

Benefits investigation definition and questions to consider



Benefits investigation: The process of verifying the patient's coverage for biologic services and administration, and defining the patient's out-of-pocket expenses (ie, co-pay, deductibles, and coinsurance) for services rendered.^{1,2*}

Questions to consider

Coverage

- What date did the patient's plan coverage begin?
- Is the service or drug covered under the patient's medical benefit, pharmacy benefit, or both?
- Will the plan cover the administration service (ie, give a specific CPT[®] code) associated with the drug?
- Are there any other benefit restrictions that apply?

Process

- What other information needs to be included on the claim and/or attached to the claim form?
- Are there any special distribution requirements (eg, mandatory specialty pharmacy distribution, mail order)?

Cost

- Does a deductible apply?
- What is the patient's co-pay and/or coinsurance?
- Is there a separate cost-share for the administration procedure?
- Does the patient have an out-of-pocket maximum?

CPT[®] is a registered trademark of the American Medical Association.

*Benefits may vary depending on the payer and the specific plan in which a patient is enrolled.

1. National Association of Medication Access & Patient Advocacy, Inc. Accessed April 14, 2025. <https://www.namapa.org/medical-vs-pharmacy-benefit> 2. CMS. Medicare & You 2025. Accessed April 4, 2025. <https://www.medicare.gov/pubs/pdf/10050-medicare-and-you.pdf>

What is utilization management?



Utilization management: A set of techniques used by or on behalf of purchasers of healthcare benefits to manage healthcare costs by influencing patient care decision-making through case-by-case assessments of the appropriateness of care prior to its provision.¹

Prior authorization^{2,3}

- Process of obtaining advanced approval for a biologic, prior to administration
- Used to ensure that certain drugs or services are used correctly and only when medically necessary
- The use of prior authorizations is expected to continue to increase

Step edit/therapy^{1,4,5}

- Sometimes also called a “fail first policy”
- A requirement to try one or more drugs before authorizing the drug the physician selected
- Step edits are usually a component of prior authorizations

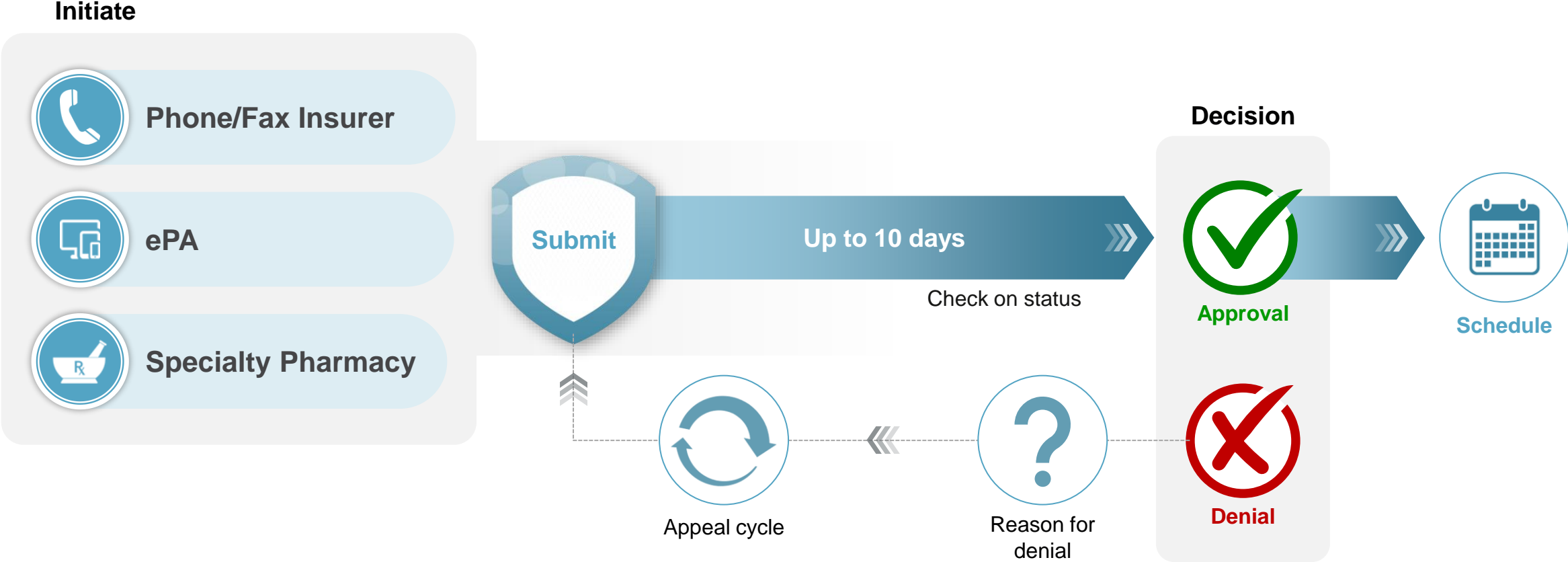
Partial fill/quantity limits^{1,5}

- To avoid wastage of a high-cost specialty drug, some payers provide less than a full cycle*
- More common for oral specialty drugs but can also apply to injections
- Over 40% of payers utilize partial fill programs to manage specialty drugs (including biologics)

*Using a 30-day supply rather than 90 days.

