HOUSE OF REPRESENTATIVES
COMMONWEALTH OF PENNSYLVANIA

* * * * * * * * * *

House Bill 2849

* * * * * * * * * *

House Judiciary Committee

Neumann Room
St. Agnes Hospital
Philadelphia, Pennsylvania

Monday, September 16, 1996 - 10:30 a.m.

--oOo--

BEFORE:

Honorable Thomas Gannon, Majority Chairman
Honorable Kathy Manderino

ALSO PRESENT:

Brian Preski, Esquire
Chief Counsel for Judiciary Committee

Galina Milohov
Minority Research Analyst

ORIGINAL

KEY REPORTERS
1300 Garrison Drive, York, PA 17404
(717) 764-7801 Fax (717) 764-6367

1996-100

1 C O N T E N T S

WITNESSES	PAGE
PA Academy of Family Physicians	
Charles I. Artz, Esquire	3
Stephen Wiener, D.O. Public Policy Commission Chairman	17
Pennsylvania Medical Society	
Jonathan E. Rhoads, Jr., M.D., Pres.	44
Donald McCoy, Director Regulatory Affairs & Spec. Legislation	58
Bernard Smalley, President Philadelphia Trial Lawyers Ass'n	78
Andrew Wigglesworth, President Delaware Valley Hospital Council	96
Sam Marshall, V.P. and General Counsel The Insurance Federation of PA	119

2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

1 CHAIRMAN GANNON: We are going to
2 begin. We're waiting for some other members to
3 arrive. I don't want to be sitting here all
4 day. Let's begin with our first witness.
5 Let me just make an introductory remark.
6 This is a hearing before the House
7 Judiciary Committee on House Bill 2849. Our
8 first witness is Stephen Wiener, Doctor of
9 Osteopathy, Public Policy Commission Chairman,
10 Pennsylvania Academy of Family Physicians, and
11 Attorney Charles I. Artz, Esquire.
12 MR. ARTZ: Good morning, Mr. Chairman.
13 CHAIRMAN GANNON: Welcome, Mr. Artz.
14 MR. ARTZ: Thank you. Mr. Chairman,
15 I'm going to be delivering the bulk of the
16 testimony. Doctor Wiener then will present
17 clinical examples for your committee's
18 consideration as to the need from a practical
19 and a clinical standpoint for this legislation.
20 The Pennsylvania Academy of Family
21 Physicians assisted in the drafting of House
22 Bill 2849 and supports this legislation. This
23 testimony is presented to provide the committee
24 with public policy and legal rationale
25 substantiating the enactment of House Bill 2849.

1 The problem is, insurer arbitrariness.
2 The academy's physician members report numerous
3 circumstances where all types of third-party
4 payers deny reimbursement for medical care,
5 contending that services were, quote, not
6 medically necessary.
7 If the insurance company action is
8 appropriate, it cuts payers' expenses. If it's
9 inappropriate, it still cuts payer costs, but
10 wrongly jeopardizes a patient's access to
11 medical services, shifts costs to patients
12 and/or providers, and increases costs by adding
13 paperwork and hassle to an already overburdened
14 health care delivery system.
15 Governor Ridge and the General
16 Assembly have made a positive and concerted
17 effort to create a pro-business environment in
18 Pennsylvania, including decreasing the
19 unnecessary hassles for conducting business in
20 the Commonwealth.
21 The academy's 4,200 members include
22 over 2,400 both small and mid-sized health care
23 businesses that should not have to endure
24 arbitrary and unnecessary hassles in treating
25 their patients. The approximately 9,000 total

1 physicians practices, which includes all
2 specialties in group practices, in the
3 Commonwealth merit the same pro-business support
4 while treating Pennsylvania consumers.
5 Because the linchpin of payment for
6 and access to health care is the term medical
7 necessity, an objective uniform definition of
8 that term is crucial. Nevertheless, no
9 objective definition of the term medical
10 necessity exits under Pennsylvania law.
11 The definition of medical necessity
12 changes literally depending on who is making the
13 determination and the kind of insurance plan or
14 coverage that's at issue.
15 Reasonable and medically necessary
16 care is consistently denied by insurance
17 companies regardless of the payer system
18 involved. That is why the statute addresses the
19 entire panoply of health care payer systems.
20 Typically, the cost to litigate a
21 breach of contract action, which is the cause of
22 action that would arise in one of these
23 circumstances, the cost to litigate such a
24 contract action against an insurance company to
25 collect payment for medically necessary

1 treatment typically exceeds the value of the
2 claim; thereby, rendering any possible
3 litigation really worthless.
4 The academy contends that insurance
5 companies generate substantial profits by
6 denying medically necessary care, knowing that
7 the vast majority of physicians won't litigate
8 or undertake the hassle to collect on a viable,
9 medically necessary claim.
10 So, what is the existing law in
11 Pennsylvania? As I noted earlier there is no
12 objective statutory definition of the term
13 medical necessity under any Pennsylvania law.
14 The Motor Vehicle Financial Responsibility Act,
15 based on the amendments made by Act 6 of 1990,
16 does have a definition of the term, quote,
17 necessary medical treatment and rehabilitative
18 services.
19 I include the precise definition in my
20 testimony as it's clear from that statutory
21 definition, medical care is necessary unless a
22 peer review organization says it isn't. So,
23 this definition is merely circuitous and
24 provides no objective measurement whatsoever.
25 The Health Maintenance Organization

1 Act contains no definition of the term. The HMO
2 regulations promulgated by the Insurance
3 Department define the term as I have set forth
4 in the testimony.
5 However, it's clear that when you look
6 at that definition there's no objectivity. It's
7 simply vests unfettered, absolute discretion in
8 HMO Medical Directors to make determinations of
9 medical necessity.
10 The next point of law in Pennsylvania
11 is a recent Superior Court decision that was
12 handed down on July 1, 1996. If nothing else,
13 this decision compels close scrutiny of the
14 legislation by the committee and a vote to get
15 it out of committee onto the House floor.
16 The case is Rudolph versus
17 Pennsylvania Blue Shield. I have the Atlantic
18 2d. cite included there. It was issued on
19 July 1. This decision negatively affects due
20 process and contract rights of physicians and
21 other health care providers relating to
22 Pennsylvania Blue Shield decision denying
23 reimbursement for treatment or services Blue
24 Shield considers not medically necessary.
25 In the Rudolph case the Superior Court

1 held that a physician does not have the right to
2 a de novo review of a Blue Shield Medical Review
3 Committee determination in a trial court. In
4 other words, the health care provider cannot
5 file a breach of contract suit against Blue
6 Shield in court and have a judge or jury render
7 an independent analysis of the facts and law.
8 The health care provider is essentially limited
9 to filing only an appeal from an unfavorable
10 Medical Review Committee decision, but that
11 appeal can only be filed if the provider can
12 both plead and prove allegations of fraud or
13 misconduct occurred in the Medical Review
14 Committee proceeding.
15 So, under this decision, Blue Shield
16 could perpetrate an unconscionable bad faith
17 medical necessity denial, conduct its Medical
18 Review Committee hearing in compliance with the
19 very limited requirements contained in their
20 bylaws, and then be insulated from judicial
21 review.
22 In its rationale, the Superior Court
23 concluded that the Blue Shield statute, its
24 provider contract which Blue Shield calls its
25 regulations, and Blue Shield Bylaws for

1 participating providers, quote--this is what
2 Superior Court held--clearly contemplate the
3 finality in the Blue Shield Medical Review
4 Committee decision, end quote. The Court
5 reasoned that the legislature created a, quote,
6 constitutionally adequate method, end quote, in
7 the Medical Review Committee hearing procedures
8 because physicians are given notice of the
9 reimbursement denial that there's going to be a
10 lack of medical necessity determination against
11 them, and a hearing.
12 Unfortunately, the Court clearly
13 ignored the fundamental due process requirement
14 of fairness in any hearing. In particular, the
15 Court ignored the fact that the Medical Review
16 Committee members are appointed and hand
17 selected by the Chairman of the Board of
18 Pennsylvania Blue Shield. The members of the
19 Medical Review Committee, therefore, are clearly
20 not impartial nor are they disinterested in the
21 outcome of the decision. As the dissenting
22 opinion noted in that case, this situation is a
23 flagrant abuse of the due process rights of
24 doctors.
25 As an added note, I spoke with counsel

1 to the provider in this case and a petition for
2 allocatur to the Pennsylvania Supreme Court has
3 been filed and a response has been filed as
4 well. We are awaiting the Supreme Court's
5 decision on the allocatur petition.
6 The recently enacted Emergency Medical
7 Care legislation in the form of House Bill 1415,
8 which was Act 112 of 1996, requires insurance
9 companies to reimburse patients or providers for
10 medically necessary services provided in a
11 hospital emergency facility due to a, quote,
12 medical emergency.
13 Now, Act 112 appropriately defined the
14 term medical emergency. However, the crucial
15 term medically necessary remains undefined in
16 the law and continues to allow managed care
17 organizations or health insurance companies to
18 impose arbitrary denials based on medical
19 necessity definitions in which the insurance
20 company's medical director has broad or absolute
21 discretion to make that decision. Therefore,
22 Act 112 is a hollow victory for health care
23 consumers without the enactment of an objective
24 definition of the term medically necessary since
25 payment turns on medical necessity.

1 The final point of the Pennsylvania
2 law is that, the Medical Assistance regulations
3 focus on whether a service is compensable under
4 the Medicaid program. Thus, if the program pays
5 for it, it's necessary. Again, there's no
6 objectivity here because coverage is not
7 equivalent to medical necessity. That is the
8 summary of the existing Pennsylvania law on this
9 issue.
10 The next topic is managed care
11 organization contracts. Most of those contracts
12 don't define the term at all. Of those that do
13 define the term, the vast majority of the
14 contracts with physicians follow the Insurance
15 Department's authority, under which the managed
16 care organization medical director retains
17 absolute discretion to interpret what treatment
18 is medically necessary. I have myself reviewed
19 and negotiated scores of these contracts. I can
20 attest to that personally.
21 Many other managed care organization
22 contracts never even disclose any definition or
23 criteria to be used and do not make this
24 information available to the patient or
25 physician; thus, creating a disjointed and

1 confusing definition in the minds of patients
2 and providers.
3 The next point is that there's a
4 criminal component to this. The U.S. Attorney
5 for the Eastern District of Pennsylvania
6 recently outlined his plans for increased
7 criminal prosecutions against physicians seeking
8 reimbursement for care beyond that which is
9 medically necessary. He also plans to prosecute
10 physicians for not providing enough medically
11 necessary care in managed care contract
12 arrangements.
13 These criminal prosecutions are not
14 intended to be brought under the Medicare
15 program, the Medicare Exclusion Statute or the
16 Medicare Fraud and Abuse Act or payment denial
17 under the Stark legislation. Instead, they are
18 planned against physicians under any commercial
19 insurance contract based on a mail fraud theory.
20 This is what the U.S. Attorney stated:
21 Quote: We've shied away,
22 historically, from medical necessity fraud cases
23 because they were so hard to prove because we
24 thought it would be a swearing contest between
25 doctors. Now, sophisticated databases exist

1 that outline the parameters of the given plan's
2 acceptable practice standards. We see medical
3 necessity as an issue of the future where we
4 will no longer rely on our own experts saying
5 what happened. We will rely on the databases
6 that hospitals have, that the doctors have, and
7 the insurance companies have.
8 Incredibly, the federal government
9 believes physicians can be held criminally
10 liable for providing too much or too little care
11 merely by looking at statistics, even though
12 that term is not defined under state law. This
13 classic double bind presents compelling
14 rationale to enact an objective definition of
15 medical necessity as contained in House Bill
16 2849.
17 The remainder of the testimony on this
18 page, Mr. Chairman, is a clinical perspective.
19 Rather than going through the theoretical part,
20 I thought I would at the close of my testimony,
21 which will be in a moment or so, give Doctor
22 Wiener the opportunity to discuss some real life
23 examples. I'm now moving over to page 6, the
24 legislative solution.
25 The Medical Necessity Act, or as it's

1 now captioned, The Wrongful Denial of Medically
2 Necessary Treatment Act, would, first, require
3 all health insurance policies and networks to
4 pay for medically necessary care. It would
5 define the term medical necessity in objective
6 terms. It would apply the definition to every
7 type of insurance policy or plan including
8 commercial insurance, HMO's, PPO's, the Blues,
9 workers' comp, auto, third-party administrators
10 and provider networks. It would not apply to a
11 particular type of care if an insurance contract
12 expressly and lawfully excluded that type of
13 care. So, this is not a coverage mandate.
14 And finally, would permit a physician,
15 hospital or other licensed health care provider
16 to recover compensatory damages, interest at 12
17 percent per year, court costs, attorney's fees,
18 and triple damages if bills were not paid when
19 treatment provided satisfied the definition.
20 My next and last point is the
21 interplay with the tort system. Conflicts
22 between medical ethics and professional
23 liability often arise as a result of the lack of
24 an objective definition of the term medical
25 necessity. If an insurance company concludes

1 that a service is not medically necessary, and
2 the physician's clinical analysis suggests that
3 it is medically necessary, the physician is
4 faced with an ethical and liability quandary.
5 The quandary is this; if the physician
6 provides the care, the physician won't be paid.
7 If the physician abides by the insurance company
8 determination, for example, on concurrent
9 review, the physician could be subject to
10 professional liability for failure to provide
11 necessary care. Unknowingly, the patient is
12 caught in the middle.
13 A classic example of this Catch 22
14 situation arose in litigation in the California
15 Appellate Courts that imposed liability on a
16 utilization review organization that dictated
17 premature, that should say cessation of benefits
18 and treatment resulting in a patient's suicide.
19 The passage from the court's statement is there
20 for your review and consideration. It really
21 makes the point that I just stated.
22 So what is the source of the
23 definition of medical necessity? The academy
24 assisted in the development of this legislation
25 by analyzing and incorporating provisions from

1 the Medicare statute, regulations and Medicare
2 Carriers Manual, as well as case law from
3 various federal and state jurisdictions, ERISA
4 contracts, and most important, common sense and
5 experience.

6 The academy submits along with our
7 testimony a supplemental, extensive memorandum
8 of law detailing the authoritative sources
9 relied on in developing this term. That is in a
10 memorandum that appears under my stationery for
11 submission to the committee as well.

12 What House Bill 2849 will not do is
13 also an important point as I close. It will not
14 create cookbook medicine by proscribing
15 precisely the care that is medically necessary.
16 Instead, it provides objective guidelines
17 against which all treatment can be judged for
18 validity.

19 It will not create any coverage
20 mandates. In fact, page 2, lines 8 through 11
21 expressly state that nothing in the act requires
22 an insurance company to pay for any treatment
23 expressly and lawfully excluded by a health
24 insurance policy. This legislation applies only
25 to covered services under an existing policy.

1 Finally, it will not result in
2 automatic reimbursement for all services
3 rendered by physicians. Under this statutory
4 framework, care that is proven not to satisfy
5 the definition need not be paid.
6 As I conclude, insurance company
7 denial of medically necessary care based on
8 20/20 hindsight and paper reviews is unfair to
9 patients, health insurance policyholders,
10 physicians and the Commonwealth of Pennsylvania.
11 The academy respectfully requests that the
12 Judiciary Committee approve the measure and give
13 us the opportunity for a House floor vote.
14 Thank you.
15 I will now turn the testimony over to
16 Doctor Wiener who has a few cogent clinical
17 examples. And then we'll be happy to take
18 questions.
19 CHAIRMAN GANNON: Thank you.
20 DOCTOR WIENER: Thank you. Thank you
21 for allowing me to speak with you this morning.
22 I have just 5 basic points that I feel were
23 clinically relevant in my everyday practice
24 concerning this issue. I'll give them as brief
25 as possible and answer any questions afterwards.

1 The first one involves a patient of
2 ours who was involved in a motor vehicle
3 accident in October of '94 causing the patient
4 to have pain in the neck, shoulders and low
5 back. The patient was given medications,
6 physical therapy with some limited improvement.
7 The patient was seen by a physiatrist or a rehab
8 specialist as well as a neurologist. The
9 patient was diagnosed in January of '95 with
10 neck, back strain and bilateral carpal tunnel
11 syndrome as well as a cervical radiculopathy.
12 Despite unremarkable MRI's of the
13 cervical lumbar spine the patient continued to
14 have pain in the neck and back. He was sent to
15 an Achievement Center in February of '95 for
16 aquatic therapy since standard physical therapy
17 proved to not be of much help. This, in fact,
18 did improve some of his symptoms. He completed
19 this program in March of '95.
20 An initial peer review was done in
21 February 27th of '95 denying care as well as
22 therapy from January 17th of '95 on. An MRI of
23 the lumbar spine was also denied. A
24 reconsideration was asked for, and on April 28th
25 of '95 also denied treatment after January 13th

1 of '95. This patient ultimately underwent
2 surgery for the carpal tunnel syndrome in March
3 of 1995.
4 The patient was released back to work
5 in April of '95. He quickly developed
6 increasing back pain at work; was seen by an
7 independent medical examiner, which was an
8 neurologist, who felt that the patient could
9 return to work. He was seen by myself to which
10 he could hardly move and bend; was sent to an
11 orthopedic surgeon who requested another MRI;
12 diagnosed as subsequent herniated disk, and the
13 patient ultimately went to surgery.
14 Another such example is another
15 patient of ours who was involved in a motor
16 vehicle accident in February of '95 working for
17 SEPTA and was a bus driver at the time; thus, it
18 was a workmen's comp issue. He was seen in
19 March of '95 with complaints of neck pain, back
20 pain and headaches. He also was given
21 medication, medical equipment and physical
22 therapy.
23 Utilization review began in April of
24 '96, and denied payment after the first 16 weeks
25 of treatment stating that these were just soft

1 tissue injuries and the patient should have been
2 fine after that time. A reconsideration was
3 asked for, and in June of '96 stated that the
4 patient had reached maximum medical improvement
5 by October of '95; thus, anything after that was
6 not medically necessary.
7 The patient, however, continued to
8 complain of neck and back pain; was subsequently
9 seen by a neurologist in October of '95,
10 diagnosed with a cervical radiculopathy and a
11 flareup of previously asymptomatic arthritis.
12 He was seen by a neurosurgeon in March of '96,
13 also diagnosed with a cervical radiculopathy,
14 spinal stenosis with cord compression and
15 received a series of 3 steroid blocks to the
16 neck for his pain.
17 Eventually, the patient did go back to
18 work on light duty, although he continued to
19 complain of pain in his neck and back. We
20 continued to closely follow the patient and he
21 continued to receive therapy, but he was forced
22 back to work in August of this year as he was
23 told to return to work or be fired because of a
24 neurosurgical review in May of '96 stated that
25 he was totally recovered and no further

1 treatment was necessary.

