DiabetesSisters Life Class Webinar: Appeals & Denials

with Cherise Shockley and Melissa Lee

supported by

through an independent grant
It’s on you.

Blood glucose logs? Device downloads?
Logbooks? It’s on you to know what your insurance wants to see in order to approve the therapy you’re pursuing coverage for.
Google your insurer’s medical policy!
**Medical Policy**

**POLICY**

Intermittent monitoring (i.e., 72 hours) of glucose levels in interstitial fluid may be considered **medically necessary** in patients with type 1 diabetes whose diabetes is poorly controlled, despite current use of best practices (see Policy Guidelines). Poorly controlled type 1 diabetes includes the following clinical situations: unexplained hypoglycemic episodes, hyperglycemic unawareness, suspected postprandial hyperglycemia, and recurrent diabetic ketoacidosis.

Intermittent monitoring of glucose levels in interstitial fluid may also be considered **medically necessary** in patients with type 1 diabetes prior to insulin pump initiation to determine basal insulin levels.

Continuous (i.e., long-term) monitoring of glucose levels in interstitial fluid, including real-time monitoring, as a technique of diabetic monitoring, may be considered **medically necessary** when the following situations occur, despite use of best practices:

- Patients with type 1 diabetes who have recurrent, unexplained, severe (generally blood glucose levels less than 50 mg/dL) hypoglycemia that puts the patient or others at risk; or
- Patients with poorly controlled type 1 diabetes who are pregnant. Poorly controlled type 1 diabetes includes unexplained hypoglycemic episodes, hyperglycemic unawareness, suspected postprandial hyperglycemia, and recurrent diabetic ketoacidosis.

Other uses of continuous monitoring of glucose levels in interstitial fluid as a technique of diabetic monitoring are considered **investigational.**

---

**Aetna**

**III. External Insulin Infusion Pumps for Diabetes**

Aetna considers external insulin infusion pumps medically necessary DME for the persons with diabetes who meet the criteria in section A or in section B below:

**A. Members must meet all of the following criteria:**

1. The member has been on a program of multiple daily injections of insulin (i.e., at least 3 injections per day), with frequent self-adjustments of insulin dose for at least 6 months prior to initiation of the insulin pump; and
2. The member has completed a comprehensive diabetes education program; and
3. The member has documented frequency of glucose self-testing an average of at least 4 times per day during the 2 months prior to initiation of the insulin pump**; and
4. The member meets at least one of the following criteria while on multiple daily injections (more than 3 injections per day) of insulin:
   a. Dawn phenomenon with fasting blood sugars frequently exceeding 200 mg/dL; or
   b. Elevated glycosylated hemoglobin level (HbA1c) greater than 7.0%, where upper range of normal is less than 6.0%; for other HbA1c assays, 1% over upper range of normal; or
   c. History of recurrent hypoglycemia (less than 60 mg/dL); or
   d. History of severe hypoglycemic excursions; or
   e. Wide fluctuations in blood glucose before mealtime (e.g., pre-prandial blood glucose levels commonly exceed 140 mg/dL); or

**B. The member has been on a pump prior to enrollment in Aetna, and has documented frequency of glucose self-testing an average of at least 4 times per day during the month prior to Aetna enrollment.**
Your Doctor, Your Advocate

1) Your insurer has a **dedicated phone line** for your provider.
2) Your provider can request a **peer-to-peer** with a physician at the insurance company.
3) This is not your provider’s first rodeo. **They know how to get to yes.**
4) Your insurer will request your **provider’s notes** about your care, including visit notes.

Every visit, make sure that your healthcare team is **noting your concerns** in your visit notes.
You have advocates on the inside at your insurer, your HR, & the therapy company.

Ask your employer’s HR or Plan Administrator to intervene on your behalf.

Ask to speak to a health advocate at your insurance company.

Call the company that makes the therapy you’re seeking coverage for. They have fought this before.

Who can use Health Advocate?

You can use this service if you’re a Blue Cross Blue Shield of Michigan or Blue Care Network member enrolled through GlidoPath.

Your whole family can use Health Advocate. You, your spouse, dependent children, parents, and parents-in-law can call as often as they need to. It doesn’t cost you anything. The service can help even if they’re not covered by your medical plan.

How it works

When you use Health Advocate, you’ll be connected with a personal advocate who can help you:

- Sort through information from doctors, dentists, specialists and other health care professionals
- Schedule appointments and arrange for second opinions
- Set up special procedures and tests
- Get answers about test results, diagnoses and medications
- Research newest treatment options
- Transfer medical records, X-rays and lab results
- Negotiate payment plans for your out-of-network medical bills
- Understand your appeal rights for bills from doctors, hospitals and other health care professionals
- Find in-home care, adult day care, assisted living and long-term care
- Understand Medicare, Medicaid and Medicare supplemental plans
- Coordinate care between different doctors and hospitals
- Research transportation to appointments
On the Phone to Your Insurer?

Keep calm and keep a notebook!
Thank you for joining us!

Melissa Lee
- @sweetlyvoiced * sweetlyvoiced.com

Cherise Shockley
- @sweetercherise * @diabetessocmed * DiabetesSocMed.com