List (058147)](https://thesource.cvshealth.com/nuxeo/thesource/" \l "!/view?docid=6753488f-3996-45d9-88ba-257575369a98) as needed.  **Task Type**: Commercial Urgent Verbal Requests  Include the following in the **Notes** field:   * Name of the medication the Appeal is regarding. * Details of the situation with the members’ expectations. * Confirmation that member has been educated to have the Provider fax the letter of medical necessity ([Letter of Medical Necessity](#_Process_for_Handling) section).   **Example:** Urgent (life threatening) Review regarding member’s <Specify Drug name and strength>. Member is requesting an urgent review of adverse determination (drug not covered, PA required, etc.). Member has been informed to have medical necessity letter faxed by Provider. | |
| **3** | Provide turnaround time and advise the member that we are happy to submit the request, but it may help the process move more quickly if they contact their provider to notify them to respond to our request, provide the Letter of Medical Necessity, and to clearly indicate “Urgent” on the letter. | |

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| External Review Support Task |

 **External Review should not be proactively offered.**

 Review the CIF to see if the plan allows for the External Review process, and who handles them. An External Review (3rd level Appeal), or sometimes called a Peer Review, is conducted by an Independent Review Organization not related to the plan to further review the plan’s decision to deny coverage. An External Review may be available after the internal Appeals process has been exhausted. If requested, that decision is final and completes the Appeal process. An external review exhausts **all** Appeal rights.

**External Review Process Information:**

* External review requests must be received within four months (120 days) of the date of receipt of a notice of the final internal adverse determination (FAD).
* The preliminary review to verify eligibility is conducted within 5 business days for the date of receipt for non-urgent and immediately for urgent requests.
* Within one business day of the preliminary review, written notice is sent to the claimant with a copy to the attending physician of whether the request is eligible for external review or not.
* Caremark randomly assigns one of the 5 Independent Review Organizations (IRO), making sure that agency was not involved in any previous reviews.
* The assigned IRO will notify the claimant in writing of the request's eligibility and acceptance for external review.
* The IRO reviews the claim from the beginning and is not bound by any decisions or conclusions reached during the internal claims and appeal process.
* The IRO will notify the member of the approval or denial of medical necessity via US mail and copy CVS Caremark. CVS Caremark will immediately authorize payment of the medication if the IRO overturns the internal denial. Compass will be updated after the decision.

**External Review for Urgent Claim:**

* The 72 hour TAT requirement starts when the IRO receives the request. The IRO is responsible for meeting this TAT.

**External Review for Non-Urgent Claims:**

* The 45-day TAT requirement starts when the IRO receives the request. The IRO is responsible for meeting this TAT.

**Prior Authorization Contact Information:**

Mail:

CVS Caremark

Appeals Department, MC109

P.O. Box 52084

Phoenix, AZ 85072-2084

Fax: 1-866-443-1172

Phone: Customer Care Number on medical benefit ID card **Note:** An external review should only be requested if the PA, 1stlevel Appeal, and 2nd level Appeal have all been denied. If a plan does not offer 2nd level Appeals, the 1st level Appeal would need to be denied before requesting an external review. Check the CIF for client-specific guidelines regarding 2nd level Appeals process.

Complete the steps below:

|  |  |
| --- | --- |
| **Step** | **Action** |
| **1** | Determine if the plan allows for an External Review. Refer to CIF for plan specific process. |
| **2** | From the **Quick Actions** panel on the Claims Landing Page, click the **Override/PA History** hyperlink. Navigate to the **PA Status** section to determine if there are two denied appeals on file.  **Note:** Any letter after the PA number identifies this as an appeal. Letters may vary based on specifics of the appeal.    A screenshot of a computer  AI-generated content may be incorrect. |
| **3** | Advise caller that an External Review is the final Appeal process. This exhausts all Appeal rights.   * If an External Review is requested, create a Support Task as follows:   From the **Case Data** section that appears at the top of all Compass screens, click the **Create Support Task** button. Refer to [Compass - Create a Support Task (050031)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=64f18e5a-4d56-4175-ba8e-e7d094e501d6) as needed.  **Task Type:** Commercial Urgent Verbal Requests  Include the following in the **Notes** field:   * That the task is for an External Review * Name of the medication the appeal is regarding * Details of the situation with the members’ expectations * Confirmation that member has been educated to have the doctor fax the letter of medical necessity (Refer to the [Letter of Medical Necessity](#_Process_for_Handling) section as needed.)   This task is **ONLY** used if the member or Third-Party caller has been advised that the External Review process exhausts all Appeal rights. |
| **4** | Educate the caller on the turnaround time.  The **standard** turnaround time is 45 calendar days, and 72 hours for **urgent** requests once the Independent Review Organization receives the request. You should receive a determination letter in the mail once the review is complete. |

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| Member Requesting Clinical Guidelines for Appeal Denial |

When a member receives an Appeal denial letter, the letter advises that members can contact Customer Care to request the clinical guidelines and rationale used in making the decision.

