

# How Providers Can Help Patients Access Care

Patient outcomes and quality of life can be significantly improved when patients are connected to members of the health care team who can discuss their health insurance coverage, preferences around managing work and cancer treatment, and access to financial assistance.

*Cost of Care  
Health Insurance Appeals*



## Cost of Care

Cancer treatment is expensive. Connecting patients to resources that assist with accessing and paying for their care can help mitigate the financial burden of a cancer diagnosis. For example, consider:

### GENERICS

May a generic version of the drug be equally effective?

### FORMULARY TIERS

Which formulary tier does a drug fall on for the patient's plan?  
Is there another equally effective option on a lower tier with a lower out-of-pocket cost for the patient?

### DRUG DISCOUNT CARDS

Is the patient aware of the many drug discount cards that can be used at a pharmacy instead of health insurance to lower out-of-pocket costs?

### STATE PHARMACEUTICAL ASSISTANCE PROGRAMS

SPAP • Is the patient aware of a state program to help with the cost of prescription drugs?

### PATIENT ASSISTANCE PROGRAMS

Is the patient aware of the pharmaceutical company and nonprofit programs that help with the cost of prescription drugs?

### LAB TESTS

Is the lab that we are sending the patient's test to an in-network provider for the patient's health plan?

### IMAGING SCANS

Is the imaging center that we are sending the patient to an in-network provider for the patient's health plan?



## Health Insurance Appeals

Many patients experience a denial of coverage from an insurance company at some point during their treatment. While many take “no” for an answer, appealing the denial may allow a patient to access the care that was prescribed by their health care team. As many as 60% of external appeals are decided in favor of patients, making them an important tool to improve access to care and mitigate financial toxicity.



When a patient is denied coverage by their insurance company, providers can help patients access care by appealing the denial through an internal appeal and external appeal, if necessary.

## Specific Reasons for Denials and How Providers Can Help:



### **MISTAKES**

There may be errors with the patient information, billing details, or CPT/HCPCS codes.

### **HOW PROVIDERS CAN HELP**

Correct any mistakes and resubmit the claim.

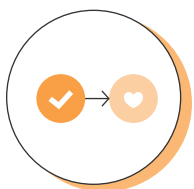


### **EXPERIMENTAL OR INVESTIGATIONAL**

Insurance companies may deny care that they believe is experimental or investigational.

### **HOW PROVIDERS CAN HELP**

Help your patient appeal those denials and provide information about why the care is medically necessary.



### **PRE-AUTHORIZATION**

Insurance companies are not required to pay for care if it was not pre-authorized in advance.

### **HOW PROVIDERS CAN HELP**

Help the patient obtain necessary pre-authorizations before care.



### **SERVICE NOT COVERED**

A patient can check their policy to see if the service is specifically listed as “excluded.”

### **HOW PROVIDERS CAN HELP**

If not, and the care is medically necessary, they can appeal that denial.



There are different rules for filing appeals depending on a patient's health insurance coverage. Medicare, Medicaid, military, and Veterans plans all have specific rules. Those who have private individual health insurance or an employer-sponsored plan generally have two chances to appeal a denial of coverage via an **internal appeal** and an **external appeal**.

## Internal Appeal

After an insurance company has denied care, either the patient or the health care provider can file an "internal appeal" with the insurance company.

### STANDARD APPEAL

For situations that are not urgent, a standard appeal can be filed within 180 days of receiving the denial. If an internal appeal is unsuccessful, there may be a second level of appeal within the insurance company.

**Pre-Authorization:** a health plan is required to provide a decision, in writing, within **30** calendar days of receiving an appeal.

**Post-Treatment:** a health plan is required to provide a decision in writing within **60** calendar days of receiving an appeal.

### EXPEDITED APPEAL

An expedited, or urgent, appeal can be filed if the patient has not received treatment or is in the middle of treatment and the condition could involve imminent or serious threat to their health. The health plan is required to respond to the appeal within **72 hours** of receiving an appeal. An expedited appeal may be filed both internally and externally at the same time.

### PEER REVIEW

As a part of the internal appeals process, a provider can elect to have a peer review call with a doctor that works for the health insurance company. This may happen before a formal internal appeal is filed or as a part of the formal appeal. During this call you have the opportunity to explain why the treatment you have prescribed is medically necessary. If you are not successful, either you or the patient can file a formal internal appeal or, if the internal appeals process has been exhausted, an external appeal.

## External Appeal

Under the Affordable Care Act, all states must have an external appeals process, sometimes referred to as External Medical Review or Independent Medical Review. State insurance agencies or the U.S. Department of Health & Human Services (HHS) run external appeals through independent review organizations that determine if the insurance company should pay for the medical care. Standard external appeals must typically be filed within 60 days of receiving the internal appeal denial. An external appeal decision must be made within 45 days of the filing. Urgent appeals, which can be filed at the same time as the internal appeal, are decided within 72 hours. Decisions are binding on the insurance company.



## How to Help Patients with the Appeals Process

- ★ Request a Peer Review call, ask to speak to a health care professional who would be familiar with the treatment being discussed, and provide information about the medical necessity of the treatment.
- ★ Offer to file the appeal on the patient's behalf.
- ★ Write a letter of support providing information tailored to the patient's situation that explains the medical necessity of the care being denied.
- ★ Ensure that your notes in a patient's medical record are thorough and include all relevant information related to the patient and their need for a particular treatment.
- ★ Provide any current guidelines, medical literature, or research studies documenting the medical effectiveness of the prescribed care for experimental or investigational treatments.
- ★ Provide any peer-reviewed articles from professional journals that support the recommended treatment plan.

**CAUTION** The following types of health insurance plans may not have to comply with state or federal appeals rules: self-insured student plans, church plans, Farm Bureau plans, association health plans, short-term health plans, and health care sharing ministries.

For more information on the appeals process, visit

→ [TriageCancer.org/Cancer-Finances-Appeals](https://TriageCancer.org/Cancer-Finances-Appeals)