

Making Sense of

Health Plan Denials

The first step to understanding and responding to denials is recognizing the difference between medical necessity and medical benefits.

James Bare



Health care plans' assumption of medical necessity determinations has been one of the most contentious changes brought about by managed care. Physicians, consumers and politicians have rallied around this issue in denunciation of managed care, and their efforts are beginning to make a difference.

Several recent court decisions have enhanced patients' ability to sue health plans over coverage limitations or treatment denials (see page 40), and two sets of regulations are scheduled to take effect next year that will significantly enhance the ability of individuals to successfully appeal adverse determinations. The Department of Labor (DOL) has developed a set of regulations¹ that will apply to individuals covered by self-insured health plans (most large employers have self-insured health plans), and the Health Care Financing Administration is currently determining how to implement similar appeals provisions for Medicare patients as mandated by the Benefits Improvement and Protection Act of 2000. Both sets of regulations have Jan. 1, 2002, implementation dates.

Despite these developments, conflicts surrounding whether a service is medically necessary and whether it's a medical benefit under the terms of a particular health plan rage on. This article brings the key issues into focus for you and your patients. ►

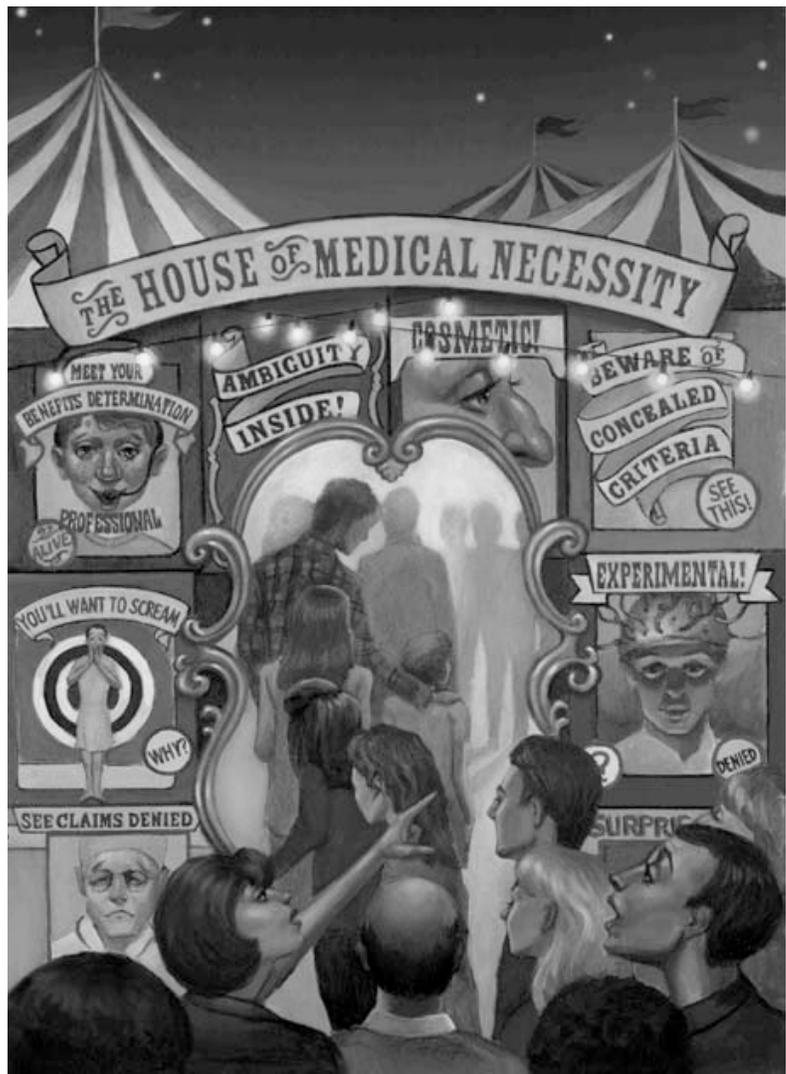


ILLUSTRATION BY LORI KOEFOED

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Recent court decisions and pending regulations will increase patients' chances of successfully appealing health plan denials.



