

ONCOLYTICS TODAY

EMPOWERING THE MEDICALLY INTEGRATED ONCOLOGY PHARMACY PRACTICE | **FALL 2023**

ONCOLOGY FACES A HOST OF RISING CHALLENGES



... AND WE MUST CONTINUE
TO EDUCATE AND ADVOCATE FOR
NEEDED CHANGE TO SOLVE THEM
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NCODA



DON'T TAKE NO FOR AN ANSWER

KEY TIPS FOR NAVIGATING HEALTH INSURANCE DENIALS

By Joanna Fawzy Doran, Esq.

At some point during cancer treatment, it is not uncommon for a patient to experience a denial of coverage from an insurance company, whether for a prescription drug, imaging scan, treatment, procedure or even a genetic test. This is sometimes called an “adverse benefit determination.”

And, most people take “no” for an answer.



Joanna Fawzy Doran

Many patients assume that their insurance company has made a correct decision, accept the denial of coverage and then try to find a way to pay for the medical care themselves. That can include applying for financial assistance programs, crowdfunding or even mortgaging their home.

However, if an insurance company denies coverage, patients have the right to appeal the decision. Those who don't accept the denial, and pursue the appeals process, may actually win and get coverage for the care prescribed by their healthcare team, up to 60% of the time.

Key stakeholders in the continuum of a patient's care are uniquely positioned to help patients become aware of, and effectively navigate, the appeals process. That includes members of healthcare teams, pharmacists, community health

workers and patient advocates.

Even if healthcare providers are not filing appeals on behalf of patients, they still play a key role in the appeals process and can help provide valuable information to help patients get access to the care that they need.

IDENTIFY THE TYPE OF COVERAGE

Appeals can look very different based on an individual's type of coverage:

- ▲ Employer-sponsored plans (insured or self-insured)
- ▲ Individual plans (e.g., Marketplace plans)
- ▲ Medicare (fee-for-service or managed care)
- ▲ Medicaid (fee-for-service or managed care)
- ▲ Military and veterans coverage

Medicare, Medicaid, military, and veteran's coverage each have specific appeals processes. The Patient Protection and Affordable Care Act (ACA) is a federal law that requires individual and employer-sponsored plans to provide an external appeals process, in addition to an internal appeals process. This is also sometimes referred to as External Medical Review or Independent Medical Review. Note: some states also have these consumer protections at the state level and may actually be more protective.

The regulation of the appeals process also depends on what type of plan patients have. It might be regulated by the U.S. Department of Health & Human Services (HHS) or a state agency or both. To learn more about the federal and state

laws governing the appeals process, visit [TriageCancer.org/StateLaws](https://www.triagecancer.org/StateLaws).

Certain types of coverage for healthcare are not considered insurance at all, such as a healthcare-sharing ministry, and may not be required to have an appeals process.

UNDERSTANDING INTERNAL VS. EXTERNAL APPEALS

If patients have a private insurance plan, like a Marketplace plan or a plan through their employer, they generally have two chances to appeal a denial of coverage: an internal appeal and an external appeal.

When an insurance company first denies coverage for their care, they can file an internal appeal, asking their insurance company to reconsider. Each insurance company has their own internal appeals process, but there are required time frames related to filing an internal appeal.

Standard appeal: For situations that are not medically urgent, a standard appeal can be filed within 180 days of receiving the denial.

If the denial is for a pre-authorization, the insurance company is required to provide an answer, in writing, within 30 calendar days of receiving an appeal.

If the denial is for care that has already been received, the insurance company is required to provide an answer, in writing, within 60 calendar days of receiving an appeal.

Expedited appeal: An expedited appeal

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(or urgent appeal) can be filed when a delay in treatment would seriously jeopardize the life and/or overall health of a patient, affect a patient's ability to regain maximum function, or subject a patient to severe and intolerable pain. Decisions must be made within 72 hours of receiving the appeal.

If an insurance company denies the internal appeal, a patient can request an external appeal, where an independent entity decides whether or not the care that the patient is being prescribed by their healthcare provider is medically necessary. If they decide that it is, then the insurance company has to cover the care. The external appeals process is meant to ensure a fair and objective review of claim denials.

Standard appeal: Within four months of receiving an insurance company's denial of the internal appeal, a patient can file a written external appeal (note: some states provide additional time). External appeals are completed within 45 days of filing.

Expedited appeal: If urgent, reviews can be expedited, filed at the same time as an internal appeal, and decided within 72 hours.

A patient can file an external review if:

- ▲ The internal appeal was denied;
- ▲ The plan fails to return its decision for the internal appeal in the time allowed; or
- ▲ The patient has an extremely urgent issue and can request to have an external appeal at the same time as the internal appeal.

Appeals can be filed both before and after medical services are provided. The process for filing an appeal before care and after care are slightly different.

For example, if an insurance company has denied a pre-authorization for a prescription drug, the patient can appeal that denial using the internal and external appeals process, if needed.