2 Another example that I have is a

3 female patient of ours who was involved in a

4 motor vehicle accident in July of '91, where she

5 was rear-ended. She saw her family doctor and

6 then was referred to us in August of '91 with

7 complaint of left hip pain, neck pain, headaches

8 and left hand tingling. Her past medical

9 history was positive only for hypertension.

10 X-rays at that time showed arthritis

11 to her left hip and low back, and was negative

12 of her neck and middle back. She was diagnosed

13 initially with cervical, dorsal and lumbosacral

14 strain and neuropathy of the left upper

15 extremity, as well as blunt trauma to the left

16 hip.

17 She was given physical therapy,

18 medication; seen by a rheumatologist in October

19 of '91, and diagnosed with Sjogren's syndrome,

20 which is a condition consisting of dry eyes, dry

21 mouth, fatigue, poor sleep, low-grade fevers and

22 color changes to her fingers.

23 She was subsequently seen by

24 orthopedics where x-rays and a bone scan were

25 negative. An MRI was ordered of the left hip

1 and showed to have aseptic necrosis, which is
2 where there's lack of blood supply to the ball
3 of the hip joint. A rheumatologist felt the
4 necrosis was, in fact, due to the motor vehicle
5 accident.
6 An initial peer review in November of
7 '91 basically negated all of our care and that
8 of my partner's. A peer review by an orthopedic
9 surgeon dated February of '92 also felt that the
10 hip was the result of the Sjogren's syndrome and
11 not the motor vehicle accident.
12 A peer review reconsideration on the
13 part of the medical care was overturned in March
14 of '92, but a reconsideration on behalf of the
15 orthopedic surgeon dated April of '92 agreed
16 with the initial review that the aseptic
17 necrosis was not a part of the motor vehicle
18 accident; and thus, all the orthopedic visits
19 except for his initial visit were denied as they
20 were unrelated to the motor vehicle accident.
21 A follow-up by the rheumatologist
22 still felt that the Sjogren's syndrome was not
23 the cause of the hip necrosis. Up to this point
24 and through 1994-95 despite lack of payment the
25 orthopedic surgeon continues to see this patient

1 with continued left hip pain despite denials and
2 receiving reimbursement.
3 Another example that I have is a case
4 that we recently had in our office from an
5 insurance company who basically denied coverage
6 for a patient who had fungal toenails, a very
7 common problem amongst many people. Although we
8 tend to see this more in the elderly population,
9 we have many young patients who come in with
10 early signs of fungal toenails.
11 This particular health plan wrote us
12 back saying that there is insignificant
13 documentation to support that the patient was
14 functionally impaired due to the nail fungus
15 and/or is a diabetic, which the patient is not.
16 Without medical documentation we cannot
17 authorize the use of medications under this
18 policy, and only care that is essential and
19 necessary is a covered benefit.
20 To which I recently wrote back a reply
21 on behalf of my partner, and I basically stated
22 that this patient -- that we were requesting an
23 appeal for denial of medication to this patient
24 for the purpose of treating Onychomycosis or
25 fungal toenails. This condition has not allowed

1 this patient to wear certain athletic footwear;
2 has caused him to replace countless pairs of
3 socks due to tearing, and he continues to have
4 discomfort to his feet.
5 I stated in my letter that I felt, as
6 my partner did, that the use of the particular
7 medication which was to be prescribed would be
8 appropriate. This medication would be given
9 less than half of the time that the generic
10 medications which we used to use would be given.
11 Testing for potential liver function and bone
12 marrow abnormalities would be required as all
13 medications that we use for treating this
14 condition. But by giving the drug 50 percent
15 less time, there would be 50 percent less cost
16 involved.
17 I wrote in my letter that I realize
18 the effectiveness of these medications are
19 limited, but given the patient's complaints I
20 feel the treatment is medically necessary and
21 justified, as this does cause functional
22 impairment and is not just cosmetic.
23 Finally, I have several examples in my
24 office of motor vehicle accident patients,
25 workmen's comp patients where we have been --

1 and this is across the board for different
2 insurance companies -- where we provide
3 manipulation as a service of being an
4 osteopathic physician. Most of these cases we
5 see the patient in the office for an accident.
6 We go through a subjective questioning of how
7 they're feeling on that particular visit, do an
8 examination to compare one visit to the next.
9 They may or may not require manipulation of
10 their back or spine, and then we make an
11 appropriate assessment and a plan of what we're
12 going to do and then a certain follow-up time.
13 I have multiple examples here where
14 insurance companies have decided from one point
15 to the next whether they are going to pay for
16 what things and what is medically necessary and
17 what isn't. Many of these examples show that
18 they will pay for the manipulation because it is
19 a cheaper charge, but they won't pay for the
20 office visit. They claim that it's all part of
21 the same procedure code, but obviously, there's
22 a visit code and there's a manipulation code.
23 But whichever one tends to be the cheapest is
24 the one they decide to pay for and claim it is a
25 bundle service.

1 We've actually had people over the
2 phone who are nonphysicians telling me that my
3 manipulation is part of me being a D.O. and
4 that, therefore, it's expected on every office
5 visit. I wonder what they expect me to do with
6 a patient who comes in with a common cold or
7 diabetes.
8 These are multiple examples where
9 medical necessity is basically through the form
10 of manipulation, but it's not all right for me
11 to ask the patient questions and do a physical
12 exam on them because that's not a covered
13 service.
14 If there's any questions that you
15 have, I'd be happy to try to answer them.
16 CHAIRMAN GANNON: I have a couple of
17 questions. In your testimony you talked about
18 the fact that this bill provides for a
19 definition for some framework for medical
20 necessity. Have any other states to your
21 knowledge promulgated a statute that sets up
22 parameters or a definition of what is medical
23 necessity?
24 MR. ARTZ: I have looked at that
25 through all sources of -- any number of ways to

1 try to track that. The answer is no.
2 CHAIRMAN GANNON: So most of this
3 would be on a case law basis which would be on a
4 case by case?
5 MR. ARTZ: Right. And that's why I
6 addressed that in a supplemental memorandum.
7 CHAIRMAN GANNON: The other thing is,
8 do you believe that if this bill would become
9 law that it would objectively constrain a peer
10 review process concerning treatment?
11 MR. ARTZ: No; just to the contrary.
12 I think it would assist the peer review process
13 by giving the PRO's some definite parameters by
14 which to judge the physician's care rather than
15 the arbitrary methods that they use now.
16 CHAIRMAN GANNON: Doctor Wiener, do
17 you handle Medicare patients?
18 DOCTOR WIENER: Yes.
19 CHAIRMAN GANNON: Have you been
20 handling them for long?
21 DOCTOR WIENER: Medicare patients?
22 CHAIRMAN GANNON: Yes.
23 DOCTOR WIENER: Since I've been in
24 practice.
25 CHAIRMAN GANNON: Before the enactment

1 of Act 6 or Act 44?

2 DOCTOR WIENER: Yes.

3 CHAIRMAN GANNON: It's my

4 understanding that there's a peer review process

5 under Medicare. Has that ever been a problem,

6 and if so, what type of problems have you seen

7 with the Medicare peer review process?

8 DOCTOR WIENER: Of what I could think

9 of in that particular process, although it's

10 probably pretty limited for myself because of

11 the years that I've been in practice, I have not

12 seen any significant problems. Most of the

13 problems that I see with peer review tend to

14 come through workers' comp and motor vehicle

15 accidents.

16 CHAIRMAN GANNON: Could that be

17 because of the types of patients that you have?

18 In other words, you have very few Medicare

19 patients and lots of patients where --

20 DOCTOR WIENER: Not specifically, no.

21 I think we probably have about 20 to 25 percent

22 Medicare patients actually. We have a very

23 diverse practice.

24 CHAIRMAN GANNON: Then the 75 percent

25 is a mix?

1 DOCTOR WIENER: About 50 percent is
2 managed care; about 20 percent is Medicare;
3 5 percent is Medicaid; then other third-party
4 payers. Obviously, our practice has the
5 Medicaid's, the Medicare's, the HMO's, worker's
6 comp, and motor vehicle accidents involving
7 personal injuries. So we're very diverse on the
8 type of patients we cover.
9 CHAIRMAN GANNON: What I'm trying to
10 get to, is there a disproportionate peer
11 review -- Let me put it this way. I'm going to
12 say adverse peer review process in auto and
13 workers' comp as opposed to the other types of
14 services --
15 DOCTOR WIENER: Yes. Most of the peer
16 reviews that I'm involved with are not with
17 Medicare. They are with motor vehicle accident
18 and workmen's comp for denials.
19 CHAIRMAN GANNON: I believe there's a
20 company called MedPro--Is it MedPro?--the peer
21 review that did the Medicare, the primary --
22 MR. ARTZ: Keystone Peer Review.
23 CHAIRMAN GANNON: Keystone. KeyPRO.
24 MR. ARTZ: KeyPRO, right.
25 CHAIRMAN GANNON: I was involved when

1 we were working on Act 6 in the Insurance
2 Committee. It's always been my recollection and
3 my understanding, we were trying to model that
4 after the KeyPRO process, the Medicare. I'm a
5 strong advocate of peer review. If it's done
6 properly, I think it works well. I was just
7 trying to find out whether or not -- if my sense
8 was right that that's not the way it's gone.
9 DOCTOR WIENER: I would say in the 8
10 years that I have been in practice I have had
11 some KeyPRO reviews as well, but the majority of
12 the time I was able to speak with another
13 physician, although it may have been initially
14 reviewed by a nurse. If I had a question, most
15 of the time the issues was cleared up relatively
16 quickly over the phone and I was just told to
17 put it in writing and things were fine. This
18 does not really occur as much when you come to
19 the motor vehicle accidents and the reviews for
20 workmen's comp.
21 CHAIRMAN GANNON: In your testimony,
22 Mr. Artz, you touched on something that is I
23 guess a conundrum, and that is where a physician
24 has a patient that he honestly feels needs
25 additional treatment and the peer review or the

1 insurer as a result of a peer review comes back
2 and says no. Does he continue to treat the
3 patient because he honestly feels the treatment
4 is necessary, or does he stop because the peer
5 review has said no treatment is necessary, so
6 they are not going to pay?
7 Now you threw in another element, and
8 that is this criminal activity by the U.S.
9 Attorney. Where would he fall? Is he going to
10 fall on the peer review where they said the
11 treatment is not necessary, or is he going to
12 fall with some another expert who said that the
13 treatment should have continued even though the
14 physician was not going to get paid?
15 I'm just wondering if legislation like
16 this were in place that sets up parameters for
17 what type of treatment is reasonable and
18 necessary; in other words, everybody is reading
19 out of the same page in the same book, what
20 element would that add to an example of where
21 the U.S. Attorney was going to use the mail
22 fraud statute to go after a provider or either
23 give me treatment that was not reasonable or not
24 necessary or not give me treatment that was
25 reasonable and necessary?

1 MR. ARTZ: The U.S. Attorney -- It
2 depends on the payer system and that will guide
3 the U.S. Attorney's perspective. For example,
4 if it's indemnity insurance, the government
5 prosecutors believe that there is an incentive
6 there to provide more care. The more care you
7 provide, the more money you make. The incentive
8 goes to that direction.
9 With managed care the incentive is
10 arguably to the other extreme where there's
11 actually a disincentive to provide medical
12 necessary care. He would be looking for doctors
13 who wouldn't provide enough care in order to
14 keep their costs in their office down, and their
15 capitation payment which remains the same would
16 be positively affected and they may receive
17 bonuses. Many managed care contracts provide
18 for bonuses to physicians based upon fewer
19 amount of care, less amount of care provided.
20 So we have 2 different incentives.
21 I would say that this legislation
22 which would affect both parts of the criminal
23 equation as posited by U.S. Attorney for
24 indemnity plans which this clearly addresses.
25 It would give parameters that if a physician

1 could show that the care provided met within
2 those parameters, it's clearly not criminal and
3 I wouldn't have a prosecution. Likewise, if the
4 care provided from a managed care perspective
5 under that kind of contract was within these
6 parameters, then it would affect it that way as
7 well. Did I answer your question, Mr. Chairman?
8 It was a tough question.
9 CHAIRMAN GANNON: Yes. It's something
10 that I hadn't considered. You brought it out in
11 your testimony about the potential for criminal
12 charges against a physician who's being placed
13 in a very difficult situation, assuming that
14 there's no criminal intent here. Certainly if
15 he's treating a patient who he never saw, if
16 he's billing for a patient he never saw or if
17 treating for injuries that don't exist, I don't
18 think anyone would conclude that that treatment
19 was reasonable and necessary in any way and
20 certainly criminal prosecution is warranted.
21 But, I'm concerned about where these
22 definitions of what is reasonable and necessary
23 are very, very subjective, depending on where
24 you are on this. From a patient's standpoint,
25 he or she wants to get well, so any treatment

1 that makes them feel better is reasonable and
2 necessary.
3 On the other hand, the insurer taking
4 advisory information from the peer reviews wants
5 to pay as little as possible under the policy
6 and, of course, the doctor is trying to make a
7 living as well as treating patients. Of course,
8 his primary purpose is to get the patient well.
9 He has a continuing obligation irrespective of
10 whether or not there's treatment. Now he's got
11 another element thrown in that says, well, if
12 you treat this patient that didn't need the
13 treatment even though in your judgment they did,
14 somebody else comes in and says they don't, that
15 you're going to be subject to possible criminal
16 conduct. Or, if you don't treat the patient and
17 the other party says, well, they should receive
18 treatment, that you might be subject to criminal
19 conduct.
20 That's kind of very disturbing
21 particularly when we look at who the U.S.
22 Attorney says he's going to rely on, you know,
23 the insurance companies and doctors. In many
24 instances the insurance company, the peer review
25 reviewers are medical doctors, who have only

1 done a paper review of a patient's treatment.
2 I don't know what the answer is. I
3 don't even know whether or not the U.S.
4 Attorney, if this would become law, would be
5 compelled to follow this statutory language, if
6 it was a state law.
7 MR. ARTZ: At least would provide a
8 defense. I guess that's the point. It at least
9 would provide some measure of defense. You say,
10 well, you think this is criminal. I took this
11 insurance company to court and I recovered. How
12 could it be criminal?
13 CHAIRMAN GANNON: One of the things,
14 just to comment, Doctor Wiener, you talked about
15 one case where the insurer had denied benefits
16 because they said the treatment was not related
17 to the accident. This bill would not help you
18 because it specifically says it only covers
19 treatment that's covered under the policy.
20 Obviously, if it's not covered or it's
21 not related to an event that's covered under the
22 policy, irrespective of whether or not it's
23 reasonable and necessary, this particular
24 statute if it were enacted would not help you in
25 a situation like that.

1 Any questions? Representative
2 Manderino.
3 REPRESENTATIVE MANDERINO: No. Thank
4 you, Mr. Chairman.
5 MR. PRESKI: I have two questions.
6 The first question, doctor, is that in many of
7 the times in the examples that you had stated
8 where there was denial of payment, you started
9 off your quotations with, due to the lack of
10 documentation, XYZ payment was denied. You
11 finished your testimony with an example where
12 you were told by the doctor from the insurance
13 company that if you put it in writing it would
14 be fine, and I assume it would be paid.
15 Do you find that that's the function
16 of the majority of these cases where there's a
17 denial; that it's a documentation problem on the
18 part of the insurance company?
19 DOCTOR WIENER: Most of the time the
20 insurance companies don't even ask for the
21 progress notes. In this particular situation a
22 patient was given a prescription for medication,
23 and through the pharmacy, the pharmacy then took
24 it back to CIGNA because it was a very expensive
25 medication, and they denied it; yet, at that

1 time they had never seen, they never spoke with
2 my partner. They never saw a progress note
3 about the patient's complaints.
4 In that situation they're talking
5 about documentation to prove that they should
6 pay for the medication because they feel the
7 diagnosis itself is cosmetic and was not
8 medically necessary for them to cover the
9 service.
10 MR. PRESKI: That leads to this
11 question then. Do you find where the insurance
12 companies then deny merely because of a
13 prescribed treatment? You say that this
14 prescription was denied. Do you think that in
15 all cases such a prescription would be denied
16 regardless of the prescribed treatment?
17 DOCTOR WIENER: I get the feeling that
18 some insurance companies today, particularly
19 some of the HMO's because they are starting to
20 put together formularies. They're making
21 certain deals with the various pharmaceutical
22 companies to have their drug put on a formulary
23 where others are denied.
24 They'll also put out formularies for
25 the physicians to know what drugs are the

1 cheapest that they think we should prescribe,
2 versus certain drugs that are extremely
3 expensive, offer what they feel is no further
4 benefit to the patient for those expensive
5 medications. So they would prefer that we use
6 something certainly that would work that's less
7 expensive.
8 In this particular situation they
9 didn't recommend that. They just wanted to deny
10 coverage based on the diagnosis; not because of
11 the drug that we were utilizing.
12 MR. PRESKI: Mr. Artz, a question for
13 you. The definition that you worked up within
14 here for medical necessity you said that it
15 comes from a compilation of court cases, prior
16 statutes. Having not read your memorandum on
17 the court cases yet, do you think that the
18 courts are working towards this definition of
19 medical necessity?
20 MR. ARTZ: Around the country slowly,
21 yes.
22 MR. PRESKI: My question then becomes
23 is that, since the definition for medical
24 necessity will only apply to this section of
25 Title 42 should this pass, do you think that the

1 courts given their prior uses of the word
2 medical necessity in court cases will adopt this
3 for all sections and all types?
4 MR. ARTZ: I think they will look at
5 it as compelling, maybe persuasive; certainly
6 not controlling, but I think they will look at
7 it in a favorable fashion. Because some courts
8 in other states have looked at the federal
9 Medicare definition and have concluded that some
10 of those elements which we've included here are
11 appropriate and are compelling enough to be
12 adopted.
13 MR. PRESKI: My last question is this:
14 In your testimony when you talk about the U.S.
15 Attorney it says, he also plans to prosecute
16 physicians for not providing enough medically
17 necessary care. One of the concerns that we
18 consistently hear about House Bill 2849 is that,
19 by allowing the doctor to define what medical
20 necessity is, the doctor then will go out and do
21 every test or do everything in order to provide
22 what they would see as enough medical necessary
23 care. How do you respond to that?
24 MR. ARTZ: Well, this does not create
25 a floor nor would it create a standard of care.