1. Pharmaceutical Strategies Group. 2024 Trends in Specialty Drug Benefit Design Report. Accessed April 4, 2025. <https://www.psgconsults.com/industry-report/2024-trends-in-specialty-drug-benefits-report/> 2. National Board of Prior Authorization Specialists. Accessed April 1, 2025. <https://www.priorauthtraining.org/prior-authorization/> 3. Accreditation Council for Medical Affairs (ACMA). Accessed April 1, 2024. <https://www.priorauthtraining.org/prior-authorization/> 4. Rheumatology News. Accessed April 1, 2025. <https://www.mdedge.com/rheumatology/article/105977/rheumatoid-arthritis/step-therapy-and-biologics-easier-road-ahead> 5. Magellan Rx Pharmacy Trend Report 2019. Accessed April 1, 2025. https://issuu.com/primetherapeutics/docs/medical_pharmacy_trend_report_2019 5. Pharmacy Times. Accessed April 1, 2025. <https://www.pharmacytimes.com/view/partialfill-programs--good-practice-or-barrier-to-care>

The prior authorization process¹⁻⁴



ePA = electronic prior authorization.

1. Rim MH, et al. *Am J Health Syst Pharm.* 2021;78(11):982-988. 2. American Medical Association. Accessed April 1, 2025. https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/premium/psa/prior-authorization-tips_0.pdf 3. National Council for Prescription Drug Programs. Accessed April 1, 2025. <https://ncdpd.org/NCPDP/media/pdf/WhitePaper/NCPDP-Specialty-Pharmacy-Benefit-Coverage-Identification-White-Paper.pdf> 4. Moore KJ. *Fam Pract Manag.* 2000;7(9):43-46.

Prior authorization considerations*

PA Request Form (Completed)

Request for a Prior Authorized Drug Exception or Step Therapy

Member Name: John Smith	DOB: 1/1/70
Member ID Number: 123456	Date: 1/12/2025

Diagnosis: M06.049

Drug Requested (generic and/or brand name, dose prescribed, dosage form, frequency of dose, quantity prescribed, and expected duration of therapy):
Product D XXmg Q8wks

Reason(s) Drug Is Requested:
Patient would like to continue on present Tx w/ good relief of symptoms. Please see attached office note. Patient's weight XXX lbs.

Other Formulary Drug(s) Tried and Results of Treatment:
Product A, Product B, Product C

Response for a Prior Authorized Drug Exception or Step Therapy

1/12/2025

To: Medical Practice

RE:
John Smith ID#: 123456 DOB: 2/5/70
Request for Product D submitted on 1/12/2025

Approved Product D Xmg Q8wks – bill JXXXX Expiration date: 7/12/2025

Approved with modification

Denied

Does not require prior authorization

Other

Letter of Medical Necessity

- Physician name and ID included in the letter
- Patient history and physical findings
- Previously given treatments/therapies
- HCP chart notes
- Relevant test and lab results
- Hospital admission/emergency department notes

Supporting Docs

- ✓ Patient Authorization and Notice of Release of Information
- ✓ Copy of the patient's health plan or prescription card (front and back)
- ✓ Product Prescribing Information

! What if a payer or EMR flags a different product as preferred from the one the clinician requested?

