Disputed Claims Information for Medical Claims

What if I disagree with a decision and want to Dispute a Pre-Service Medical Claim?

If you have a pre-service claim and you do not agree with Medical Mutual's decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review within 6 months of Medical Mutual's initial decision.

To dispute an initial decision, send Medical Mutual the following:
A statement about why you believe our initial decision was incorrect, based on your benefit provisions. Include copies of documents that support your claim, such as physicians' letters, operative reports, and medical records. You can also call Customer Care Center at 800.315.3144 if you have any questions about how to file an appeal.

Send this information to:
Medical Mutual
P.O. Box 94580
Cleveland, OH 44101-4580
Website: www.MedMutual.com
Fax: (216) 687-7990 or (866) 691-8260

Medical Mutual will review the original decision and provide you with a determination within 30 days from the date we received your request.

If you have a serious or life-threatening condition (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call Medical Mutual at 800-315-3144. We will expedite our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's PSIO at 202-936-0002 between 8 a.m. and 5 p.m. Eastern Time.

Unless we request additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will expedite the review process, which allows oral or written requests for appeals and the exchange of information by telephone, electronic mail, facsimile, or other expeditious methods

What if I disagree with a decision and want to Dispute a Post Service Medical Claim?
If you have a post-service claim (a claim where services have already been provided) and you do not agree with our decision, you have the right to dispute a decision within 6 months from the day you receive the explanation of benefits from Medical Mutual. To dispute a decision, you must send Medical Mutual the following:

A statement about why you believe our initial decision was incorrect, based on your benefit provisions. Include copies of documents that support your claim, such as physicians' letters,

operative reports, bills, medical records and explanation of benefits (EOB) forms. Call our Customer Care Center at 800.315.3144 if you have any questions about how to file an appeal.

Send this information to:

Medical Mutual
P.O. Box 94580
Cleveland, OH 44101-4580

Medical Mutual will review the original decision and provide you with a determination within 30 days from the date we received your request.

If you do not agree with Medical Mutual's decision, you may ask the Office of Personnel Management (OPM) to review it within 90 days after the date of Medical Mutual's letter upholding the initial decision. Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in the plan brochure
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records and explanation of benefits (EOB) forms
- Copies of all letters you sent to us about the claim
- Copies of all letters we sent to you about the claim
- Your daytime phone number and the best time to call
- Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly if you give your email address.

OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals.

What if I disagree with a decision and want to Dispute a Pharmacy Claim?

If your pharmacy tells you that your prescription cannot be filled as written, the pharmacy will give you a written notice explaining how to contact Express Scripts Medicare to ask for a coverage decision.

Who may file an appeal?
You or someone you name to act for you (your authorized representative) may file an appeal. You may appoint another person to act for you by providing us a signed and dated statement authorizing that person to act on your behalf. Call our Customer Care Center at 800.315.3144 for assistance in obtaining the form.

Can I request copies of information relevant to my claim?
If you wish, you may ask for reasonable access to, and copies of, all documents relevant to the appeal free of charge. You may also ask for a copy of the actual benefit provision, guideline,

protocol or other similar criterion on which the appeal decision was based. In addition, you may request the diagnosis code, treatment code, and their corresponding meanings. If the information is available, it will be provided to you. To request this information, please submit a detailed written request to:

Medical Mutual
Member Appeals department
P.O. Box 94580
Cleveland, OH 44101-4580
Fax: 216.687.7990 or 866.691.8260

Disputed Claims Information for Pharmacy Claims:

Are there any limitations on medications my doctor might order?

Some medications may have quantity limits, require prior approval or have other requirements that must be met before your prescription will be covered. For some formularies, certain medications may be excluded from coverage and are referred to as non-formulary drugs. You can call the Rx Information number on your ID card and ask if your medication is subject to limitations or prior approval requirements. To determine coverage rules, log in to My Health Plan at MedMutual.com/Rx and click on the Sign on to Express Scripts button. To review your medication's coverage notes, select Prescriptions and then Price a Medication.

A coverage review is a process to consider whether prescriptions that are covered only when medically necessary meet the criteria for coverage. To request a coverage review, ask your healthcare provider to complete an electronic prior authorization request through their electronic health record (EHR) system. For assistance or alternative submission options, have your healthcare provider visit the Express Scripts website at ESRX.com/PA or call Express Scripts at 1-800-417-1764 to arrange a review.

Products that are approved by the U.S. Food and Drug Administration for cosmetic use or weight loss are not covered under most prescription benefit plans

What if my provider prescribes a medication that is non-formulary?

Talk with your doctor or healthcare provider to see if the formulary includes a medication to treat your condition. In most cases, your provider will find one that meets your needs.

In the rare instance that none of the covered medications is appropriate for you and a non-formulary medication is required, you may request an exception to cover the non-formulary medication by asking for a coverage review. Ask your healthcare provider to complete a prior authorization request through their electronic health record (EHR) system. For assistance or alternative submission options, have your healthcare provider visit the Express Scripts website at ESRX.com/PA or call Express Scripts at 1-800-417-1764 to arrange a review.

If an exception is made based on medical necessity, you will only pay your plan's applicable cost share (e.g., generic, non-preferred brand, specialty) for the non-formulary medication. If your provider does not request a coverage review and you fill a prescription for a non-formulary medication, you will pay the full cost.

How can I file an appeal if my prescription drug is not on the formulary or was denied?

Appeals for the medical necessity of a prescription drug are handled by licensed pharmacists or physicians from Express Scripts. Appeals should be submitted with related medical information to the address below within 180 days of receipt of your denial notice. Appeals related to urgent matters will be decided within 72 hours.

Express Scripts Attention:
Clinical Appeals Department
P.O. Box 66588
St. Louis, MO 63166-6588
Phone: 1-800-935-6103 (Monday through Friday, 7 a.m.–6 p.m. Central)
TTY: 1-800-716-3231
Fax: 1-877-852-4070

Appeals related to membership eligibility or excluded prescription drugs should be submitted to the address below or may be submitted electronically through your plan's website or by logging into My Health Plan.

Medical Mutual Member Appeals
P.O. Box 94580
Cleveland, OH 44101-4580
Fax: 1-216-687-7990 or 1-866-691-8260

You will receive notice of appeal decisions in writing. If the original decision is not overturned, our notice will describe any additional appeal rights you have.

PSHB Fact Sheet