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*CT-DPH and CTAAP*

*Teleconference Series*

# Medical Necessity Denials: Strategies for Success



The Mission of the Office of the Healthcare Advocate is to assist consumers with healthcare issues through the establishment of effective outreach programs and the development of communications related to consumer rights and responsibilities as members of managed care plans.



Office of the  
Healthcare  
Advocate  
STATE OF CONNECTICUT

- Focus on assisting and educating consumers to make informed decisions when selecting a health plan
- Assist consumers to resolve problems with their health insurance plans
- Identify issues, trends and problems that may require executive, regulatory or legislative intervention.
- Educating consumers about their rights and how to advocate on their own behalf when they have a problem or concern about their managed care plan.
- Answer questions and assist consumers in understanding and exercising their right to appeal a managed care plan's denial of a benefit or service.



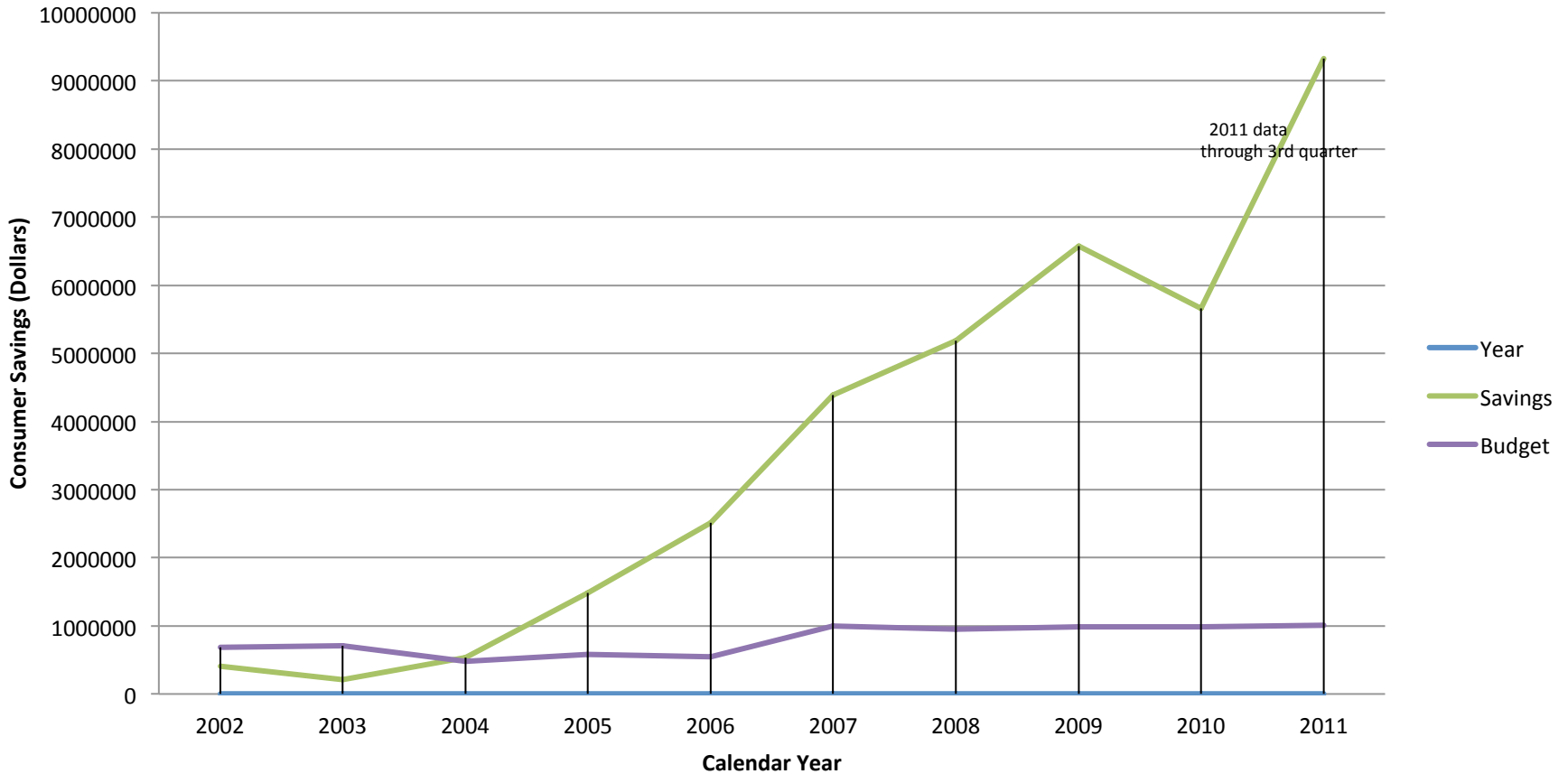
# What else do we do?

