

Prior Authorization, Step Therapy, and Appeals



As women living with diabetes, we also must be warriors. We are often required to be warriors as we find ourselves battling insurers over diabetes treatment plans prescribed by medical professionals. It's common to hear about insurance denying prescriptions, services, devices like insulin pumps or continuous glucose monitors (CGM), or even the number of blood glucose test strips we need for a minimum number of readings per month.



Dealing with the processes to request prior authorizations or step therapy requests, or to appeal insurance denials, is time-consuming and frustrating, but your health is worth it. Knowing the steps and being prepared can help you navigate the processes with a little less stress, and hopefully success in getting the diabetes care you need.

Prior Authorization

One cost-savings measure restricting access to the medication or services you need for your diabetes is “prior authorization.” The first time someone hears the term is often at the pharmacy counter, when the pharmacist states that they are unable to process the prescription until the prescriber has contacted the insurance company.

Prior authorizations are a method to keep insurer costs down, rather than what your medical team and you feel are best for you. Patients are not involved with the process. The pharmacy sends notification to your medical professional’s office. The office staff must call a line only given to medical professionals, to discuss and/or fill out forms explaining why you have been prescribed a particular drug. Once this process is complete, your medical professional’s office or your pharmacy should call you back with a decision.

If the drug you are prescribed is not authorized by the insurer, you have a choice: pay the full amount for the prescription (the insurance company will not pay for it at all) or have your provider prescribe a different medication. You can also appeal the insurance company’s decision, with the understanding that this will not be an immediate reversal.

The most important (and often only) thing you can do for prior authorizations is work with your prescriber, giving them information that they may need to discuss the decision to prescribe that particular treatment over another.

Quantity Limit Prior Authorizations

Many insurance companies may limit the number of blood glucose test strips that a person with diabetes can receive through a prescription each month. The insurance company may base the limit on the type of diabetes diagnosis (Type 1, Type 2, Gestational, or other), but other insurers choose a number arbitrarily. One woman with Type 1 diabetes was shocked to find that her insurance company would only allow 50 test strips per month unless her endocrinologist requested a *quantity limit prior authorization*.

As with any other prior authorization, your medical team will work to get the necessary amount of test strips for your diabetes management. They may need to supply clinical notes and reasoning for the additional daily number of test strips (such as hypoglycemia unawareness, pregnancy, or major therapy changes requiring more frequent monitoring).

Most prior authorizations are approved for one year and need to be renewed annually, when your insurance policy resets. Even if nothing has changed, the insurance company may require you to provide proof of diabetes diagnosis at this time.

Step Therapy

Step therapy is a way for insurers to coerce patients to try a less expensive medication or treatment before they will consider covering what the medical professional has prescribed. Step therapy is also known as “treat to fail” or “fail first” protocols, and the focus is on “fail.” If a formulary guide states that a particular drug is part of its step therapy program, patients are required to show that they have attempted other medications — and these medications have failed to treat their diabetes effectively — through medical team clinical notes.

If your medical team believes that a medication is the best option for your diabetes management, they prescribe a particular drug. They treat you as an individual, not simply as a “woman with diabetes.” Your medical professional has reviewed all your options and chose to treat you with a particular drug.

Why must you go through one or more other drugs to be able to be on the treatment you need?

Step therapy is about cost-savings for the insurer. Insurers claim that by having patients use “less expensive” medications, the insurer and the patient will both save money. However, studies have shown that step therapy can increase insurer and patient costs through outpatient expenditures.¹ Patients must fill a prescription and then return to a medical office, incurring additional copays or coinsurances, to “try” a medication. Your diabetes may not be managed properly during the 90 days or more that is required to “try” and possibly, “fail,” a medication. In addition, medical office staff expends time and effort filling out step therapy requests. No one wins; everyone fails.