1 If somebody is going to be concerned that they
2 have to do more and more diagnostic tests, for
3 example, to avoid malpractice liability, the
4 legislature clearly would not do that.
5 Secondly, it only provides objective
6 standards. It doesn't create a cookbook, so it
7 doesn't tell what must be done or what can't be
8 done. It just says, we need to look at these
9 objective factors with a unique situation of
10 every patient that comes in. And much like we
11 do every day when we practice law, we merge the
12 objective principles into the subjective facts
13 and come out with the answer.
14 MR. PRESKI: Thank you.
15 CHAIRMAN GANNON: Can I have just a
16 follow-up? Frequently in these peer reviews
17 you'll see language that, for example, the
18 patient has plateaued and, therefore, is not
19 going to get better and, therefore, any further
20 treatment is not necessary or reasonable.
21 You'll see comments like, according to
22 research or guidelines or whatever, this patient
23 should have only required 6 weeks of treatment;
24 therefore, anything beyond 6 weeks is not
25 reasonable or necessary. And you'll also see

1 comments such as, according to standards
2 treatment should have gone on for only a certain
3 period of time and the treatment beyond that
4 time is not reasonable and unnecessary.
5 These comments are made without any
6 individual assessment of that patient. They are
7 taking a described diagnosis and a described
8 injury, if you will, and then making generalized
9 statements. I'm just wondering how would the
10 language in this provision, or this proposal
11 deal with that type of an analysis of a
12 patient's treatment as to whether or not it was
13 reasonable or necessary?
14 MR. ARTZ: Three points in response to
15 that, Mr. Chairman. The first is that, when any
16 third-party payer would give a reference to a
17 body of medical knowledge, it says after 60 days
18 or 90 days, for example, a soft tissue injury
19 must be -- patient is recovered. The PRO's tend
20 to apply that in a wooden -- I'll call that a
21 wooden fashion. It means that's the absolute
22 rule. There's two problems with that.
23 The first problem is that, these
24 standards that they look to, all of those that
25 are well-researched medical documents have

1 outliers that says, while the majority of people
2 respond within 90 days, you have to look at the
3 patient's unique circumstances and then there
4 could be an additional 30 or 60 depending on the
5 severity of the injury, depending on the
6 patient's age, the patient's condition, which
7 leads me into the next point. That, if we look
8 at page 4 of the legislation, line 17, right
9 below the definitional aspect, it says a
10 determination of medical necessity, et cetera,
11 et cetera, must take into consideration all
12 relevant clinical data pertaining to the
13 patient's condition as a whole, which has been
14 provided.
15 So the direct answer then to your
16 question is that, this legislation would force
17 the carrier to look at the outlying
18 circumstances that are in those parameters that
19 are used and have care paid for when a patient
20 goes beyond that wooden parameter, when the
21 unique circumstances of the patient's condition
22 warrants it.
23 I would add that in my memorandum
24 somewhere I refer to a case from a California
25 federal court. It's on page 4, and it's near

1 the bottom. It says, a federal district
2 court -- next to the last paragraph -- A federal
3 district court in Vorster versus Bowen reasoned
4 that arbitrary and capricious denial of benefits
5 under the Medicare statute occurs when a
6 utilization reviewer relies on bureaucratic
7 instructions rather than individual assessments
8 in determining medical necessity.
9 Then I cite the two other federal
10 courts which have disregarded arbitrary
11 presumptions or rules of thumb. For example,
12 the 90-day rule where a patient maybe has been
13 rear-ended and is 60 years old with osteoporosis
14 or something like that may need more care. I
15 would argue that this provision that we have in
16 here would take care of that circumstance or
17 require that care to be reasonable and
18 necessary.
19 CHAIRMAN GANNON: Thank you, Mr. Artz.
20 Thank you, Doctor Wiener. Our next witness is
21 Doctor Jonathan Rhoads, President of the
22 Pennsylvania Medical Society and Mr. Donald
23 McCoy, Director of the Medical Society's
24 Department of Regulatory Affairs and Specialty
25 Legislation. We've also been joined by

1 Representative Kathy Manderino from
2 Philadelphia. Doctor Rhoads, whenever you are
3 ready you may begin.
4 DOCTOR RHOADS: Good morning. My name
5 is Jonathan Rhoads, Junior. I am a practicing
6 surgeon from York, Pennsylvania. I appear
7 before you as the President of the Pennsylvania
8 Medical Society. The Medical Society is the
9 largest physician professional association in
10 the Commonwealth, representing physicians of all
11 medical and surgical specialties and their
12 patients who are your constituents.
13 I am please to appear before the House
14 Judiciary Committee to present the views of the
15 Medical Society concerning House Bill 2849.
16 With me is Mr. Donald McCoy, Director of the
17 Medical Society's Department of Regulatory
18 Affairs and Specialty Legislation. Mr. McCoy
19 may assist me in responding to any comments or
20 questions at the conclusion of my prepared
21 remarks.
22 The Medical Society supports House
23 Bill 2849, Printer's Number 3959, which
24 addresses wrongful denial of reimbursement for
25 medically necessary treatment. This legislation

1 responds to the concerns of the medical
2 community over decisions related to coverage for
3 diagnostic and treatment services provided to
4 subscribers or beneficiaries under various forms
5 of health insurance currently offered to
6 Commonwealth citizens through employment or
7 through direct purchase.
8 These concerns are with the criteria
9 used to make insurance payment or coverage
10 decisions regarding the necessity of the
11 services provided, the qualifications of those
12 making such decisions, the timeliness of those
13 decisions, and the rights of due process
14 available to the patient and the health care
15 provider to challenge those decisions.
16 We can talk about terms such as
17 medical necessity and medical reasonableness.
18 They are not the same. Depending on the
19 individual circumstances, a diagnostic or
20 treatment service may be both reasonable and
21 necessary or may be just one of the two. Many
22 would argue that the care is necessary when it
23 is for themselves while reasonable, but not
24 critical in the care of others.
25 Severely ill patients, including those

1 in need of organ transplants are often placed in
2 this situation. Too often, however, the
3 rationale for making these decisions concerning
4 care provided comes into conflict with the
5 decisions regarding whether the service is
6 reimbursable.
7 The criteria for necessity decisions
8 by insurers is often based on statistical data
9 obtained from the previous utilization
10 experience of the insurer. Unfortunately, such
11 empirical data doesn't take into consideration
12 the dynamics of the situation at the time the
13 diagnosis or treatment decision was made. It
14 can't factor into the equation the training and
15 experience of the physician or other health care
16 provider who provides the care. It can't
17 comprehend the alternative treatment options
18 which might have been considered and then
19 discarded for various reasons.
20 Insurers will argue that they always
21 pay for medically necessary services. They do
22 not share with the patients, their subscribers,
23 your constituents, or with the health care
24 providers the criteria for their consideration
25 of the necessity of a service. The patient must

1 then depend on the health care provider to use
2 his or her best judgment in making the right
3 diagnosis and/or treatment decision. Both then
4 must await the decision of the third-party payer
5 as to whether the decision fits the payer's
6 criteria and is, therefore, reimbursable. The
7 process is only somewhat expedited in the
8 instance of precertification for elective and
9 nonurgent procedures. The problem is still the
10 criteria used by the third party in making that
11 decision.
12 House Bill 2849 attempts to establish
13 some clinical basis for necessity decisions
14 which can be uniformly applied by all types of
15 third-party payers that is consistent with the
16 standards of practice for the provider community
17 and can be fairly and evenly applied in all
18 situations. It would require that medically
19 necessary care be consistent with the patient's
20 conditions; be furnished by or under the
21 supervision of a licensed health care provider
22 in a setting appropriate to the patient's
23 medical needs; and would be documented in the
24 patient's record. The bill would further
25 require that the overall condition of the

1 patient be considered in rendering a necessity
2 decision regarding a specific service or
3 treatment.
4 Review of the necessity of care can
5 play a positive role in reducing unnecessary
6 health care costs and improving quality.
7 However, safeguards are necessary to assure that
8 such review decisions are made correctly and in
9 the patient's best medical interests.
10 Otherwise, such decisions will adversely affect
11 quality and patients can be harmed when
12 decisions are incorrect or unduly delayed.
13 In debates over legislation such as
14 House Bill 2849, there is always the demand for
15 proof of damage caused by a third-party action
16 to either the access or to the quality of the
17 care provided. Unfortunately, the damage isn't
18 as easy to identify, since in most cases the
19 challenge of the medical necessity comes after
20 the service has been delivered. The potential
21 damage occurs in the future treating
22 relationship between the health care provider
23 and his or her patients.
24 If a procedure is denied as not
25 medically necessary, its use the next time will

1 be questioned by the health care provider.
2 Despite the provider's training and experience
3 and firsthand knowledge of the patient's
4 condition as well as the reasons for considering
5 the use of the procedure or service, the
6 provider may opt not to perform that procedure
7 or service, or the provider may decide to treat
8 the patient less aggressively or may pursue
9 other options.
10 Take the example of how this might
11 occur in the real world. A Pennsylvania
12 radiologist recently received correspondence
13 from a physician, based in California and
14 affiliated as a clinical officer with a large
15 managed care plan, regarding a CAT Scan of the
16 brain which the radiologist had performed on the
17 basis of a referral from the treating physician,
18 a patient subscriber of the plan here in
19 Pennsylvania. This CAT Scan was not approved
20 for payment. Based upon a review of, quote,
21 available clinical information, unquote, the
22 procedure did not meet the managed care plan's
23 criteria for medical necessity.
24 The correspondence went on to state
25 that the desire of the plan's medical directors

1 was that, specialty consultation should be
2 sought prior to this imaging procedure. The
3 plan's clinical officer, who, by the way, is not
4 currently licensed in Pennsylvania, did not
5 bother to share with the Pennsylvania physician
6 the clinical information considered in arriving
7 at the decision. The plan didn't mention any
8 review of the basis for the referral to the
9 radiologist or that it had been considered in
10 the plan's recommendation for a specialty
11 consultation.
12 You can certainly imagine the fear and
13 anxiety in the mind of a patient whose symptoms
14 suggested to the radiologist, which is a
15 specialty that routinely also receives requests
16 for consultative and diagnostic services, the
17 need for a CAT Scan. You can imagine that the
18 patient's or a subsequent patient's reaction to
19 being told that they must be referred to another
20 physician for added consultation before
21 receiving the scan.
22 This example is typical of the
23 numerous complaints received by the Medical
24 Society. It is the reason that the society
25 supports legislation such as House Bill 2849 and

1 other utilization review and managed care
2 safeguard legislation.
3 House Bill 2849 is actually a minimum
4 safeguard. The bill only requires that all
5 forms of insurance plans in Pennsylvania define,
6 quote, medical necessity, unquote, in objective
7 terms. The legislation would not extend
8 coverage, nor would it establish a cookbook
9 approach by specifying the exact care which
10 would qualify as medically necessary. Instead,
11 the legislation provides guidelines by which all
12 treatment can be judged.
13 The Pennsylvania Medical Society has
14 several concerns with regard to this act.
15 First, the Medical Society believes there should
16 be disclosure of the patient's review
17 requirements, criteria and procedures to
18 enrollees and their treating physicians. In the
19 example cited above, the requirement, if it is a
20 requirement, that a specialty consultation be
21 requested before a CT Scan is ordered should
22 have been made known to the subscriber and the
23 physician before the fact, so that treatment
24 could have been adjusted accordingly and the
25 appropriate referrals sought. The, quote,

1 available clinical information, unquote, should
2 likewise be known. The source of the
3 information, its timeliness, and the extent of
4 its dissemination are important pieces of
5 information.
6 For example, is the information the
7 result of a single study or broad research? Is
8 the opinion that of a national specialty society
9 such as the American College of Radiology or the
10 American Neurological Association? Is the
11 information the result of a clinical research
12 conducted at a center for medical training or a
13 teaching hospital? Has the information been
14 validated for accuracy?
15 The Medical Society recommends that
16 criteria for making medical necessity decisions
17 be developed with input from physicians and
18 other health care providers who actively provide
19 such care to the payer's plan enrollees. The
20 plan must permit some form of appeal of a
21 negative decision made by the third-party payer
22 or the challenge of the clinical information
23 used as a basis for the decision.
24 The second concern of the Medical
25 Society, which House Bill 2849 addresses,

1 relates to the qualifications of the persons
2 rendering medical necessity decisions for the
3 third-party payers. House Bill 2849 requires
4 that final determinations as to medical
5 necessity shall be made only by health care
6 providers who are licensed by the Commonwealth
7 in the same profession and having the same
8 specialty as the provider whose treatment is
9 subject to review. The Medical Society strongly
10 supports this requirement and would suggest two
11 further modifications.
12 First, in instances where the decision
13 is an appeal of an earlier decision or where the
14 provider of the services under review is a
15 physician who is Board certified by an American
16 Board of medical specialties or its osteopathic
17 equivalent, the provider making the decision
18 should be likewise Board certified.
19 The second recommendation is that, the
20 reviewer, in addition to being Pennsylvania
21 licensed, should be engaged in active clinical
22 practice. This requirement is critical to
23 assure that the reviewer maintains currency in
24 changes in practice of his or her profession.
25 Federal requirements for utilization and peer

1 review of Medicare stipulate that reviewers
2 shall maintain an active clinical practice of at
3 least 20 hours per week. This requirement as
4 well as the certification requirement have also
5 been accepted for qualifications of reviewers
6 under the Workers' Compensation Law.
7 The Medical Society is also pursuing
8 more encompassing legislation dealing with all
9 forms of legislation (sic) and peer review
10 performed in Pennsylvania. House Bill 2849 is
11 certainly a step toward standardization of the
12 review processes utilized by the various third-
13 party payers and should be adopted as needed
14 patient safeguards.
15 A third concern of the Medical Society
16 is the timeliness of the medical necessity
17 decision. As previously mentioned, the decision
18 as to whether or not a service or procedure is
19 medically necessary is usually made at a time
20 after the service has been provided to the
21 patient. Despite language in virtually every
22 insurance statute requiring timely payment of
23 claims, insurers are notorious for delaying such
24 decisions and the resulting payments.
25 Often the first notice a physician

1 receives that a service or procedure is being
2 challenged for necessity is when the physician
3 inquires as to the status of the claim. This is
4 especially troublesome when the care is ongoing
5 such as with physical therapy, et cetera. After
6 a number of services have been provided, the
7 physician or other provider is notified that
8 treatment after a specified number or date are
9 determined to be medically unnecessary.
10 A related problem which the Medical
11 Society is examining is the practice of payment
12 slowdown, especially by health maintenance
13 organizations. There is no indication that
14 claims have been suspended for review or that
15 added information is needed to process the
16 claim. The physician hears nothing, and despite
17 contractual language obligating the HMO to
18 timely payment, unpaid balances remain
19 outstanding for 60, 90, 120 days or even up to a
20 year.
21 When the physician's office inquires
22 as to the status of the claim, they are given
23 numerous excuses and often promised payment,
24 either partial or full. When the promises
25 aren't kept and the physician renews attempts to

1 resolve the outstanding claims, the excuses may
2 turn to abuses. Threats of deselection and
3 restriction on referrals are becoming
4 increasingly common.
5 Investigation of this latest problem
6 indicates that there is little remedy available
7 to the physician under existing statute or state
8 agency relation. The Medical Society recommends
9 that House Bill 2849 be amended to provide a
10 remedy for wrongful denial of timely payment of
11 undisputed health insurance claims. The society
12 would ask that provision be made for the
13 assessment of damages for such nonpayment, and
14 that the Insurance Department be given the
15 authority to investigate provider complaints for
16 such actions and take the necessary remedial or
17 disciplinary actions against such plans. The
18 society would be pleased to provide draft
19 language to accomplish this goal.
20 The Pennsylvania Medical Society
21 deeply appreciates the opportunity to offer
22 comments regarding this important legislation.
23 We would ask the committee to report the bill to
24 the full House so that it may be considered when
25 the General Assembly returns for the fall

1 session next week.

2 Mr. McCoy and I would be pleased to

3 address any questions and comments from members

4 of the committee.

5 CHAIRMAN GANNON: Thank you, Doctor

6 Rhoads. Representative Manderino.

7 REPRESENTATIVE MANDERINO: No

8 questions, Mr. Chairman.

9 CHAIRMAN GANNON: You referred in your

10 testimony to something that I think should be

11 pointed out. It's my understanding, and you can

12 correct me on this if I'm wrong, a peer review;

13 in other words, when a person reviews another

14 physician's records or another health care

15 provider's records and reports to make some type

16 of a determination as to whether treatment is

17 medically necessary or medically reasonable,

18 that that is the practice of medicine.

