

Migraine Patients

KNOW YOUR RIGHTS



Do you get frequent migraines?

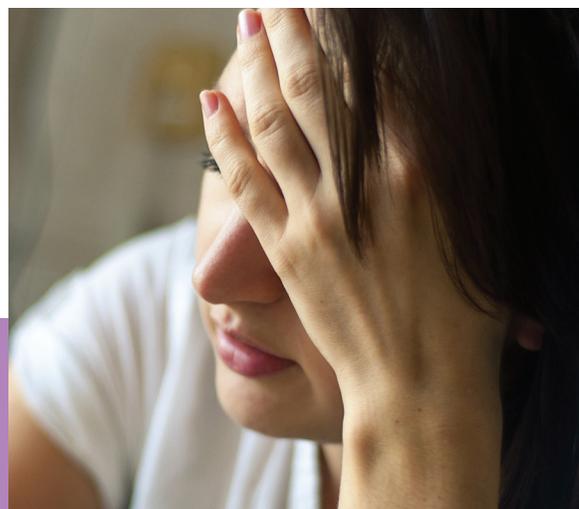
Today, 37 million Americans suffer from debilitating migraine headaches, including about 5 million who get at least one migraine a month. Besides the throbbing pain, migraines are often accompanied by nausea, vomiting, and extreme sensitivity to light and sound. There can also be warning symptoms before or during the headache, such as flashes of light, blind spots, or tingling on one side of the face or in your arm or leg. What is worse, each migraine can last for many hours or even days.

If you get migraines, you know how miserable you can feel. But did you know that when left untreated, more than 91 percent of migraine sufferers have to miss work or are not able to perform their normal daily functions?

Effective medications are available to relieve pain and help prevent some migraines from occurring. Therefore, if your health care provider prescribed a migraine treatment and your insurer denies coverage, read on. There are steps you can take to get the care you need.

What can I do if my insurer will not pay for my migraine treatment or delays my care?

Health insurers use various approaches to cut costs for migraine medications. This can mean your health plan may not cover the medication your health care provider prescribed to you or having to prove your migraines have gotten worse before you can access your medication, for example. Luckily, state or federal laws may protect you from these practices.



To find out whether your insurer may have improperly delayed or denied access to your migraine treatment, ask yourself the following questions:



Step Therapy

Did my insurer make me try a different treatment before covering the migraine medication that my health care professional prescribed?

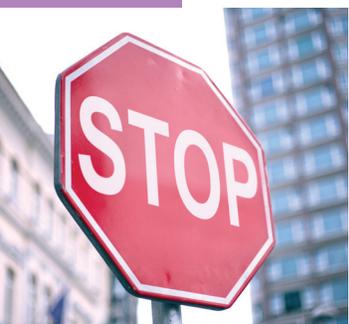
This practice is called “step therapy” because it requires patients to try other treatments first and show that they do not work. Your insurer may require you to try and fail on a lower-cost medication before covering the one prescribed by your health care professional, even if your migraines are very severe or last for many hours or days and keep you incapacitated, before covering the one prescribed by your health care professional.³ Step therapy policies may violate certain federal and state laws if your insurer treats you and others with migraines differently because of your health condition.⁴



Nonmedical switching

Is my insurer forcing me to take a different medication, even though my current migraine medication works well, by refusing to cover it any longer or increasing my co-pay?

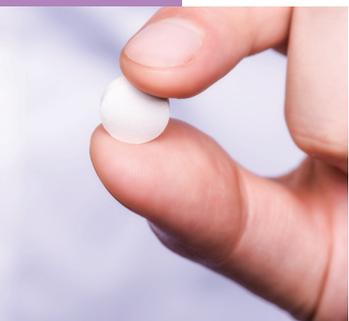
This practice is referred to as “nonmedical switching.” It occurs when your insurer (not your health care professional or pharmacist) forces you to switch from your current migraine medication to a different (but not a generic equivalent) medication by either refusing to cover your drug any longer or increasing the out-of-pocket cost of your drug.⁵ For example, if you are on a preventative treatment, your insurer may force you to switch to an “acute” medication, which is used to stop a migraine after it has begun. The insurer might also force you to switch between different classes of preventative medication (such as from an anticonvulsant to a beta blocker). It could be especially troublesome if you have tried several medications over the years and finally found one that works for you. Non-medical switching can violate certain state consumer protection laws.



