

Purpose: This document provides member-friendly overviews on the processes and procedures involved with coverage reviews, coverage appeals and external reviews for Commercial clients.

Initial coverage review

A member has the right to request that a medicine be covered or be covered at a higher benefit (such as a lower copay or higher quantity). The first request for coverage is called an initial coverage review. Express Scripts reviews both clinical and administrative coverage review requests.

- **Clinical coverage review request:** A request for coverage of a medication that is based on clinical conditions of coverage that are set by the Plan. For example, medications that require a prior authorization.
- **Administrative coverage review request:** A request for coverage of a medication that is based on the Plan's benefit design.

How to request an initial coverage review

To request an initial clinical coverage review, also called prior authorization, the prescriber submits the request electronically. Information about electronic options can be found at [express-scripts.com/PA](https://www.express-scripts.com/PA).

To request an initial administrative coverage review, the member or his or her representative must submit the request in writing using a **Benefit Coverage Request Form**, which can be obtained by calling the Customer Service phone number on the back of the prescription card.

Complete the form and fax it to **877.328.9660** or mail to:









Express Scripts
Attn: Benefit Coverage Review Department
P.O. Box 66587
St Louis, MO 63166-6587

If the patient's situation meets the definition of urgent under the law, an urgent review may be requested and will be conducted as soon as possible, but no later than 72 hours from receipt of request.

In general, an urgent situation is one, which in the opinion of the attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function or would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. If the patient or provider believes the patient's situation is urgent, the provider must request the expedited review by phone at **800.753.2851**.

How an initial coverage review is processed

In order to make an initial determination for a clinical coverage review request, the prescriber must submit specific information to Express Scripts for review. For an administrative coverage review request, the member must submit information to Express Scripts to support their request. The initial determination and notification to patient and prescriber will be made within the specified timeframes as follows:

Type of Claim	Decision Timeframe Decisions are completed ASAP from receipt of request and no later than:	Notification of Decision			
		APPROVAL		DENIAL	
Standard Pre-Service*	15 days (retail) 5 days (home delivery)	 Patient	 Prescriber	 Patient	 Prescriber
Standard Post-Service*	30 days	Automated call (and letter, if call unsuccessful)	Electronic or fax (and letter, if fax unsuccessful)	Letter	Electronic or fax (and letter, if fax unsuccessful)
Urgent	72 hours**	 Patient	 Prescriber	 Patient	 Prescriber
		Automated call and letter	Electronic or fax (and letter, if fax unsuccessful)	Live call and letter	Electronic or fax (and letter, if fax unsuccessful)

* If the necessary information needed to make a determination is not received from the prescriber within the decision timeframe, a letter will be sent to the patient and prescriber informing them that the information must be received within 45 days or the claim will be denied.

** Assumes all information necessary is provided. If necessary information is not provided within 24 hours of receipt, a 48-hour extension will be granted.

Level 1 appeal or urgent appeal

How to request a level 1 appeal or urgent appeal after an initial coverage review is denied


When an initial coverage review has been denied, also referred to as an adverse benefit determination, a request for appeal may be submitted by the member or authorized representative within 180 days from receipt of notice of the initial adverse benefit determination. To initiate an appeal, the following information must be submitted by mail or fax to the appropriate department for clinical or administrative review requests:

- Name of patient
- Member ID
- Phone number
- The drug name for which benefit coverage has been denied
- Brief description of why the claimant disagrees with the initial adverse benefit determination
- Any additional information that may be relevant to the appeal, including prescriber statements/letters, bills or any other documents

Clinical appeal requests and administrative appeal requests can be mailed or faxed to the following addresses and fax numbers:

Clinical appeal requests

Express Scripts
Attn: Clinical Appeals Department
P.O. Box 66588
St. Louis, MO 63166-6588

 877.852.4070

Administrative appeal requests


Express Scripts
Attn: Administrative Appeals Department
P.O. Box 66587
St. Louis, MO 63166-6587


 877.328.9660

If the patient's situation meets the definition of urgent under the law, an urgent appeal may be requested and will be conducted as soon as possible, but no later than 72 hours from receipt of request. In general, an urgent situation is one, which in the opinion of the attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function or would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If the patient or provider believes the patient's situation is urgent, the expedited review must be requested by phone or fax. Claims and appeals submitted by mail will not be considered for urgent processing unless a subsequent phone call or fax identifies the appeal as urgent:

Urgent clinical appeal requests

 800.753.2851

 877.852.4070

Urgent administrative appeal requests













 800.946.3979

 877.328.9660

How a level 1 appeal or urgent appeal is processed

Express Scripts completes appeals per business policies that are aligned with state and federal regulations. Depending on the type of appeal, appeal decisions are made by a pharmacist, physician, trained prior authorization staff member or independent third-party utilization management company.

Appeal decisions and notifications are made as follows:

Type of Appeal	Decision Timeframe Decisions are completed ASAP from receipt of request and no later than:	Notification of Decision			
		APPROVAL		DENIAL	
Standard Pre-Service	15 days	 Patient Automated call (and letter, if call unsuccessful)	 Prescriber Electronic or fax (and letter, if fax unsuccessful)	 Patient Letter	 Prescriber Electronic or fax (and letter, if fax unsuccessful)
Standard Post-Service	30 days	 Patient Automated call and letter	 Prescriber Electronic or fax (and letter, if fax unsuccessful)	 Patient Live call and letter	 Prescriber Electronic or fax (and letter, if fax unsuccessful)
Urgent*	72 hours	 Patient Automated call and letter	 Prescriber Electronic or fax (and letter, if fax unsuccessful)	 Patient Live call and letter	 Prescriber Electronic or fax (and letter, if fax unsuccessful)

* If new information is received and considered or relied upon in the review of the appeal, such information will be provided to the patient and prescriber together with an opportunity to respond prior to issuance of any final adverse determination. In an urgent care situation, only one level of internal appeal is provided prior to an external review.