¹ <https://www.ncbi.nlm.nih.gov/pubmed/18803994>



Appeals

Despite diligent research or the determination of what is best for your health, insurance companies may choose to deny a procedure, device, service, or medication. It's important to keep a calm head and persevere through an appeals process. Many decisions are reversed upon appeal, as insurers do not expect their clients to question why a claim would not be covered.

When you receive a denial, print out two items: the section of your insurance benefits pertaining to the denial, and the Explanation of Benefits (also called an EOB). You will need to reference both of these items frequently. You'll also want to create an online or physical folder, where you will keep your correspondence and notes.

As you go through the steps in the appeals process, keep your own meticulous notes. For each phone interaction, log the date, time, name of the insurance company's customer service representative or person of authority you speak with, and the subject of the conversation, including any requests from you or the insurer for follow up.

Step 1: Call the Insurer

While you may feel frustrated or angry with an answer that might be given, remember that there is another person on the end of the line. That person's job is to relay accurate information about your appeal.

In some cases, the Explanation of Benefits (EOB) will explain why the claim was denied. Other times, the reason for denial may be cryptic or contain jargon you may not understand. Call the phone number listed on the EOB and ask for further explanation as to why the denial occurred. The denial can be due to various reasons, such as:

- Not deeming the service, drug, or device "medically necessary"
- Not having enough clinical data to determine if the service, drug, or device is effective or efficient for the condition for which it is prescribed
- Stating that the service, drug, or device is experimental or investigational
- Not covering the service, drug, or device under the health plan you currently have
- It may be a clerical error that can be resolved immediately.

Every insurer must clearly state how a patient covered by their insurance can file an appeal. You can find this information online or within the benefits packet you receive.

Before hanging up with the representative, ask for a "case number." This is the number assigned by the insurer to your initial call, and will keep the chain of all your calls on this issue in one place. Case numbers are valuable when being transferred or escalated.

Step 2: Gather Your Information for the Appeal

Most insurers require additional documentation to consider your request for appeal. In addition to the paperwork that is unique to the insurer, most experts recommend providing the following:

- A letter from your medical professional supporting your request
- Clinical notes/test results from your medical record at the medical professional's office
- Results from clinical studies published in peer-reviewed medical journals (These can be especially helpful with appeals for denials of "experimental" or "investigational")
- A letter from the patient stating the reason you need this drug/device/service

Do not delay in gathering this information, as the clock begins ticking when the insurance company denies the device, service, or medication your provider prescribes. Most insurers give patients 180 days from the published date of the denial to submit an appeal. "Expedited appeals" are only allowed when your medical provider believes your life or level of function is in jeopardy; or if you are already receiving the treatment that has been prescribed, as in the case of a particular drug.

Reach out to the company that provides the drug, device, or service and ask for their assistance in appealing the denial. Some diabetes companies have a team on staff that specifically deal with insurance appeals. Ask for their expertise.

Peer-to-Peer (P2P) Conference Call

As you gather this information, you can also ask your medical professional to request a Peer-to-Peer (P2P) conference call, also called a "First Level Appeal." This is a conversation about the denial between your medical team and a medical professional within the insurance company. After confirming the credentials of the insurer's medical professional, they discuss the clinical outcomes for using a particular device, drug, or service. Your medical professional essentially provides support for the specific medication, device, or service that you need. The appeals process is expedited, and a repeal of the original denial can be swifter than going through the next step in the process.

If the Peer-to-Peer conference call is not successful, you'll send in the paperwork and supporting documentation for the internal review by your insurer.

Writing Your Personal Letter for Your Appeal

By effectively stating your reasons why you believe you should not be denied this service, device, or drug, you are able to provide personal insight as to the quality of life that you would receive if the denial was overturned.

Here is a template that you can use to help craft your personal letter:

[DATE]

[Name of Insurer's Appeals Department]

[Insurer's Address]

[Your Name]

[Your Address]

[Your Insurance ID]

Appeals case: [Case Number]

To Whom It May Concern:

I am writing in reference to the EOB dated [date of denial], for which I was denied.

