Prior Authorizations, Step Therapy, and Appeals
Women with diabetes are warriors. We have to be, as we often find ourselves battling with insurers over our daily management prescribed to us by medical professionals. It’s common to hear of being denied devices like insulin pumps or continuous glucose monitors (CGM), medications, services, or even the amount of blood glucose test strips we should use monthly.

Dealing with step therapy requests, prior authorizations, or appealing insurance denials is time consuming and frustrating, but your health is worth it. Knowing the steps and being prepared will help you navigate the processes and hopefully provide you with the care you deserve.

Prior Authorizations

One cost-savings measure restricting access to the medication or service you need for your diabetes is “prior authorization,” and often the first time you hear of this term is at the pharmacy counter. The pharmacist will state that she is unable to process the prescription until your prescriber has contacted the insurance company.

Prior authorization is simply a method to keep insurer costs down, rather than what may be best for you. You are not involved with this process at all. The pharmacy sends notification to your medical professional’s office. They must call a line that is only given to medical professionals to discuss and/or fill out forms explaining why you have been prescribed a particular drug. Either your medical professional’s office or your pharmacy will call back with a decision.

If your drug is not authorized, you have a choice: pay the full amount for the prescription (the insurance company will not pay for it at all) or have your prescriber offer you a different medication. You can also appeal the 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 choose that particular drug over another.
Quantity Limit Prior Authorization

Many insurance companies may limit the number of blood glucose testing strips that a person with diabetes can receive through a prescription each month. The limit may depend on your 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 proper 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 (e.g., hypoglycemia unawareness, pregnancy, or major therapy changes requiring more frequent monitoring).

Most prior authorizations are approved for one year. Be prepared to have this battle when your insurance policy resets, as most insurers “forget” that you have diabetes.

Step Therapy

Step therapy is a way for the insurer to force you to try a less expensive medication or treatment before allowing coverage of what the medical professional has prescribed you. It’s 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 their step therapy program, you will be required to show that you have attempted other medications—and these medications have failed to treat your diabetes effectively—through your medical team’s 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 of your options and chose to treat you with a particular drug. Why is it that you must go through one or more other drugs to be able to be on the treatment you need?

It’s 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. Unfortunately, that isn’t the case. Studies have shown that step therapy can increase insurer and patient costs through outpatient expenditures. 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 “fail” a medication. In addition, medical office staff expends time and effort filling out step therapy requests. No one wins; everyone fails.
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 bank on their clients not questioning why a claim would not be covered.

Upon receiving your denial, print out two items: the section of your insurance benefits pertaining to the denial and your explanation of benefits (also called an EOB). You’ll be referencing both frequently. You’ll also want to create a folder, whether online or physically, 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 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 is trying to help, not hinder you, in relaying information about your appeal.

In some cases, your Explanation of Benefits (EOB) will explain why the claim was denied. Other times, the response can 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 the insurer:

• 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
• And, of course, it may be a clerical error that can be resolved immediately

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

Before hanging up with the representative, you’ll ask for a “case number.” This is the number that will keep the chain of all your calls on this particular issue in one place, and it’s valuable when being transferred or escalated.
Step 2: Gather Your Information for the Appeal

Most appeals will require additional documentation to support your request. In addition to the paperwork that is unique to the insurer, most experts recommend the following:

- A letter from your medical professional supporting your request
- Clinical notes/tests from your files kept at the medical professional’s office
- Results from clinical studies that have been published in peer-reviewed medical journals (These are especially helpful with “experimental” or “investigational” denials)
- A letter from you stating the reasoning for the request
- Reach out to the company that provides the drug, device, or service and ask for appeal assistance. Some diabetes companies have a team on staff that specifically deal with insurance appeals. Use their expertise!

Note: Do not delay in gathering this information, as the clock begins ticking when your device, service, or medication is denied. Most insurers give their members 180 days from the published date of the denial. Also, “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.

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, which is also called “First Level Appeal.” This is a conversation regarding the denial between your medical team and a medical professional within the insurance company. After confirming the credentials of the insurer’s medical professional, the discussion of the clinical outcomes for using the particular device, drug, or service will ensue. Your medical professional essentially “goes to bat” for you. 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 overtaken.

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 without the drug, device, or service are. 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 document, send the packet via certified mail, return receipt requested or via other 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 being denied, there are additional steps that 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 3: 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. (It’s whoever prescribed and signed onto the original appeal.)

The external review must be completed by an independent review organization (IRO), and will involve the materials that you initial 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 in which the final level of appeal is not the outcome you want 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 on the course of 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 companies do offer “cash only” discounts and others have payment plans (especially devices).

Talk 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, as insurance plans change coverage for drugs, devices, and medications annually, as you choose your plan for the next year, review carefully to see if any favorable changes have been made that might allow you to receive the initial treatment prescribed to you. If you also have an option to switch plans, seek out the one that provides the drug, service, or device coverage you and your physician believe is best for you.