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CORRESPONDENCE MEMORANDUM

DATE: October 19, 2012

TO: Group Insurance Board

FROM: Emily Loman, Manager, Alternate Health Plans
Bill Kox, Deputy Administrator, Division of Insurance Services

SUBJECT: Appeals Process Related to Cases of Medical Necessity

This memo is for informational purposes only. No Board action is required.

Background

At the request of a member of the Group Insurance Board (Board), the Department of Employee Trust Funds (ETF) has reviewed whether ETF and the Board should cease providing administrative review of disputes, such as medical necessity, that are eligible for independent review under Wis. Stat. §632.835 and Wis. Admin. Code § INS 18.11.

The independent review process was established under 1999 Wisconsin Act 155. The law requires that all health benefit plans develop internal grievance procedures and independent review procedures. The law also allows an insured to request an independent review of an adverse medically necessary determination or an experimental treatment determination. Independent Review Organizations (IRO) can review claims disputes and order payment of a treatment or service. However, IROs do not have the authority to order payment of a treatment or service that is specifically excluded under the group health insurance contract. IRO decisions are final and binding. Historically, determinations of medical necessity, experimental treatment, and referrals were reserved to the health plans, as set forth in the contract.

Board	Mtg Date	Item #
GIB	11.13.12	3E

Reviewed and approved by Lisa Ellinger, Administrator,
Division of Insurance Services

Lisa Ellinger
Signature

10/29/12
Date

Under statute, independent review is available whenever a health plan denies coverage because it maintains that the treatment is not medically necessary or is experimental. Independent review of medical necessity also includes denial of a member's request for out-of-network services when the member believes the clinical expertise of the out-of-network provider is medically necessary. Independent review is also available whenever a health plan denies coverage for treatment based on a pre-existing condition exclusion or rescission.

Independent review is not available if the requested treatment is not a covered benefit. For example, independent review is not available if the contract specifically excludes coverage of a treatment even if the participant believes treatment is medically necessary. Independent review is not available to determine whether premium was paid on time. These types of disputes would still be subject to administrative review by ETF and the Board.

ETF first considered the scope of the IRO law in 2002, when the independent review process was initially implemented. At that time, ETF recommended to the Board that ETF send Health Maintenance Organization (HMO) participants a letter explaining that members may request an ETF review, but the review would cease once the health plan notifies ETF that an Independent Review has been requested. In accordance with Wis. Stat. §632.835 and Wis. Admin. Code § INS 18.11, ETF also recommended that the letter explain that participants have no further right to administrative review by the ETF or the Board once the IRO decision is rendered. Section 2.10 (2) of the State and Local contract reflect this policy.

Staff recommended in 2002 that the Standard Plan administrator offer independent review to participants according to a policy that parallels the HMO in order to provide a less cumbersome process with more streamlined results.

In 2002 staff also acknowledged that determinations regarding medical necessity, experimental/investigative treatments, and related issues such as custodial care had been the most troublesome for administrative review by ETF and the Board because ETF has no medical staff. Staff believed it was more appropriate for these types of disputes to be handled by IRO, which have medical expertise available, and that claimants should have the option to seek a binding review.

Discussion

In light of the Board member's request, ETF has decided that, effective January 1, 2014, if a dispute is eligible for independent review, the ETF will no longer issue a Departmental Determination. This means that disputes concerning medical necessity, experimental treatment, and referrals would not be subject to administrative review by

the ETF and the Board. If a dispute appears eligible for IRO, but the IRO determines it is outside of its jurisdiction and declines to take it, the matter can be reviewed by the ETF and the Board. The intent of this policy change is to direct these disputes to the most appropriate forum.

In arriving at this decision, ETF considered both arguments in support of and against discontinuing administrative review in medical necessity cases. On balance, ETF thinks that the arguments in support of discontinuing administrative review are stronger than those arguments against it.

ETF considered the following arguments supporting discontinuing administrative review in medical necessity cases:

- Eliminating administrative review would simplify the appeal process for members whose claim denials are eligible for independent review. Although members have the option to file a civil lawsuit against the agency and the health plan following a health plan's final grievance decision, members may not concurrently file a civil lawsuit and request an independent review. Since the decision of an IRO is final and binding, the decision of the IRO may not be reviewed in civil litigation. While it might be argued that the Department could see an increase in lawsuits brought against it at the earlier stages of a dispute, this is highly speculative. The Department thinks that the great majority of members will prefer independent review over filing a civil lawsuit because of lower costs, more rapid decision making, simpler procedures, and greater ease of self-representation.

  By not presenting an option for administrative review of medical necessity cases to those members who are determined to file a civil lawsuit against the Department, the Department will not incur costs defending actions in two forums. It would probably be less expensive for the Department to litigate first in those particularly tough cases where the problem will not be finally resolved by even the full administrative process.

- The independent review process is quicker for members and is a meaningful review. In 2011, the independent review process overturned approximately 30% of plans' adverse decisions in the State Group Health Insurance program. The independent review process also allows a member to make a request for an expedited review when the situation involves a medical condition where the time for completion of a standard independent review would seriously jeopardize the member's life or health.

- Medical experts trained in the particular fields at issue will hear cases rather than a citizen board comprised of non-medical experts. Now that the IRO process has

been in existence for about ten years, staff has greater confidence in the IRO process to more consistently render fair results of disputes that require medical expertise.

ETF considered the following arguments against discontinuing administrative review in medical necessity cases:

- Eliminating administrative review of medical necessity would eliminate judicial review of an administrative decision in these types of cases. Courts called on to review administrative decisions usually defer to the agency's determination. A deferential review is typically less demanding on a court. However, this argument is predicated on the assumption that an agency decision is rendered by administrators with greater technical backgrounds who can reach more factually accurate decisions than a court. Since the GIB is comprised of citizens with non-medical training, a court may do just as well as the GIB in reaching a factually accurate decision in medical necessity cases even without the benefit of deferential review.

- Eliminating administrative review of medical necessity places members into two categories: one with administrative review rights and the other with only independent review rights. This type of dual grievance track could create a perception of unfair treatment by the Department. Administrative issues could also arise if a member does not clearly state the nature of his or her case and, as a result, is placed in the wrong category for appeal rights.

- The ultimate effect of the Patient Protection and Affordable Care Act on the independent review process is unknown at this time. However, it is likely that over time our health plans will be governed by the federal appeals process, which will include a greatly expanded subject matter jurisdiction for the independent review process. This could mean that the GIB would eventually lose authority over virtually all insurance claim denial cases.

Under this policy change, if a member requests a Departmental Determination for medical necessity, experimental treatment, or referral, the appropriate ETF staff will send the member a letter explaining that ETF will not provide administrative review because the dispute is eligible for IRO. The letter also provides IRO rights and emphasizes that the decision of the IRO is final and binding.

ETF will use the same IRO procedure for the Standard Plan for consistency of administration.

ETF will review any future determinations by OCI about which types of disputes are eligible for IRO before deciding whether such disputes should go to administrative review by ETF and the Board or go to IRO.

This policy change will apply to disputes relating to treatment or services performed on or after January 1, 2014. By implementing this change in 2014, the Department will have sufficient time to amend relevant contract provisions for the 2014 benefit year, provide pertinent guidance on implementation to health plans, and further analyze any potential impacts of PPACA.

Staff will be available at the November 13, 2012, meeting to answer any questions.