Appeals Process

EmpiRx Health has an established appeals policy and procedure that complies with PPACA and ERISA. The member, prescriber, or appointed designee has the right to request a review of denied claims on behalf of a member. The appeals process consists of the following levels:

Level 1

EmpiRx Health will review the decision regarding the claim and/or services requested. The review will include, as required, evaluation of the claim against the plan design and evaluation for clinical appropriateness. Personnel involved in a Level 1 appeal review are not involved in the initial determination that is the subject of the appeal. EmpiRx Health provides a written determination letter to the member and provider with a timely decision on the status of all appeals. The letter provides information to the member and provider regarding the rationale behind the appeal decision and, if a denial is upheld, information regarding initiating the next level of appeal.

Level 2

If the member and/or prescriber is not satisfied with our determination at Level 1, they have the right to a Level 2 internal appeal which can be approved by a clinician. If the determination outcome is a denial, the claim is reviewed by our medical director based on the same criteria above.

Level 3

If the member and/or prescriber disagree with the determination after the above steps have been taken, they can submit another appeal and the case will be forwarded to one of our three contracted Independent Review Organizations (IROs), between which we alternate.

Appeal Review Time Frame:

Our average turnaround time for internal appeals is 15 days for standard requests and 72 hours for expedited requests. We adhere to all federal guidelines as it pertains to appeal turnaround times. Turnaround times for external, Level 3 appeals, vary by IRO.

If you have any questions, please contact EmpiRx Health Member Services at 1-833-419-3436/TDD:711, Monday-Friday 8am-10pm or Saturday 10am-6pm EST.