[Take a paragraph to explain your diabetes (or other medical condition). Explain your diagnosis, the impact that it has had on your daily life, and what your expectations of a future with diabetes are without the drug, device, or service. While you may know a lot about diabetes, most people don't, so it's helpful to give a quick clinical explanation as to what diabetes is.]

I believe that [insurer's name] should approve [device, drug, or service], as it will [insert reason why your medical condition will improve]. The body of clinical evidence supporting this reasoning is listed below:

[insert articles of peer-reviewed journals showing the safety, efficacy, or improvement in the quality of life for the device, drug, or service — include the name of the article, the name of the journal, the date of the journal's publication, page number of the article, and a URL if possible]

Note: if you have come to understand that part of the denial is based on cost, you may also want to include a paragraph on the cost savings of using the drug, medication, or service versus hospitalization, ER costs, or other cost issues that could occur if the denial was not overturned.

My medical team, [insert name of professional(s)], also concurs with the clinical evidence and that the approval of [drug, device, or service] will not only provide overall cost savings to [insurer], but increase adherence and potential for positive outcomes for my diabetes in the short- and long-term. Please contact my team [insert name of professional(s) and phone numbers for additional information, as [he/she/they] [has/have] given me full support through prescribing this [drug, service, or device] as the best treatment decision.

Based on the clinical evidence, support of my medical team, and the lack of alternative options that would be the best, and most cost-effective course of treatment, I am asking that you overturn your denial of [drug, device, or service], as it is medically necessary for me.

Thank you for your thoughtful consideration and support. I look forward to hearing a favorable decision from you within [insert number of days that insurer has stated an appeal decision would be given — often 7 to 10 business days].

Sincerely,

[your name]

[your phone number]

[your email address]

Step 3: Submit for Second Level of Appeal or Internal Review

Once you have written your letter and gathered the supporting documents, send the packet via certified mail, return receipt requested, or with another delivery service that provides proof that the insurer received the documents.

The documents will be reviewed by a medical professional within the insurance company. They will carefully examine the evidence presented and read your letter. From there, they may recognize that the appeal should be overturned based on the information received and that it is within the coverage guidelines. You should receive a formal notice within 30 – 60 days.

If you receive a notification from your insurance company that the service, device, or drug is still denied, there may be additional steps you can take. The internal review decision letter will explain that you have an opportunity to request an external review and what needs to be done.

Note: If the denial is because it's not under your plan or that you have reached the maximum limit (i.e., number of visits as stated in the plan), there are no further options. External reviews cannot be initiated for those reasons.

Step 4: Submit for Third Level of Appeal or External Review

External reviews are completed by an independent board-certified physician who is within the same specialty area as the prescribing medical professional. For people with diabetes this could be an endocrinologist, nephrologist, podiatrist, or cardiologist, depending on the drug, service, or device.

The external review must be completed by an independent review organization (IRO) and will involve the materials that you initially provided for your appeal as well as documentation submitted by the insurer. The unbiased organization's representative will determine within 45 days of submission whether the appeal should be overturned, based on the information provided by all parties.



Negative Appeal Outcomes: What Can You Do?

Unfortunately, there are times when the final level of appeal is not the outcome you desire, and you are denied the drug, device, or service that your medical team believes is the best course of treatment for your diabetes.

If you choose to continue taking the drug, using the device, or availing yourself to the service, it will be outside of your insurance company's plan. You will pay 100% of the charges. Some device or drug companies or medical services offer "cash-only" discounts, and some others have payment plans (especially devices).

Discuss with your physician as to what the *next* best treatment may be for your diabetes and review your coverage to ensure that it falls under your plan.

Finally, insurance plans may change coverage for drugs, devices, and medications annually. As you choose insurance coverage for the coming year, review options carefully to see if any favorable changes have been made that might allow you to receive the initial treatment prescribed to you. If you are able to switch plans, see if one is available that provides the drug, service, or device coverage you and your physician believe will work best for you.