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Medical Necessity Appeals And Demanding A Quality Review By The Payer

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What does “Medical Necessity” Mean

“Our foremost challenge is to interpret the phrase “medical necessity,” because how we define it dictates what we cover, or pay for. Though it has no useful literal meaning, it is a commonly used phrase that begs for definition. Once, but no longer, it may have meant “anything a doctor wants to do.” Today it means different things to different people. Since there is no universal definition, and in order to clarify our contractual responsibility, we must define what we mean.”

Quote from Bernard Mansheim, MD, VP & Chief Medical Officer for Coventry Health Care in 2004 Corporate Address

Medical Necessity - No Universal Definition

- To carriers, it is a “contractual obligation.” It is necessarily flexible, but carriers use a number of means to limit its scope, ie utilization review procedures, clinical guidelines, technical assessments, review panels etc.
- Doctors and patients make decisions in a high pressure, health-focused environment. Therefore, they rely on the breadth and flexibility of the term.
- Independent Review Panels - Results vary state by state. However, about 45% are decided in favor of the consumer from 21% in AZ and MN and 72% in CT.

Courts' Med Nec Interpretations

There is relatively little law in MN interpretation cases.

Courts are primarily concerned with clinical benefit to the patient bringing suit, not 'population health' or 'cost-effectiveness.'

Courts acknowledge the potential conflicts of interest among MN decision-makers and often view case information as "untrustworty".

Hallmarks of procedural fairness, such as clear explanations regarding denials, timely access to appeals and external review, reassure courts of the fairness of the decision previously reached.

Source: William M. Sage - Managed Care's Crimea

Good Process = Good Decision

- Flexibility to allow for Patient Specific Variables and Appreciation for Complexities of Medial Care
- Consistency In Treatment Allowed For Similar Patients
- Highly Qualified Personnel
- Reliance on Written Criteria
- Transparency
- Information Seeking

Common Procedural Problems in Medical Necessity Determination Processes

- Decisions made in arbitrary or capricious manner w/o consideration of individual patient needs
- Decisions made inconsistently
- Claims Reviewers unqualified or not appropriately trained
- Application of arbitrary and unreasonable coverage limits
- Insufficient information provided in claims denials:
  - **No disclosure of clinical rationale used in making decision**
  - **No disclosure of qualifying credentials of reviewer**
  - **No disclosure of evidence or documentation used in decision**
  - **No description of grievance procedures**
- Failure to consult with treating physician or consider medical evidence provided by patient
  - **Source: Medical Necessity in Private Health Plans**

What Does This Have to Do With Me????

- Medical Necessity Appeals should extend beyond the clinical issues and incorporate the following three components:
  - –Patient-specific clinical information in the context of industry standards of care
  - –Assessment of Carrier's Claim Review Procedures affecting Denial (Disclosure of denial detail, timeliness of UR and appeals response, credentials reviewers, use of independently developed care standards)
  - –Potentially Applicable Compliance/Regulatory Issues

What Goes Wrong With My Appeals?

- Untimely Appeals. Medicare appeals must be filed within 120 days of the claim decision; most commercial insurers require appeals within 180 days from the denial.
- Proper Disclosure of Claim Denial Basis is not Demanded during Process. You can’t rebut what you don’t know.
- Potential Compliance Issues are not Raised. Relying solely on citing clinical information makes it easy to redeny your request.
- Appeals are not exhausted.

4 Medical Necessity Appeals Sample Appeal Letters

- The following four letters can be used in utilization review appeals and/or post treatment claim appeals:
  - **Request Peer-to-Peer Review. Letter A**
  - **Request Peer-to-Peer Discussion and cite peer-reviewed literature that supports treatment, if possible. Letter B**
  - **Request Clinical Review Criteria and cite internal quality care guidelines that support treatment. Letter C**
  - **Request Policy/Plan definition of medical necessity/experimental/investigational. Letter D**

What Do These Letters Have In Common?

- *Letters must be customized to Summarize Patient's Condition and Care*
  - **Cite directly from Medical Record Documents and Attach Records**
  - **Doctors know the standards of care but they do not reference them in the medical record. Fill in the Documentation Gaps with supplementary information regarding standards of care, justification of treatment**
  - **Provide and Cite supporting independent standards of care - Peer-Reviewed Literature, InterQual - where possible**

What Do These Letters Have In Common?