Health plans frequently attribute denials to their determination that a service isn't medically necessary or that it isn't a covered benefit.



Definitions of medical necessity vary from health plan to health plan.



In determining medical necessity, health plans also take into account corporate protocols and standards that reflect economic criteria.

Necessity and benefits

Medical necessity and medical benefits are distinct concepts that patients and physicians struggle to understand. While health plans often initiate pre- and post-enrollment education of members to explain plan basics, the plans rarely explain the difference between medical necessity and medical benefits and how coverage decisions are really made. This becomes the family physician's chore. (See the patient handout facing page 42 for help.)

While there are as many definitions of medical necessity as there are health plans, the definitions do have some common elements. Most include the following:

- The care should be appropriate;
- The care should resolve a problem or improve the patient's health, functioning or well being;
- The care should be provided in accor-

KEY POINTS

- For each health plan denial they encounter, physicians need to determine whether the decision is due to a lack of medical necessity or because the benefits outlined in the patient's contract don't cover the service.
- Physicians need to explain to patients how insurance coverage works. A patient handout like the one facing page 42 may help.
- New regulations and several recent court decisions have enhanced patients' rights in this area.

dance with standards of good medical practice or generally accepted medical practice;

- The care should not be experimental, educational or investigational.

From the perspective of the physician, a patient's needs are based on perceived clinical necessity. Patients share this point of

WHEN DENIALS LEAD TO LAWSUITS

While the Supreme Court has affirmed that health plans cannot be sued for giving doctors financial bonuses to hold down treatment costs (*Pegram et al v Herdrich*), health plans can be sued for denials of care. In general, the courts appear inclined to treat these cases as quality of care issues rather than denial of benefits issues, thereby permitting many cases that might have otherwise been dismissed to go forward. One emerging legal strategy is to file these cases in state courts under the Racketeer Influenced and Corrupt Organizations Act (RICO), which allows for larger damage awards than cases filed under the Employee Retirement Income Security Act of 1974 (ERISA) in federal courts.

Many of the cases filed under RICO have been consolidated into one case under one judge. It is worth noting that state medical associations from California, Georgia and Texas have joined this suit, alleging "a pattern of racketeering activity to deny necessary medical care." These associations represent nearly 80,000 doctors.

Most of these cases have repetitive themes. The central allegation is that health plans falsely represented to enrollees that all coverage and treatment decisions would be made on the basis of "medical necessity" when, in fact, the following occurred:

- Coverage and review decisions were based on a variety of concealed cost-based criteria that were unconcerned with the medical needs of enrollees.
- Insurers concealed from enrollees the use of estab-

lished sets of financial incentives for claims reviewers designed to encourage denial of claims without regard to enrollees' medical needs.

- Some insurers subcontract the claims review process and the authority to decide the scope of medical coverage to third parties. These entities often hire people without appropriate medical training to make claims determinations and use criteria different from and more restrictive than the insurer's medical necessity criteria. An additional complication may arise if the subcontractor receives incentives based on financial performance, thereby creating a motive to deny medically necessary care.

- Insurers "concealed" from enrollees that financial incentives are provided to physicians and other health care professionals to deny coverage to enrollees even when the proposed treatment satisfies the definition of medical necessity. In the *Pegram et al v. Herdrich* case, the Supreme Court's decision stated that a plan administrator could be obligated to disclose plan characteristics if that information affects beneficiaries' material interests. In a related action, a New York appellate court ruled that Prudential members can sue for fraud, breach of contract and deceptive trade. The basis of this class-action suit was that, through its marketing tools, Prudential said its doctors would make medical determinations when, in fact, the determinations were made by nurses using the much-debated clinical guidelines produced by the actuarial firm of Milliman & Robertson.

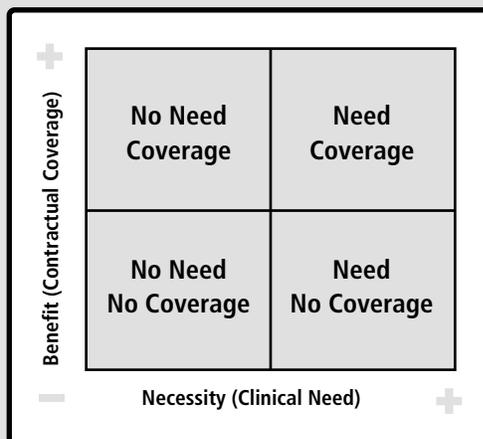
A NECESSITY-BENEFIT MATRIX

This simple illustration of the relationship between medical necessity and medical benefits indicates how the two affect health plans' decisions about whether to pay for services.

