BIOLOGIC COORDINATORS
OF DERMATOLOGY

Appeal… HELP!!!

Common reasons for denials and what actions can be taken for payor reconsideration

1. **COST:** Is it denied due to cost? Maybe the insurance wants to cover a "cheaper option". For example, maybe the insurers are suggesting light therapy at $150 per treatment vs $3,500 a month for a TNF. Phototherapy works; however, results are slow. Supplying pictures of the patients cracked hands or feet and explaining how their quality of life is suffering due to severe pain and inability to walk may help dodge this bullet. Light therapy may take weeks/months to notice a change, whereas a biologic may clear them faster, increasing their ability to heal and quality of life issues to improve.

2. **MISINFORMATION:** Was the information you submitted accurate? If not, supply the insurance company with reasons why the appeal was incorrectly denied. For example, maybe the patient has used Methotrexate and the chart notes were missing. Supply the chart notes documenting the usage of MTX and request the insurance company re-review the case.

3. **CONTRAINDICATIONS:** Does their insurance company require a medication that is contraindicated for the patient? This is where you "plead the patient's case" and supply any information you may have regarding why the patient cannot use a specific step edit. Maybe the patient's lab work is out of range; or they have a history of UC so a IL17 is not an option; or a family history of MS so a TNF should be avoided. Whatever it may be, you are acting as the voice of the patient. Let these insurance companies know how crucial it is for your patient to be on drug.

4. **OFF-LABEL USE:** Is the medication denied due to an off-label indication? Maybe an appeal is needed for an indication that has yet to be studied and approved by the FDA. Contact the Medical Science Liaison for the specific drug you are trying to get approved. Often, the MSL can provide articles or case studies regarding patients using off-label medication. Maybe a drug is still denied after the appeal. Is PAP an option? Some companies provide patient assistance for some of these cases.

THE APPEAL LETTER: Once all the pertinent information is identified and gathered, it is time to compose your appeal letter. Include the original denial for therapy, along with the new information, such as chart notes, medical articles, or case studies from an accredited source, etc. Your letter should include reasons why the insurance companies' recommendations do not suit this specific patient.

Being an **ADVOCATE** for the patient is the job responsibility of a biologic coordinator. We exercise this through appeal letters.

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