•*Detailed Disclosure Demand: "If benefits remain denied, please provide the following information in addition to the specific information requested above:*

- Name of the board certified (specialty) reviewer who reviewed this claim and a description of any applicable advanced training or experience this reviewed has related to this type of care;
- Board certified (specialty) reviewer's recommendation regarding alternative care for treatment resistant patients;
- A copy of applicable internal clinical guidelines, if such exists, and the date of development;
- An outline of the specific records reviewed and a description of any records which would be necessary in order to justify coverage of this treatment;
- Copies of any peer-reviewed literature, technical assessments or expert medical opinions reviewed by your company in regard to treatment of this nature and its efficacy;"

What Do These Letters Have In Common?

- *Request for Disclosure Compliance*:
  - **"It is our position that failure to provide the requested information may violate state and/or federal claim processing disclosure laws or, in the minimum, non disclosure reflects a poor quality medical process which discourages treatment provider input. Disclosure standards are meant to ensure that all qualified parties have access to the information necessary to properly appeal an adverse determination. Therefore, we appreciate your prompt, detailed response to this request."**

Disclosure Laws

- State Disclosure, Utilization Review and Appeals/Grievances laws. Go To AppealLettersOnline.com to Research Your State Regulatory Protections.
- Section 502(c) of ERISA. See ERISA Claims Procedure Regulation.
- Medicare Modernization Act requires medical necessity reviews to be done by “physicians and other appropriate personnel” and requires specific denial wording to provide information on how decision was reached

NY MCCBOR Disclosure Violations

•*NY Attorney General - "Violation of the MCCBOR is not an abstract problem. The direct consequences of such violations are likely to be confusion, anxiety and fear among consumers with real medical needs. Navigating the health care market is no easy task, and when the choice is compounded by an imminent or existing medical need, full disclosure by health plans takes on added significance. Each time a plan neglects to provide clinical review criteria, the consumer is cast into a state of limbo in which a critical life decision is reduced to uncertain guesswork and high-risk speculation. Each miscalculation caused by a lack of information could leave the prospective enrollee with the choice of either paying for expensive treatment out of pocket or foregoing necessary medical care. The MCCBOR was passed so that consumers would not face that choice. Our survey demonstrates the urgent need to ensure that New York health plans comply with the law.*
(www.oag.state.ny.us/press/reports/hmo_coverage_info_report.pdf)

Lack of Disclosure is No Abstract Problem

- Disclosure allows for the Full Assessment of Carrier Claim Review Procedures
- Utilization Review and Level I appeals should seek disclosure of reviewer's credentials and clinical guidelines used to make determination.
- Denials almost always cite generalities when specifics are needed to assess quality of decision.
- More than 1500 clinical practice guidelines have been developed in the U.S. according to a 1998 article in Pediatrics (PEDIATRICS Vol. 101 No. 5 May 1998, pp. 825-830). There have been vast changes in how they are written in regards to precision and population inclusion.

Precertification Denials

- Use Sample Appeal Letters A - D to seek disclosure. Customize to cite Decision making time frames:
  - **Urgent Care Decisions - 72 hours (ERISA, URAC)**
  - **Prospective Pre-Service Non-Urgent Care Decision - 15 (ERISA, URAC)**
  - **Retrospective Review - 30 days w/ 15 day extension**
  - **Concurrent Review - 24 - 72 hours depending on timeliness of request**
- Cite the Prudent Layperson Standard to appeal emergency care denials. Appeal Letter E
- Cite URAC if dealing with a URAC-accredited payer. See urac.org for accredited companies and standards summary and AppealLettersOnline.com for URAC specific Appeals. Appeal Letter F

Assessment of Level I Responses

- "Our physician reviewer reviewed your claim and . . ."
- "According to our written guidelines . . ."
- "This treatment does not met the terms and conditions of the ABC benefit plan which states that not medically necessary treatment is excluded."
- "You may request a copy of . . ."
- Denial Upheld.