Need/Coverage. The upper right quadrant illustrates situations in which the health plan determines there is both clinical need and contractual coverage. Most care falls into this category.

Need/No Coverage. The lower right quadrant illustrates situations in which the health plan determines there is clinical need for a treatment but no coverage. For example, consider a patient who is a candidate for Viagra but whose employer has excluded the drug as a treatment for impotence.

No Need/No Coverage. The lower left quadrant illustrates situations in which the health plan determines there is no clinical need and no coverage for a particular treatment. For example, consider a request for surgery or a corrective device for a child born with a cranial deformity. Since health plans might argue there is "no observable adverse impact" from the deformity, the surgery could be deemed cosmetic rather than medically necessary, and cosmetic



surgery is not a covered benefit under the terms of the family's contract with the health plan. Conflict is likely since the parents will probably perceive the existence of a very real need, even if the treatment is considered by the physician not to be medically necessary.

No Need/Coverage. The upper left quadrant, which illustrates situations in which a patient clearly has coverage for a proposed service but the health plan determines there is no need, has the greatest potential for conflict. The administration of epidural injections for a patient with acute, localized back pain and no prior administration of oral pain medications or other conservative and noninvasive therapies is one example.

view, though some confuse what they want with what they need and are unconcerned with the ramifications of applying the same coverage decision to a larger population. The proliferation of health-related information on the Internet and direct-to-consumer advertising by pharmaceutical companies has increased patients' demands.

From the perspective of the health plan, a patient's needs are based on medical necessity, which takes into account perceived clinical necessity *plus* corporate protocols and standards that reflect economic criteria such as relative cost-effectiveness, the availability of less costly alternatives and the benefit structure of the patient's health plan. Unless the case is submitted to outside review or arbitration, the health plan has the final word on medical necessity.

Whether a service is a medical benefit is a contractual issue. Services may be covered under the terms of the patient's contract but

not medically necessary, or they may be medically necessary but not covered. Because it will never be possible to include exhaustive lists of covered and excluded services in a contract, denials that result from coverage decisions can be as ambiguous as those having to do with medical necessity.

The potential for conflict is greatest when a patient clearly has coverage for a proposed service but the health plan determines there is no need, although a

number of other scenarios may generate conflict as well. (See the illustration above.)

Denials

The degree of conflict surrounding health plan denials depends in large part on the reason given for the denial. The health plan may simply disagree with the physician's recommendation or may argue that it conflicts with the health plan's protocol for the disease or condition in question. ►

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The patient's contract with the health plan determines whether a service is a medical benefit.



Denials having to do with medical benefits can be as ambiguous as those having to do with medical necessity.



The greatest conflicts occur when a physician orders a service that the patient has coverage for but that the health plan determines isn't medically necessary.



A health plan might deny treatment because the physician's recommendation conflicts with the health plan's protocol or because the treatment is "experimental."

There are as many definitions of medical necessity as there are health plans.



New regulations will require plans to provide "the specific reason or reasons" for denials.



Health plans must cover services that are mandated by federal or state legislation.



Health plans can be held liable for denials of care.



Physicians, especially those working as medical directors, could be at risk for their involvement in denials of care.

Another reason often given for denials is that the treatment in question is experimental. But when does a treatment cease being experimental and what criteria do health plans use to make this determination? Generally, a procedure or technology is no longer



considered experimental when it has FDA approval or, in the case of a drug, when major drug compendia have listed it as safe and efficacious for a particular use. However, these criteria may not be sufficient from the perspective of some health plans. The FDA tests primarily for safety, not effectiveness. Most FDA reviews are 510(k) reviews, or reviews meant to assess claims of substantial equivalency with a device marketed before 1976. It is entirely possible that a manufacturer may produce a product that is equivalent to a procedure or technology of no value. Only 20 percent of medical interventions in current use have substantial research support.²

Even when scientific evidence clearly demonstrates the value of an intervention (i.e., it prevents or lessens the impact of disease more effectively than does the current established standard of care), health plans may not agree to pay for the intervention. The new DOL regulations will require health plans to provide "the specific reason or reasons" for rejected claims and reduced benefits. In the case of denials due to the experimental nature of the requested service, the health plan will also be required to "explain the scientific or clinical judgment of the plan" on request.

