Common utilization management (UM) hurdles that IBD specialists face WORKSHEET

Inflammatory bowel diseases (IBD) affect about 3 million Americans, with peak onset between ages 15 and 30.[1] Evidence shows that early biologic therapy for moderate-to-severe IBD leads to faster, higher remission rates, reducing hospitalizations and surgeries.[2] This has shifted the treatment paradigm from the traditional "step-up" approach to early biologic initiation, now reflected in clinical guidelines for ulcerative colitis and Crohn's disease.[3,4] Despite advances in care, significant barriers to treatment remain, largely driven by health insurance policies and market-driven health care decisions.[5]

QUICK REFERENCE

Key documentation for common UM hurdles

Patient and insurance information

- Member/patient name (as listed on insurance card)
- Health plan ID number
- Date of birth and gender
- Full contact details (address, phone, email if available)
- Health plan name and type (e.g., commercial, Medicare Advantage)

Diagnosis and clinical history

- ICD-10 code to highest level of specificity (e.g., K50.13 for Crohn's with fistula)
- Complete treatment history (including failed therapies or contraindications)
- Provider notes describing current symptoms, disease severity, or complications
- Results of relevant tests (e.g., CRP, fecal calprotectin, endoscopy, imaging)
- Evidence of therapeutic failure, loss of response, or high disease burden

Medication request details

- Requested medication, dose, route, and frequency
- CPT/HCPCS codes for infused/injectable drugs
- Rationale for request (especially if non-standard dosing or step therapy exception)

Provider and clinic information

- Physician name and credentials
- NPI number and tax ID
- Clinic address, phone, and fax
- Contact person for PA follow-up

Language that supports medical necessity

Use clear, guideline-aligned phrases such as:

- "Clinical remission" or "Endoscopic response"
- "Severe disease with high flare risk"
- "Treatment failure on [previous drug]"
- "Fistulizing Crohn's requiring dose escalation"
- Avoid vague terms like "patient is doing okay"

According to 2020 census data, approximately 90% of people in the United States have health insurance coverage, 66.5% of which is commercial and 34.8% of which is public.[6] Commercial insurance is purchased from large payor companies and provided by employers, typically regarded as private insurance. Public insurance is provided by the government but often administered by private insurance companies. The U.S. health care system is fragmented with different incentives for different kinds of payors, see the AGA Drug Use Management Infographic for more details. IBD drugs may be covered via the pharmacy benefit or the medical benefit, which impacts who makes the coverage decisions across different kinds of payors:

	Health plan	Pharmacy benefits manager (PBM)	Managed care organization/ integrated delivery system	Third-party administrator for self-insured employers
Examples	UnitedHealthcare, Aetna, Cigna, Anthem, Humana, Blues plans	CVS Caremark, Express Scripts, OptumRx, Prime Therapeutics	Kaiser Permanente	UMR (a UnitedHealthcare company), Meritain Health, Trustmark Health Benefits
Pharmacy benefits Retail and specialty prescription drugs, mail-order medications, specialty pharmacy drugs (self-administered or oral), utilization management (prior auth, step therapy), formulary development and tiering	✓*	✓	✓	
Medical benefits Physician visits, hospital care, outpatient surgery, diagnostic imaging, infused/injected drugs (if billed under the medical benefit)	✓		✓	✓

*Sometimes carved out and fully managed by a PBM or subcontracted entity

Several common barriers to care for patients with IBD currently impact physicians and while not all practices have dedicated staff for managing payor utilization management, following the below steps and examples can help your practice minimize the impact of utilization management hurdles and ensure your patients receive their medications without delay or significant financial toxicity.