19 DOCTOR RHOADS: Yes.

20 CHAIRMAN GANNON: If that individual

21 who is doing that review is not licensed -- for

22 example, if they are reviewing a Pennsylvania

23 physician and essentially practicing medicine,

24 if they are not licensed in Pennsylvania,

25 without a license.

1 DOCTOR RHOADS: We would interpret it
2 that way.
3 CHAIRMAN GANNON: The other point, I
4 agree with your view about the timeliness of
5 payment where the insurer has an agreement to
6 pay within a certain time period and then goes
7 beyond that time period without notifying the
8 provider or even telling them why. But, it
9 would be my view that House Bill 2849 would
10 address that type of a situation because I think
11 it could be argued under this proposal that
12 there was a constructive denial of payment for
13 treatment that was reasonable and necessary.
14 My point is that, if the insurers
15 said, look, we're going to pay within 30 or 60
16 days or something like that after submission of
17 a bill and the requested records have been
18 submitted and there is still no payment within
19 that time period, it would be my view that the
20 provider, if he wished, could file an action
21 under this proposal arguing that, in fact, the
22 insurer has denied payment for treatment that's
23 reasonable and necessary.
24 MR. McCOY: Any way we can accomplish
25 the correction of the problem we would certainly

1 entertain.

2 CHAIRMAN GANNON: Your other

3 recommendation, I was not aware of the federal

4 requirement in Medicare that stipulates the

5 review shall maintain an active clinical

6 practice, because I have heard of instances,

7 particularly in the automobile peer review area

8 where the reviewers are not even engaged in an

9 active practice. Most of the time they are just

10 reviewing.

11 DOCTOR RHOADS: Exactly. We think

12 that's an abuse. We think we should be dealing

13 with people who face the same clinical decisions

14 on a regular basis that the practicing

15 physicians face.

16 MR. McCOY: You mentioned in your

17 earlier comments about Keystone Peer Review

18 Organization. That's is the PRO that functions

19 for Medicare review. They do have that as part

20 of their agreement and would because they're a

21 Medical Society subsidiary even if it weren't a

22 federal requirement.

23 CHAIRMAN GANNON: So the reviewers for

24 KeyPRO are at the physician level?

25 MR. McCOY: At least at the physician

1 level they are Board certified and they are in
2 active clinical practice at least 20 hours a
3 week.
4 CHAIRMAN GANNON: Would you have a
5 problem with that if that type of a scenario was
6 ported over say to automobile or workers'
7 compensation where your initial -- As I
8 understand it, KeyPRO, the initial review can be
9 by a nurse.
10 MR. McCOY: That's correct. They can
11 also use screening criteria.
12 CHAIRMAN GANNON: And there's
13 screening criteria. Then if there's an issue,
14 then it goes to a reviewer who is in that
15 specialty and in that clinical practice.
16 DOCTOR RHOADS: That's correct.
17 CHAIRMAN GANNON: Would you have a
18 problem with that type of a setup under the
19 automobile or the workers' compensation as
20 opposed to what's done now?
21 MR. McCOY: No. In fact, we have
22 testified, and testified just last week on the
23 medical cost containment provision of Act 6
24 suggesting some of those same requirements.
25 CHAIRMAN GANNON: Do you think that

1 would lessen some of the litigation and the hard
2 feelings that we see?
3 MR. McCOY: It may lessen and I think
4 also the procedures for physician contact, for
5 the opportunity to discuss the case, for the
6 opportunity for the due process appeal of a case
7 similar to what is in the KeyPRO contractual
8 language which you saw, would certainly help to
9 mitigate some of the problems. We have 120
10 PRO's in the state currently authorized by the
11 Insurance Department to do peer review
12 functions. They don't all meet those standards
13 I can guarantee you.
14 CHAIRMAN GANNON: To your knowledge
15 does KeyPRO do automobile or workers' comp peer
16 reviews?
17 MR. McCOY: They do both. To a lesser
18 extent under auto because that is an insurer
19 selection. They do about 10 to 12 cases per
20 months on the random selection for workers'
21 compensation.
22 CHAIRMAN GANNON: When they do the
23 reviews under the workers' comp, which procedure
24 do they follow? Do they have an initial review
25 by a nurse?

1 MR. McCOY: They follow their standard
2 procedure for review whether it's Medicare or
3 whether it's auto or workers' comp which would
4 be the screening, the first-level review and
5 then the physician or other provider review.
6 CHAIRMAN GANNON: Because the workers'
7 comp and the automobile statute are pretty
8 prescribed in the process. It would be somewhat
9 different than the Medicare, where, I don't
10 think a nurse could do an initial review under
11 Act 6 or Act 24.
12 MR. McCOY: There is the requirement
13 for the provider, it has to be like specialty.
14 Again, you have to look at whether or not it's
15 an approval or a denial. If it is denial under
16 the Medicare requirement, that has to be made by
17 the licensed physician. The nurse can screen
18 and can approve. She cannot deny.
19 CHAIRMAN GANNON: Okay.
20 MR. McCOY: He or she cannot deny.
21 CHAIRMAN GANNON: You're saying at the
22 threshold there's a screening; whereas, I would
23 imagine when you're talking about the workers'
24 comp and the automobile, that screening is being
25 done by a person who's not even licensed.

1 MR. McCOY: I would have to say in
2 some instances that's true.
3 CHAIRMAN GANNON: I'm talking about a
4 claim agent is making that initial screening.
5 DOCTOR RHOADS: And the issue is at
6 what point does a physician get involved. Now,
7 on a prospective case, one of my surgeons in my
8 department wanted to admit a patient the day
9 before surgery for preparation for the surgery
10 because of the difficulty they had had preparing
11 this patient for a procedure a week before, and
12 it was repeatedly denied by the carrier. He
13 tried three times to call the Medical Director
14 and discuss the case with the Medical Director,
15 and he never could reach the Medical Director
16 who never returned his phone call. So that,
17 things were not all they might have been in the
18 care of that patient.
19 CHAIRMAN GANNON: Just one other
20 comment too. You talked about this radiologist
21 who had done a scan and then was turned down by
22 a company in California. He wasn't given any of
23 the clinical basis for that denial?
24 DOCTOR RHOADS: No.
25 CHAIRMAN GANNON: He was just told,

1 we're not going to pay?

2 DOCTOR RHOADS: Basically.

3 MR. McCOY: The company in California

4 were contracted with the managed care plan which

5 does sell HMO insurance in Pennsylvania. That's

6 how the patient was covered.

7 CHAIRMAN GANNON: Do you see that very

8 often where --

9 MR. McCOY: We are seeing it more

10 increasingly, especially with the types of

11 services that can be either accessed or

12 performed through telemedicine.

13 CHAIRMAN GANNON: Most of my

14 experience has been in the automobile area

15 because I'm also a member of the Insurance

16 Committee and also with the workers' comp to a

17 certain extent. With the introduction of this

18 legislation which broaden it to other areas, and

19 also because of the activity of Representative

20 King on the HMO issue, and also that was before

21 the Insurance Committee.

22 But apparently, this is happening a

23 lot in the HMO area, and there's very little

24 redress at this point for the provider if you're

25 turned down.

1 This case involving Blue Shield
2 where--I don't know if that was an HMO case or
3 not--the provider was denied payment.
4 Apparently what happened here is, you had two
5 panels looked at his treatment. One was a panel
6 appointed by Blue Shield that said no. The
7 other was an independent panel appointed by the
8 Court and the panel of physicians who said this
9 treatment was reasonable. Then the Superior
10 Court came in and said, well, the panel
11 appointed by the insurance company was going to
12 be the final say and then also told the provider
13 that's it. You have no other recourse. You're
14 done.
15 Apparently, that's more prevalent than
16 we would think that that's happening; that the
17 providers are coming up against a panel
18 appointed by the insurer, being denied
19 reimbursement or payment for the care and then
20 that's the end of it. There's no other
21 recourse.
22 MR. McCOY: As we mentioned in the
23 statement, we are supporting other legislation.
24 There are several pieces of legislation,
25 including House Bill 2797, which does deal with

1 the concerns about the due process under managed
2 care plans. Again, we testified last week under
3 the auto insurance provisions that there should
4 be additional due process requirements for
5 PRO's. We would like to see the reconsideration
6 phase under auto done away with as it was with
7 workers' comp because the Supreme Court in
8 Pennsylvania has said that it cannot be a fair
9 process since the PRO's are basically obligated
10 to the insurers in the auto situation for their
11 future livelihood. They're not likely to make
12 decisions in the long run that are going to be
13 contrary to the insurer's wishes.
14 CHAIRMAN GANNON: Do you think that
15 this measure would have an impact on how the
16 HMO's are conducting themselves, would maybe
17 make them a little more responsive?
18 MR. McCOY: I think as Doctor Rhoads
19 has indicated, the provider should have the
20 right, as should the subscriber or patient, to
21 know exactly what the criteria they are being
22 judged under rather than do a good job until you
23 don't and then we'll come down on you but we
24 won't tell you what the rules of the games are.
25 DOCTOR RHOADS: In addition, the law

1 provides for financial penalties for HMO's or
2 insurance companies that don't pay when they
3 should.
4 CHAIRMAN GANNON: When I was working
5 to draft this legislation, one of the issues
6 that was presented is when you have -- a
7 physician's time is valuable, just as anyone
8 else's time is valuable. And to get involved in
9 trying to sort out whether or not you should be
10 paid for treatment can take time away from your
11 practice or other endeavors. The issue becomes,
12 this becomes uncompensated time.
13 In other words, you've treated a
14 patient and your charge is X number of dollars.
15 Now you've got to get into a big fight with the
16 insurer over whether or not this treatment is
17 reasonable and necessary. You've got to maybe
18 go before some panel or submit documentation to
19 a panel and go through a great deal of
20 correspondence. All you're ever going to get
21 out of that is what the charge was for treating
22 that patient.
23 DOCTOR RHOADS: Exactly.
24 CHAIRMAN GANNON: There's a tremendous
25 incentive in my view for the insurer to hold on

1 to that money. They may ultimately pay it, but
2 in the meantime they've had the use of those
3 funds.
4 DOCTOR RHOADS: Right.
5 CHAIRMAN GANNON: My view was, the
6 playing field should be level so that if the
7 provider is going to have to make a case, that
8 the treatment that he provided was reasonable
9 and necessary, there should be some additional
10 compensation for that time. That is why we put
11 the attorney's fees and the treble damages in
12 there so that the provider wasn't going to be
13 sitting there saying -- because in my view, and
14 I have talked to many doctors who have said,
15 look, it's not worth my time and my effort to go
16 after the payment for the treatment because my
17 bill was only a couple hundred dollars or maybe
18 a thousand dollars or a small amount. It would
19 cost me more to pursue that.
20 If you multiple that times thousands
21 of treatments by hundreds of doctors, that turns
22 out to be a substantial amount of money that is
23 not being paid for care. That's kind of how I
24 was viewing this when I was developing this
25 legislation.

1 DOCTOR RHOADS: I think you're
2 absolutely right. It's a real problem for the
3 medical profession and other people who rely on
4 insurance company payments for their services.
5 CHAIRMAN GANNON: Thank you very much.
6 DOCTOR RHOADS: Thank you, sir.
7 CHAIRMAN GANNON: Oh, I'm sorry.
8 MR. PRESKI: I have two questions,
9 gentlemen. The relationship between the
10 individual doctor and the insurer is
11 contractual, is that correct?
12 MR. McCOY: It depends.
13 DOCTOR RHOADS: Often; not always, but
14 often. For example, I take care of a lot of
15 people who are injured in automobile accidents.
16 I get automobile insurance. We submit bills and
17 I don't believe I have a contract with any of
18 them.
19 MR. PRESKI: What about the regular,
20 the family physician or the physician you see
21 every day?
22 DOCTOR RHOADS: With HMO's, the family
23 physician would be contracting with these HMO's,
24 you're right.
25 MR. PRESKI: Now my question is, does

1 the Medical Society negotiate those contracts on
2 the basis of all doctors or are all doctors just
3 presented with this? If you want to take our
4 patients, you've got to accept this.
5 DOCTOR RHOADS: That's the latter.
6 MR. PRESKI: Thank you.
7 CHAIRMAN GANNON: Just a quick
8 question. I think I know the answer to this. I
9 want to ask so it's on the record. One of the
10 complaints that we have had in terms of medical
11 care in Pennsylvania and this country is the
12 tremendous amount of paperwork that's required
13 by a doctor, provider, and this has been adding
14 to the cost. This is one of the big items
15 adding to the cost of health care in this state
16 and this country.
17 With the introduction of these peer
18 review process and Act 6 and Act 44, have these
19 helped or aggravated the situation? If so, why?
20 If not, why?
21 DOCTOR RHOADS: I think they have
22 aggravated the paperwork requirements. One of
23 the orthopedic practices in my community hires
24 somebody full time to copy records to send to
25 companies that are wanting copies of the

1 records. I believe it has aggravated the
2 paperwork activities.
3 CHAIRMAN GANNON: There's a form, I
4 think it's called a HCFA.
5 MR. McCOY: HCFA 1500 Form.
6 CHAIRMAN GANNON: And this has a great
7 deal of information. Apparently, this was
8 developed in cooperation with doctors and
9 hospitals and insurance companies to provide all
10 of the information that would be needed to make
11 a payment.
12 DOCTOR RHOADS: No, it really doesn't.
13 It provides the information in many
14 circumstances, but there are situations where a
15 surgeon would be asked to submit a copy of the
16 operative note in addition to the HCFA 1500.
17 So, the reviewer could read that note and decide
18 if, in fact, the code represented what was
19 described in the operative note.
20 I think there are times when they
21 really want copies of your office records,
22 particularly in the cases where you have
23 prolonged treatment, course of treatment like
24 the physical therapy, and the patient isn't
25 getting better. They are still having symptoms

1 and you want to be paid for treating the patient
2 and the insurance company is taking the point of
3 view there's more treatment than ought to be
4 needed, and that sort of thing. Under the
5 circumstances, the HCFA 1500 doesn't give the
6 information they want. They need more detailed
7 information on that.
8 CHAIRMAN GANNON: Okay. You made a
9 point that I wanted to make, and that is, that
10 the 1500 should take care of the bulk.
11 DOCTOR RHOADS: It does. It does.
12 CHAIRMAN GANNON: Okay. My experience
13 is that, in many instances the insurance
14 companies are requiring the office notes and
15 reports for every single claim that's being
16 submitted, particularly in the automobile area.
17 DOCTOR RHOADS: I think it's in the
18 cases of protracted treatment. I take care of a
19 lot of automobile patients. They don't bother
20 me for that sort of thing. I have the patient
21 in the hospital for a while and I see them once
22 or twice in the clinic afterwards.
23 But, they may continue with a course
24 of physical therapy under the care of some other
25 physician. Although I don't get bothered with

1 that, it may well be those other physicians are
2 getting bothered with it. I know some of the
3 orthopedic surgeons for sure are.
4 One orthopedist in my community, his
5 group had a thousand appeals for unpaid amounts.
6 He was going to court to try to get some of that
7 money. He's not talking about a lot of money
8 each visit, so they were not big ticket items.
9 They were being hassled pretty much. As I say,
10 he had a thousand appeals and he was taking some
11 of them to court.
12 CHAIRMAN GANNON: That's the issue
13 that we're getting to with this bill where you
14 have these, quote, not big ticket items where
15 the provider is not being paid. Maybe you
16 should. In those instances where you shouldn't
17 be paid, that's not a problem. But in those
18 instances where you should and a just appeal
19 from a standpoint of time and effort and cost is
20 not worth it. I think that's really shutting
21 that provider out of the process.
22 DOCTOR RHOADS: In the case of the
23 HMO, of course, the troublemaker is going to get
24 deselected. That's an important concern that
25 physicians have that I don't think this bill

1 addresses at the present time.

2 CHAIRMAN GANNON: No, it doesn't, and

3 I think you made that point in your testimony.

4 That's kind of interesting. That concerns me

5 where a provider would challenge and then end up

6 being locked out because he challenged.

7 MR. McCOY: Actually, several sessions

8 going back to claim form, the General Assembly

9 mandated the use of the uniform claim form, and

10 as a result the 1500 form was developed for

11 physicians and provider services and a hospital

12 equivalent.