In determining what services to cover, health plans are also subject to pressures unrelated to the demonstrated value of the procedure or technology. For example, health plans must comply with legislative mandates that are the result of constituent and lobbying pressures. (It is estimated that 22 percent of total benefit dollars are associated with legislative mandates.³) Federal and state legislative mandates supersede contractual obligations and require the health plan to cover mandated services even when the issue of whether the services are experimen-

tal or mainstream is unresolved. To determine what services are mandated in your state, contact any of the health plans you contract with or your state insurance commissioner's office.

Liability for coverage

Who is liable for coverage decisions and under what circumstances? Liability in this context is difficult to define, but in general, the health plan could be held liable for not complying with a contractual obligation or for failing to approve standard medical procedures (like anesthesia for surgery). A health plan's liability would be greatest where scientific evidence supported the efficacy of the intervention and the health plan still failed to approve it. In other words, widespread application of a procedure the health plan denies coverage for would probably not suffice to determine liability.

Employers can also limit or refuse to offer services at their discretion (unless the services are legislatively mandated). For example, it is not uncommon for an employer to limit physical therapy benefits to 30 or 60 days per condition. The health plan would then be

justified in refusing to authorize additional services, regardless of how beneficial they might be.

Employers can limit or refuse to offer services at their discretion.

The allegation that health plans provide financial incentives to physicians

to limit care raises questions about the liability of those physicians. Physicians practicing in capitated situations could be at risk and should be clear about reasons for delaying care, denying care or selecting particular interventions. Health plan medical directors are increasingly being held accountable for their involvement in coverage decisions. (See "In the hot seat" on page 44.)

Appeals

When a service is denied, the physician or patient can appeal the denial. Every physician should be aware of how the process works. Most plans offer internal and external appeals. (See "Navigating the Patient Appeals Process," *FPM*, October 2000, page 43.) The internal process is developed by the health plan, while the external process might be the result of the health plan's policy or of a state legislative mandate. At press time, 33 states require external appeals. ►

Understanding Your Insurance Coverage

Your health insurance policy is an agreement between you and your insurance company. The policy lists a package of medical benefits such as tests, drugs and treatment services. The insurance company agrees to cover the cost of certain benefits listed in your policy. These are called “covered services.”

Your policy also lists the kinds of services that are not covered by your insurance company. You have to pay for any uncovered medical care that you receive. Keep in mind that a medical necessity is not the same as a medical benefit. A medical necessity is something that your doctor has decided is necessary. A medical benefit is something that your insurance plan has agreed to cover. In some cases, your doctor might decide that you need medical care that is not covered by your insurance policy.

Insurance companies determine what tests, drugs and services they will cover. These choices are based on their understanding of the kinds of medical care that most patients need. Your insurance company’s choices may mean that the test, drug or service you need isn’t covered by your policy.

Your doctor will try to be familiar with your insurance coverage so he or she can provide you with covered care. However, there are so many different insurance plans that it’s not possible for your doctor to know the specific details of each plan. By understanding your insurance coverage, you can help your doctor recommend medical care that is covered in your plan.

- Take the time to read your insurance policy. It’s better to know what your insurance company will pay for **before** you receive a service, get tested or fill a prescription. Some kinds of care may have to be approved by your insurance company before your doctor can provide them.

- If you still have questions about your coverage, call your insurance company and ask a representative to explain it.

- Remember that your insurance company, not your doctor, makes decisions about what will be paid for and what will not.

Most of the things your doctor recommends will be covered by your plan, but some may not. When you have a test or treatment that isn’t covered, or you get a prescription filled for a drug that isn’t covered, your insurance company won’t pay the bill. This is often called “denying the claim.” You can still obtain the treatment your doctor recommended, but you will have to pay for it yourself.