Prior authorization

Do I need to get my insurer’s approval before I can refill my migraine prescription?

This practice is called “prior authorization.” It happens when your insurer requires you or your health care professional to contact your insurer and get approval before the treatment is covered. Prior authorization policies can delay or interrupt care, waste time, and complicate medical decisions. For example, your insurer may require your health care professional to document that your migraines are accompanied by vomiting before your insurer will cover a nasal spray instead of a pill. Your health care professional may also have to show that you have had a certain number of migraines per month before your insurer will cover a preventative treatment. These policies can violate state and federal laws if applied in a certain manner.



Quantity Limits

Has my insurer limited the amount of migraine medication I can get at one time?

This restriction is called “quantity limits.” Often times, insurers will only approve a small quantity of migraine medications for short-term episodic treatment. These policies can create additional hassle, including more frequent and unnecessary visits to your health care professional or pharmacy. These policies may also violate state or federal law if applied in a discriminatory manner.

My insurer refuses to cover a migraine treatment that my health care professional prescribed to me. **What can I do?**

If you answered yes to any of the questions above, here are three steps you can take to challenge your insurer's decision:

- Appeal the decision;
- Request an external review; or
- File a complaint.

How do I appeal the decision?

If your insurer denies your claim, you have the legal right to an internal appeal.⁷ This means you can ask your insurer to conduct a full and fair review of its decision. To appeal the denial, you should do the following:

Review the determination letter. Your insurer should have sent you a determination letter to tell you that it would not cover your claim. Review this document so you can understand why your insurer denied your claim and how you can appeal the denial.

Collect information. Collect the determination letter and all other documents the insurance company sent you. This includes your insurance policy and your insurer's medical necessity criteria. "Medical necessity criteria" refers to your insurer's policy for determining whether a treatment or service is necessary for your condition.⁸

Request documents. If you did not receive the determination letter and/or do not have your policy, the medical necessity criteria, or the instructions and forms for filing an appeal, call the customer service representative at the insurance company and ask for these documents. The company website will list the toll-free telephone number to call.

Call your health care professional's office. The health care professional's office or clinic has people on staff to help with the appeals process. They will tell you how to fill out the forms to request an appeal, write an appeals letter on your behalf, or handle the appeals request for you.

Submit the appeal request. It is important for you or your health care professional's office to submit the appeal request as soon as possible along with the letter from the health care professional and all additional information the insurer requested.

Once you file an appeals request, expect to wait up to 30 days to hear back from the insurance company regarding a treatment you hope to receive. It can take up to 60 days for a response if you received the treatment and are waiting for reimbursement.

Follow up. Follow up with your insurer regularly until you hear back. Be sure to keep a record of the name of any representative you speak with about the appeal, the date and time you spoke with that person, a confirmation number for the call, and a summary of your discussion.

What if my insurer denies my appeal?

Under law, you are entitled to take your appeal to an independent third party for an "external review," which means the insurance company no longer gets the final say over whether to approve a treatment or pay a claim. The situation applies if the health plan denies your appeal or if your medical situation is urgent and waiting would jeopardize your life or ability to function.

How do I request an external review?

To trigger an external review, file a written request with the independent organization within 60 days of the date your insurer sent you a final decision. The process should take no more than 60 days. However, in urgent situations requiring an expedited review, the process should take no longer than four business days. To find out whom to contact in your state to request an external review, please go to www.CoverageRights.org.

How long will the external review process take?

The external review process should take no more than 60 days. If you request an expedited external review, the process should take no longer than four business days after your request is received.

How do I file a complaint?

If your insurer denies your coverage after the external review process, you can file a complaint with the insurance commissioner or attorney general in your state. To determine whom to contact and how to submit the complaint, please go to www.CoverageRights.org.