13 The problem, as Doctor Rhoads has

14 alluded to, is the fact that there is no uniform

15 data element component of that, so that, for one

16 carrier they may want this information. For

17 another they want this information. The bill is

18 really designed for electronic claims submission

19 to make it a paperless system; yet, you can't

20 attach things, at least not currently to an

21 electronic submission. You always have that

22 request for additional information. If that can

23 be made consistent so that, regardless of

24 whether it's auto or workers' comp or commercial

25 insurance or HMO that you know what information

1 is to be supplied with that. You know that if
2 unusual circumstances exist, they need to be
3 explained and documented. That would go a long
4 way to improving the paperwork problems that
5 Doctor Rhoads has alluded to.
6 CHAIRMAN GANNON: Representative
7 Manderino.
8 REPRESENTATIVE MANDERINO: Thank you,
9 Mr. Chairman. This question is a little bit
10 broader than 2849, but based on the last
11 discussion and concerns that you expressed about
12 deselection and things like that, I'm curious as
13 to whether or not the Medical Society has
14 thought about either through a survey of their
15 members or some systematic way of seeing if you
16 can collect data as to which are the good and
17 which are the bad insurers out there vis-a-vis
18 these kinds of practices.
19 The reason I say that, I just sat
20 through a whole summer worth of hearings on some
21 other issues, somewhat related, but it seems to
22 me that the balance of power has shifted maybe a
23 little bit too much to all of the shots being
24 called by the payers for services. And that
25 instead of the provider sitting there and being

1 so afraid they are going to be deselected by the
2 payers, I'd love to see the balance of power
3 shift so that the providers could be saying to
4 their constituencies, we're not accepting these
5 payers anymore. So you want to get the heck out
6 of those kinds of payer plans because they are
7 detrimental to your health.
8 Is there any kind of thought being
9 given to whether or not that is the kind of
10 information through your society you can
11 collect?
12 DOCTOR RHOADS: Your point is well
13 taken. We have been collecting more or less
14 isolated instances. I don't think we have gone
15 about it systematically to get this data. At
16 this point in time there are enough physicians
17 and other providers out there that they're kind
18 of anxious to get whatever part of the market or
19 the business that they can, so that, for the
20 most part they're not identifying insurers as
21 difficult insurers.
22 There are some physicians who decline
23 to contract with HMO's or certain HMO's.
24 You may recall that the legislature
25 passed as an amendment to the Maternal and Child

1 Safety Act a provision against the so-called gag
2 rule, the gag rule which keeps insurance
3 companies from telling patients that it should
4 be done differently from what the insurance
5 company has allowed. The legislature has, in
6 fact, taken action on that. We thank you very
7 much for that. I think we may have some work to
8 do, probably, in finding out more detailed
9 information.
10 MR. McCOY: We do have a process just
11 about a year old that allows a physician, rather
12 a provider to submit what's called a quality
13 alert form where they talk about problems they
14 have had with a particular type of carrier. We
15 have used those as example on specific
16 complaints with the Insurance Department and the
17 Health Department. Most recently we met with
18 both of those departments on the issue of HMO
19 nonpayment and have started to collect that kind
20 of information. It's not systematic. We
21 haven't refined it yet, but we will be doing
22 that.
23 REPRESENTATIVE MANDERINO: That's
24 good. Thank you. Thank you, Mr. Chairman.
25 CHAIRMAN GANNON: Thank you,

1 Representative Manderino. Thank you very much,
2 Doctor Rhoads and Mr. McCoy.
3 DOCTOR RHOADS: Thank you, sir.
4 CHAIRMAN GANNON: Our next witness is
5 Bernard Smalley, President of the Philadelphia
6 Trial Lawyers Association. However, Mr.
7 Smalley, I'd like to take about a 5-minute break
8 to give our stenographer's fingers a rest and
9 then we'll proceed.
10 (Short recess occurred)
11 CHAIRMAN GANNON: The recess having
12 expired, our next witness is Mr. Bernard
13 Smalley, President of the Philadelphia Trial
14 Lawyers Association.
15 MR. SMALLEY: Good morning, Mr.
16 Chairman.
17 CHAIRMAN GANNON: Welcome, Mr.
18 Smalley.
19 MR. SMALLEY: Good morning, Mr.
20 Chairman. How are you? Representative
21 Manderino.
22 REPRESENTATIVE MANDERINO: Good
23 morning.
24 MR. SMALLEY: Mr. Preski.
25 MR. PRESKI: Good morning.

1 MR. SMALLEY: My name as stated
2 earlier is Bernard Smalley. I'm a practicing
3 attorney in the Commonwealth, primarily here in
4 Philadelphia, and I'm currently the President of
5 the Philadelphia Trial Lawyers Association. The
6 Philadelphia Trial Lawyers Association is an
7 organization of approximately 1,500 attorneys
8 who practice here in Philadelphia County and
9 virtually every county in the Commonwealth.
10 I appreciate the opportunity to appear
11 before the committee, and I am here to speak in
12 favor of House Bill 2849. I've had the
13 opportunity to review the proposed amendments to
14 Title 42, and I recommend its passage by this
15 committee.
16 I did have the opportunity and I heard
17 with interest the testimony of Doctor Rhoads and
18 Mr. McCoy earlier today. We are, in fact, on
19 the same page. It's my opinion that the
20 wrongful denial of reimbursement for medically
21 necessary treatment through the use of peer
22 review organizations, as well as utilization
23 review, delays proper payment to health care
24 providers. But most importantly, and I
25 underline that most importantly, it has a

1 negative impact on the continuity of treatment
2 for patients.
3 While my testimony here today may be
4 short, it's based on my professional experiences
5 both with clients as well as with health care
6 providers.
7 In the past, and I continue today to
8 represent a number of physicians as their
9 personal counsel. In that capacity I've become
10 aware of problems with peer review, especially
11 its negative impact on the continuity of service
12 and the receipt of reimbursement to the
13 providers themselves.
14 It would appear that peer review can,
15 in some instances, operate to impose an
16 artificial ceiling on the nature and level of
17 treatment provided which is directly contrary to
18 the provider's medical judgment. As we all
19 know, medicine is not an exact science and
20 medical judgment must stand as given by the
21 provider at the time of diagnosis or treatment,
22 of when that treatment is initially started.
23 The reviewer does not stand in issues
24 of the medical health care provider at the time
25 that diagnosis is made or treatment is made.

1 Hindsight also has the tendency to be 20/20.
2 The imposition of an artificial ceiling may
3 especially be true when the initial peer review,
4 which questions or stops reimbursement, is made
5 by someone outside of the provider's area of
6 expertise or specialty.
7 An example would be, a nurse who
8 initially reviews a physician's treatment plan
9 and finds it excessive; or a physician who
10 requests a referral within the provider network
11 to a neurosurgeon for a diagnostic test and has
12 been told that an orthopedist will do.
13 Initial screening, even though it may
14 be ultimately determined by a physician, initial
15 screening does have the tendency to set up or
16 create the lay of the land, so to speak. Once
17 that's done, it's difficult to swim against the
18 tide once that is created.
19 The results, if inappropriate, can be
20 devastating and can, in fact, lead to a
21 subsequent claim for medical negligence in a
22 court of law where the health care provider has,
23 in fact, requested but been denied the
24 opportunity for proper referral.
25 In the main like that is in the area

1 of medical negligence. Unfortunately, I've been
2 in the position where I deposed a physician and
3 asked the question--because the underlying basis
4 of the particular instance that I'm thinking
5 about is one where there was a failure to
6 refer--and had that physician look me in the eye
7 and tell me that not only did he want to make
8 the referral, but he had, in fact, attempted to
9 make the referral and the referral was denied.
10 That was not the only basis for our
11 claim against that particular physician, but you
12 can see if it was, it would have been an
13 instance where this particular physician would
14 have attempted to make the referral, but been
15 denied the opportunity for that referral. Of
16 course, a claim resulted.
17 In general, as with any other
18 profession, there is a need for health care
19 providers to be paid for their professional
20 services. Inappropriate denial of reimbursement
21 should not reward the insurer by allowing the
22 insured to hold onto, in this case the insurer
23 to hold onto the proceeds of payment for an
24 inordinately long period of time or to engage in
25 a running battle of negotiation with the health

1 care provider to reduce the overall amount of
2 reimbursement. It may be argued in this case
3 that the penalties or damages provided under
4 Section 2849 are excessive, the damages as
5 outlined in the bill as proposed. I believe
6 it's to the contrary.
7 The damages under Section 8371 point
8 1(b) will negate the present advantage that
9 insurers have to hold onto their money pending
10 resolution of peer review, without penalty. The
11 overall effect of this legislation, if passed
12 and signed into law, will be to assist in
13 streamlining the delivery of health care
14 services to patients and to provide proper
15 payment reimbursement on a timely basis.
16 In that regard, there remains adequate
17 provision for medical treatment which is really
18 deemed unnecessary not to be reimbursed. One of
19 the critical issues or changes as proposed in
20 the current bill that we are discussing here
21 today is the fact that it requires that a final
22 determination of medical necessity be made only
23 by health care providers licensed by the
24 Commonwealth in the same profession and having
25 the same specialty as the provider for whose

1 treatment, care or services which is subject to
2 review.
3 The institution of this critical
4 provision will eliminate any doubt as to the
5 responsibility of the reviewer to be of the same
6 specialty, and that is in question as I
7 understand it currently. This will be
8 especially helpful in the area of health
9 maintenance organizations or HMO's where
10 referrals to specialists and requests for
11 diagnostic tests can be initially or ultimately
12 rejected by a reviewer who is not within the
13 specialty of the proposed referrer.
14 For the foregoing reasons, I am in
15 support of House Bill Number 2849 and the belief
16 of health care providers that they should be
17 reimbursed for diagnosis and treatment provided
18 and penalties should be imposed for the wrongful
19 denial of reimbursement of medically necessary
20 treatment.
21 I stand ready for any questions the
22 committee may have. Thank you.
23 CHAIRMAN GANNON: Thank you, Mr.
24 Smalley. Representative Manderino.
25 REPRESENTATIVE MANDERINO: Thank you,

1 Mr. Chairman. Two questions, Bernard. In the
2 medical mal example that you gave with regard to
3 the payer denying the provider a referral, and I
4 think I know the answer but I want to make sure.
5 What cause of action, if any, does the patient
6 have in that circumstance vis-a-vis the payer;
7 and are you increasingly adding or does the law
8 allow you to add as a party to the suit the
9 insurer in instances like that?
10 MR. SMALLEY: The answer -- and you
11 sort of posed it as part of your question.
12 There is the ability, if the patient knows and
13 if the attorney knows that there has been a
14 wrongful denial of a refer and it occurs before
15 the statute has run, to bring a separate claim
16 against the HMO. HMO's traditionally will file
17 a claim or file preliminary objections based on
18 preemption under ERISA because they believe that
19 HMO's are, in essence, a defined benefit plan.
20 As a result, they are exempt from state law.
21 We have been successful in a number of
22 instances, especially when it comes to the area
23 of credentialing of specialists as well as the
24 failure to refer. Case law I think gives us the
25 opportunity in most recent cases to bring a

1 claim directly against the HMO. But again, it's
2 in those instances where you know and you know
3 in time.
4 REPRESENTATIVE MANDERINO: That may
5 have answered my second question which was,
6 remedies that specifically go to the patient for
7 the denial of payment. If I walked into your
8 office with that kind of situation, meaning to
9 the best of my knowledge -- And I have had
10 constituents come in and say to me, my doctor
11 told me that I can't get this treatment because
12 the insurance company won't pay for it.
13 How easy or difficult is it for me to
14 exercise any sort of legal right? What
15 procedure would I have to be going to? Would I
16 have to be filing a cause of action, a tort
17 claim against that insurer, and then how easy or
18 difficult is it for me to pursue that claim?
19 Again, I already know that answer probably
20 depends on how egregious --
21 MR. SMALLEY: The harm is.
22 REPRESENTATIVE MANDERINO: -- my harm
23 is.
24 MR. SMALLEY: Yes. While there are
25 inroads that are being made, it is extremely

1 difficult at this point. There are a series of
2 cases that involve health maintenance
3 organizations that define very specifically the
4 areas in which they can be brought into court
5 and where damages can be heard as between the
6 ultimate recipient or the patient and the
7 provider of the service, the HMO. They have
8 principally been in the area where there's a
9 question as to credentials.
10 Where there is a determination that
11 the service proposed to be rendered is one that
12 the HMO deems inappropriate or unnecessary--the
13 law is not clear as to whether or not you
14 can--we are proceeding and those cases will work
15 their way through the appellate court.
16 But, I can't sit here and tell you
17 today that there's a definitive right aside from
18 your own grievance procedure if you are the
19 holder of an HMO or you're a participant in an
20 HMO through the HMO itself. I can't sit here
21 and tell you definitively that you will have the
22 right to do that.
23 REPRESENTATIVE MANDERINO: Thank you.
24 Thank you, Mr. Chairman.
25 CHAIRMAN GANNON: Mr. Smalley, under

1 House Bill 2849, peer review process would still
2 continue. We are not saying that an insured
3 cannot do a peer review or a utilization review.
4 What we're trying to do is set up parameters as
5 to how you would deal objectively what is
6 treatment that is reasonable and necessary, or
7 what is treatment that is not reasonable and not
8 necessary, as opposed to literally on a
9 case-by-case basis that we're seeing now in very
10 subjective determinations.
11 My question, you obviously read the
12 proposal and agree with it, but do you think
13 that carriers, insurance companies would end up,
14 if this became law -- that because of this being
15 the law that they would pay for treatment that
16 is not needed or not necessary?
17 MR. SMALLEY: No. No, I do not. I do
18 not think -- It puts some parameters or it puts
19 some skin on the bones, so to speak, in terms of
20 what is medically necessary, what a peer review
21 organization can or cannot do. I don't think
22 it's going to require an insurer to pay for
23 services that truly aren't medically necessary.
24 CHAIRMAN GANNON: You mention the
25 HMO's coming in and arguing about the federal

1 preemption. How do you think, just at first
2 blush, this House Bill 2849 if it became law
3 would affect that type of an argument by the
4 HMO?
5 MR. SMALLEY: That is really a
6 difficult question to answer as to whether or
7 not -- At first blush I believe it would pass
8 muster. In other words, it would not be
9 preempted by ERISA, but that is at first blush.
10 I did not look at it. I did not look at the
11 pending legislation from that perspective.
12 CHAIRMAN GANNON: I'm familiar with --
13 There's a case that involved a hospital where a
14 gentleman went in and apparently they called the
15 HMO and they refused treatment because they said
16 he was in the wrong hospital. Apparently by the
17 time it all ended he was either in a very
18 serious condition or he died.
19 MR. SMALLEY: He in fact died.
20 CHAIRMAN GANNON: A suit was filed
21 against the HMO. I think the suit was filed
22 against the hospital and the hospital joined the
23 HMO.
24 MR. SMALLEY: Joined the HMO.
25 CHAIRMAN GANNON: Looking at a

1 scenario a little bit different where not so
2 much in that situation, but in the situation
3 where -- because my guess would be that that
4 cause of action was couched into negligence.
5 But I'm looking at a situation where the HMO
6 decides to do a peer review of a particular
7 treatment and then contracts with a peer review
8 organization and then contracts with a reviewer
9 who comes back and says no, it's not reasonable.
10 MR. SMALLEY: It's not necessary.
11 CHAIRMAN GANNON: Then the peer review
12 then notifies the HMO, who, in turn, notifies
13 the doctor and the insured. In that group you
14 could -- the HMO could argue, well, that's only
15 a recommendation. They don't really have to
16 follow what the peer review tells them.
17 I'm just wondering from the terms of
18 accountability, if under this legislation you go
19 directly against the insurer, which would be in
20 this instance the HMO, could they come out and
21 say no, there's a federal preemption you can't
22 go after us, even though to make a determination
23 as to whether or not, in fact, we deny payment
24 appropriately?
25 Yet, on the other hand, what they're

1 getting from the peer review is only an
2 advisory. I'm just wondering how, in your view,
3 this legislation would play into that type of
4 scenario?
5 MR. SMALLEY: Initially there would be
6 no question in my mind that they would certainly
7 argue in favor of preemption as a preliminary
8 matter. I certainly would argue that my client,
9 the patient, in that instance is really a third-
10 party beneficiary and has the right to expect,
11 and it really would depend on the specific
12 language of that master group policy.
13 But, if there was language in there
14 that I could latch onto and create a third
15 party -- not even create, but point out to the
16 Court that there is, in fact, a third-party
17 beneficiary relationship, I would then have the
18 linkage because they are following the
19 recommendation of the peer review group or
20 organization. As such, they take on that
21 responsibility.
22 CHAIRMAN GANNON: That's an important
23 point. They're following the recommendation,
24 which they don't have to follow if they believe
25 that that recommendation is inappropriate.

1 MR. SMALLEY: But you're sort of
2 bootstrapping negligence theory in a contractual
3 relationship.
4 CHAIRMAN GANNON: Right. Brian.
5 MR. PRESKI: I have a couple of
6 questions. In your capacity as personal counsel
7 to a physician, have you ever had the ability or
8 have you even been called upon to comment on one
9 of these contractual relationships prior to the
10 doctor entering into it?
11 MR. SMALLEY: Yes. Yes, I have.
12 MR. PRESKI: Have you ever attempted
13 to negotiate a better deal for the doctor?
14 MR. SMALLEY: Yes.
15 MR. PRESKI: One of the things that
16 you raised is the timely payment. Have you been
17 able to negotiate that in the contract?
18 MR. SMALLEY: No.
19 MR. PRESKI: How come or what's the
20 response?
21 MR. SMALLEY: The response basically
22 is, and I've had two instances where it's been
23 an issue, this is our provider contract. This
24 is what we expect. Everyone else in your
25 service group or practice group is signed on.