Requests like this must come directly from the covered member and be sent directly to the Appeals Department.

Complete the steps below:

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| --- | --- |
| **Step** | **Action** |
| **1** | Confirm the member received a denial and is requesting a copy of the clinical guidelines used in making the decision. Refer to the [Checking the Status of an Appeal](#_Checking_the_Status_1) section. |
| **2** | Advise the member to send a written request directly to the Appeals Department, either via mail or fax:  <PBM Name>  Appeals Department  MC109  P.O. Box 52084  Phoenix, AZ 85072-2084  Fax: **1-866-443-1172** |

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| Scenario Guide |

Review the below scenarios for **Reject Examples** (to determine the reason for the rejection).

* Educate the member about the rejection, using [Compass - Test Claims (050041)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=60c20ea0-1d07-46e3-809a-b54734b80fbe) as needed to clarify coverage for that drug.
* You may also look at [Frequently Asked Question](#_Frequently_Asked_Questions)s (FAQs).

For information on how to handle each scenario, refer to [Compass - Prior Authorization, Exceptions, Appeals Guide (063978)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=657ddfe3-27d1-4a21-8f51-8cbd3961001c).

Refer to the following Scenarios as needed:

|  |  |
| --- | --- |
| **Description** | **Example** |
| **Reject 75** Prior Authorization needed rejection | A close-up of a computer screen  AI-generated content may be incorrect. |
| **Reject 70** Clinical Exception needed rejection | A screenshot of a computer  AI-generated content may be incorrect. |
| **Non-Clinical Exception** needed (MAC/DAW Penalty) | A screenshot of a number of numbers  AI-generated content may be incorrect. |

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| Turnaround Time |

Non-urgent Appeals are normally processed within 30 calendar days from date received.

Urgent Appeals are processed within 72 hours. However, there are some clients who require a shorter turnaround time.

External Reviews turnaround time is 45 calendar days once the Independent Review Organization receives the request.

Refer to the table below:

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| --- | --- |
| **Timeframe for Member to File an Appeal** | |
| 1st Level Appeal | Within 180 days from the date of the prior authorization denial |
| 2nd Level Appeal | Typically, within 180 days from the date of the 1st Level Appeal denial, however some clients require that it be submitted within 90 days from the first denial. Check the CIF for specific guidelines. Instructions will also be listed on the 1st Level Appeal Denial Letter. |
| External Appeal | Within 4 months from the date of an Urgent 1st level appeal or any 2nd level appeal denial. |

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| Alternatives |

Refer to [Compass - Test Claims (050041)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=60c20ea0-1d07-46e3-809a-b54734b80fbe).

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| Frequently Asked Questions (FAQs) |

There are many common questions that a member may ask regarding an Appeal. It is important that the information is explained to members in a way that allows them to understand the process the first time.

View the table below to see **examples** of how to answer these questions in plain language:

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| **Q1:** | **Why isn’t the medication covered?** |
|  | Not all medications under the prescription plan are covered. If you would like more information about which medications are covered under your prescription plan, you can register online at our web portal. You will be able to obtain a copy of the medications covered under your prescription plan when you click on **Understanding My Plan and Benefits**. If you would like, I will be happy to search for potentially cost-saving alternatives that are covered under your plan. Refer to [Compass - Viewing and Running Test Claims for Alternative Rx(s) (056849)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=b3dbfb44-1c9e-47a6-b8f4-6010f553731b). |
| **Q2:** | **What is an Appeal?** |
|  | An Appeal is a review process that may be used by plan members whose drug has been denied coverage by the prescription plan. Please keep in mind that an Appeal does not guarantee coverage.  **Note:** Review the CIF to verify there are no DAW, Non-Covered Drug Formulary, or Tiering exceptions available for the client. |
| **Q3:** | **How to identify an Appeal****?** |
|  | Click on the Override/PA History hyperlink, navigate to the PA status dropdown, look for a letter at the end of the PA number. Refer to [Checking the Status of an Appeal](#_Checking_the_Status_1) section. |
| **Q4:** | **How do I request an Appeal?** |
|  | **We handle the Appeal:**  I understand that obtaining your medication is important to you. You do have an Appeal process under your plan. Please keep in mind that an Appeal does not guarantee coverage. To file an Appeal, please ask your Provider to **fax** a letter of medical necessity to the Appeals Department at **1-866-443-1172**. Your Provider may also send the request by mail if they prefer. The Appeals process may take up to 30 calendar days to complete, after which time you will receive a letter informing you of the results.  **We do not handle the Appeal:**  I understand that obtaining your medication is important to you. We do not handle Appeals for your prescription plan. Please contact your benefits office for information on how to request an Appeal.  Refer to [Requesting an Appeal](#_Requesting_an_Appeal_1) section. |
| **Q5:** | **What if my Appeal is urgent? (If CIF states CVS handles Appeals)** |
|  | An Urgent Appeal can be requested when there is an urgent situation. If your Provider believes the situation is urgent as defined by law, you or your Provider may request an urgent Appeal.   Refer to [Urgent (Life Threatening) Appeals Support Task](#_Urgent_(Life_Threatening)) section. |
| **Q6:** | **What is a letter of Medical Necessity?** |
|  | A letter of Medical Necessity is a letter written by your Provider stating why the medication should be considered for coverage or additional coverage. The letter of Medical Necessity should include:   * Your name, DOB, and ID# * Name of requested drug * Statement of why the Appeal should be approved or the Provider’s disagreement with the denial reason * Reason medication is medically necessary * Include any office/chart notes, labs, or other clinical information to support the Appeal   Refer to [Letter of Medical Necessity (LOMN)](#_Process_for_Handling) section. |
| **Q7:** | **What if my Appeal is denied?** |
|  | I understand that obtaining your medication is important to you. If your Appeal is denied, you may contact your Provider to discuss alternative medications covered under your plan if appropriate. If you would like, I will be happy to search for potentially cost-saving alternatives. Refer to [Compass - Viewing and Running Test Claims for Alternative Rx(s) (056849)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=b3dbfb44-1c9e-47a6-b8f4-6010f553731b). |
| **Q8:** | **Why was my Appeal denied?** |
|  | I understand that obtaining your medication is important to you. I can provide the reason for the denial that we received from the Appeals Department; however, the information is usually clinical in nature and may require you to contact your Provider for further explanation. <Provide reason in Compass>. Refer to [Checking the Status of an Appeal](#_Checking_the_Status_1) section.  If you would like, I will be happy to search for potentially cost-saving alternatives that may not require prior authorization. Refer to [Compass - Viewing and Running Test Claims for Alternative Rx(s) (056849)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=b3dbfb44-1c9e-47a6-b8f4-6010f553731b). |
| **Q9:** | **Can I obtain a copy of the guidelines used in making the decision?** |
|  | Yes, you may send a written request to the [Appeals (004378)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=f22eb77e-4033-4ad9-9afb-fc262f29faad) Department, either by mail or fax.  Refer to [Member Requesting Clinical Guidelines for Appeal Denial](#_Appeal_Denials_-) section. |
| **Q10:** | **Can I file a second Appeal or request an external review?** |
|  | **Member can request a second-level Appeal. That information is provided in the denial letter.**  I understand that obtaining your medication is important to you. You may request a second-level Appeal. That process is provided to you in the denial letter.  **Member requests an external review and our PBM handles the Appeal:**  **External Review should not be proactively offered.**  There is a review process for your Appeal. I have submitted a request for an external review. The standard turnaround time is up to 45 calendar days once the Independent Review Organization receives the request, and you should receive a determination letter in the mail once the review is complete. If you would like, I will be happy to search for potentially cost-saving alternatives. Refer to [External Review Support Task](#_External_Review_Support) section.  **Member requests an external review and our PBM does not handle the Appeal:**  I understand that obtaining your medication is important to you. Our Pharmacy Benefits Manager does not handle Appeals for your prescription plan. Please contact your benefits office for information on how to have your Appeal reviewed. If you would like, I will be happy to search for potentially cost-saving alternatives. |
| **Q11:** | **How long do I have to request an Appeal?** |
|  | I understand that obtaining your medication is important to you. The deadline to file a request for an Appeal is 180 calendar days from the date of the original denial. After this deadline, the Prior Authorization/Appeals process would need to be restarted. Refer to [Compass - Prior Authorization, Exceptions, Appeals Guide (063978)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=657ddfe3-27d1-4a21-8f51-8cbd3961001c). |

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| Standard Appeal Approval Member Letter Sample |

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**Approval Member Letter Sample**

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| Standard Appeal Denial Member Letter Sample |

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**Text

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| Related Documents |

[Customer Care Abbreviations, Definitions, and Terms Index (017428)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=c1f1028b-e42c-4b4f-a4cf-cc0b42c91606)

[Compass - Prior Authorization, Exceptions, Appeals Guide (063978)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=657ddfe3-27d1-4a21-8f51-8cbd3961001c)

[MED D - Coverage Determinations and Redeterminations (Appeals) Landing Page (004825)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=1e7d7ad7-e1c1-4fa1-8258-215a1c0ff32b)

[Compass - Test Claims (050041)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=60c20ea0-1d07-46e3-809a-b54734b80fbe)

**Parent Document:** [CALL 0049 Customer Care Internal and External Call Handling](https://policy.corp.cvscaremark.com/pnp/faces/DocRenderer?documentId=CALL-0049" \t "_blank)

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