Appeal Process Assessment

- Our “Physician Reviewer” reviewed your claim and . . .
- Demanding Names/Credentials of the Reviewer may seem inflammatory
- ERISA, many state laws and accreditation requirements require the carrier to provide the clinical rational used in the decision as well as the name and credentials of the medical reviewer.

> Q: Under what circumstances must a group health plan (or disability benefit plan) disclose the identity of experts consulted in the course of deciding a benefit claim?
>
> A: The regulation provides that, in order to allow claimants a reasonable opportunity for a full and fair review of their claim, a plan’s claims procedures must provide, when requested, the identification of medical experts whose advice was obtained on behalf of the plan in connection with an adverse benefit determination. See § 2560.503- 1(h)(3)(iv) and (4).(Source: www.dol.gov/ebsa FAQs)

Level II Appeal – Unsatisfactory Reviewer ID/Qualifications Appeal

- Sample Letter G
- Acknowledges Information Supplied About Reviewers Credentials but seeks a more qualified, experienced reviewer in active practice. Reviewers in active practice are not solely dependent on insurance $ for their income.
- If a review by a (Specialty) physician in active practice in not provided, it is your duty to demonstrate that a quality medical review was undertaken. This sentence leads to further disclosure demands.
- Note Customization Suggestions, both highlighted and at the end of the letter.

Case Study: Hughes v Blue Cross

- Inpatient psych care denied
- Medical Director stated he devoted about 12 minutes to claim review/claim
- Medical Director disavowed any responsibility for collecting all medical records necessary to review claim
- Court decision:

(B)y omitting any explanation of the medical grounds for the intended denial of coverage, the letters placed an undue burden of inquiry on the insured's physician. The Blue Cross witnesses, in fact, defended the letters on the ground that the physician was free to write or call the medical review department to gain more information. The covenant of good faith and fair dealing, however, places the burden on the insurer to seek information relevant to the claim. This requires that the necessary letters to a treating physician be drafted in a manner calculated to elicit an informed response. Source: www.harp.org/hughes.htm

Appeal Process Assessment

- “According to our written guidelines . . .”
- Review Applicability of Cited Written Guidelines
- Guidelines are discretionary but you still MUST respond in detail to the applicability to the information being cited. It is frustrating when carriers do not respond to patient-specific clinical information. Likewise, it is frustrating for carriers when providers do not respond to written guidelines cited by carrier.
- Guidelines are based on aggregates. Patients are unique. Guidelines do not apply well to patients with multiple diagnoses, treatment-resistant conditions and other complications. Does the patient have a history of poor responsiveness to less aggressive treatment? Side effects?
- Chance for readmission, reinjury, reoccurrence if treatment goals are not met?

Level II Appeal – Unsatisfactory Use of Written Criteria Appeals

- Sample Letters H, I, J, K
- Acknowledges Carrier's Written Criteria but explains either (1) inappropriate application of criteria which justifies deviation from the criteria or (2) questions carrier interpretation of criteria by discussing how the actual wording in criteria could supports treatment in questions.
- One limitation of Written Criteria Utilization is that such criteria may not adequately address geriatric and "Treatment Resistant" Patients who do not respond to lower level of care are those who are considered for more aggressive, less "routine" and more highly scrutinized care.
- Note Customization Suggestions, both highlighted and at the end of the letter.

Guidelines - Practical vs Optimum

•According to a 2003 study conducted by the URAC Commission, most insurers use an externally developed medical review guideline, with the most widely used standard being Milliman & Robertson. A hospital negotiator discusses his successful efforts to specify that their MCO contract use Interqual instead of Milliman & Robertson due to the fact the Milliman & Robertson is based on "optimal efficiencies" which some rural hospitals cannot reach: www.ksinsurance.org/legal/bcbs/public_testimony/intervenors/kms/statement_Fairbank.pdf

IC more than M&R may deny compensation for Medicare hospitalizations. The observation that agreement between the two criteria sets is poor raises questions about the validity of either set of criteria. Source: Retrospective Evaluation of Potential Medicare Admission Denials Using Interqual and Millman and Roberts Admission Criteria By Irvin, Monfette and Lowe

Case Study: McGraw v Prudential

•Attorney submitted 25 peer-reviewed articles.

