Compass Rose Health Plan

Disputed Claims Appeal Process

Standard Option and High Option

This guide outlines the appeal process for members enrolled in the Compass Rose Health Plan:

- Standard Option
- High Option

If you are enrolled in Compass Rose Medicare Advantage or Medicare Prescription Drug Plan (PDP) EGWP please refer to your Evidence of Coverage, which describes the Medicare appeals process separately.

For explanations of key terms used throughout this guide, such as types of appeals, please refer to the ***Terms and Definitions*** section at the end of this document.

Member Rights

If we deny a claim or coverage requested by you or your provider, you may request an appeal through our disputed claims process. Refer to the information below for details on how to submit your appeal, including required forms, important addresses, and deadlines.

The disputed claims appeal process, including your rights, can also be found in Sections 3 and 8 of our FEHB Plan brochure at **compassrosebenefits.com/brochure**.

Important Tips

Accessing Your Information

You can check the status of prior authorizations and view your claims by logging in to your myCompass account online and going to UMR or Optum Rx® at **member.compassrosebenefits.com**.

Consult Your Healthcare Provider Throughout the Appeal Process

If a prior authorization is denied, you and your provider will receive a denial letter from the appropriate source: UMR (for medical denials), Optum Rx (for pharmacy denials), or the Office of Personnel Management (OPM) (for an OPM appeal). If a post-service medical request is denied, refer to your Explanation of Benefits (EOB) or denial letter.

The denial letter or EOB will include the reason for denial and instructions for submitting an appeal for your specific situation. Your provider can help determine whether appealing the denial is appropriate or if an alternative treatment may be more suitable.

We recommend that you stay in contact with your provider throughout your appeal. Most providers' offices have designated staff who are skilled at navigating these processes.

If a prescription is denied at the pharmacy, the rejection will include a message explaining the reason, which the pharmacy should communicate to you. If the pharmacy is unable to explain or fix the rejection, or if you have questions, call Optum Rx at **800-557-5785**.

Disputed Claims Appeal Process

Different Processes for UMR, Optum Rx, and OPM

With few exceptions, you must first appeal a denied coverage request or claim directly with UMR (for medical denials) or Optum Rx (for pharmacy denials), before you may appeal to OPM. While these processes are similar, they are not identical. Required forms, addresses, and contact information are different.

1st Level Appeal Process for Medical Denials (UMR)

You must submit a 1st level appeal request to UMR within **6 months (180 calendar days)** of the initial decision. For questions, please call UMR at **888-438-9135**. Your appeal must include the following:

1. **A written appeal request** – This should include a statement explaining why you believe the initial decision was incorrect. State whether your request is standard or urgent (please refer to definitions).
2. **Disputed Claim Form** – Your written request and statement may be included on this form or attached to it. The form is available at **compassrosebenefits.com/disputedclaim**.
3. **Authorization of Representative (AOR) Form** – Required if someone other than you, the member, is submitting the appeal. In urgent cases, a healthcare professional with knowledge of your medical condition may act as your representative without your express consent.
   - Download the Pre-service AOR Form at **https://www.compassrosebenefits.com/hubfs/forms-and-brochures/UMR_Designation_of_Authorized_Representative_Form_Pre-Service.pdf**
   - Download the Post-service AOR Form at **https://www.compassrosebenefits.com/hubfs/forms-and-brochures/UMR_Designation_of_Authorized_Representative_Form_Post-Service.pdf**
4. **Supporting documentation** – This may include medical records, physician letters, bills, and/or explanation of benefits.

In addition, you and/or your provider have the right to request the information reviewed to make the initial decision — free-of-charge. Refer to your denial letter or EOB for information on making this request.

UMR will provide a determination within **30 days** following receipt of all requested information, or within **72 hours** for urgent requests. The determination will be mailed to you, your provider, and/or the facility. You may provide an email address within your appeal to have the determination emailed to you.

1st Level Appeal Process for Pharmacy Denials (Optum Rx)

You must have a denied prior authorization before you may submit a 1st level appeal to Optum Rx.