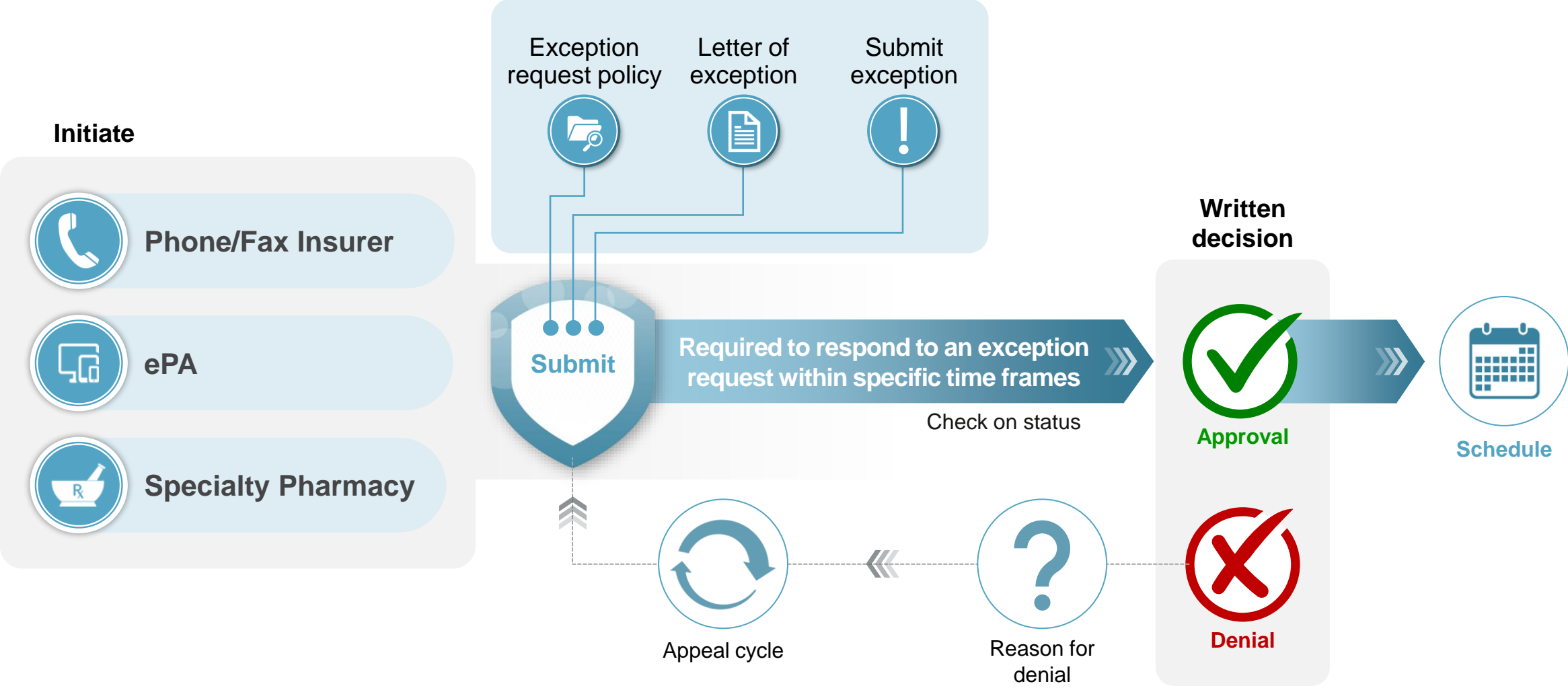
If another biologic product is mentioned, verify policy and the patient's coverage rights:

Confirm if it is a voluntary trial suggestion or a mandated requirement

If mandated: Confirm the step therapy requirements for this patient prior to receiving coverage for this medication

*Prior authorization requirements vary by health plan. Please contact the patient's health plan for specific prior authorization requirements to ensure efficient and timely review. Failure to obtain prior authorization may result in non-payment by the plan. EMR = electronic medical record.

