Medical Necessity and Due Process

What is the significance of "medical necessity" in a managed care contract?

The standard for determining whether care is "medically necessary" in a managed care setting has become an issue of national importance. Generally speaking, managed care organizations (MCOs) will pay for "covered services" that are "medically necessary." However, MCOs across the country have taken control of medical decisionmaking by blurring the definition of medical necessity—a clinical determination—with covered services—a business determination. At the same time, MCOs specifically disclaim any responsibility for medical decisionmaking and seek to place all liability on physicians.

Some managed care contracts leave the determination of medical necessity squarely in the hands of the MCO medical director with no stated role for the treating physician. This allows the medical director to override the treating physician's decision. A medical necessity definition without a clear role for the treating physician is harmful to patients and physicians operating in a managed care environment.

Equally troubling is the fact that many MCOs factor cost criteria into the definition of medical necessity. It is the position of the AMA that cost containment has no place in medical necessity determinations.

Section 1.11 of the AMA Model Managed Care Contract defines medical necessity as:

> *Health care services or procedures that a prudent physician would provide to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease or its symptoms in a manner that is (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate in terms of type, frequency, extent, site, and duration; and (c) not primarily for the economic benefit of the health plans and purchasers or for the convenience of the patient, treating physician, or other health care provider.*

How does "medical necessity" relate to "covered services"?

"Covered services" refer to the medical services and procedures that the MCO has specifically stated that it will cover under the enrollee's benefits package. MCOs have an obligation to clearly inform physicians in their contracts and consumers in their subscriber agreements about what services and procedures are "covered." However, MCOs often use the terms "non-covered" and "not medically necessary" interchangeably, which is confusing to patients. A service or procedure may be "non-covered" or excluded from the MCO's coverage, despite the fact that the service or procedure is determined to be medically necessary by the treating physician.

How does the AMA Model Managed Care Contract address the distinction between "medical necessity" and "covered services?"

In addition to using the "prudent physician" standard to define medical necessity in Section 1.11, Section 2.4 provides that covered services provided through the agreement must be specifically described in an exhibit to the contract. If the MCO fails to do so or does so in a non-specific manner, the MCO is required to pay the physician his or her billed charge for the service or procedure performed.

What can be done if a MCO overrules a physician's clinical judgment that a service or procedure is medically necessary?

Physicians play a critical role in helping their patients navigate the process of appealing a medical necessity denial. There are several important avenues of appeal available.

- **United States Department of Labor (DOL) regulations**

In 2000, the DOL issued regulations that provide important protections to patients who receive their health insurance through an Employee Retirement Income Security Act (ERISA) plan, whether fully-insured or self-insured. The "regulations require ERISA plans to process claims within a certain time period and also to make timely decisions when a claim for benefits that were denied is appealed. If state law provides more generous patient protections than the DOL regulations, then state law applies. Under the DOL regulations, the MCO is required to have procedures in place that adopt the following timelines:

- Urgent care claims must be decided by the MCO no later than 72 hours after receipt of the claim. Any appeals must also be decided within this period.

- Pre-service claims must be decided no later than 15 days after receipt of the claim. Appeals of pre-service claims must be decided within 15 days of the submission of appeal.

- Post-service claims must be decided not later than 30 days after receipt of the claim.

The regulations also require that if the claim for benefits is denied because the service or procedure was determined to be not medically necessary or was determined to be experimental treatment, the plan must disclose an explanation of the scientific or clinical judgment for the determination, applying the terms of the patient's plan. Once the decision is rendered, the MCO cannot require more than two levels of internal appeal before the patient can go to court to challenge the benefit denial under ERISA. The MCO's procedures also cannot include mandatory arbitration that would prevent the patient from filing a lawsuit.

The DOL has issued "frequently asked questions" (FAQs) about the regulations, which are available at ***http://www.dol.gov/ebsa/FAQs/faq_claims_proc_reg.html***. The FAQs make clear that with respect to urgent care, a plan must permit a treating physician to act as an authorized representative of the patient. With respect to pre-service care, the claims procedure cannot preclude an authorized representative of a patient from acting on his or her behalf, but the plan can establish procedures for determining whether an individual has been authorized to act on the patient's behalf.

Physicians should be aware of these regulations and be prepared to help their patients, especially in the case of urgent care situations.

- **Independent external appeal**

Forty-three states and the District of Columbia have enacted laws that require an independent external review process for appeals of adverse medical necessity decisions. It is critical that physicians and patients take advantage of these processes if a MCO has overruled a physician's medical necessity judgment. A significant number of external review decisions on medical necessity are in favor of patients. External appeals laws require that patients exhaust internal appeals processes before accessing the external appeals processes. To learn about your state's external review process, contact your state medical association.

In a victory for patients and physicians, in 2002, the U.S. Supreme Court in *Moran v. Rush Prudential HMO*, held that the Illinois HMO Act, which provides for external review of medical necessity decisions, was not preempted by ERISA. The AMA and the Illinois State Medical Society filed "friend of the court" briefs in support of the plaintiff, Debra Moran, in both the U.S. Court of Appeals and the U.S. Supreme Court. The *Moran* decision makes clear that external review laws applicable to fully-funded health plans, like the Illinois law, are not preempted by ERISA. However, the Supreme Court did not rule on whether the Illinois HMO Act applied to patients who receive their insurance through self-funded plans. This is another reason the DOL regulations are so important.

Does the AMA Model Managed Care Contract provide physicians a right to appeal adverse medical necessity or coverage decisions?

Yes. Section 5.2 of the AMA Model Managed Care Contract requires that adverse decisions relating to medical necessity or coverage are subject to a due process review that is ultimately decided by independent peers, rather than by the MCO in its sole discretion. This process closely resembles the peer review process traditionally found in hospital medical staff bylaws. It also must be consistent with the laws of the states in which services are provided, including any external appeals laws.

What is the AMA doing to address the continuing lack of accountability on the part of MCO's for their medical necessity decisionmaking?

The AMA continues to advocate that health plans be held responsible for their medical necessity decisions that harm patients. The AMA does not believe that when ERISA was passed in 1974, Congress envisioned managed care as it exists today or that ERISA would function as a barrier to accountability of health plans making medical treatment decisions. The AMA believes that Congress has the responsibility to determine what approach is most appropriate to protect Americans from medical necessity decisions that are made by health plans.