1 That's the deal. That's it. It was very little
2 negotiation.
3 MR. PRESKI: One of the things that
4 we've heard consistently this morning is that,
5 doctors don't know the criteria by which
6 insurance companies approve or do not. Was
7 there an attempt in your negotiations to get
8 that also or, was it the same response?
9 MR. SMALLEY: In the two instances
10 which I was involved it didn't reach quite that
11 level. We were looking at very specific
12 requirements within the provider agreement, at
13 least for the 2 physicians that I was
14 representing. So, it never approached that
15 level. But I do know in the instances in which
16 I have attempted, in actions that I brought
17 against HMO's to get their criteria, it is
18 extremely difficult.
19 There is a recent opinion, and I
20 believe it's a Superior Court opinion that says
21 that an HMO is not provided with the same mantle
22 of protection as a physician would be in the
23 sense of peer review, the confidentiality of
24 that information, number of claims, limitations
25 on practice entities. As an organization they

1 are not provided with the same amount of
2 protection. Under the Superior Court opinion we
3 now have the opinion to get more information,
4 but in the past it's been very difficult.
5 MR. PRESKI: But even under that
6 Superior Court decision, the only way that
7 you're going to get it then is through
8 discovery, after there's been a denial and a
9 claim is made.
10 MR. SMALLEY: Yes. An action has to
11 be filed.
12 CHAIRMAN GANNON: I'm sorry. You
13 raised an interest in this. The contracts that
14 you've seen, have they had this language that's
15 come or these provisions that come to forefront
16 in this case involving this doctor out in
17 Pittsburgh where, apparently, if there was a
18 dispute that he was required to go to a panel
19 appointed by, in this instance with Blue Shield,
20 and that was it? That was the end of it?
21 Whatever this panel decided there was no further
22 recourse? Have you seen --
23 MR. SMALLEY: I have not seen that
24 directly, but I am aware of a situation in which
25 a retired Philadelphia Common Pleas Court judge

1 was the arbiter over a situation much like that.
2 In fact, I believe it was identical where there
3 was a group of 3 physicians who were provided by
4 this HMO to make a determination as to whether
5 or not he would continue as part of that
6 practice entity or not. There was no right of
7 appeal behind that.
8 CHAIRMAN GANNON: I can understand
9 where you would have an arbitration where you
10 could pick an arbitrator or we agree on an
11 arbitrator. But in this particular instance it
12 seems that wasn't the latitude that was provided
13 to the physician. He had to accept whatever was
14 appointed by the insurer.
15 MR. SMALLEY: That was the final.
16 CHAIRMAN GANNON: That's what I'm
17 saying. You don't know if you have seen
18 language like that?
19 MR. SMALLEY: I have not personally
20 seen language like that.
21 CHAIRMAN GANNON: I guess you weren't
22 looking for it because it wasn't an issue that
23 was in front of you. I guess you will go back
24 now and look for that.
25 MR. SMALLEY: I think I would be duty

1 bound to do that now.
2 CHAIRMAN GANNON: That's all I have.
3 Thank you, Mr. Smalley, for presenting your
4 testimony.
5 MR. SMALLEY: Thank you, Mr. Chairman.
6 CHAIRMAN GANNON: Our next witness is
7 Andrew Wigglesworth, President of the Delaware
8 Valley Hospital Council. Welcome, Mr.
9 Wigglesworth.
10 MR. WIGGLESWORTH: Thank you, Mr.
11 Chairman. Mr. Chairman, members of the
12 committee, my name is Andrew Wigglesworth. I'm
13 President of the Delaware Valley Hospital
14 Council, which represents more than 70 hospitals
15 and health systems in this region of the state.
16 I'm also a Senior Vice President of the Hospital
17 Association of Pennsylvania, which, as you know,
18 is the statewide organization of hospitals and
19 health systems in the Commonwealth.
20 On behalf of hospitals and health
21 systems, I appreciate the opportunity to appear
22 before you and to offer our comments on this
23 bill. I think, as has been evident throughout
24 the testimony this morning, health care is
25 experiencing very rapid and major changes, both

1 in Pennsylvania as well as across the country.
2 Hospitals and health systems are
3 responding to those changes in a variety of
4 different ways, so the idea basic objective of
5 building community-based integrated systems. As
6 it has been pointed out on a couple different
7 occasions this morning, managed care
8 organizations and insurance companies have moved
9 largely from their traditional role of financing
10 care to, in a sense, directing the delivery of
11 care.
12 I think, again, just to underscore
13 what has been obvious in the way of testimony,
14 in health care you continually strive to
15 maintain a balance between cost, quality and
16 assess. I think in many respects we're in
17 danger of losing an appropriate balance. In
18 many ways the health care system is being driven
19 by the relatively short-term economic interest
20 of a few key players, at the expense of other
21 important benefits.
22 While there are many excellent managed
23 care organizations, all too often some
24 organizations appear to be managing costs; not
25 care; seeking to avoid risk as opposed to

1 managing risk. Five percent of the people are
2 responsible for about 50 percent of the costs.
3 And the game is, how can you keep those 5
4 percent out of your plan and avoid incurring
5 those costs? All too often it seems that the
6 objective is how can we cost shift as opposed to
7 work on ways to legitimately improve the
8 efficiency of the overall system.
9 You all have been working and
10 responding to these trends in a number of
11 different ways, through the maternity
12 legislation that was passed. You've also dealt
13 with the definition of emergency care for
14 coverage. There's legislation that's been
15 referenced dealing with utilization review
16 pending.
17 Congress has passed the Health
18 Insurance Reform Act to try to eliminate
19 preexisting condition limitations, as well as
20 allow for affordability of coverage. We support
21 these measures and a lot of the issues that
22 you've been talking about this morning.
23 The issues raised by House Bill 2849
24 are a significant concern to consumers and
25 providers. I think the Academy of Physicians

1 has done an excellent job of laying out the
2 problems as well as the Medical Society. I
3 think one thing that I would refer you to, in
4 the packet of material I provided there's a
5 study of utilization payment denials in this
6 region. We have done a couple of different
7 studies to try to objectively determine the
8 nature and extent of this problem.
9 Our 1995 inpatient denial study, which
10 included more than 56 hospitals, basically
11 showed that payers were issuing denials for 1 or
12 more days for 1 out of every 10 patients, and 7
13 percent of all patient days.
14 Most of the 4 out of the 5 days
15 denied, the basic reason was lack of need for
16 acute level care or medical necessity of being
17 in the hospital. The denial rates, initial
18 denial rates ranged from 2 percent to 24 percent
19 of patient days depending upon the payer that
20 you are involved in.
21 There's a lot of discussion about
22 appeals today. Seventy-nine percent of the
23 appeals that were undertaken on those days
24 denied, 79 percent were upheld by the insurance
25 company's review process. The way the U.R.

1 appeals process works is, generally, the initial
2 denial is issued. There's a secondary appeal
3 usually to the medical director of the plan, and
4 then subsequent to that to a panel selected by
5 the insurer or internal to the insurer, and then
6 there is no recourse other than to go to court.
7 In many instances, the cost of going to court
8 would outweigh the reimbursement that you would
9 get.
10 In effect, the U.R. companies'
11 insurers are acting, in effect, as the sheriff,
12 judge and jury all rolled into one.
13 We did a similar study of Emergency
14 Room denials. Initial denials in Emergency
15 Rooms ranged from 22 percent to 58 percent of
16 Emergency Room claims submitted. This was a
17 study of 7 major managed care players. In fact,
18 while it's not related to the gag rule, we were
19 sued over that study because one of the insurers
20 did not like the findings in this study.
21 Both studies give you an indication,
22 you know, overall it's the inpatient denials
23 represented about $70 million worth of care that
24 had been rendered. There's nearly 200,000 hours
25 of man hours spent on appealing denials; more

1 than $5 million spent by hospitals in this
2 region to appeal the denials that were the
3 inpatient denials in that study.
4 So, I think we strongly support the
5 objectives of this legislation. However, as I
6 have indicated previously to the Chairman, we
7 cannot support the bill as it's currently
8 drafted. The bill attempts to define the
9 characteristics of medically necessary care or
10 the standard of care.
11 As you know, the standard of care is
12 constantly evolving as a result of new
13 technologies and advances in medical practice.
14 We believe this bill could act to stifle
15 necessary and appropriate changes in the
16 standard of care, and it could as well retard
17 legitimate efforts to enhance the efficient and
18 effective delivery of care.
19 In addition, as the criteria in the
20 bill could be subject to wide interpretations,
21 we believe the bill could lead to tremendous
22 increase in litigation, particularly when
23 coupled with the bill's remedies.
24 For those reasons, we cannot support
25 the bill in its current form, but we would like

1 to suggest 3 steps that would help to achieve,
2 we believe, the objective that we all share in
3 terms of trying to bring some order to this
4 situation.
5 First, again it has been referenced
6 before. We would urge the members of this
7 committee and all the members of the General
8 Assembly to support the Health Plan
9 Accountability Act, House Bill 2797. The goal
10 of this act is really three-fold: One, to
11 establish some uniform administrative procedures
12 for utilization review because, when you
13 multiple this over hundreds of different payers
14 using different procedures to perform, it's
15 chaos from an administrative standpoint. To
16 make it a more efficient process have some
17 uniform standards.
18 To disclose the U.R. criteria. Right
19 now the criteria upon which medical necessity --
20 is generally considered proprietory and
21 confidential by the various insurance companies.
22 For the most part they don't want their
23 competitor insurance companies to see the
24 criteria they are using. But it basically, in
25 fact, would defy you to think of another

1 situation where the entity is paying for a
2 service, meaning the businesses. The people
3 receiving the service, meaning the patients, and
4 the people providing the service, meaning the
5 physicians, hospitals, whatever, are not allowed
6 to know the criteria upon which the care or
7 service that's being rendered is going to be
8 judged. In effect, it's a very sweet system if
9 you basically want to deny care or render the
10 care, prove that it's wrong or suggest that it's
11 wrong through secret and constantly changing
12 criteria.
13 The disclosure of the criteria will
14 also have the important aspect of trying to
15 promote a dialogue between payers and providers
16 over what constitutes medically necessary care,
17 which is at the root. There are good faith and
18 legitimate differences of agreement over what
19 the standard of care should be. By keeping that
20 criteria secret it's retarding the development
21 of that consensus.
22 The passage of House Bill 2797 would
23 address those problems. It would also address
24 the appeals problems, and we again would urge
25 you to support the passage of that.

1 Second, we would urge you to amend
2 House Bill 2849 to establish a pilot project to
3 evaluate the best ways to resolve disputes
4 between clinicians and insurers. Under this
5 concept--and again we can provide specific
6 language if the committee is interested in
7 working on it--have the Health Department
8 charged with the responsibility to identify, say
9 the top 5 or the top 10 DRG's where denials are
10 occurring, where there clearly is a lack of
11 consensus, and convene a panel of
12 representatives of insurance companies, managed
13 care organizations, appropriate provider
14 organizations to try to develop some model
15 protocols to resolve those disputes.
16 We are not talking about give these
17 protocols the force of law or creating the
18 cookbook, but at least it would create a
19 mechanism; an enforceable mechanism to try to
20 bring the parties together to response to some
21 of the problems. It also would place a burden,
22 I believe, on those that don't choose to follow
23 the model protocol to demonstrate why theirs is
24 a better way to go. Therefore, we again would
25 promote dialogue and consensus between providers

1 and payers.

2 Finally, as has been suggested here

3 this morning on a number of different occasions,

4 we believe that House Bill 2849 should be

5 amended to specifically deal with the delays in

6 payments. Denial of payment is one thing. The

7 delays in payments is another problem. There

8 are a number of organizations that appear to be

9 playing the float, or simply holding onto the

10 premium income as long as they possibly can in

11 order to improve their financial condition.

12 The Health Plan Accountability Act

13 doesn't have that provision in it. Again, we

14 would suggest that this bill be amended to

15 clearly state that insurers, HMO's and others

16 are required to pay claims within 30 days of

17 their receipt. Unless there's a good faith

18 dispute over legitimacy of the claim or the

19 medical necessity of the care rendered, any

20 payer which failed to pay claims within 30 days

21 would be required to pay an interest penalty of

22 one and a half percent for each month or portion

23 of the month the claim is outstanding.

24 Further, the payer should be required

25 to notify the providers within 15 days of the

1 receipt of claim that they need additional
2 information or that they intend to dispute or
3 deny the claim. They should be paying any
4 undisputed portion of the claim within the 30
5 days. In other words, you can toll the time
6 clock if there's a good faith legitimate
7 dispute. But, we want the notice that there's a
8 dispute so it's not always on the 29th day that
9 we get a notice saying we're disputing the
10 claim.
11 We also think that there should be the
12 ability to look at patterns of late payment and
13 make it clearly subject to the sanctions under
14 the Unfair Insurance Practices Act.
15 In Pennsylvania the average days in
16 patient accounts receivables for hospitals is
17 approximately 60 days. This means that on any
18 given day Pennsylvania hospitals are financing
19 $3 billion in care that's already been rendered.
20 Today's prime rate is 8.25 percent. I think we
21 all can do the math to make a determination that
22 that's a lot of money.
23 Investment borrowing costs and given
24 the pressure to reduce costs in the low margins,
25 last year hospitals in this region had negative

1 operating margins. Hospitals aren't in a
2 position to sustain. They have a built-in
3 incentive to get the claims out as quickly as
4 they possibly can because they are not going to
5 get paid if they don't get the claims out. On
6 the converse, the insurers have in some
7 instances an equally strong financial incentive
8 to delay payment of the claims in order to take
9 advantage of the float.
10 Many other states have adopted prompt
11 pay legislation with automatic payment of
12 interest. It should not be one where you'd have
13 to submit an additional claim in order to get
14 the interest payment because that would be more
15 costly than in some instances the interest
16 payment would be.
17 I hope these comments are useful to
18 the debate that this bill engendered. I would
19 like to offer just a couple of other additional
20 comments aside from my prepared testimony.
21 Mr. Chairman, I heard your comments in
22 terms of how this bill could be construed as
23 giving, in effect, a cause of action to deal
24 with delayed payments or to give providers an
25 avenue to go to court to deal with that. I

1 guess what we would prefer is, as opposed to
2 having to litigate it, to have a clearly defined
3 standard and a clearly defined process for
4 dealing with this. It should be as a matter of
5 business that they should pay their claims
6 quickly.
7 We also would strongly agree with the
8 administrative issues that you and
9 Representative Manderino raised in terms of
10 standardized billing. UB 92 is the hospital
11 form. There are about 90 data elements on it.
12 Basically, individual payers will say, in a
13 specific line, we want this information as
14 opposed to what is required on the standardized
15 form. In effect, as opposed to having a
16 standardized form, you have an individualized
17 standardized form that's customized. There
18 should be requirements to try to streamline that
19 for clean claims.
20 Also, the same kind of issue goes on
21 with coordination of benefits. There should be
22 standardized coordination of benefit forms. In
23 many instances insurers will put the burden on
24 the providers to determine the other coverage,
25 and, in fact, will delay payment while working

1 through coordination of benefit issues. We
2 should be working towards electronic submission
3 of claims.
4 In terms of information requests, for
5 most hospitals every claim that's submitted must
6 be accompanied by the full medical record. That
7 can run into hundreds of pages and in some
8 instances thousands of pages, depending upon,
9 obviously, the care that's been rendered.
10 With respect to Representative
11 Manderino's issue about making choices based on
12 which plan a patient should use, in most
13 instances it's the employers that are making the
14 choices of what plans their companies will have.
15 Therefore, there's very little avenue for
16 patients many times to change plans unless their
17 employer changes plans.
18 In terms of the complaint process,
19 generally it goes to an internal HMO process.
20 Then you can submit grievances to either the
21 Insurance or the Health Department if you don't
22 get satisfaction from the HMO itself.
23 The last point I guess I would raise,
24 based on other things, in terms of ERISA
25 preemption I think that this bill clearly would

1 be preempted if it were to apply to a
2 self-insured group. For a licensed state HMO,
3 if you make it a condition of their license or
4 certificate of authority that they abide by
5 this, I don't see where there would be an ERISA
6 preemption, and you could also get it in terms
7 of the other types of companies that contract.
8 In other words, the Health Plan
9 Accountability Act would require utilization
10 management companies to be licensed or certified
11 to operate in the Commonwealth of Pennsylvania.
12 By getting at the people that self-insured plans
13 contract with, you can get around some of the
14 ERISA preemption issues. It's a requirement in
15 order to do that sort of business in the
16 Commonwealth of Pennsylvania, which has survived
17 ERISA preemption issues in the past.
18 I would be happy to answer any
19 questions you may have. Again, we strongly
20 support your objectives, Mr. Chairman, and the
21 other sponsors of this bill. However, we cannot
22 support the bill in its current form and would
23 like to work with the committee, if appropriate,
24 to work on some other measures that might
25 achieve our same and mutual objective in terms

1 of cleaning up some of this problem.
2 CHAIRMAN GANNON: Thank you, Mr.
3 Wigglesworth. Just one question. Do the
4 hospitals that are members of the council, do
5 they have contracts, for example, with an
6 insurance company as to what they'll be
7 reimbursed for particular type of services? If
8 so, is there any time line as to when payment
9 will be made in those contracts?
10 MR. WIGGLESWORTH: Yes. It varies by
11 contract. I'm not privied to all the details of
12 each and every contract.
13 CHAIRMAN GANNON: Let me get right my
14 question. If that's the case, is there a
15 provision that the insurance company pays
16 interest on a payment made after that date?
17 MR. WIGGLESWORTH: Generally, the
18 provisions would say that we will pay within X
19 number of days. There aren't necessarily
20 interest payments in all instances. It's also
21 something that, in effect --
22 For example, in this region there are
23 two HMO's that control 88 percent of the managed
24 care market. Those two HMO's can basically, in
25 many instances, dictate the terms on things like

1 this. The leverage to deal with that is
2 basically nonexistent for most of the hospitals
3 in this region.
4 There are provisions -- Generally the
5 enforcement provisions in the contracts would
6 involve an arbitration process.
7 CHAIRMAN GANNON: The reason I raise
8 that question, you're talking about Pennsylvania
9 hospitals financing $3 billion in care.
10 MR. WIGGLESWORTH: Right. It's a cost
11 containment measure to speed up that payment.
12 CHAIRMAN GANNON: Assuming those
13 payments are not being made on a timely basis as
14 agreed to in the contract, the hospitals are not
15 being paid any interest on carrying that debt.
16 MR. WIGGLESWORTH: Right.
17 CHAIRMAN GANNON: That's the way it is
18 right now.
19 MR. WIGGLESWORTH: That number is
20 based on the fact that the average is 60 days,
21 okay, and that's what represents -- Basically,
22 that's outstanding all the time. It's taking 60
23 days on average to pay claims. There are some
24 payers that will take in excess of a hundred
25 days to pay claims. Then again, there are some

1 other payers that will pay in shorter periods of
2 time.
3 What we've also found out is that, in
4 terms of our study it takes an average of two
5 days for an insurer to deny a claim or deny a
6 portion of a claim. It's a very efficient
7 process on that side of it. It seems to be less
8 efficient on the other side of it.
9 Some claims are denied before the
10 patient leaves the hospital through concurrent
11 review which has occurred during -- Then you'll
12 have times where days are denied in the middle
13 of a stay. There are a lot of different aspects
14 to this, but the bottom line is, there are in
15 some instances good faith, legitimate disputes
16 between payers and providers over what
17 constitutes medically necessary care. There's
18 also disputes between one provider and another
19 provider; hence, creating something that --
20 We think it's an area that we need to
21 be very careful about what's legislated.
22 CHAIRMAN GANNON: Just a comment, just
23 to follow-up on what you just said. House Bill
24 2849 would not preclude a hospital or another
25 provider from entering into any other kind of

