Medical Necessity:
Filing Successful Appeals*

"Medical necessity", used so often in denials of claims or athorizations takes on diverse meanings, based on who claims it.
Eventually the final word rests with your insurance, its guidelines, the terms of your health policy and the documentation supporting your claim.

Here are some tips to help you conquer those hard-to-win appeals.

1. Standard medical practice appeal

It is imperative that your physician) must show that the normal, well established standard of care has been followed. In a nutshell, you have been prescribed the gentler, cheaper, usual, most common course of treatment, and this is not working.

Let's say your prescription is brand name, but over the counter alternatives are available. You are liable for a higher or total share of cost for the brand name. Medical necessity would be justified if the OTC version or generic prescriptions had been tried over a certain amount of time, resulting in no improvements, a worsening of the condition, a serious side effect, or were counter-indicated.

When a surgical or invasive intervention is recommended, proving medical necessity requires records that demonstrate prior conservative, pharmaceutical or non-invasive therapies are not longer effective.

2. Insurance guidelines appeal

This appeal will be more difficult to win, but all hope is not lost. Because the terms of a contract are at play, the room to maneuver is tight.

Medical necessity would be established if conservative measures have been used and become ineffective to the point of causing irreparable damage to your health. Detailed explanations of the negative impact on your daily life, professional activities, and/or on your mental or emotional state if the prescribed treatment were not administered must be presented.

Say that you have intense back pain due to an old injury. Your policy will not cover surgery as your condition is neither acute nor hazardous to your life. It will cover pain management modalities, physical therapy and supplies such as a brace.
Exposing potential risks (addiction to pain pills), reduced quality of life (loss of mobility), inability to do your job (can't sit or drive) or onset of new related conditions (depression) would have a chance of success. The medical records would need to list unusual and serious circumstances justifying the prescribed approach.

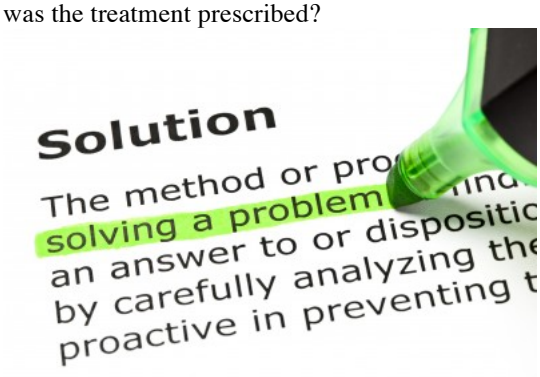
3. FDA based appeal

We are now entering a world where cooperation from your physician is indispensable.
If your treatment has been denied as "off-label" (not approved by the FDA) or inappropriate for your diagnosis, you are unlikely to win an appeal unless highly technical clinical documentation is presented.

Many specialized sources in the US are only available to physicians, while looking for supportive information elsewhere will test your research and linguistic skills.

If a prescribed treatment has a proven and effective off-label use abroad, in US drug trials (at least stage II) or as part of peer reviewed studies, it might be up for consideration. If literature supporting the physician's decision has been published in medical journals, can be located from reputable sources or is listed in the drug NCCN compendia (the "Bible of medications"), your insurance may be convinced to cover it.

Your physician must have the justification and be ready to hand over details, articles and research papers. His reasoning, supported by established facts and reasoning, should be extensively detailed in the medical records as it is out of established and standard guidelines. If not, ask yourself: on what medical grounds was the treatment prescribed?



This type of appeal is rarely done by patients, due to the complex nature of the evidence and the restricted access to resources.

In conclusion

Records from other physicians, demonstrated impact, detailed past treatments and their results should be on file in your chart. The industry's rule for payment is: " if it is not in the medical records, it did not happen". Every other insurance follows this reasoning. Unless a member of the medical profession noted it, or unless you have written proof, saying it means little. Old explanations of benefits would do, as would a history print out from a pharmacy. A letter from someone in the office, or unsigned by the physician holds no value.

Filing an appeal requires two things: stating exactly why a claim should be reprocessed or a denial overturned, and proving your point with as much relevant, legitimate documentation as you can get.

* Previously seen on NerdWallet