AADE IN PRACTICE Tip Sheet

Non-Medical Switching: Ways to Help Your Patients Obtain the Medications That Were Prescribed for Them

There are several steps you can take to help your patients when they are switched from their current medication to a different drug for reasons other than their health and saftey,

Role of the Diabetes Educator

So, what you can do to help your patients obtain their insulin and other medications that were prescribed specifically for them? There are several steps that you can take to help your patients stay on their prescribed medications.

File an Appeal

You can encourage your patient to contact the insurer and request that the original medication(s) be reinstated. If that request is denied, the patient has the right to request an internal appeal in which a complete and fair review of the decision must be done. To appeal the denial, which would come in the form of a determination letter, the following steps must be taken:

- Review the determination letter with the patient to fully understand why the insurer denied the request and the specific steps required to appeal the denial.
- Have the patient start a file and collect all documents received from the insurer, including the determination letter. This will include the patient's insurance policy and the insurer's "medical necessity criteria," which states the insurer's requirements for determining whether a treatment or service is necessary for the patient's specific condition.
- If the needed documents are not readily available or were never sent, including the instructions or forms for requesting an appeal, the patient should call the insurer's customer service representative and request that these documents be sent. The insurance company's website or patient's insurance card will list the toll-free telephone number to call.
- Have the patient call his or her health care provider's office, which has people on staff to help with the appeals process. They also can explain how to fill out the forms to request an appeal, write an appeals letter on the patient's behalf, or even handle the appeals request entirely.

It is important that each affected patient submit an appeal as soon as possible along with a letter from his or her health care provider and all additional information the insurer requested. Once the appeal is filed, patients should expect to wait up to 30 days to hear back from their insurers regarding a decision. Additionally, it is essential that patients understand that they must follow up with their insurers on a regular basis until they receive an answer (think "squeaky wheel"). Patients should keep a record of the name of every representative they speak with about the appeal, the date and time of each conversation, a confirmation phone number for the call, and a summary of what was discussed.

Request an External Review

If the insurance company denies the appeal, the patient is entitled under law to take the appeal to an independent third party for an "external review," which means the insurance company no longer gets final say for approval of a medication, treatment, or payment of a claim. To trigger an external review, the patient must file a written request with the independent organization within 60 days of the date the insurer sent him a final decision. The process should take no more than 60 days. If time is critical, and waiting 30 to 60 days could seriously jeopardize John's health or safety, then John can skip the internal review and request an expedited review of his case. An expedited review of John's case should take no longer than 4 business days.

File a Complaint

If there are still problems after the external review process, patients can file a complaint with the insurance commissioner or attorney general in their state. Insurance companies would rather not have to deal with their state regulatory authorities regarding this issue.

Forced Non-Medical Switching: Help Your Patients Know Their Rights

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