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TRAF Case Studies

Challenge

- Payor denied full treatment, claiming medical necessity
- A initial review was conducted by Payor's Associate Medical Director.
- Initial review was substandard, and hindered by by fiscal or administrative management.

Client

A 16 year old student-athlete suffered a PCL grade 2 partial tear and has knee instability. He was prescribed Physical Therapy and a custom knee brace.

Intervention

- Filed an Independent Medical Review (IMR) with the California DMHC
- ***Decisions based on medical necessity must be consistent with criteria or guidelines that are supported by clinical principles and processes.*** (HEALTH & SAFETY CODE §1367.01(B) (H)(4))
- ***Medical decisions must be rendered by qualified medical providers, unhindered by fiscal and administrative management***. (HEALTH & SAFETY CODE §1367(G))
- The Law prohibits any person from presenting false or misleading statements in response to a claim for payment or other insurance policy benefit. (GALLIMORE v. STATE FARM FIRE CASUALTY INSURANCE COMPANY, ET AL)

Payor

Monarch Healthcare, approved the Physical Therapy, but the custom knee brace was denied.

Success

- Within **one (1) week**, Payor's Medical Director reviewed the appeal, reversed their decision

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The Problem

A 16 year old student-athlete suffered a PCL grade 2 partial tear, has knee instability due to ligament insufficiency/deficiency, and was prescribed Physical Therapy and a custom knee brace by his Orthopedic Doctor (considered an integral part of the orthopedic protocol.)

The payor, Monarch Healthcare, approved the Physical Therapy, but the custom knee brace was denied by Monarch's Associate Medical Director who is a Pediatrician. Initial review was substandard, hindered by fiscal or administrative management, and Monarch refused to review the matter, stating only Health Net could be appealed.

The Solution

We filed an Independent Medical Review (IMR) with the DMHC citing Monarch's and Health Net's failure to satisfy their responsibilities under State Law.

Plans must have policies and procedures [for prospectively, retrospectively, or concurrently reviewing and approving, modifying, delaying, or denying, based in whole or in part on medical necessity, requests by providers of health care services for plan enrollees] shall ensure that decisions based on the medical necessity of proposed health care services are consistent with criteria or guidelines that are supported by clinical principles and processes. (Health & Safety Code §1367.01(b) (h)(4))

Upon an appeal to the plan of a contested claim, plans shall refer the claim to someone who is **competent to evaluate the specific clinical issues** presented in the claim. "Competent to evaluate the specific clinical issues" means that the reviewer has education, training, and relevant expertise that is pertinent for evaluating the specific clinical issues that serve as the basis of the contested claim. (Health & Safety Code §1370.2) (Also see Health & Safety Code §1367.01(c))

Plans and their capitated providers must be able to demonstrate to the department that medical decisions are rendered by qualified medical providers, unhindered by fiscal and administrative management. (Health & Safety Code §1367(g))

In GALLIMORE, Plaintiff and Appellant, v. STATE FARM FIRE CASUALTY INSURANCE COMPANY, ET AL we saw the plaintiff argue using CA Penal Code 550 (b) which prohibits any person to present or cause to be presented any written or oral statement as part of, or in support of or opposition to, a claim for payment or other benefit pursuant to an insurance policy, knowing that the statement contains any false or misleading information concerning any material fact. *We reminded Monarch of any potential personal liability under this section.*

Within **one (1) week**, Monarch Healthcare's Medical Director and Orthopedic reviewed the appeal, reversed their decision and authorized the custom knee brace, thus ameliorating harm to the patient and providing restitution for the treatment services obtained.

About TRAF

With an unprecedented 50% of the nation's hospitals losing money from operations (Thomson Reuters), The Reimbursement Advocacy Firm (TRAF) helps providers keep their doors open, ensuring patient access to critical trauma and medically necessary care. TRAF redresses power inequities that exist between health plans and providers. Our legislative voice and presence in the healthcare industry has allowed us to create a revolutionary division at the increasing demand of provider members who wanted a fresh alternative to the "conventional" collection agency. If you are a provider or billing agency, go to TRAF's website to learn about our services and what we can do for you!

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