- Track Trends & Issues
- Work with Providers, Associations & Advocacy Organizations
- Legislative “Fixes”
- Annual Legislative Agenda
- Issue or Insurance Company Specific Intervention
- Communications
  - Annual Report
  - Newsletters



# OHA Trends

## OHA Consumer Savings Over Time Compared to Budget



# Fully-Funded vs. Self-Insured Plans

## **Fully Funded Health Plans (State-licensed):**

- State-licensed managed care organizations are regulated under state law, although federal law may add additional standards and in some cases supersedes state authority.
- In Connecticut, state-licensed health plans cover approximately 50% of the privately insured citizens.
- Each state has laws that require state-licensed managed care organizations to offer or include coverage for certain benefits or services (known as mandated benefits). In Connecticut these mandated benefits are listed <http://www.ct.gov/oha/cwp/view.asp?a=2277&q=299946>

# Fully-Funded vs. Self-Insured Plans

## **Self-Funded Health Plans (Federal):**

- Although the business of insurance is primarily regulated by the state, a number of federal laws contain requirements that apply to private health coverage, including ERISA and HIPPA.
- Self-funded health plans operate under federal law and are health benefit arrangements sponsored by employers or employee organizations. Under a self-funded arrangement, the employer retains the responsibility to pay directly for health care services of the plan participants.
- In Connecticut, self-funded health plans cover approximately 60% of the privately insured citizens.

# Fully-Funded vs. Self-Insured Plans

## **Self-Funded Health Plans (Federal):**

- ERISA does not require employers or to establish any type of employee benefit plan, but contains requirements applicable to the administration of the plan; such as, requirements for disclosure, reporting and fiduciary standards, claims and continuation coverage.
- In general, ERISA preempts state laws that would regulate the operation of health plans. Therefore, any state mandates do not apply to those covered by self-funded plans.



# What is the definition of medical necessity?

## **Under Fully-Insured Plans (Connecticut General Statutes 38a-513c):**

Medically necessary" or "medical necessity" means health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: (1) In accordance with **generally accepted standards of medical practice**; (2) **clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective** for the patient's illness, injury or disease; and (3) **not primarily for the convenience of the patient, physician or other health care provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.** For the purposes of this subsection, "**generally accepted standards of medical practice**" means standards that are based on **credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community or otherwise consistent with the standards set forth in policy issues involving clinical judgment.**

# What is the definition of medical necessity?

Under self-insured plans:

- See the patient's insurance policy (Summary Plan Description) or ask the insurer to forward the definition used in their policy. The medical necessity guideline is based on ERISA/ federal mandates and tends to be less prescriptive.

# Grievances/Appeals

- Know if the Plan is Fully- or Self-Insured
- The appeals process varies considerably between self-insured plans
- Fully-insured plans generally have a utilization review, and if denied, a first level grievance, a second level grievance (sometimes voluntary) and an external grievance through the State of CT Department of Insurance

## Health Carrier Notification Time Tables – July 2011

	Initial Determination	Initial Determination Extension*	Missing Information	Failure to Meet Filing Procedures	Grievance Appeal Determination	Grievance Appeal Notices
<b>Medical Necessity Reviews</b>						
▶ Prospective	15 Days	15 Days* Notification prior to the end of the initial benefit determination period.	- Notification prior to the end of the initial benefit determination period. - Must allow 45 days for receipt of missing information.	5 Days	30 Days	<p><u>All Notices of Adverse Determination:</u></p> <p>Notification of right to submit written material to be considered by health carrier during grievance.</p> <p>Right to receive free of charge access to documents related to request for benefits.</p> <p>Grievance procedures for standard and expedited grievance.</p> <p>Right to contact the Connecticut Insurance Department and the Office of the Healthcare Advocate.</p> <p>..... Full compliance requirements provided in US DOL Technical Release 2011-01 dated 3-18-11</p>
▶ Concurrent	15 Days	None	- Notification prior to the end of the initial benefit determination period. - Must allow 45 days for receipt of missing information.	5 Days	30 Days	
▶ Retrospective	30 Days	15 Days* Notification prior to the end of the initial benefit determination period.	- Notification prior to the end of the initial benefit determination period. - Must allow 45 days for receipt of missing information.	5 Days	60 Days	
▶ Expedited Urgent Care	72 Hours  Plan years 1-1-12 and after	None	24 Hours  Must allow 48 hours for receipt of missing information.	24 Hours	72 Hours	
<b>Non-Medical Necessity Reviews</b>	30 Days	15 Days* Notification prior to the end of the initial benefit determination period.			20 Business Days + Extension* of 10 Business Days	3 Business Days Notification of right to submit written material to be considered by health carrier.

\*Extension only allowed due to circumstances beyond the health carrier's control and with prior notification.

CT Insurance Department May 20, 2011

# Tried and (Some) True Strategies

- Ask for a “doc to doc” with a “like specialty”; be sure to present full treatment history of successes and failures with other levels of care
- Know the current research
- Ask what clinical association they are using to determine their guidelines for the particular treatment (AMA, APA, AACAP, ASAM, etc.)
- Review their guidelines/criteria for the treatment and be prepared to “use it”

# Tried and (Some) True Strategies

- If they are denying based on medical necessity ask what specific part of the definition they are relying on for the denial
- Don't be afraid to "google" the credentials, licensing or educational background of reviewer
- Case Examples

# Additional Support

## Medical Necessity in Private Health Plans (HHS)

[http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp\\_publications/pubuploads/dhpPublication\\_3A45C497-5056-9D20-3DAA24F165B5678A.pdf](http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/pubuploads/dhpPublication_3A45C497-5056-9D20-3DAA24F165B5678A.pdf)