



Case Study

Heart Failure Denial Overturned For \$169K Reimbursement



Heart Failure Denial

Clinical denials are rising sharply, **now costing U.S. health systems over \$20 billion annually in unrecovered reimbursement**. Among the leading drivers of these denials are heart failure diagnoses, which frequently face payer challenges due to strict medical necessity criteria, gaps in documentation, or differences in guideline interpretation.

The complexity of appealing a heart failure denial is significant, requiring a meticulous blend of clinical evidence, coding accuracy, and payer-specific policy justification. A client delivered a complex heart failure denial to Managed Resources' KLAS-rated Denials Management team to review and appeal.

Challenge

Our client had a patient in the hospital for 100 days for acute decompensated heart failure with multiple complications and secondary diagnoses complicating the admission. The payer denied the entire stay but did not provide a denial letter detailing the specific medical reasons for the denial. The facility only received a denial determination with the EOB, noting Reason Code "CO 39 Services denied at the time precertification/authorization requested" from the payer.

Managed Resources' Clinical Appeals team encountered many unique challenges in this case.

- The patient had a long history of several hospitalizations due to noncompliance secondary to psychiatric issues.
- There were delays in care requiring 1:1 observation for safety.
- He did not have the capacity to make his own medical decisions.
- Additionally, the patient had multiple transfers between units and several barriers to discharge that increased his length of stay.
- He had a lack of social support, cognitive deficits, and limited functional abilities.
- He was at increased risk for a poor outcome due to failure to thrive.



100 Days

Length of hospital stay for patient with heart failure



\$169K

Revenue lost after payer denied heart failure claim

Appeals Team: Our clinical appeals team of Registered Nurses (RNs) and compliance specialists are employed onshore, and have an average of 20+ years of experience. Their credentials include: RN, NP, IMG, CCS, CDI, LNCC, C-DAM, CCM, CCS-P, CCDS, CDIP, CPC, RHIA, RHIT, CRCR, PMP and more.



Solution

As part of Managed Resources' industry-leading clinical appeals process, the denial was reviewed and assigned to a specialized RN to begin the appeal process.



- **Medical Necessity/MCG Criteria at Acute Level of Care:** Managed Resources utilized appropriate criteria to support inpatient admission and continued stay based on the clinical guidelines. The facility had submitted proper documentation to support the criteria. The patient had congestive heart failure with an EF of 15% and required dobutamine infusion, with multiple failed weaning attempts leading to cardiogenic shock.
- **Medicare Regulations:** Managed Resources cited regulations that were applicable to Medicare Advantage Plans. Aetna Medicare is financially responsible for the care provided to the member without prior inpatient authorization and must provide their enrollees with all basic benefits covered under original Medicare. Furthermore, CMS has provided clarification that Medicare Advantage plans must follow the guidelines set forth in the CMS "Two Midnight Rule."

The physician had anticipated the patient would require inpatient care for at least two midnights. The patient's admission spanned 100-midnights, which met regulatory guidelines as defined by the CMS "Two Midnight Rule" for medical necessity. Our team emphasized the fact that the facility did not receive a denial letter from Aetna Medicare detailing the specific medical reasons for the denial. A written notice of the review decision and the exact reasons for the denial should have been done in accordance with NYSS ISC 4802.

- **Aetna's Definition of Medical Necessity:** Managed Resources cited this definition to demonstrate that due to the patient's emergent condition, his inpatient admission and the services provided were medically necessary.

Results

After a comprehensive appeals process, **Managed Resources successfully overturned the entire stay in the amount of \$169,000.**

Aetna reviewed information including appeal and documents, Medicare guidelines, Aetna Clinical Policies and overturned the entire hospitalization stay.

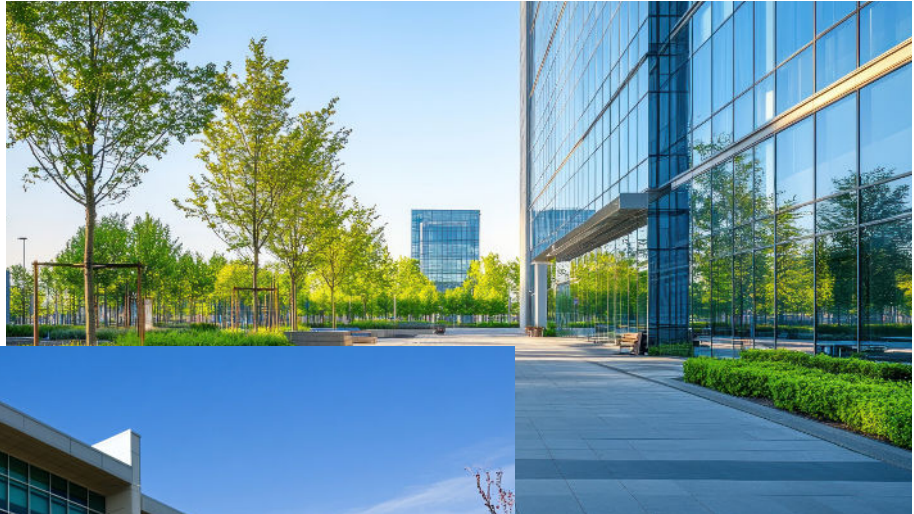
\$169K Denial Overturned

The payer overturned the entire 100-day hospital stay, and our client was reimbursed for \$169,000.

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