If your insurance company denies your claim, you have the right to appeal (challenge) the decision. Before you decide to appeal, know your insurance company’s appeal process. This should be discussed in your plan handbook. Also, ask your doctor for his or her opinion. If your doctor thinks it’s right to make an appeal, he or she may be able to help you through the process.

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This handout is provided to you by your family doctor and the American Academy of Family Physicians. Other health-related information is available from the AAFP on the World Wide Web (<http://www.familydoctor.org>). 6/01



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Physicians should become familiar with the internal and external appeals processes of the health plans they contract with.



Different decisions on similar cases could be grounds for an appeal or legal action.



Denials are overturned as a result of external appeals approximately 45 percent of the time.

Different decisions on similar cases could be grounds for an appeal or legal action. In such cases, a physician's thorough documentation, including the written explanation provided by the health plan as well as notes from any conversations with plan representatives, could be instrumental in the appeal, particularly when the plan's documentation is lacking.

Similar decisions on different cases can also provide the basis for an appeal. A health plan's efforts to be consistent across a broad geographic area may leave it out of step with the standard of care in a particular region. In this case it is important for physicians to document why standardized criteria are not applicable to an individual case. However, because the standard of care is constantly evolving, basing an appeal (or a denial) on "standard and appropriate medical practice" may not be the best strategy.

Denials are overturned as a result of external appeals approximately 45 percent of the time.⁴ Health plans may reserve the appeals process, particularly the external appeals process, for cases where there is a

Appeals based on strict coverage decisions may not be allowed to go forward.



clear conflict over whether the service is medical necessary or likely to be beneficial. Currently, appeals based on strict coverage decisions may not be allowed to go forward; however, the DOL regulations will facilitate patients' appeals of benefits-based denials such as "pre-service" determinations on coverage or authorization.

Take charge

Differences in the perspectives of physicians, health plans, employers, patients and their

families and a decision-making process that is unclear and unspoken make conflicts over medical necessity and medical benefits inevitable. By helping patients understand

how insurance coverage works, making sure you and your patients understand your rights to an appeal and, when necessary, exercising them, you can be an effective advocate for your patients and your practice. Such efforts are cumbersome and time consuming, but if they are not pursued, health

plans will, by default, become the arbiters of medical necessity. **FM**

IN THE HOT SEAT

Medical directors of health plans today face an increasingly hostile environment characterized by litigation, widespread misunderstanding of insurers' decision-making processes and increasingly aggressive attempts to curb their authority.

Last year, the Texas State Board of Medical Examiners attempted to suspend the license of a managed care medical director after he denied coverage of custodial care to a child with respiratory problems. The Board found that the medical director's decision not to pay for the care was inappropriate based on the perceived medical need. The health plan's position was that the decision was unrelated to need but, rather, was based solely on the benefits outlined in the contract. Subsequently, a federal judge ruled that the attempt to discipline the medical director violated the intent of the Employee Retirement Income Security Act of 1974 (ERISA). Under the act, an ERISA plan, defined as any self-insured health plan, cannot be sued under state law for negligence in administering the plan. Most negligence claims are based on state law.

The judge agreed that the decision to deny care was a "pure coverage" determination and the medical director had never made any type of clinical judgment in the case. Since ERISA is a federal law and supersedes state law, the medical director was protected from disciplinary action by the state body. The judge indicated that the issue of a state's ability to regulate a medical director who did "practice medicine" was still unresolved.

1. Employee Retirement Income Security Act of 1974; Rules and Regulations for Administration and Enforcement; Claims Procedure; Final Rule. *Federal Register*. Nov. 21, 2000.

2. Braslow NN, Shatin DS, McCarthy DB, Newcomer LN. Role of technology assessment in health benefits coverage for medical devices. *Am J Man Care*. 1998;4(special issue):139-150.

3. Sheingold SH. Technology assessment, coverage decisions and conflict: the role of guidelines. *Am J Man Care*. 1998;4(special issue):117-125.

4. Coleman DL. External review: both sides benefit. *Healthplan*. 2000;41(5):26-30.