Level 2 appeal

How to request a level 2 appeal after a level 1 appeal is denied

When a level 1 appeal has been denied, also called an adverse benefit determination, a request for a level 2 appeal may be submitted by the member or authorized representative within 90 days from receipt of notice of the level 1 appeal adverse benefit determination. To initiate a level 2 appeal, the following information must be submitted by mail or fax to the appropriate department for clinical or administrative review requests:

- Name of patient
- Member ID
- Phone number
- The drug name for which benefit coverage has been denied
- Brief description of why the claimant disagrees with the adverse benefit determination
- Any additional information that may be relevant to the appeal, including prescriber statements/letters, bills or any other documents

Clinical appeal requests and administrative appeal requests can be sent to the following addresses and fax numbers:

Clinical appeal requests

Express Scripts
Attn: Clinical Appeals Department
P.O. Box 66588
St. Louis, MO 63166-6588



877.852.4070



Administrative appeal requests


Express Scripts
Attn: Administrative Appeals Department
P.O. Box 66587
St. Louis, MO 63166-6587

 877.328.9660

If the patient's situation meets the definition of urgent under the law, an urgent appeal may be requested and will be conducted as soon as possible, but no later than 72 hours from receipt of request. In general, an urgent situation is one, which in the opinion of the attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function or would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If the patient or provider believes the patient's situation is urgent, the expedited review must be requested by phone or fax. Claims and appeals submitted by mail will not be considered for urgent processing unless a subsequent phone call or fax identifies the appeal as urgent:

Urgent clinical appeal requests

 800.753.2851

 877.852.4070

Urgent administrative appeal requests













 800.946.3979

 877.328.9660

How a level 2 appeal is processed

Express Scripts completes appeals per business policies that are aligned with state and federal regulations. Appeal decisions are made by a pharmacist, physician, or an independent third-party utilization management company.

Appeal decisions and notifications are made as follows:

Type of Appeal	Decision Timeframe Decisions are completed ASAP from receipt of request and no later than:	Notification of Decision			
		APPROVAL		DENIAL	
Standard Pre-Service	15 days	 Patient Automated call (and letter, if call unsuccessful)	 Prescriber Electronic or fax (and letter, if fax unsuccessful)	 Patient Letter	 Prescriber Electronic or fax (and letter, if fax unsuccessful)
Standard Post-Service	30 days	 Patient Automated call and letter	 Prescriber Electronic or fax (and letter, if fax unsuccessful)	 Patient Live call and letter	 Prescriber Electronic or fax (and letter, if fax unsuccessful)
Urgent*	72 hours	 Patient Automated call and letter	 Prescriber Electronic or fax (and letter, if fax unsuccessful)	 Patient Live call and letter	 Prescriber Electronic or fax (and letter, if fax unsuccessful)

* If new information is received and considered or relied upon in the review of the appeal, such information will be provided to the patient and prescriber together with an opportunity to respond prior to issuance of any final adverse determination.

External review

When and how to request an external review

The right to request an independent external review may be available for an adverse benefit determination involving medical judgment, rescission or a decision based on medical information, including determinations involving treatment that is considered experimental or investigational. Generally, all internal appeal rights must be exhausted prior to requesting an external review. The external review will be conducted by an independent review organization (IRO) with medical experts that were not involved in the prior determination of the claim.

To submit an external review, the request must be mailed or faxed to Express Scripts.

Express Scripts
Attn: External Appeals Department
PO Box 66588
St. Louis, MO 63166-6588



800.753.2851



877.852.4070

The request must be received within 4 months of the date of the final internal adverse benefit determination (If the date that is 4 months from that date is a Saturday, Sunday or holiday, the deadline will be the next business day).



Confidential Information

How an external review is processed

Standard external review

Express Scripts will review the external review request within 5 business days to determine if it is eligible to be forwarded to an independent review organization and the patient will be notified within 1 business day of the decision.

If the request is eligible to be forwarded to an IRO, the request will randomly be assigned to an IRO and the appeal information will be compiled and sent to the IRO within 5 business days of assigning the IRO.

The IRO will notify the claimant in writing that it has received the request for an external review, and if the IRO has determined that the claim involves medical judgment or rescission, the letter will describe the claimant's right to submit additional information within 10 business days for consideration to the IRO. Any additional information the claimant submits to the IRO will also be sent back to the claims administrator for reconsideration.

The IRO will review the claim within 45 calendar days from receipt of the request and will send the claimant, the Plan and Express Scripts written notice of its decision. If the IRO has determined that the claim does not involve medical judgment or rescission, the IRO will notify the claimant in writing that the claim is ineligible for a full external review.

Urgent external review

Once an urgent external review request is submitted, the claim will immediately be reviewed to determine if it is eligible for an urgent external review. An urgent situation is one, which in the opinion of the attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life, health or the ability for the patient to regain maximum function or would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If the claim is eligible for urgent processing, the claim will immediately be reviewed to determine if the request is eligible to be forwarded to an IRO and the claimant will be notified of the decision.

If the request is eligible to be forwarded to an IRO, the request will randomly be assigned to an IRO and the appeal information will be compiled and sent to the IRO. The IRO will review the claim within 72 hours from receipt of the request and will send the claimant written notice of its decision.