Your complaint should include the following information:

- The name, address, email address, and telephone number of the person filing the complaint (“Complainant”);
- The name of the insured individual, if different from the Complainant;
- The names of any other parties involved in the claim (for example, the plan administrator or pharmacy benefit manager);
- The name of insurance company and the type of insurance;
- The state where the insurance plan was purchased;
- Claim information, including the policy number, certificate number, claim number, dates of denial, and amount in dispute;
- The reason for and details of the complaint; and
- What you consider to be a fair resolution.

You should also submit the following documents as supporting information:

- A copy of your insurance card;
- Copies of coverage denials or adverse benefit determinations from your insurer;
- Copies of any determinations made by internal and external reviewers;
- Any materials submitted with prior appeals and complaints;
- Supporting documentation from your health care professional;
- A copy of your insurance policy; and
- All responses from your insurer.⁹

What happens after the insurance commissioner or attorney general receives my complaint?

The insurance commissioner or attorney general will assign someone to research, investigate, and resolve your complaint.¹⁰ That person will examine your account, records, documents, and transactions.¹¹ He or she may question witnesses, request additional documents from other parties, and hold a hearing.¹² If the insurance commissioner or attorney general determines that the insurer violated laws or regulations, he or she may order the insurer to give you the requested coverage or compensate you.¹³

Who should I call if I have any questions about filing a complaint?

To determine whom to call in your state, please go to www.CoverageRights.org.

Which organizations can provide me with more information about migraines?

There are several patient advocacy organizations that you can contact if you would like additional information about migraines and treatments. These organizations include:

Alliance for Headache Disorders Advocacy

www.allianceforheadacheadvocacy.org

American Headache Society

www.americanheadachesociety.org

The American Migraine Foundation

www.americanmigrainefoundation.org

CHAMP (Coalition for Headache and Migraine Patients)

www.headachemigraine.org

Global Healthy Living Foundation 50 State Network

www.50statenetwork.org

Headache & Migraine Policy Forum

www.headachemigraineforum.org

National Headache Foundation

www.headaches.org

Patient Advocate Foundation

www.patientadvocate.org

U.S. Pain Foundation

www.uspainfoundation.org

¹ Migraine, Mayo Clinic, <http://www.mayoclinic.org/diseases-conditions/migraine-headache/symptoms-causes/dxc-20202434> (last visited Nov. 14, 2016).

² Migraine Statistics, Migraine.com, <https://migraine.com/migraine-statistics/> (last visited Oct. 13, 2016).

³ Management of the Acute Migraine Headache, Am. Fam. Physician, (Dec. 1, 2002) <http://www.aafp.org/afp/2002/1201/p2123.html>.

⁴ Bill Would Quicken Access to Newer Meds, San Diego Union-Tribune (Oct. 3, 2015), <http://www.sandiegouniontribune.com/news/2015/01/03/ab374-chronic-disease/>.

⁵ Keeping Stable Patients on Their Medications, Coal. Of State Rheumatology Organizations, <http://www.csro.info/Switching> (last visited Oct. 17, 2016).

⁶ Commentary: Time to Reform Costly, Burdensome Prior Authorization and “First Fail” Protocols, Palm Beach Post (Mar. 2, 2014), <http://www.palmbeachpost.com/news/news/opinion/commentary-time-to-reform-costly-burdensome-prior-nd3Zz>.

⁷ How to appeal an insurance company decision, Healthcare.gov, <https://www.healthcare.gov/appeal-insurance-company-decision/appeals/> (last visited Nov. 14, 2016).

⁸ E.g., N.M. Admin. Code. 13.10.17.7 (2016).

⁹ Internal appeals, Healthcare.gov, <https://www.healthcare.gov/appeal-insurance-company-decision/internal-appeals/> (last visited Nov. 14, 2016).

¹⁰ Complaint to Federal Government Agency: Patient, Legal Action Center, <https://lac.org/wp-content/uploads/2016/04/10-Patient-Federal-Complaint.docx> (last visited Oct. 17, 2016).

¹¹ E.g., State of Alabama, Department of Insurance, <http://www.aldoj.gov/Consumers/ConsumerServicesBio.aspx>, last visited Oct. 17, 2016; Ala. Code Ann. §§ 27-2-7, 27-2-19 (2016).

¹² ALA. CODE ANN. § 27-2-20 (2016).

¹³ ALA. CODE ANN. § 27-2-26 (2016).