1 agreement to arbitrate disputes or to resolve
2 them in another form. It doesn't preempt any
3 other arrangement that would be had between a
4 hospital and an insurer.
5 MR. WIGGLESWORTH: I would suggest for
6 the same market dynamics then that the bill
7 probably would not achieve the objective if that
8 were the case. And that virtually all the
9 managed care organizations with the market clout
10 to do it would include a provision that expects
11 specifically -- excludes the provision of this
12 bill from applying, if that's the case. I think
13 that that would probably also apply to many of
14 the physicians in the same way.
15 Generally, in effect, it becomes a
16 voluntary process, the dynamics of this
17 marketplace and in many other places, although
18 it's not quite like it is here in our region.
19 There are places where there are some very
20 dominant players that will be able to basically
21 avoid this, if that's the understanding as it
22 relates to this bill.
23 CHAIRMAN GANNON: Representative
24 Manderino.
25 REPRESENTATIVE MANDERINO: Thank you,

1 Mr. Chairman. I will read this more closely,
2 Mr. Wigglesworth. I thank you for providing it
3 to us. I did not see in here, and it could be
4 just because I was looking quickly, any of the
5 information that you have referred to with
6 regard to Emergency Room denials. That's not in
7 here, correct?
8 MR. WIGGLESWORTH: That is not in here
9 because that particular study is the subject of
10 litigation right now. We are trying to
11 resolve -- It's unfortunate that a public policy
12 issue like that has to be dealt with through
13 litigation, but, nonetheless, we are faced with
14 that. We'll be releasing that study shortly.
15 We'll be happy to share it with you when I'm in
16 a position to do that.
17 REPRESENTATIVE MANDERINO: You don't
18 believe -- I'm thinking of the example and I
19 think it probably became a moot point with the
20 Graduate Hospital. But I'm thinking about the
21 recent example where Independence Blue Cross
22 announced based on whatever their criteria are,
23 we are not longer going to put Graduate Hospital
24 in our plan because Graduate Hospital doesn't
25 meet our criteria, whatever it was they weren't

1 doing. The bottom line is they got a big PR
2 splash out of it. I am sure that everybody who
3 used Graduate Hospital for services and had
4 Independence Blue Cross read that and said,
5 auh-oh, what's going on there?
6 MR. WIGGLESWORTH: Yeah. No, I would
7 say that. I would also --
8 REPRESENTATIVE MANDERINO: I guess
9 what I'm saying is, you don't think that that
10 same kind of information or clout works in the
11 reverse? Whether I am as an employee the direct
12 payer or whether it's my company benefits
13 manager and CEO, et cetera, who are also in that
14 same health plan, you don't think it's going to
15 affect their decision to know that all of a
16 sudden all the major players in the health care
17 provision have lost confidence in a particular
18 insurer because they seemed to be making
19 decisions that don't have to do with medical
20 care and are negatively affecting quality?
21 I mean, in a way you started -- at
22 least I have to think that you started to think
23 maybe there would be an impact because you're
24 collecting the data. I applaud you for doing
25 that. I guess my question is, don't you have

1 equal clout if you want to exercise it?

2 MR. WIGGLESWORTH: I think that it's

3 something -- Yes, you could make the argument

4 that it certainly is going to have an influence

5 on it, but I think it will not be too long

6 before the Graduate splash in the paper

7 receives -- And, in fact, Blue Cross, although

8 there was no similar splash in that sent a

9 letter saying, we are now going to resolve our

10 problems with Graduate and there will be no

11 interruption in coverage or whatever, which was

12 never --

13 REPRESENTATIVE MANDERINO: But that

14 probably happened because 2 weeks later it was

15 announced that Graduate was going to be bought

16 out by Allegheny Health System or whoever else

17 it was. That was all playing in there too. I

18 understand that.

19 MR. WIGGLESWORTH: I think the short

20 answer is yes, there absolutely is some

21 possibility of influencing that decision. I

22 would say that that decision is heavily

23 influenced by whatever the price the company can

24 get. If the price -- All things being equal in

25 terms of price, then, perhaps, it would make a

1 difference. It may also help to have the -- may
2 not result in change in the contracts, but
3 having the employee benefit people put pressure
4 on the payer to, in effect, clean up their mode
5 of conduct.
6 Absolutely, that's something that
7 could happen. It's going to be difficult. My
8 only point in saying it, I think the notion that
9 you raised is absolutely an appropriate one. I
10 just thought it would be difficult for
11 individual patients to exercise that kind of
12 choice. That's the only point.
13 I think you're absolutely right. More
14 information, more report cards on how plans are
15 operating, greater need for public oversight and
16 accountability of the behavior of various
17 elements of the health care system would be
18 appropriate and something that we would support.
19 REPRESENTATIVE MANDERINO: Thank you.
20 Thank you, Mr. Chairman.
21 CHAIRMAN GANNON: Thank you, Mr.
22 Wigglesworth. Our next witness is Sam Marshall,
23 Vice President and General Counsel, The
24 Insurance Federation of Pennsylvania. We're
25 going to take just a 5-minute break to give our

1 stenographer's fingers a rest. She's been going
2 at it pretty steady. We'll resume in a couple
3 of minutes.
4 (Short recess occurred)
5 CHAIRMAN GANNON: Recess having
6 expired, our next witness is Sam Marshall, Vice
7 President, General Counsel of the Insurance
8 Federation of Pennsylvania. Welcome, Mr.
9 Marshall.
10 MR. MARSHALL: Good afternoon. I'm
11 Sam Marshall. I'm with the Federation. As I
12 think most of you know, we represent all sizes
13 and shapes of insurers doing business here in
14 Pennsylvania. That includes all the types of
15 insurers covered in this bill with the exception
16 of the Blues; meaning that we do represent
17 managed care insurers, indemnity group and
18 individual health insurers, auto insurers, and
19 workers' comp insurers.
20 Probably to nobody's surprise, the
21 Federation opposes this bill. What is
22 surprising, at least to me, is the strong
23 support the bill has within the provider
24 community.
25 The Federation, along with providers,

1 has long been a supporter of tort reform and
2 specifically medical malpractice reform. To
3 that end, we've supported the medical
4 malpractice reforms passed by the House earlier
5 this year in Senate Bill 790. Yeah, we oppose
6 the arbitrary 10 percent rate rollback on
7 malpractice insurance rates and we oppose such
8 an arbitrary rollback on providers' rates too.
9 But we've been strong supporters of the true
10 tort reforms in that bill.
11 Among those reforms is a limit on
12 punitive damages. First, that bill imposes a
13 significantly higher threshold of proof than now
14 exists; second, it limits those damages to 200
15 percent of the compensatory damages; and third,
16 it imposes sanctions on those who fail in
17 claiming such damages. We believe, as does the
18 provider community, these are reasonable limits
19 in the effort to bring medical malpractice, and
20 the related costs it places on the health care
21 system and on those who use and pay for it under
22 control.
23 Now let's take a look at this bill,
24 and specifically Section B on damages. Whenever
25 an insurer is found to be wrong in a question of

1 medical necessity, Section B imposes treble
2 damages, plus 12 percent interest, plus the
3 costs of any challenge, plus all attorney fees.
4 Make no mistake, these are punitive
5 damages. They are considerably more generous
6 than the punitive damages allowed in Senate Bill
7 790. There, the cap is 200 percent, here it is
8 300 percent plus interest plus costs plus
9 attorney fees. The punitive damages here are
10 also more easily awarded than those in Senate
11 Bill 790. There, you need clear and convincing
12 evidence of outrageous conduct, with the
13 specific restriction that gross negligence alone
14 will not be enough. Here, you need only show
15 that the care was medically necessary, as
16 measured by a subjective rather than objective
17 standard, and that payment was denied.
18 I don't think it's right for a
19 profession to call for tort reform to reduce its
20 own liabilities, while at the same time call for
21 the expansion of the tort system to expand the
22 liabilities of those who pay for it. It may be
23 natural, but it's not right.
24 I hope the providers who are
25 attempting to straddle both sides of this fence

1 come down on the side where we, they and many
2 others concerned with the existing tort system
3 are, four-square in favor of reforms that will
4 limit, not expand, tort exposure and the drain
5 it puts on our economy.
6 I suppose somebody could argue that
7 favoring the tort restrictions in Senate Bill
8 790 is not inconsistent with favoring the tort
9 expansion in this bill. They could contend that
10 medical malpractice is a runaway train that is
11 hurting efforts to properly and economically
12 treat patients, and that's why tort restrictions
13 are needed.
14 On the other hand, the argument could
15 go, claim denials because of incorrect
16 determinations of medical necessity are a
17 runaway train in the opposite direction, with
18 expanded tort liability needed to bring them
19 under control.
20 The problem with that argument is
21 that, there is no runaway train with respect to
22 claim denials because of questions of medical
23 necessity. To the contrary, many studies show
24 that there is a real problem with excessive care
25 in this Commonwealth and this country, and

1 there's a real need for insurers and others who
2 pay for health care to be vigilant in ferreting
3 out excessive and unnecessary care. That's one
4 reason why managed care has worked at holding
5 down costs. It's one reason that the auto and
6 workers' compensation reforms have worked in
7 holding down the costs of those coverages.
8 The record is also clear that the
9 denials of medically unnecessary care have not
10 hurt the well-being of patients or the
11 availability of care to them, which should, I
12 think, be the cornerstone of your deliberations.
13 That is not to say that if an insurer
14 denies a claim on the basis of medical necessity
15 and if that denial is outrageously deliberately
16 wrong, it shouldn't be subject to heightened
17 damages. I think those damages already exist in
18 the form of the Unfair Insurance Practices Act,
19 where the Insurance Department has the power to
20 simply put a company out of business if its
21 claims handling falls into that category.
22 It may also be that a damage standard
23 similar to that established in Senate Bill 790
24 would be appropriate here. But, there is no
25 justification for providers to impose on

1 insurers the enormous sanctions of this bill
2 while wanting the reduced standards of Senate
3 Bill 790 on their own conduct.
4 There is also no justification for the
5 one-sided nature of the damages sought in this
6 bill. If the insurer and the provider have a
7 good faith dispute on a question of medical
8 necessity and it turns out the insurer is wrong,
9 along come the punitive damages.
10 On the other hand, if the provider
11 turns out to be wrong, there's nothing except
12 nonpayment for unnecessary treatment; hardly a
13 penalty. I don't think punitive damages for
14 good faith disputes are fair to any party, but
15 if the bill is going to impose them, it at least
16 should do so evenly.
17 I realize that the bill does more than
18 impose bad faith damages on insurers raising a
19 good faith dispute. Most important, it seeks to
20 impose a uniform standard on what is medically
21 necessary care.
22 We appreciate the need to address the
23 problem of setting uniform, understandable
24 parameters for determining whether a provider's
25 services are medically necessary. As insurers,

1 our commitment is to pay for medically necessary
2 care; no more; but also no less, and to do this
3 as efficiently as possible. Certainly, the
4 constant debate between provider and insurer
5 doesn't help, nor do uneven standards which are
6 always perceived as being among insurers but
7 also exist among providers.
8 I doubt this is best done by statute.
9 After all, if statutes solved all ambiguities,
10 there wouldn't be a need for lawyers.
11 The problem is that the review of
12 medical necessity is inherently a case-by-case
13 review. Yes, there are standard protocols that
14 both insurers and providers can and do use. But
15 there is also the need for judgment, both by the
16 provider and the insurer. To that end, we need
17 better dialogue between the two professions more
18 than we need another act and another cause of
19 action. That, of course, is precisely the goal
20 of managed care programs, where network
21 providers participate as part of the program in
22 establishing general guidelines and reviewing
23 individual cases.
24 I will say that this bill's standards
25 for determining medical necessity have merit. A

1 couple of concerns: First, the bill excludes
2 treatment that is solely for purposes of
3 research, experiment or education. That could
4 be unduly limiting, since it arguably would
5 allow for treatment that is primarily, or even
6 99 percent, experimental and the like.
7 Second, the standards must recognize
8 that some types of insurers have to make
9 decisions of causality in reviewing a claim.
10 For instance, an auto insurer paying for a
11 treatment of a bad back must determine whether
12 and how much of the injury is attributable to
13 the auto accident. I think that's what the bill
14 is driving at--no pun intended there. But I
15 think that's what the bill is driving at in
16 allowing insurers to not pay for treatment, but
17 that could be more clearly stated.
18 Third, the standards should be as
19 objective as possible. Who is the one who is
20 going to reasonably expect that care will help
21 the patient? Is it only the particular
22 provider, those of his specialty or those of the
23 specialty that typically manages the condition
24 being treated?
25 The bill also goes into the

1 utilization review process by requiring that all
2 relevant clinical data of the patient as a whole
3 be reviewed, and by requiring that final
4 determinations be made only by providers in the
5 same specialty as those under review.
6 As a general comment, I think the
7 issues related to utilization review are
8 sufficiently complex to merit their own bill.
9 It's already been done by Representative Vance,
10 and that's had several hearings before the House
11 Insurance Committee.
12 As to specific requisites here, we
13 support a utilization review requirement that
14 denials of medical necessity be made by licensed
15 providers of the same or similar specialty as
16 typically manages the care under review. I
17 think that's a more objective standard than
18 here. We recommend it be adopted.
19 One note, because of the number of
20 previous witnesses that testified, we don't
21 support it be simply provider license only in
22 this Commonwealth. I know from personal
23 experience, for instance, you can have a
24 question and you may want to send it down to
25 Johns Hopkins. It's down in Maryland. It is

1 affiliated with a number of insurers in this
2 area to handle ailments for children, in
3 particular, is my own experience with it. It
4 makes sense to use providers in other states
5 because sometimes providers in other states, on
6 Pennsylvania as far as anybody, but sometimes
7 they do know as much or more.
8 I would say, I'm not sure what's meant
9 by all relevant data of the patient's condition
10 as a whole. This may inundate the review
11 process with more paper than is needed, as it
12 may require the records from a patient's other
13 providers. In any event, given the time
14 constraints that are on insurers using
15 utilization review, especially in auto and
16 workers' comp, it makes sense to at least impose
17 some time constraints on providers submitting
18 this data, as well as the requirement that they
19 submit all of it when asked.
20 Finally, a drafting glitch. The bill
21 defines the health insurance policies it intends
22 to cover as group policies. That would leave
23 out all the individual health policies and all
24 auto policies. While I don't want the bill to
25 apply to any insurance policy, I believe its

1 intent is to cover individual and auto policies,
2 though I point that out here.
3 I also think the definition should
4 exclude such policies as Medicare supplement,
5 hospital indemnity and other fixed cost or per
6 diem coverages where the questions of medical
7 necessity don't arise in the first place.
8 Obviously, thank you for the chance to
9 be here today. Just a couple of comments. The
10 luxury of going last is that you do get to hear
11 everybody. A couple comments on some of the
12 points that have been raised.
13 There was great deal of discussion
14 about the need for greater disclosure of the
15 criteria that insurers use in making decisions
16 of medical necessity. That's something we are
17 happy to do. As I believe all of you know, the
18 Federation supported the recent enactment in
19 Pennsylvania, the 48-hour coverage bill. That,
20 for instance, established that the standards of
21 medical necessity there, would be those of the
22 American College of Gynecologist or the
23 Pediatric Academy. Those are the types of
24 things that I think we can work with.
25 Also, there were a lot of allegations

1 on insurers somehow holding back on claims
2 payments and living by the float. I'd welcome
3 you -- I'm happy to provide information from our
4 membership as to how long it takes to process a
5 claim. I'd also welcome you to ask the Health
6 Department and the Insurance Department about it
7 because it's on their records. I would note
8 there are 30-day requisites that apply to auto
9 and workers' compensation. I believe most of
10 our managed care companies, indemnity companies
11 are within that, certainly once they get all the
12 information they need.
13 I also note that insurers are
14 co-partners along with providers in the national
15 developments for greater use of electronic data
16 interchange for submitting claims and for
17 greater use of electronic transfers for paying
18 claims.
19 I can tell you just from what I know
20 about insurer financing, no insurer lives on the
21 float of holding back in paying claims. Gee,
22 I'll wait an extra 15 days. The fact is, it
23 ends up costing more in administrative costs
24 because you have a claims manager sitting on
25 open files, things of that nature. Your

1 exposure both to your regulator and to the Trial
2 Bar is considerable in something like that.
3 CHAIRMAN GANNON: Representative
4 Manderino, do you have any questions?
5 REPRESENTATIVE MANDERINO: No.
6 CHAIRMAN GANNON: Let's take a couple
7 of observations. I don't see the inconsistency
8 between opposing Senate Bill 790 and supporting
9 this proposal.
10 MR. MARSHALL: I would agree with you.
11 There is no inconsistency between opposing
12 Senate Bill 790 and supporting this bill. There
13 is an inconsistency between supporting Senate
14 Bill 790 and supporting this bill.
15 CHAIRMAN GANNON: You talked about the
16 damages remedy already exist under the Unfair
17 Insurance Practices Act, which has the power to
18 put a company out of business if its claims
19 handling falls in this category. In light of
20 that comment, the Unfair Claims Practices Act
21 only applies if there is a pattern of behavior
22 that can be established.
23 Would you support amending that act to
24 provide for an action in an instance where
25 there's an unfair claim practice?

