# Editorial

## Using Evidence-Based Medicine to Appeal Medical Coverage Decisions

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Physicians are experiencing an increasing number of challenges regarding their medical judgment. Payment for services can be denied based on medical necessity or contractual exclusion of a service. Patients often call and ask for help because their prescription coverage was denied. I will present my approach to appealing coverage decisions. The approach has served my patients well over the years and involves 6 key messages: (1) understand the rules; (2) act professionally; (3) understand the process; (4) accept when the coverage decision is appropriate; (5) be persistent when the coverage decision is inappropriate; and (6) effectively use evidence-based medicine to help your patient.

### Understand the Rules

It is important to become familiar with local coverage policies. Most of these policies are posted online and do not take a long time to read. It also is important to know who you are dealing with. In the past, payers mostly were the insurance companies who assumed the risk for providing health care coverage and established the policies for those plans. Now many payers act as health benefits administrators for employers who self-insure. These employers are faced with rising health care costs and a workforce of individuals who do not want cuts in their benefits. When faced with the choice between cutting benefits and rigorously ensuring that payments only are made for appropriately performed and covered services, most employers will opt for the latter. The health benefits administrator is accountable to the employer who pays the bills but does not set a policy regarding what is or what is not covered by the plan. In this scenario, the insurance company does not set a policy but merely carries out the policies of the employer.

Physicians also must determine if the denial of coverage was based on medical necessity or contractual exclusion. Health insurance plans sometimes exclude certain diagnoses or procedures; these exclusions specifically are stated in the contract. When the patient accepted the coverage plan, he/she accepted the contractual exclusions. Fortunately these exclusions tend to be rare and most denials are procedural or based on the judgment of medical necessity. Experimental treatments commonly are excluded from coverage, but in some cases, Medicare may cover clinical trial therapy. It is good to know the specific details of the most common policies that cover your patients' health care. Some policies require preauthorization for certain services and other policies may require a trial of a less expensive therapy prior to the authorization of a more expensive option. You will encounter fewer problems if your office employees are familiar with the procedures.

### Act Professionally

Insurers need dermatologists to see their patients. They do not want to antagonize physicians but may not understand the clinical situation. If you and your office employees act professionally and consider your communication as an opportunity to educate payers about a condition and its treatment, you are more likely to prevail and to build a meaningful relationship with the payer. The payers rely on the specialists in the community to act as consultants of skin conditions and you can act as a consultant by becoming a knowledgeable resource when future questions arise. The credibility you build is important.

### Understand the Process

It is easy to become frustrated when trying to navigate the appeals process. You must be knowledgeable of the appeals process for your major payers because it will save you time and effort in the long run. An extended description of how to appeal a denial is presented in Table 1. The payer's policies typically will be posted online. It takes time to read through them, but most of the policies are similar, and once you become familiar with the general rules, you will find the process less onerous. It may be helpful to invite a payer representative to speak to your state dermatologic society

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Table 1.

**Key Points to Remember When Appealing a Denial**

- Be professional and pleasant. You are representing your specialty as well as the patient
- Distinguish contractual exclusions from medical necessity determinations
- Distinguish between an insurer and a benefits administrator: an insurer sets a policy and a health benefits administrator follows a policy
- Provide published references to support your recommendations: case reports carry little weight, but higher levels of evidence can effectively be used to help your patient
- Understand the appeals procedure
- Know who you are talking to and his/her role
- Be professional but persistent if you are in the right
- Involve your state society in the process if you feel you are not getting anywhere and the decisions have broad implications

or have a representative of the state society approach the carrier medical director about recurrent issues. The medical director generally wants to maintain good relationships with the specialty societies and will engage in a dialogue.

## Accept When the Coverage Decision Is Appropriate

You are not always going to win. Appropriate decisions are those decisions that are in keeping with the insurance policy rules. You may not agree with the rules, but you are unlikely to prevail simply by annoying the payer. Contractual exclusions are a good example. Whether or not you agree with the exclusions, the patient agreed to them when he/she accepted the policy. The decision is unlikely to be overturned and blind persistence will decrease your chances of prevailing in subsequent cases. Pick your battles.

