The ARGUS Advantage Series:
Understanding Medical Necessity Review Procedure

ARGUS Claim Review is responsible for making sure medical providers are compensated for the services they perform on behalf of our client's employees and family members. It is also our duty to be sure the services being billed are payable under a client's Summary Plan Description (SPD) – and are medically necessary.

That is why all claims submitted by any provider are subject to review to determine if the treatment rendered meets the terms of the Plan's SPD, including medical necessity.

While it is often difficult for a patient to understand how something their physician orders may not be medically necessary, all providers are required to thoroughly document the patient's records of all pertinent information to substantiate their decision-making process. The decisions made must be in accordance with the generally accepted standard of care set by their peers in the medical field.

While the specific Medical Necessity language varies from SPD to SPD, the core aspects of it are the same. The treatment rendered must be ordered by a licensed practitioner within the scope of their license; performed within generally accepted standards of medical management in the United States; and must not be primarily for the convenience of the patient or the provider. The fact that a provider may prescribe, order, recommend, perform, or approve a service, supply or treatment does not, in and of itself, make the service, supply, or treatment medically necessary.

Needless to say, not all treatments rendered by providers are medically necessary. Sometimes it may be a matter of inadequate documentation where they can't substantiate their decision-making process; sometimes the provider is not following the generally accepted standard of care; and, possibly, excessive/abusive treatment is performed solely to generate revenue for the provider. The National Health Care Anti-Fraud Association estimates that of the $2 trillion spent in the United States on health care annually, 3% – or $68 billion – is lost to fraud and abuse.

How does ARGUS Claim Review determine if the treatment rendered is truly medically necessary or not?

We utilize the services of Medical Review Institute of America (MRIoA) in making these determinations. Since being incorporated in 1982, MRIoA has provided external physician review utilizing a nationwide network of over 750 active practicing and board-certified physician specialists and other healthcare professionals in all specialties and sub-specialties of medicine.

MRIoA itself is accredited by URAC, an independent, nonprofit organization, well known as a leader in promoting health care quality through its accreditation and certification programs. URAC reviews a company's operations to ensure that the company is conducting business in a manner consistent with national standards.

When a claim is received by ARGUS Claim Review where the medical necessity of the procedure might be in question, complete medical records are requested directly from the provider billing for the service. However, the patient is also copied in on this correspondence and has the opportunity to submit any information they feel is pertinent to their situation, as well (such as records from physicians seen prior to their current physician, etc.).

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Under the terms of ERISA, both the provider and/or the patient have 45 days to submit all of the requested information to our office. If this information is not received within this timeframe, the charges are considered ineligible for consideration, and the next step would be the appeal process.

If all of the information is submitted within this timeframe, the file is then forwarded to MRIoA for independent peer review by a physician of the same specialty as the rendering provider. In making their determinations, MRIoA researches many different sources, including but not limited to Official Disability Guidelines (ODG), the Centers for Medicare and Medicaid Services (CMS), Local or National Coverage Determinations (LCD/NCD) and MEDLINE.

If the services are found to be not medically necessary, a letter is sent to the patient detailing the Plan language and their appeal rights. Under ERISA, the patient has 180 days to submit an appeal from the date of the denial. A copy of the review detailing the clinical rationale used in the denial is also sent, along with an Appeal Form. A copy of all of this is sent to all parties who have submitted bills for the treatment in question (surgeon, facility, anesthesiologist, etc.)

Under ERISA, providers do not have authorization to appeal charges on a patient's behalf unless the patient specifically authorizes them to do so. This is to protect the patient's best interests as, depending on the Plan, there are only one or two levels of appeal available.

Once those appeals are exhausted, and if the services are still found to be not medically necessary, that is the final decision of the Plan. Therefore, it is important that the patient understands the process and is involved in it.

The Appeal Form sent to the patient explains the above and allows them to either designate a provider to appeal the charges for them, or to appeal the charges themselves. They may submit any documentation they feel will help determine that the services were medically necessary. Once the patient signs and dates the Appeal Form and submits it to our office, the appeal is formally initiated.

The file, along with any new documentation submitted, is then sent to MRIoA for the next (or final) level of appeal. The file is reviewed by another physician (other than the original reviewer) and treated as a new and separate review.

It is never our intent to make the patient feel as though they did something wrong by trusting their provider to give them the appropriate medical treatment. However, it is also our duty to our clients to ensure that the plan is only paying for treatment which is medically sound and meets all the terms of the Plan SPD.

ARGUS continually monitors industry-related guidelines, costs and other factors to ensure we are always using best practices to ensure claims are accurate, ultimately resulting in savings and effective cost-containment for our clients.

If you have any questions about Medical Necessity Review, ARGUS Claim Review or other benefits-related topics, feel free to contact us – we're happy to answer any questions you have.