Pennsylvania
MEDICAL SOCIETY®

Facsimile Cover Sheet

To: Jonathan E. Rhoads Jr., MD
Company:
Phone:
Fax: (717) 851-4466

From: Don McCoy
Company: PA Medical Society
Phone: (717) 558-7823
Fax: (717) 558-7841

Date: 09/13/96
Pages including this cover page: 11

Comments:

Dr. Rhoads:

Here is a corrected copy of the testimony.

I plan to see you at the hearing in Philadelphia on Monday.

Don

Tort Reform NOW! Support Amended SB 790

Statement
on behalf of
The Pennsylvania Medical Society
before
House of Representatives
Judiciary Committee
on
House Bill 2849, Printer's Number 3959

September 16, 1996

Good Morning! My name is Jonathan E. Rhoads, Jr., MD. I am a practicing surgeon from York, Pennsylvania. I appear before you as the President of the Pennsylvania Medical Society. The Medical Society is the largest physician professional association in the Commonwealth, representing physicians of all medical and surgical specialties and their patients. I am pleased to appear before the House Judiciary Committee to present the views of the Medical Society concerning House Bill 2849. With me is Mr. Donald McCoy, Director of the Medical Society's Department of Regulatory Affairs and Specialty legislation. Mr. McCoy will assist me in responding to any comments and questions at the conclusion of my prepared remarks.

The Pennsylvania Medical Society supports House Bill 2849, Printer's Number 3959, addressing wrongful denial of reimbursement for medically necessary treatment. This legislation responds to concerns of the medical community over decisions related to coverage for diagnostic and treatment services provided to subscribers or beneficiaries under various forms of health insurance currently offered to Commonwealth citizens through employment or direct purchase. Those concerns are with the criteria used to make insurance payment/coverage decisions regarding the necessity of the services provided, the qualifications of those making such decisions, the timeliness of those decisions, and the rights of due process available to the patient and the health care provider to challenge those decisions.

"Medical necessity" and "medical reasonableness" are terms of art. Depending on the individual circumstances, a diagnostic or treatment service may be both reasonable and necessary or may be either. Many would argue that the care is necessary when it is for them while reasonable but not critical in the care of others. Severely ill patients, including those in need of transplant organs are often placed in this situation. Too often, however, the rationale for making these decisions concerning care provided comes into conflict with the decisions regarding whether the service is reimbursable. The criteria for necessity decisions by insurers is often based on statistical data obtained from the previous utilization experience of the insurer. Unfortunately, such empirical data doesn't take into consideration the dynamics of the situation at the time the diagnosis or treatment decision was made. It can't factor into the equation the training and experience of the physician or other health care provider who provides the care. It can't comprehend the alternative treatment options which might have been considered and then discarded or for what reason.

Insurers will argue that they always pay for medically necessary services. They do not share with the patients (their subscribers) or with the health care providers the criteria for their consideration of the necessity of a service. The patient must then depend on the health care provider to use his or her best judgment in making the right diagnosis and/or treatment decision. Both then must await the decision of the third party payer as to whether the decision

fit the payer's criteria and is therefore reimbursable. The process is only somewhat expedited in the instance of pre certification for elective and non-urgent procedures. The problem is still the criteria used by the third party in making that decision.

House Bill 2849 attempts to establish some clinical basis for necessity decisions which can be uniformly applied by all types of third party payers that is consistent with the standards of practice for the provider community and can be fairly and evenly applied in all situations. It would require that medically necessary care be consistent with the patient's condition(s); be furnished by or under the supervision of a licensed health care provider in a setting appropriate to the patient's medical needs; and would be documented in the patient's record. The bill would further require that the overall condition of the patient be considered in rendering a necessity decision regarding a specific service or treatment.

Review of the necessity of care can play a positive role in reducing unnecessary health care costs and improving quality. However, safeguards are necessary to assure that such review decisions are made correctly and in the patient's best medical interests. Otherwise, such decisions will adversely affect quality and patients can be harmed when decisions are incorrect or unduly delayed.

In debates over legislation such as HB 2849, there is always the demand for proof of damage caused by third party action to either the access to or the quality of care provided. Unfortunately, the damage isn't as easy to identify, since in most instances, the challenge of the medical necessity comes after the service has been delivered. The potential damage occurs in the future treating relationship between the health care provider and his or her patients. If a procedure is denied as not medically necessary, its use the next time will be questioned by the health care provider. Despite the provider's training and experience and first-hand knowledge of the patient's condition as well as the reasons for considering the use of the procedure or service, the provider may opt not to perform that procedure or service, or the provider may decide to treat the patient less aggressively or may pursue other options.

Let me give you an example of how this occurs in the real world. A Pennsylvania radiologist recently received correspondence from a physician, based in California and affiliated as a clinical officer with a large managed care plan. A brain CT scan performed the radiologist, on the basis of a referral from the treating physician, on a patient subscriber of the plan here in Pennsylvania was not approved. Based upon a review of "available clinical information," the procedure did not meet the managed care plan's criteria for medical necessity. The correspondence went on to state that the desire of the plan's medical directors was that specialty consultation should be sought prior to this imaging. The plan's clinical officer, who by the way is not currently licensed in Pennsylvania, did not bother to share with the Pennsylvania physician the clinical information considered in arriving at the decision. The plan didn't mention any review of the basis for the referral to the radiologist or that it had been considered in the plan's recommendation for a specialty consultation.