Requesting an exception¹⁻⁶

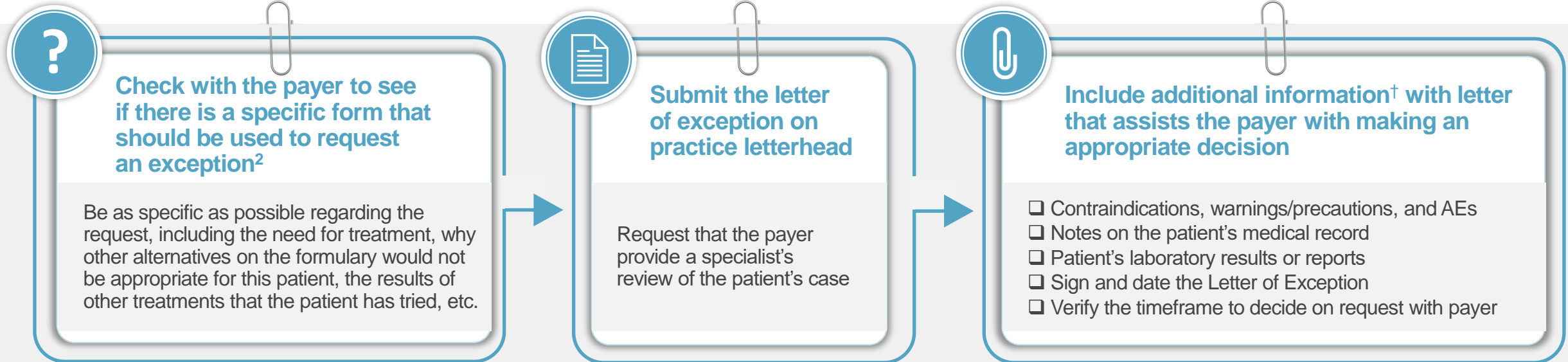


ePA = electronic prior authorization.
 1. Rim MH, et al. *Am J Health Syst Pharm*. 2021;78(11):982-988. 2. American Medical Association. Accessed April 1, 2025. https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/premium/psa/prior-authorization-tips_0.pdf 3. National Council for Prescription Drug Programs. Accessed April 1, 2025. <https://ncpdp.org/NCPDP/media/pdf/WhitePaper/NCPDP-Specialty-Pharmacy-Benefit-Coverage-Identification-White-Paper.pdf> 4. Moore KJ. *Fam Pract Manag*. 2000;7(9):43-46. 5. CMS. Parts C & D Enrollee Grievances Organization/Coverage Determinations, and Appeals Guidance. Accessed April 4, 2025. <https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/Parts-C-and-D-Enrollee-Grievances-Organization-Coverage-Determinations-and-Appeals-Guidance.pdf> 6. CMS. Exceptions. Accessed April 24, 2025. <https://www.cms.gov/medicare/appeals-grievances/prescription-drug/exceptions>

Considerations for developing a letter of exception



Letter of exception: Used to request a biologic if it is not on the formulary, if the plan requires a step through other treatments*, or if it has a National Drug Code (NDC) block. The lists below contain examples of information that payers may require to request an exception.¹



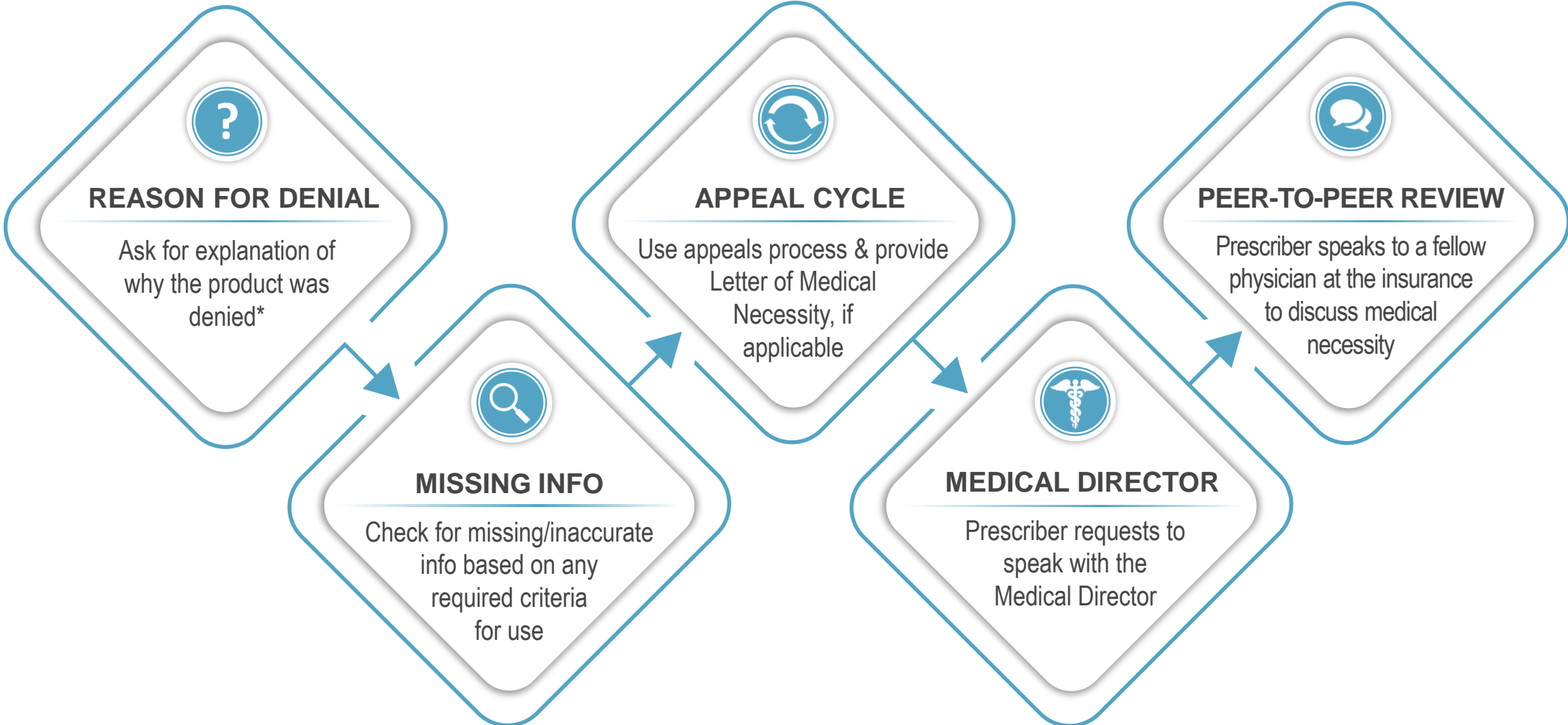
*Check with the payer to confirm if specific requirements or information are needed as part of the request.

