



**CASE FILE #0901**

*The Appeals Process for* **MEDICAL NECESSITY DENIALS**



# SUMMARY OF CASE

- Diagnostic understanding of denied claim provided direction to solving denial through appeals.
- Forensic study of case allowed a clear path of laws, insurance bureaucracy to achieve success.
- Persistence on behalf of client achieved full recovery of funds due to hospital.

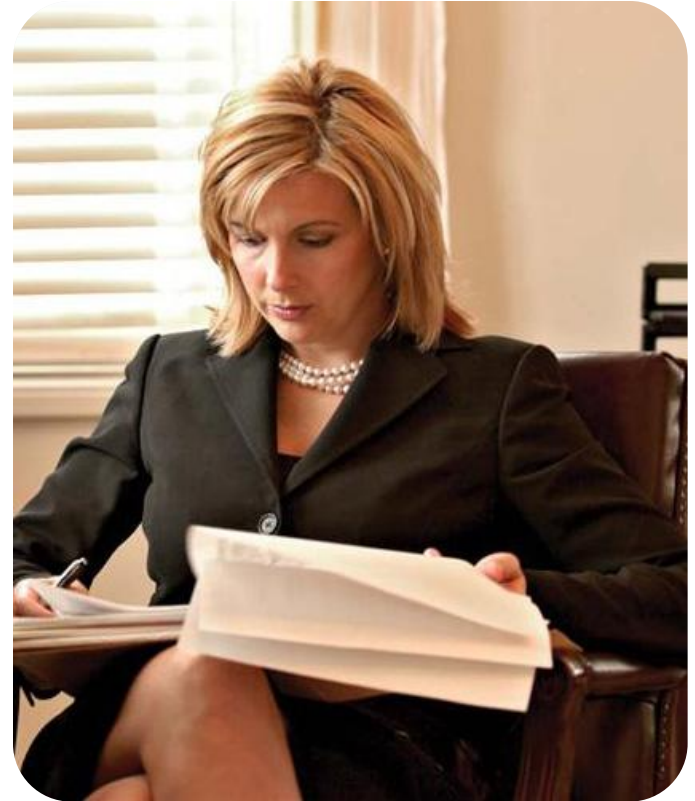


# CASE PROFILE #0901

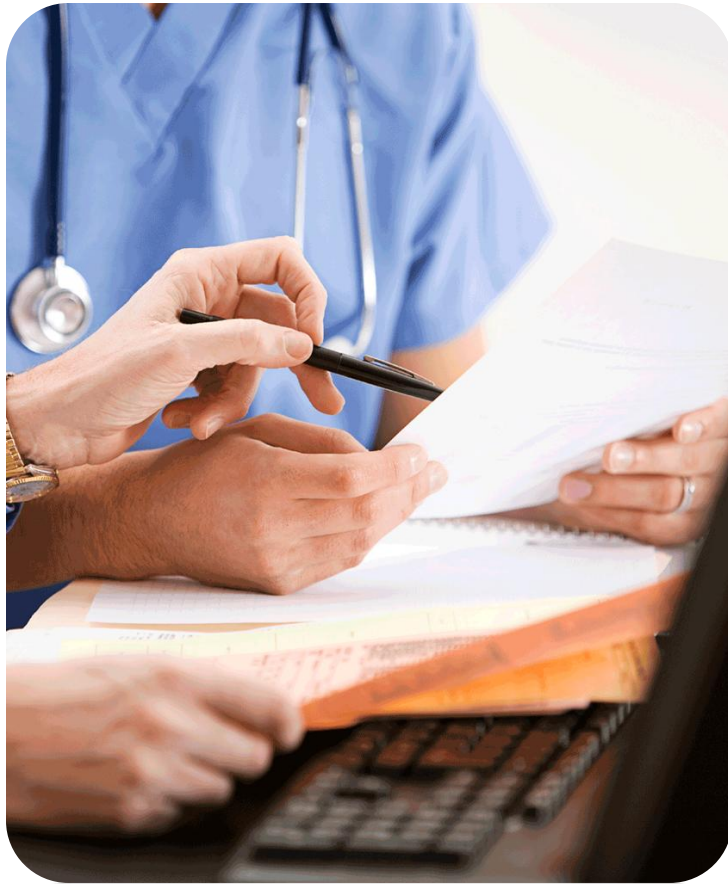
- Service provided - inpatient hospitalization for three days including a surgical procedure
- Facility obtains authorization for inpatient stay
- Billing notes document the authorization number and corresponding number of days approved
- **CLAIM SUBMITTED** - Aetna Insurance Company
- **CLAIM DENIED** - denial due to patient's treatment determined to be not medically necessary
- Case referred to **Appeals Expert**

# ERS CASE #0901

- **Forensic/Appeals Expert** determines plan type to be a PPO plan, governed by TDI.
- Verification of denial reason; insurance company asked to clarify basis of denial.
- Copy of determination letter requested.



# ERS CASE #0901 *cont...*



- **Appeals Expert** verifies with insurance company that Interqual criteria was used to make the determination.
- Expert informs insurance company that benefits were quoted to hospital and authorization was issued.



# ERS CASE #0901 *cont...*

- Expert submits request for documents needed from referring facility:
  - copy of Assignment of Benefits
  - copy of EOB
  - copy of the claim
  - copies of the collection/billing notes, including the Verification of Benefits (VOB)
  - copies of all correspondence from the insurance carrier
  - copies of all medical records, including copy of insurance card
- Expert will determine if additional medical records are needed from physician's office or other facility to support medical necessity.



# PROCESS OF SUCCESS

1. Review Aetna Clinical Policy Bulletin regarding bariatric surgery.
2. Determine if patient met the Aetna criteria for bariatric procedure.
3. Review coding submitted to determine coverage for this procedure; forward case to certified coder if necessary.
4. Expert determines Aetna Clinical Policy Bulletin basis to support claim.
5. Aetna's policy requires patient must have BMI >35.



# SUCCESS *cont...*

6. Critical fact to support claim is documented in the record but not coded when claim is submitted to Aetna.
7. Coding error is corrected and claim is revised to reflect the BMI > 35.
8. Expert works to make determination if patient met the applicable InterQual criteria.
9. If criteria is not met to support claim, consulting physician is engaged for medical review of the case
10. Determination is made by physician that patient did meet criteria for inpatient status.



# SUCCESSFUL RECOVERY

- ✓ Appeal letter is crafted.
  - Includes reasons why patient not only met the Aetna criteria, but also Interqual criteria.
- ✓ Appeal is sent via certified mail with supporting documentation.
  - Includes copies of the medical records, copies of the EOB, the claim, the VOB, and the billing notes.
- ✓ Dates, contact efforts, trail of forensic work is documented to support efforts.

# RECOVERY *cont...*

- ✓ Denial is overturned based upon forensic work and expert understanding of clinical criteria and administration processes.
- ✓ Aetna makes partial payment based upon facts.
- ✓ EOB indicates that the last day of service was denied as not medically necessary.





# RECOVERY *cont...*

- ✓ Second level appeal letter is crafted.
- ✓ Citation of the applicable VOB laws, and well as authorization laws used.
- ✓ Appeal is submitted again with copies of all records.
- ✓ Aetna is contacted within 30 days and denial is overturned.
- ✓ **Balance of revenues due hospital are paid!**