1 MR. MARSHALL: A practical matter --
2 I've spent a lot of time over the years with the
3 Unfair Insurance Practices Act on both sides.
4 Generally, the Department does use it to go
5 after isolated offenses. But, I think it does
6 have to be a pattern, and a pattern of the
7 Department's practice of it is more than once.
8 To put somebody out of business
9 because one claims manager one time made one
10 mistake, I don't think makes a whole lot of
11 sense.
12 CHAIRMAN GANNON: Then it's really not
13 a remedy. It's not an alternative remedy under
14 this act because Unfair Claims Practices --
15 MR. MARSHALL: I don't believe of any
16 of the people testifying -- I think everybody
17 who has testified certainly said that when
18 they've alleged that insurers are dilatory in
19 paying claims they have certainly alleged a
20 pattern. I don't think isolated bills are the
21 appropriate avenue for protractive regulatory
22 proceedings or for putting people out of
23 business.
24 I think that's almost an academic
25 question because, from listening to the previous

1 witnesses there are apparently allegations of
2 routine, widespread delay, arbitrary delay in
3 claims payments. I don't think that's true, but
4 if there is, there's already an avenue to
5 prosecute that and to prosecute it very
6 forcefully.
7 CHAIRMAN GANNON: We are not talking
8 about the same thing. You were talking about
9 some of the comments of witnesses that there
10 seemed to be a consistent pattern of delay in
11 payment. That clearly would be something that
12 would be remedied under the Unfair Claims
13 Practices Act.
14 MR. MARSHALL: I also think that the
15 Insurance Department -- I not only think this, I
16 know this; that the Insurance Department does
17 use the Unfair Insurance Practices Act to
18 address individual cases. It's exactly why they
19 have it.
20 CHAIRMAN GANNON: You didn't finish
21 the sentence, Sam. The finish is, in particular
22 instances to find out whether or not there is a
23 pattern. It doesn't stop there, if there's no
24 pattern of behavior.
25 In other words, if they get a report

1 of one instance and they are asked to
2 investigate, the purpose of their investigation
3 is not to find out whether or not there was
4 something irregular in that one instance, but to
5 find out whether there is a pattern of that type
6 of irregularity. If there is no pattern of that
7 type of irregularity, then there is no remedy
8 under the Unfair Claims Practices Act.
9 There's always got to be that little
10 caveat at the end. What I'm suggesting is, we
11 stop exactly where you said. If there is one
12 instance of an irregularity, that that would be
13 something that could be under the Unfair Claims
14 Practices Act without a showing of a pattern.
15 MR. MARSHALL: You are correct that
16 the Unfair Insurance Practices Act specifically
17 applies only to claims practices. I'd welcome
18 you to contact the Department because the
19 Department uses that to enforce conduct on
20 insurers on individual cases. This is just the
21 way it's gone into practice.
22 In addition, my experience, obviously,
23 is primarily on the regulatory side, so I always
24 refer to the Unfair Insurance Practices Act.
25 But there is a consumer protection law that I

1 think goes in the same direction. That would be
2 for individual claims.
3 CHAIRMAN GANNON: Another comment too,
4 on page 7 you say, I'm not sure what is meant by
5 relevant data of the patient's condition as a
6 whole. It may inundate the review process with
7 more paper than needed as it may require the
8 records from a patient's other providers.
9 The workers' compensation regulations
10 specifically require that the peer review obtain
11 records from other providers. I don't remember
12 the insurance industry complaining about that
13 when those regulations were adopted.
14 MR. MARSHALL: Actually, if memory
15 serves correctly, the Insurance Federation was
16 the lead opponent of those regulations. So no,
17 we've complained about every aspect of those.
18 The concern here, and this is to
19 determine whether something is medically
20 necessary. If you are looking and trying to see
21 whether -- and it is a question as to exactly
22 what the bill means. But if you are treating a
23 patient and you are treating him for a back
24 injury and he has also sustained a broken foot
25 in the course of that auto accident, it doesn't

1 make much sense to say here, you also got to
2 look at his medical records for the broken foot.
3 It may or may not be relevant to a determination
4 of whether the treatment to the back is
5 necessary. I'm not sure it's automatic.
6 CHAIRMAN GANNON: I misunderstood your
7 comment. That certainly wouldn't be the intent.
8 The intent would be all relevant records with
9 respect to the treatment of the back.
10 MR. MARSHALL: To the treatment of the
11 back.
12 CHAIRMAN GANNON: Okay. I
13 misunderstood.
14 MR. MARSHALL: That's when I referred
15 to the patient's condition as a whole. Many
16 times particularly in auto and workers' comp
17 scenarios, you have more than one condition for
18 the given patient.
19 CHAIRMAN GANNON: But your comment at
20 the beginning was correct. This would permit
21 the insurer, for example, in an auto instance,
22 to say that this is not a related -- there would
23 be no action if it was not something that was
24 covered under the policy.
25 MR. MARSHALL: Okay. I gathered that

1 that was the meaning.

2 CHAIRMAN GANNON: So we're giving you

3 what you want.

4 MR. MARSHALL: Now, of course, you're

5 not giving it to me in the exact same language

6 that I might prefer. That's sometimes where the

7 rubber meets the road.

8 CHAIRMAN GANNON: The other, just an

9 observation, on page 3 of your testimony you

10 talked about there's no runaway train with

11 respect to claim denials because of the question

12 of medical necessity. There was some concern

13 that insurers may be punished for denying

14 treatment; that is, denying payment for

15 treatment that is excessive and unnecessary.

16 That's just the opposite of what is intended

17 here.

18 If an insurer denies payment for

19 treatment that is unnecessary or excessive or

20 unneeded, then it would have no concern about

21 any remedies under this proposal.

22 MR. MARSHALL: You do in the sense --

23 I guess I bring over to that consideration the

24 fact that, we heard a great deal this morning

25 from a number of providers as to the cost

1 incurred on them when they challenge a denial
2 based on a question of medical necessity.
3 Understand that it also costs insurers dollars
4 to identify and to stop unnecessary payment.
5 They have an obligation to do it. Because, if
6 you don't do it, it's simply giving the provider
7 community a blank checkbook. That's been proven
8 to be irresponsible.
9 Understand when you say okay, here,
10 anytime you're wrong we are going to impose
11 treble damages. That should only concern you if
12 you're wrong. So, what's the big problem? The
13 difficulty I guess I'll use the parallel of
14 nuisance claims. Every lawyer is well aware the
15 fact that sometimes insurers say, you know what,
16 this is a nuisance claim. I'll simply pay--
17 Maybe it's a relatively insignificant amount,
18 but it's a claim that I don't think is a valid
19 claim, simply because, to oppose it and incur
20 those costs isn't worth it.
21 That's exactly what will happen here.
22 When you sit there and say, you may well be
23 right. It's a good faith dispute. You may well
24 be right. But if you're wrong, you're really
25 going to get stunned. If you're right, good for

1 you. There's just no balance.
2 The savings that you get from being
3 right are greatly outweighed from the penalty
4 when you're wrong. A good faith dispute, that's
5 going to leave you to start paying claims that's
6 nuisance claims. I don't think that that's a
7 good goal for anybody.
8 CHAIRMAN GANNON: Okay.
9 REPRESENTATIVE MANDERINO: I wasn't
10 going to ask questions, although one of the
11 areas that I highlighted is the one you exactly
12 asked Mr. Marshall about; that is, the notion
13 of -- that the bill has about having to look at
14 the person as a whole and whether that stuff is
15 relevant. I guess I'm just shocked by your
16 answer. I want to do a follow-up question.
17 Using the exact example that you and
18 Representative Gannon had a dialogue about. I'm
19 a lay person and I absolutely see the
20 relationship between a person who is in an auto
21 accident and had only a back injury, and the
22 person who was in an auto accident and had a
23 back injury and a broken leg. If I'm treating
24 those people, my length of treatment I have to
25 suspect for the person with the back injury and

1 the broken leg is going to be a lot longer than
2 the person just with the back injury.
3 Because the reality of it is, if I'm
4 sitting in a room looking at records and saying,
5 why the heck did it take them 12 weeks of
6 treatment for this guy's back when it should
7 have only taken them 6 weeks? It's probably
8 because that additional 6 weeks was because I
9 couldn't be as aggressive as I could have had
10 there only been a back injury because he had a
11 broken leg at the same time.
12 MR. MARSHALL: And what --
13 REPRESENTATIVE MANDERINO: How could
14 that not be relevant? How could it not be
15 relevant to look at the whole of a person and
16 say, the chart say this injury should be treated
17 in 6 weeks. But, because this was a woman with
18 a history of osteoporosis and something else
19 that's going to complicate how aggressively we
20 can treat and, therefore, how long the treatment
21 is going to take, how could that person's whole
22 medical history not be relevant to how long
23 you're going to reimburse or decide treatment in
24 that particular instance was medically
25 necessary?

1 MR. MARSHALL: You may need some of
2 that. One of the difficulties -- we can ask for
3 it. I will tell you, when you ask for it and
4 say here, now I want it from all the other 5
5 doctors who are being treated and I want all of
6 their data. All the people who complained about
7 the excessive paperwork and the delay in claims
8 are going to say, good God, that's going to
9 delay it even more and it's going to add to the
10 paperwork even more.
11 I would agree with you. Probably a
12 foot and the back, that may be a bad example.
13 You could deal with a neurologist and a foot
14 doctor.
15 REPRESENTATIVE MANDERINO: But my
16 whole point --
17 MR. MARSHALL: If I may please,
18 Representative. I'm not sure that you always
19 need all the relevant data from every other
20 provider. Take the foot and the back example.
21 I'm speaking as a layman as well so it may not
22 be the best example to be given.
23 Take the foot and the back doctor, you
24 may not need to have every single medical record
25 from the foot doctor if you are reviewing the

1 back doctor. All you may need to know is that
2 it's a broken leg and the guy is still on
3 crutches. You may not need all of the x-rays
4 and all of the relevant treatment that he's
5 undergone under physical therapy for the foot.
6 You may not need all of that.
7 It's a matter of saying, rather
8 than -- And that's as I said before, so much of
9 this should be handled on a case-by-case basis
10 rather than by a statute. A statute can be used
11 as a hiding point for either side. It can be
12 used as a point to delay or to refute a case on
13 either side. You may not always need all the
14 relevant data from all the providers. You may
15 need the cornerstone of knowledge, but you don't
16 need every single new one.
17 For all the people complaining about
18 the paperwork and the delays, it seems to me
19 that that may be an invitation for it.
20 Understand this, and everybody always seems to
21 think that insurers love excessive paperwork.
22 Understand, we don't get any bonus for sitting
23 on claims. No insurance company pays its
24 employees saying, here, great, you delayed in
25 paying claims. That's a good way to be

1 rewarded. You have been a claims manager. I
2 think you know that from personal experience.
3 Also understand that all those paper
4 costs hit us as well. Ultimately, that hits our
5 policyholders. If policyholders can't afford
6 what we're selling, we're out of business. We
7 love to reduce administrative costs. That's an
8 area that we are very committed to.
9 REPRESENTATIVE MANDERINO: Maybe we
10 just have a different understanding of what the
11 word relevant means, vis-a-vis this particular
12 proposal. I took it as the providers were
13 saying, I as a provider should have an
14 opportunity to tell you that there's other
15 things involved besides the back injury if that
16 is having a direct impact on how long it's
17 taking me to treat the back injury.
18 He wouldn't tell you about my
19 gynecological history if it didn't impact, but
20 it would tell you about my foot injury if it did
21 impact. I guess I understood that that's what
22 they were asking is for an ability to do just
23 that.
24 I'm not really sure what opinion I
25 have about it. I just don't see how you can

1 from a medical necessity point of view carte
2 blanche say none of that other stuff is
3 relevant. That was my only statement.
4 MR. MARSHALL: Understand, I'm not
5 suggesting that it isn't. I'm trying to come up
6 with some way, and I may not have an answer
7 right now. I'm trying to come up with some way
8 so that you do get the relevant data and you
9 don't have a lot of arguments as to what's
10 relevant.
11 This goes to the whole notion of
12 trying to pay claims correctly. In the back
13 doctor-foot doctor deal, the insurer who says,
14 okay, here, now wait a minute back doctor. Let
15 me see all that the foot doctor gives me. The
16 foot doctor says, what incentive do I have to
17 give you all of the information. I don't have a
18 bill before you. My bill has already been paid,
19 et cetera. I'm damn near out of the picture.
20 Maybe my information is relevant to getting the
21 back doctor paid, but it has no bearing on my
22 own bill. So, I'm not going to give you the
23 information right away. It's not a priority of
24 mine. I'll get around to it when I get around
25 to it.

1 You don't want something like that to
2 happen and allow the delay of claims. It
3 doesn't serve in anybody's interest.
4 REPRESENTATIVE MANDERINO: Yeah, but I
5 can't see that that would happen unless you, as
6 the insurer, would require it. I as the back
7 doctor provider said to you, my treatment of
8 patient X took 12 weeks instead of 6 weeks
9 because he was in a cast. Then you could accept
10 the notation in my book that he was in a cast
11 under the treatment of doctor X for this foot.
12 It's only if you want to disagree with
13 and deny whether or not he actually had his foot
14 in the cast for that long and whether that
15 impeded -- You then would go to the doctor who
16 treated his foot and ask for those records.
17 MR. MARSHALL: The problem is, if you
18 go to the doctor treating the foot and say,
19 here, give me your records, what happens when
20 that doctor says, sure, I'll send them into you,
21 and 30 days go by, 45 days go by, 60 days go by?
22 REPRESENTATIVE MANDERINO: So then the
23 question as to whether or not the delay was
24 necessary rests with you as to whether or not it
25 was necessary for you to go to the foot doctor

1 and ask how long it was in the cast?

2 MR. MARSHALL: I think it's a fair --

3 There's nothing more bizarre than two lay people

4 arguing about medical terms anymore than it is

5 listening to some of the earlier doctors talk

6 about medical terms, which went right over my

7 head. I imagine it went over even some of the

8 heads of all of you.

9 But understand, in something like that

10 it may well be very appropriate for the insurer

11 to look at the foot doctor's records. Not so

12 much because it's in a cast, but you can break

13 one bone in a foot as opposed to another. Gee,

14 maybe the recovery should have been a little

15 quicker, whatever the case may be. It makes

16 sense to try to verify that. You need some

17 mechanism of making sure that you get that other

18 provider's records on a timely basis.

19 REPRESENTATIVE MANDERINO: Thank you,

20 Mr. Chairman.

21 CHAIRMAN GANNON: Just a comment. I

22 think Representative Manderino is absolutely

23 right; that considering the patient as a whole

24 may be very critical in determining whether or

25 not specific treatment was reasonable and

1 necessary.

2 I think in most statutes, particularly

3 Act 44 and Act 6 there is a requirement either

4 in the statute itself or in the regulations that

5 there be some personal contact between the

6 reviewer who is reviewing the doctor's treatment

7 and the doctor so he can have an opportunity to

8 advise the reviewer. By the way, there is some

9 complications here. There's some underlying

10 condition, so that the reviewer can then

11 consider that information.

12 I don't want to get it below the

13 policy level, but certainly if the doctor

14 refuses to provide the records for your

15 information that comes to a defense against any

16 claim that there was a denial of treatment. I

17 think it's important that in determining that

18 treatment, that arbitrary benchmarks are not

19 used, the ideas of plateaus and stuff like that

20 that I commented on earlier. That's when you

21 get into the issue of treatment, considering the

22 patient's condition as a whole as to whether or

23 not this specific treatment was reasonable and

24 necessary.

25 I don't think you are going to find

1 many instances where that's going to be
2 overburdening because, quite frequently, it may
3 just involve a couple of visits or some question
4 as to whether or not a specific routine was
5 required. I think in most instances the
6 question can be resolved based on the provider's
7 treatment that is under review as opposed to
8 demanding records from everybody that ever saw
9 this person.
10 That may not be necessary to arrive at
11 a determination. But, I think in many instances
12 you can find that out by the contact with the
13 provider who gave the care. You can simply say,
14 was there anything else involved here? No.
15 Okay.
16 MR. MARSHALL: To the extent that then
17 an insurer would need to look at another
18 provider's records to see the whole condition, I
19 think you ought to consider imposing time
20 sanctions on providers to submit information to
21 insurers.
22 CHAIRMAN GANNON: That will be taken
23 care of. We're not trying to set up a peer
24 review process here. There are statutes. This
25 doesn't preempt peer review processes in any

1 other act. That can still go its course.
2 What we are doing here is providing
3 another remedy where treatment that is
4 reasonable and necessary is denied, to say that
5 an insurer will pay for the treatment,
6 attorney's fees, interest and treble damages. I
7 heard your arguments about why you oppose
8 punitive damages if there's a reasonable dispute
9 between the parties. I can take a look at that.
10 I have no problem.
11 MR. MARSHALL: I would note, I had the
12 chance to talk to Mr. Smalley as he left. He
13 said, that's a very good point. I would agree
14 with you, let's impose punitive damages on both
15 sides. I guess it shouldn't have surprised me
16 that the trial lawyers would have thought that.
17 If you are going to whip me, at least whip my
18 colleague. Misery loves company.
19 CHAIRMAN GANNON: Thank you very much,
20 Mr. Marshall. This concludes the public hearing
21 of the House Judiciary Committee on House Bill
22 2849.
23 (At or about 1:35 p.m. the hearing
24 concluded)
25 * * * *

1 C E R T I F I C A T E

2

3 I, Karen J. Meister, Reporter, Notary

4 Public, duly commissioned and qualified in and

5 for the County of York, Commonwealth of

6 Pennsylvania, hereby certify that the foregoing

7 is a true and accurate transcript of my

8 stenotype notes taken by me and subsequently

9 reduced to computer printout under my

10 supervision, and that this copy is a correct

11 record of the same.

12 This certification does not apply to

13 any reproduction of the same by any means unless

14 under my direct control and/or supervision.

15 Dated this 26th day of October, 1996.

16

17

18

19

20

21

22 Karen J. Meister - Reporter
Notary Public

23 My commission
expires 10/19/96

24

25