•Medical Director acknowledged that, before making the decision, he did not review patient medical records, did not talk to her neurologist, did not examine patient and did not read any medical literature "[b]ecause it was such a simple straightforward decision."

•MD explained that Prudential's internal protocols required showing improvement.

•Court decision:

–Prudential modified its definition of medical necessary with the additional requirement that treatment provide “a measurable substantial increase in functional ability for a condition having potential for significant improvement.” However SPD only required that the treatment be ordered by a doctor, generally accepted for the treatment of the condition and neither educational or investigational. Source: **www.oscn.net/applications/oscn/DeliverDocument.asp?CiteID=150591**

Appeal Process Assessment

- "The treatment does not met the terms & conditions of the ABC Benefit Plan Clinical which states that not medically necessary care is excluded."
- An argument can frequently be made that the broadly defined medical necessity definition and the more narrowly defined clinical care guidelines are contradictory.
- Medical necessity definition typically references at least three components:
  - Care that is within accepted standards of care
  - Care that is provided at the appropriate level of care
  - Care that is not primarily for the convenience of the patient

Level II Appeal – Contradiction Between Medical Necessity & Clinical Care Guidelines

- Sample Letter L
- Acknowledges Carrier's Written Criteria but focuses on how care meets the medical necessity definition.
- Note Customization Suggestions, both highlighted and at the end of the letter.

Guideline Varies From Standard

- Guidelines too focused on presenting problems or “so called why now factors”
- UBH Guidelines make clear that the “presenting problems” refer to the specific, acute symptoms that necessitated treatment not underlying mental health conditions
- As soon as the crisis precipitating admission on eases (even if condition is unresolved) coverage of LOC ceases unless stepping down would be unsafe

Source: https://secure.dahladmin.com/UBH/content/documents/OrderGrantingMotionforClassCertificationDkt174.pdf

Guideline Varies From Standard

Guidelines require a patient to show —constant improvement, even over relatively short time frames (every 2-3 days or each week), in order for coverage to continue, demonstrating that the guidelines‘ focus is on addressing short-term acute symptoms, rather than ensuring a patient‘s long-term recovery.

Source: https://secure.dahladmin.com/UBH/content/documents/OrderGrantingMotionforClassCertificationDkt174.pdf

Appeal Process Assessment

- "You May Request a Copy of . . ."
- Level II Sample Appeal Letters. Taking issue with failure to provide disclosure
  - **Medicare Medical Necessity Disclosure. Letter M**
  - **Clinical, Quality of Review, Compliance Review Request Appeal. Letter N**
- NY MCCBOR study: "Some plans did provide general handbook or contract materials that referenced the medical condition or service queried, but the information referenced did not constitute clinical review criteria. When a plan sent a member handbook that did contain clinical review criteria, this was noted as a satisfactory response."

Medicare Disclosure Requirements

- Beneficiary initial determination denials must include the reasons for the determination, including whether a LMRP, LCD or NCD was applied, and instructions on obtaining additional information and appealing decision.
- Both redetermination and reconsideration denials must include the specific reasons for the denial, a summary of the clinical or scientific evidence used in making the determination and a description of how to obtain additional information such as coverage rules, CMS policies.
- QICs are not bound by LMRPs and LCDs. Members of the QIC panel must have “sufficient medical, legal and other expertise, including knowledge of the Medicare program.” Denial Notices must include, "to the extent appropriate", a detailed explanation of the decision, a discussion of the pertinent facts and applicable regulations, and, in medical necessity decisions, an explanation of the medical and scientific rationale for the decision.

Attachments Make Appeals More Effective

- Claim Appeal Procedure laws typically require review of all information submitted with the appeal
- Attachments Addendum

Resources

•AppealTraining.com has a number of state-specific and ERISA appeal letter templates citing ERISA law

- review state specific Managed Care, UR and appeal grievance letters
- obtain letters available for your most frequent denial issues (download limit - 25 letters)
- review extensive articles about denial prevention and effective appeals
- review and post questions at AppealTraining.com Users Forum