You can certainly imagine the fear and anxiety in the mind of a patient whose symptoms suggested to the radiologist (which is a specialty that also routinely receives requests for consultative and diagnostic services) the need for the CT scan. You can imagine that patient's or a subsequent patient's reaction to being told that they must be referred to another physician for added consultation before receiving the scan.

This example is typical of the numerous complaints received by the Medical Society. It is the reason that the Society supports legislation such as HB 2849 and other utilization review and managed care safeguard legislation.

HB 2849 is actually a minimum safeguard The bill only requires that all forms of insurance plans in Pennsylvania define "medical necessity" in objective terms. The legislation would not extend coverage, nor would it establish a "cookbook" approach by specifying the exact care which would qualify as medically necessary. Instead, the legislation provides guidelines by which all treatment can be judged.

The Medical Society believes that there should be disclosure of the payer's review requirements, criteria, and procedures to enrollees and their treating physicians. In the example cited above, the requirement, if it is a requirement, that a specialty consultation be requested before a CT scan is ordered should have been made known to the subscriber and the physician before the fact, so that treatment could have been adjusted accordingly and the appropriate referrals sought. The "available clinical information" should likewise be known. The source of the information, its timeliness, and the extent of its dissemination are important pieces of information. For example, is the information the result of a single study or broad research? Is the opinion that of a national specialty, such as the American College of Radiology or the American Neurological Association? Is the information the result of clinical research conducted at a center for medical training or a teaching hospital? Has the information been validated for accuracy?

The Medical Society recommends that criteria for making medical necessity decisions be developed with input from physicians and other health care providers who actively provide such care to the payer's plan enrollees. The plan must permit some form of appeal of a negative decision made by the third party payer or the challenge of the clinical information used as a basis for the decision.

The second concern of the Medical Society which HB 2849 addresses relates to the qualifications of the person(s) rendering medical necessity decisions for the third party payers. House Bill 2849 require that final determinations as to medical necessity shall be made only by health care providers who are licensed by the Commonwealth in the same profession and having the same specialty as the provider whose treatment is subject to review. The Medical Society strongly supports this requirement and would suggest two further modifications. First, in instances where the decision is an appeal of an earlier decision or where the provider of services under review is a physician who is board certified by an American Board of Medical Specialties or its osteopathic equivalent, the provider making the decision shall be likewise certified.

The second recommendation is that the reviewer, in addition to being Pennsylvania licensed, should be engaged in active clinical practice. This requirement is critical to assure that the reviewer maintains currency in changes in practice of his or her profession. Federal requirements for utilization and peer review of Medicare stipulate that reviewers shall maintain an active clinical practice of at least twenty hours per week. This requirement as well as the certification requirement have also been accepted for qualifications of reviewers under the Workers' Compensation Law.

The Medical Society is also pursuing more encompassing legislation dealing with all forms of utilization and peer review performed in Pennsylvania. House Bill 2849 is certainly a step toward standardization of the review processes utilized by the various third party payers and should be adopted as needed patient safeguards.

A third concern of the Medical Society is the timeliness of the medical necessity decision. As previously mentioned, the decision as to whether or not a service or procedure is medically necessary is usually made at a time after the service has been provided to the patient. Despite language in virtually every insurance statute requiring timely payment of claims, insurers are notorious for delaying such decisions and the resulting payments. Often the first notice a physician receives that a service or procedure is being challenged for necessity is when the physician inquires as to the status of the claim. This is especially troublesome when the care is ongoing such as with physical therapy, etc.. After a number of services have been provided, the physician or other provider is notified that treatments after a specified number or date are determined to be medically unnecessary.

A related problem which the Medical Society is examining is the practice of payment slowdown, especially by health maintenance organizations (HMOs). There is no indication that claims have been suspended for review or that added information is needed to process the claim. The physician hears nothing, and despite contractual language obligating the HMO to timely payment, unpaid balances remain outstanding for 60, 90, 120 days even up to a year. When the physician's office inquires as to the status of the claim, they are given numerous excuses and often promised payment, either partial or full. When the promises aren't kept and the physician renews attempts to resolve the outstanding claims, the excuses may turn to abuses. Threats of de-selection and restriction on referrals are becoming increasingly common.

Investigation of this latest problem indicates that there is little remedy available to the physician under existing statute or state agency regulation. The Medical Society recommends that HB 2849 be amended to provide a remedy for wrongful denial of timely payment of undisputed health insurance claims. The Society would ask that provision be made for the assessment of damages for such nonpayment, and that the Insurance Department be given the authority to investigate provider complaints of such actions and take the necessary remedial or disciplinary actions against such plans. The Society would be pleased to provide draft language to accomplish this goal.

The Pennsylvania Medical Society appreciates the opportunity to offer comments regarding this important legislation. The Society would ask the Committee to report the bill to the full House so that it may be considered when the General Assembly returns for the fall session.

Mr. McCoy and I would be pleased to address any questions and comments from the members of the Committee.