[†]Examples of documentation that may be sent with the Letter of Exception include previous treatments with date and duration of therapy.

AE = adverse events.

1. CMS. Parts C & D Enrollee Grievances Organization/Coverage Determinations, and Appeals Guidance. Accessed April 4, 2025. <https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/Parts-C-and-D-Enrollee-Grievances-Organization-Coverage-Determinations-and-Appeals-Guidance.pdf> 2. CMS. Exceptions. Accessed April 24, 2025. <https://www.cms.gov/medicare/appeals-grievances/prescription-drug/exceptions>

If denied coverage, consider the following to request coverage for the patient¹⁻⁶



*Payers are required to state the exact reason for the denial of services and provide an opportunity for the physician to discuss the denial with the reviewer (This applies only to denials due to a lack of medical necessity, not to denials due to benefits being excluded in the patient's contract).
1. Akosa A. *Fam Pract Manag.* 2006;13(6):45-48. 2. Moore KJ. *Fam Pract Manag.* 2000;7(9):43-46. 3. Rim MH, et al. *Am J Health Syst Pharm.* 2021;78(11):982-988. 4. National Association of Insurance Commissioners. Accessed April 1, 2025. <https://content.naic.org/sites/default/files/consumer-health-insurance-what-is-medical-necessity.pdf> 5. Blue Cross Blue Shield of Michigan. Accessed April 4, 2025. <https://ereferrals.bcbsm.com/docs/common/common-p2p-request-process.pdf> 6. CMS. Parts C & D Enrollee Grievances Organization/Coverage Determinations, and Appeals Guidance. Accessed April 24, 2025. <https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/Parts-C-and-D-Enrollee-Grievances-Organization-Coverage-Determinations-and-Appeals-Guidance.pdf>

Considerations for understanding payers



Consider creating a payer quick reference guide that includes profiles for each payer



General info

- Payer name
- Website
- Payer provider number

Points of contact

(Phone, fax, address, and/or website for each)

- Payer representative
- Eligibility
- Customer service
- Case management
- Care management
- Claims
- Payer web access

Renewal terms

- Date of last renewal
- Contract length
- Automatic renewal

Policy

- Notification of coverage/policy changes
- Form requirements
- PA/step edits/formulary
- Drug reimbursement methodology
- Timing of drug reimbursement adjustments

Claims/reimbursements

- Address for claims submission
- Submission process
- Required documentation
- Payer-specific coding
- Reimbursement terms
- Claim filing limits
- Payer response time

PA/step edit requirements

- Length/duration
- Number of infusions

Referral requirements

- Site of care
- Specialty pharmacy

Appeals

- Address for appeals submission
- Submission process
- Appeals filing limits
- Limits for recouping incorrect payments
- Levels of appeals
- Review panel
- Payer response time

Verifying details of payer agreements



Information to obtain	Frequency	Annual verification of benefits
Benefits verification	Every treatment Determine if/how often a referral is required from primary care	Re-verify (both medical and pharmacy)
Plan date	Every treatment (determine status of plan and plan year)	Verify current plan year
Prior authorization	Per payer policy	Per payer policy
Pre-determination	Per practice guidelines (if no to prior authorization requirement)	Per practice guidelines (if no to prior authorization requirement)
Demographic information	Verbally: Every visit Written: Yearly	Pre, during, and post
Patient cost	Yearly (unless treatment, dosage, or insurance changes)	Always verify with patient before initiating treatment
Signed financial agreement with practice	Yearly	Always obtain (do not receive 1 st treatment of year without signing)
Guarantor information other than self <i>(must have employer information and ss#)</i>	Yearly	Always obtain (do not receive 1 st treatment of year without information)