PRIOR AUTHORIZATION (PA) AND STEP THERAPY

Despite the consensus shift in IBD management away from a "step-up" approach as is evident in U.S. gastroenterology societies' clinical practice guidelines, many health care insurance companies in the U.S. still require patients to try and fail lower cost medications such as corticosteroids, mesalamines, and thiopurines before approving biologics or small molecule therapies.[7]

Steps to alleviate prior authorization burdens[8]	
Be proactive **Check PA requirements before sending prescriptions to the pharmacy to avoid rework, reduce medication nonadherence, and consider possible alternative medications.**	Maintain a readily accessible database of payor-specific rules and PA requirements for the most prescribed medications to ensure compliance. One of the most common reasons a PA request is delayed or not approved is that it's missing critical details (see Standardize Documentation). Authorization denials occur in a wide variety of clinical scenarios, including denials of standard and nonstandard medication dosing.[9]
Standardize documentation **Establish a protocol to consistently document data required for medication PAs in the medical record. Missing minor details can result in automatic denials.** PA completion can be accelerated when concise, complete information, including a full medical history, is readily available in the medical record. This also minimizes physician involvement in PA, as other staff can retrieve the needed information from the medical record and submit it to the health plan on the physician's behalf. Finally, quality documentation prevents follow-up patient contact or additional appointments to obtain information needed to fulfill PA requirements.	Identify a specific person to submit and deal with the PA process for the care team. **Provide quality documentation:** ☐ *Patient information* ○ Member or patient name as it appears on the health ID card ○ Health ID card number ○ Date of birth ○ Gender ○ Address ○ Phone number ○ Email (if available) ○ All relevant clinical information, including: · ICD-10 code, to the highest level of specificity · Provider notes · Results of relevant tests, including labs, imaging (e.g., x-ray, MR enterography, CT enterography reports), and endoscopic findings · Patient history (e.g., patient-specific contraindications, failed therapies) · Physical findings, including any signs and symptoms · All office visits related to this condition · Requested tests with CPT codes and units (if applicable) ☐ *Physician information* ○ Name ○ Provider tax ID number ○ National Provider Identifier (NPI) number ○ Address ○ Phone and fax number ○ Email (if available) ☐ *Contact name*

Key terms to consider in documentation		
General recommendations ○ Clinical remission ○ Endoscopic remission ○ Endoscopic response ○ Partial response ○ Persistent endoscopic disease ○ Loss of response ○ Low therapeutic drug level ○ Severe disease ○ Biochemical response (e.g., C-reactive protein [CRP], fecal calprotectin) ○ Treatment failure on [drug] ○ Intolerance to preferred formulary option ○ High disease burden ○ Risk of surgery or hospitalization ○ Therapeutic failure despite adherence ○ Lack of efficacy on current treatment	**Structure documentation phrasing to communicate the rationale for clinical decisions:** ○ Fistulizing Crohn's disease requiring dose escalation ○ Persistent symptoms despite standard dosing ○ Biochemical evidence of active inflammation	**Avoid language that undermines appeals (e.g., "patient doing okay".)** If previous progress notes have conflicting language, add an addendum to the note clarifying why you are recommending this medication.
Use technology **Select the PA method that will be most efficient, given the specific situation and health plan/pharmacy benefit manager's PA options.** Utilize online payor portals to access claim status updates, submit resubmissions, and review denial details quickly.	Submit your request through the payor web portal. This is the fastest, easiest, and most efficient way to obtain a prior authorization and it takes approximately 3-5 minutes. Submitting your request using the web portal increases the likelihood of receiving a real-time decision and will save time. Calling the health plan/pharmacy benefit manager to complete an expedited PA over the phone is another option with 24- to 72-hour turnaround time. Some plans will request additional progress notes/ supporting documents to be faxed after completing the clinical questions over the phone. Consider AI tools and Doximity ChatGPT to assist with drafting appeal letters.	
Payor Portal Examples		
CareFirst · **Portal name:** *CareFirst Direct* · https://provider.carefirst.com · **Use:** PAs, claims, eligibility verification, and checking status of submitted requests.	**Cigna** · **Portal name:** *Cigna for Health* Care Professionals (CignaforHCP) · https://cignaforhcp.cigna.com · **Use:** Electronic PAs, claim submissions, appeal tracking, and benefit eligibility.	**UnitedHealthcare (UHC)** · **Portal name:** *UnitedHealthcare Provider Portal (formerly Link)* · https://www.uhcprovider.com · **Use:** PAs, real-time claims tracking, eligibility, and peer-to-peer request management.