## Be Persistent When the Coverage Decision Is Inappropriate

If the treatment that was denied is supported by medical evidence and is not contractually excluded from the coverage, your role is to educate the insurer or health benefits administrator so that they understand the basis for your recommended treatment. You also must document the failure of standard therapy as well as the comorbidities and contraindications to the alternative treatments that typically may be required by the policy. If the alternative treatments clearly are contraindicated, the requirement should be waived. You should not become discouraged if an initial attempt at an appeal is rejected. The first review usually is done by a clerical employee who must determine if a mistake was made or if company policy was followed. This individual typically does not have the authority to override a written policy.

The second level of review, which usually requires a second letter from you, commonly is done by a nurse who has more of an understanding of the conditions involved and also may have a better understanding of the existing provisions to waive the alternative treatments in the presence of contraindications. Review by a medical director may only occur following the submission of a third letter or a specific request to have the appeal reviewed by a medical director. The medical director may be able to override a policy when it is medically appropriate and more importantly to recommend changes in a policy when a policy is shown to be inappropriate. Even if the payer is a medical benefits administrator, the payer is in close contact with the policy makers at the employer facility and can help to change bad policies.

If your appeal is turned down by a medical director, you should carefully review the facts and determine if it is worth pursuing a further appeal. At this point, it may be best to work with your state society, especially if the society has an established relationship with the payer.

Patients have the right to appeal to a senior medical director, to file a grievance with the insurance plan, or to file a grievance with the state's insurance regulators if all other avenues have been exhausted. If the patient files a grievance, your role is to provide a calm, professional, and dispassionate explanation of the medical condition and treatment. Additionally you must explain why the treatment is the best option and why the alternative treatments are contraindicated. Your credibility and the credibility of your society are at stake, so choose your words wisely. If you are in the right, you typically will prevail; however, it is unusual for the patient to have to resort to filing a grievance.

## Effectively Use Evidence-Based Medicine to Help Your Patient

When presenting data to support your recommendations, it is helpful to use standard terminology to

Table 2.

**Standard Terminology Used for Levels of Evidence in Evidence-Based Medicine**

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| Level Ia: evidence from meta-analysis of randomized controlled trials |
| Level Ib: evidence from at least 1 randomized controlled trial |
| Level IIa: evidence from at least 1 controlled study without randomization |
| Level IIb: evidence from at least 1 other type of experimental study |
| Level III: evidence from nonexperimental descriptive studies, such as comparative studies, correlation studies, and case-control studies |
| Level IV: evidence from expert committee reports or opinions and/or clinical experiences of respected authorities |

Table 3.

**SORT (Strength of Recommendation Taxonomy) Criteria**

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| Level 1: good-quality patient-oriented evidence |
| Level 2: limited-quality patient-oriented evidence |
| Level 3: other evidence including consensus guidelines, opinion, or case studies |

communicate effectively. Standard medical treatment is reflected in drug labeling or is supported by current, vetted, evidence-based guidelines of care. The American Academy of Dermatology guidelines typically are published in the *Journal of the American Academy of Dermatology* and can be found online. Evidence-based guidelines from other societies can be found in the National Guideline Clearinghouse (www.guidelines.gov). If the guidelines are produced following the current standards for evidence and conflict of interest policies, they generally are recognized as authoritative evidence that a treatment has gained acceptance. Standard textbooks of dermatology, such as Bolognia et al's[1] *Dermatology* and *Andrews' Diseases of the Skin*,[2] also can serve as evidence that treatments have gained acceptance. Case reports represent a low level of evidence and may not be of much help, but higher levels of evidence carry more weight. Table 2 notes standard terminology for levels of evidence. The current American Academy of Dermatology guidelines of care do not use this level of evidence terminology but use the SORT (Strength of Recommendation Taxonomy) criteria (Table 3).

## Summary

We are here to serve our patients and do what is right. Keep a calm and level head and get to know the system and the rules. It takes a little time but will be well worth the effort.

## REFERENCES


1. Bolognia JL, Jorizzo JL, Rapini RP, eds. *Dermatology*. 2nd ed. Spain: Mosby Elsevier; 2008.
2. James WD, Berger TG, Elston DM, eds. *Andrews' Diseases of the Skin: Clinical Dermatology*. 11th ed. London, England: Saunders Elsevier; 2011.


## QUICK POLL QUESTION

Test your knowledge! A health benefits administrator sets policy and can change rules.

- True
- False

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