State insurance agencies or HHS administer external appeals. The HHS

process is free, but states cannot charge more than \$25 for an external appeal.

USAGE OF THE APPEALS PROCESS

The nationwide data on external appeals shows that on average, external appeals are successful for patients about 50% of the time. Despite being successful for patients, the external appeals process is a very well-kept secret of the healthcare system.

The only types of plans that are required to report data on their numbers of claims, denials, and appeals are Marketplace plans. This requirement was contained in the ACA. Based on 2021 data for Marketplace plans, more than 43 million claims were denied. Only .01% of those claims were appealed to the internal appeals process.

That means that 99.9% of the time that patients were accepting "no" for an answer. And that means that those patients were either paying for that care out of pocket, or not getting access to the care that was prescribed by their healthcare team, because they couldn't afford to pay for it out-of-pocket.

Lack of patient and provider knowledge of the external appeals process is contributing to patients' challenges with access to care, and to the financial burden of a cancer diagnosis.

THREE STEPS TO THE APPEALS PROCESS

1 It is important for the patient to understand why the care was denied. That may be clear from the explanation of benefits. It might also require contacting the insurance company to ask for a detailed explanation of the denial and the company's internal appeals process.

There are several reasons why insurance companies may deny a claim, including:

Mistakes: There may be errors with the patient's information, billing details, or CPT/HCPCS codes. Review the bills, contact providers, and request they resubmit the claim with correct information, and explain the resubmission to the insurance company.

Pre-Authorization: Insurance companies are not required to pay for care if the patient did not get pre-authorization before receiving certain types of care, including prescription drugs.

"Experimental or Investigational": An insurance company may deny care, claiming that it is experimental or investigational. An appeal can be filed. Healthcare providers can help provide information about why they believe that the care is medically necessary.

Service Not Covered: If an insurance company says that the care is not covered, a patient can check their policy to see if the service is listed as "excluded." If not, a patient can contact the insurance company and ask for more information about the denial. They may claim the service was unnecessary. If so, a patient can contact their provider and ask for help showing that the care is medically necessary.

Timely Submission: Claims submitted too long after services were provided may be denied. However, if a provider is within network, fixing this error usually only requires a phone call to the provider. As they are in charge of submitting claims, providers are usually held responsible for this delay.

Coordination of Benefits (COB): If a patient has both a primary and a secondary insurance policy, it's essential to complete and submit COB forms every year. Failing to complete these forms can result in claim denials.

2 A patient should work with their providers to gather evidence for why the medical care should be covered. Evidence to support the appeal can include:

- ▲ Notes and/or letters of support from healthcare providers;
- ▲ Results of tests and procedures related to the care in question;
- ▲ Relevant medical literature, professional journals, and studies showing the effectiveness of the care, especially when appealing denials of care for being experimental or investigational; and

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▲ A brief and factual personal statement from the patient, describing the need for the requested care.

3 Patients should make sure to pay attention to the deadlines and requirements for their insurance companies' appeals process.

EDUCATING PATIENTS ABOUT THE APPEALS PROCESS

This information can be shared with patients throughout the continuum of a patient's care.

If healthcare providers are not going to file an appeal on behalf of a patient

when care is denied coverage, then they can educate patients on the steps to appeal. Healthcare providers can even proactively share the availability of the appeals process when they are discussing treatment options with a patient.

Financial and billing counselors can educate patients and help them understand steps to take if they have received a bill where the claim was denied coverage. And, pharmacists can educate patients about the appeals process if their medications are denied coverage.



For more information about the insurance appeals process, scan the QR code above.

Helping patients successfully navigate the appeals process will not only improve the chances that patients get access to the care that they need, but also mitigate the financial burden of a cancer diagnosis.

Visit [TriageCancer.org/Cancer-Finances-Appeals](https://www.triagecancer.org/Cancer-Finances-Appeals) for details on the steps to the appeals process based on

different types of health insurance plans.

▲ **Joanna Fawzy Doran, Esq.**, is a cancer rights attorney and Chief Executive Officer of Triage Cancer in Chicago, Illinois.



CORPORATE PARTNER TRAINING PROGRAM

This specialized and exclusive NCODA offering allows our partners to be trained by experienced faculty and key opinion leaders in the medically integrated oncology and hematology space.

The NCODA University team will coordinate and customize the training based on the partner's needs from start to finish.

The process includes:

- Development of training agenda tailored to partner product and disease state
- Identification of leading oncology professionals that will be on-site to conduct the live training
- A collaborative atmosphere to ensure partner team members are well-equipped and knowledgeable on the medically integrated space at the conclusion of the training



To learn more, please contact:

Pat Connelly | Chief Development & Strategy Officer | Patrick.Connelly@ncoda.org

Stacey McCullough, PharmD | Chief Pharmacy Officer | Stacey.McCullough@ncoda.org