Communicate regularly **Follow up to ensure timely PA approval**	Dated and time-stamped PA submission materials, along with a formalized follow-up process, ensure that submitted PA requests don't fall through the cracks. Many practices find "tickler" files helpful in triggering follow-up with health plans regarding delayed responses. Use tools like task snoozing (e.g., in gMed) to manage pending reauthorizations and deadlines. In addition, the pharmacy electronic PA (ePA) process includes a computerized audit capability to confirm when information has been received by the health plan or benefit manager. Practices can also view a list of electronically submitted and pending prescription PAs in their EHRs with ePA.
Managing appeals **If a PA is inappropriately denied, submit an organized, concise, and well-articulated appeal with supporting clinical information.** Under the Affordable Care Act, all health plans are required to have an appeal process for denied PAs. If the health plan upholds its initial decision, an external appeal by an independent third-party reviewer may be requested. Physicians can request an urgent or expedited review of PA appeals, with decisions completed within 72 hours or sooner, depending on the medical urgency of the situation. If coverage is denied or delayed, consider initiating a manufacturer-sponsored patient assistance program while pursuing appeal.	More than 80% of denied PA requests that were appealed are overturned.[10] Identify problems: Address missing or incorrect information. This can be anything from a blank field (e.g., demographic information) or incorrect plan code, to technical errors like a missing modifier. Payors also benefit from resolving denial issues, so a payor-provider collaboration can help in addressing them more efficiently, which will also help achieve system efficiency more rapidly. Societies, such as CCF and NASPGHAN, provide customizable letters of medical necessity to use in the prior authorization process.[11,12] **Peer-to-peer** ○ Ask for a gastroenterologist reviewer ○ Clarify the reviewer's clinical specialty and experience ○ Use clear, concise clinical rationale in conversation ○ Use terms that reflect guideline-supported care
Medication affordability If a patient is having challenges affording their medications or if health plan coverage is delayed or denied.	○ Encourage the patient to sign up with the pharmaceutical manufacturer patient assistance/bridge programs after completing PA/appeal. ○ Benefits eligibility investigation will be completed by the bridge program to ensure the patient meets criteria for assistance programs. ○ A pharmaceutical manufacturer bridge program, also known as a starter or quick-start program, provides eligible patients with a temporary supply of a medication, often a high-cost specialty drug, to bridge coverage gaps or delays.

CONSIDERATIONS AROUND TIERED FORMULARIES AND PATIENT OUT-OF-POCKET COSTS

Biologics and small molecules are often considered ”specialty drugs” by many health insurance plans, a designation that places coverage into higher formulary tiers and often includes higher patient cost-sharing, which may require patients to pay a percentage of the total cost and this can be more than tens of thousands of dollars annually. Biosimilars are emerging as cost-effective alternatives within health care systems and can be used both in biologic-naïve patients and in patients already treated with originator drugs.[13,14] The main reason for switching from an originator drug to a biosimilar is its lower cost. The Humira biosimilar market finally emerged in 2023. In addition to the Humira reference product, there are currently 22 biosimilar versions of adalimumab in the U.S. market plus one “follow-on biologic” (Cordavis).[15] For 2025, Stelara is the biggest biosimilar launch for pharmacy benefits.

NON-COVERED SERVICES

Comprehensive care for patients with IBD requires services that U.S. insurance companies frequently do not cover. This can lead to financial strain for patients and worsen clinical outcomes. An important aim of the ACA was to reinvigorate patient-centered medical homes by offering financial incentives through increased reimbursement. Given the rising cost in IBD and barriers to care, the concept of a medical home extended to subspecialties such as gastroenterology.[16] It can remove barriers to obtaining previously non-covered services such as nutrition and mental health. Digital platforms have the potential to extend these benefits by providing digital services and virtual visits to those who do not have in-person access to a medical home.

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