Pharmacy (Part D) Appeals

What is an appeal?
If a coverage determination is not in your favor and you do not agree with the decision, you can ask for an appeal. You can appeal our decision not to cover a drug (including denial of a quantity limit, tier, or non-formulary exception) or our decision not to reimburse you for all or some of a Part D drug that you paid for. You can also appeal our decision not to reimburse you for a cost sharing amount that you think you should receive. You will receive a Notice of Denial of Medicare Prescription Drug Coverage. The first level of appeal is called a "redetermination." There are four additional levels of appeal that a member may request.

Who may file an appeal?

For a standard appeal, you or your appointed representative may file the request. An expedited ("fast") appeal may be filed by you, your appointed representative, or your prescribing physician.

How do I appoint a representative?

> You can name a relative, friend, advocate, doctor, attorney, or anyone else to act for you as your appointed representative. Some other persons may already be authorized under State law to act for you. If you want someone to act for you, then you and that person must sign and date a statement or fill out the Medicare Appointment of Representative form (Form CMS-1696) (PDF). This statement or form gives the person legal permission to act as your appointed representative. Send the statement or Medicare Appointment of Representative form with your appeal to Aspirus Health Plan Member Complaints, Appeals, and Grievances, P.O. Box 51, Minneapolis, MN 55440-9972. Or call 715-631-7440 or 1-855-931-4858 (toll free). Or fax your written appeal for Coverage Determination to 715-631-7439 or 1-855-931-4857 (toll free).

When should I file my appeal?

You must file your appeal within 60 calendar days from the date on the notice of our coverage determination. We can give you more time if you have a good reason for missing the deadline. Medicare rules state who may file an appeal.

How do I file an appeal?

To file an appeal, call or write Aspirus Health Plan Member Complaints, Appeals, and Grievances.

Call: 715-631-7440 or 1-855-931-4858 (toll free)

Write: Aspirus Health Plan
Attn: Appeals and Grievances
P.O. Box 51
Minneapolis, MN 55440-9972

Or fax your written appeal to:
715-631-7439 or 1-855-931-4857 (toll free)

How does the appeal process work?

When we receive your request to reconsider the coverage determination, we must gather all the information we need to make a decision about your appeal. Then we give the request for an appeal to people at our organization who were not involved in making the coverage determination. This helps ensure that we will give your request a fresh look. We will make a decision for a standard appeal within seven calendar days, but will make it sooner if your health condition requires.

Information about fast appeals

If your appeal concerns a decision we made about authorizing a Part D benefit that you have not received yet, then you and/or your physician will first need to decide whether you need a fast appeal. You, your physician, or your appointed/authorized representative can request a fast appeal (rather than a standard appeal). If your physician asks for a fast appeal for you or supports you in asking for one, and the physician states that waiting for a standard decision could seriously harm your health or your ability to function, we will give you a fast appeal. If we decide that your medical condition does not meet the requirements for a fast appeal, we will send you a letter informing you that if you get a physician's support for a fast appeal, we will automatically give you a fast decision. The letter will also tell you how to file a fast grievance if you disagree with our decision to deny your request for a fast appeal. If we grant your request for a fast appeal, we will give you our decision within the 72 hours.

How will I find out about the appeal decision?

We will send you a letter informing you of our appeal decision. For fast appeals we will also call you and, as appropriate, your physician, with the appeal decision. We will authorize or provide the medication within the appeal timeline. For reimbursement decisions, we must send payment to you no later than 30 calendar days after we receive your request for an appeal.

Other levels of appeal

If we do not give you our decision within the required appeal timeline, your request for an appeal will automatically go to Appeal Level 2, where an independent organization will review your case. If we deny any part of your appeal, you or your appointed representative has the right to ask this independent organization to review your case. At Appeal Level 2 your appeal is reviewed by an outside, independent review organization that has a contract with the Centers for Medicare & Medicaid Services (CMS), the government agency that runs the Medicare program. There are three additional levels of appeal if the appeal decision continued to be unfavorable to you. You or your appointed representative may continue your appeal by asking for further review provided filing time lines and dollar value of the contested Part D benefit meets the minimum requirement provided under Medicare Part D regulations. The three additional levels of appeal are explained in detail in your Evidence of Coverage. These levels of appeal include:

- Appeal level 3: Review by an Administrative Law Judge
- Appeal level 4: Review by Medicare Appeals Council
- Appeal level 5: Federal Court

Questions?
Call Aspirus Health Plan Customer Service if you:

- Have questions about coverage determinations, appeals, or grievances.
- Want to get an aggregate number of Aspirus Health Plan grievances, appeals, and exceptions.
- Have questions about the status of a coverage determination request.

Local number: 715-631-7411 or 1-855-931-4850 toll free
TTY: 715-631-7413 or 1-855-931-4852 toll free.

<Material ID number>

U11718 (03/2022)