You must submit a 1st level appeal request to Optum Rx within **6 months (180 calendar days)** of the date on the denial letter you received from Optum Rx. For questions, please call Optum Rx at **888-403-3398**.

Electronic prior authorization (ePA) is the preferred method for submitting appeals to Optum Rx. The ePA system is available to all prescribers. If you or your prescriber choose not to submit your appeal via the ePA system, your appeal should include the following:

1. **A written appeal request** – This should include a statement or comments explaining why you believe the initial decision was incorrect. State whether your request is standard or urgent (please refer to definitions).

2. **Authorization of Representative (AOR) Form** – This form should be included if anyone other than you or your prescriber is making the appeal request. Download the form at **https://www.compassrosebenefits.com/hubfs/forms-and-brochures/Optum-Rx_AOR-member-Personal-Representative-Form-508-English.pdf**

3. **Supporting documentation** – This may include medical records, provider letters, or any other documents relevant to the appeal.

In addition, you may request a copy of the drug coverage policy, actual benefit provision, guideline, protocol, or other information used to make the initial decision — free of charge. Refer to your denial letter for information on making this request.

Optum Rx will provide a written determination within **30 calendar days** following receipt of your appeal, or within **72 hours** for urgent requests.

2nd Level OPM Appeal Process (both Medical and Pharmacy Denials)

With few exceptions, you must first appeal a denied coverage request or claim directly with UMR (for medical denials) or Optum Rx (for pharmacy denials), before you may appeal to OPM.

If you would like to file an appeal with OPM, you must submit the appeal request no later than **90 days** after the 1st level appeal was upheld. Your appeal must include the following:

1. **A written appeal request** – This should include a statement explaining why you believe the initial decision was incorrect. State whether your request is standard or urgent (please refer to definitions).

2. **Supporting documentation** – This may include medical records, explanation of benefits, physician letters, or copies of all communication sent to us and to you about this coverage request or claim.

3. **Contact information** – Provide your daytime phone number and the best time to call. If you would like OPM's decision to be sent to you via email, also provide your email address.

Mail your request to:

United States Office of Personnel Management
Healthcare and Insurance, Federal Employee Insurance Operations, FEHB 2
1900 E Street, NW
Washington, DC 20415-3620

If your request is urgent you may call OPM at **202-606-3818**.

OPM will provide a determination or notify you of the status of the review within **60 days**. If you need urgent care, OPM will expedite your review if notified in your request.

If you disagree with OPM's decision, you have the right to file a lawsuit against OPM no later than December 31 of the third year after the year in which you were denied prior approval or received the disputed service.

Terms & Definitions

This section provides definitions and explanations of key terms used throughout this guide. It also outlines important distinctions — such as the difference between pre-service and post-service appeals — to help you better understand the appeals process and what may apply to your situation.

Medical vs. Pharmacy Appeal

Medical Appeal – A request to dispute a coverage denial for a coverage request (e.g. prior authorization or pre-certification) or claim submitted to UMR by your provider.

Pharmacy Appeal – A request to dispute a coverage denial of a prescription billed to Optum Rx by a network pharmacy.

Pre-Service vs. Post-Service Appeal

Pre-Service Appeal – A request to dispute the denial of a service that has not yet been received.

- *Example*: Most pharmacy appeals are considered pre-service appeals because the pharmacy will attempt to bill for your prescription electronically, in real-time, *before* they dispense your medication.

Post-Service Appeal – A request to dispute the denial of a service that has already occurred.

Standard vs. Urgent Appeal

Standard Appeal – A request to dispute the denial of a service where an expedited (urgent) review is not required.

Urgent Appeal – A request to dispute the denial of a service that, if not received in a timely manner, could:

- Jeopardize your life or health.
- Jeopardize your ability to regain maximum function.
- Subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the coverage request or claim.

1st Level vs. 2nd Level Appeal

1st Level Appeal – An initial request to either UMR or Optum Rx to dispute a denied coverage request (e.g. a prior authorization or pre-certification) or claim.

2nd Level OPM Appeal – A request to OPM to review a denied 1st level appeal that was upheld by UMR or Optum Rx.