

Independent Review Key to Fairer Health System

Texas' independent review system works but does not apply to many patients. Expanding access to independent review will help resolve payment disputes when doctors have provided care but can't get paid because the insurer questions "medical necessity."

The prompt payment of health care providers has recently been a key issue in Texas managed care debates. Often a delay in payment is caused by a disagreement between the health plan and the health care provider as to whether the care received by a patient was medically necessary or appropriate. A patient may be unaware of this debate and find out services will not be covered long after receiving the care.

The "prompt pay" solution should include making the independent review process available to all patients who have been denied coverage for services based on medical necessity or appropriateness through the utilization review process, including those whose services have been denied *after* the care has been provided.

review in which the health plan, or a utilization review (UR) agent on behalf of plan, determines if that service is medically necessary. Depending on the type of managed care plan—HMO or preferred provider organization (PPO)—and the service being reviewed, UR takes place at different times: before treatment is provided (prospective), during the course of treatment (concurrent), or after the care is delivered (retrospective).

Currently only patients who are denied coverage prior to or concurrent with receiving services have access to an independent review. Most of them are covered by HMOs. Patients denied coverage for care retrospectively can only seek review by the health plan that denied the service in the first place. Most of these people are covered by PPOs.

of retrospective denials of care. Prior to that, retrospective denials of care were treated in the same manner as the prospective and concurrent denials. According to the Texas Medical Foundation, the only IRO at that time, about half of the reviews done in the first year involved retrospective denials.

Today, a person who requests an independent review after their care has been provided is advised by TDI that an internal appeal to their health plan is their only option. In light of the findings of the recent Consumers Union analysis of independent reviews in Texas (see back), many claims being questioned for prompt payment could be settled quickly by an independent reviewer's decision.

RECOMMENDATION

- Texas independent review should be made available to consumers who have received care and are denied p a y m e n t retrospectively, using the same process as for prospective and concurrent reviews.
- The Texas Department of Insurance should analyze reviews to determine whether changes in insurance company payment guidelines are needed.



THE TEXAS INDEPENDENT

REVIEW LAW

U n d e r managed care, patient access to certain services is subject to a process called u t i l i z a t i o n

HISTORY OF INDEPENDENT REVIEW IN TEXAS

The Legislature created independent review in 1997. The review, done by an independent review organization (IRO), has proved to be a valuable tool for consumers who are unfairly denied medical services.

In 1999, TDI declared that the law did not allow for independent review

In Short

Currently, independent reviews are only available for people who are denied care before or during the time the care is being given (concurrent review) but people who get the care only to find that the insurer won't pay for it have been excluded from the IRO process.



Independent Review Gets Needed Care to Patients

(Based on May 2002 CU analysis of IRO process)

Five years after the Texas Legislature passed the law creating an independent review process, Consumers Union evaluated its effectiveness, studying 263 review decisions filed during a six-month period in 2001. We found that consumers benefit from independent review because the reviewers overturn the worst kinds of insurer denials but also hold doctors to a standard of medical necessity that discourages unnecessary hospitalization or therapies.

FINDINGS

Overall, the independent review system appears to work for both consumers and the larger health finance system. Consumers receive an unbiased assessment of their individual medical needs, but reviewers do not approve care that is not supported by the medical record or where reasonable alternatives are available.

- The reviewers overturned slightly more than half of the health plan/HMO denials. Out of the 263 cases we reviewed, 55% were either completely or partially overturned. In all the overturned cases, consumers were able to get more care covered by their health plan/HMO.

- Health plans/HMOs consistently deny and are overturned on the same issues – mental illness treatment, gastric bypass for obesity, and substance abuse treatment. This raises concerns about health plan practices with respect to these conditions. Patients released prematurely from an outpatient setting may land right back in the hospital, in worse condition than before.

- Mental health and substance abuse treatment constitute only 8% of the nation's medical care costs; private insurance only pays 27% of the price. Yet, these conditions together accounted for 38% of care denials sent for independent review in our sample. 70% of mental health treatment denials by health plans/HMOs were overturned.

- Independent reviewers rarely overturned a health plan's decision not

to pay for certain drugs. Typically, reviewers supported alternatives proposed by the plan.

Despite the strong likelihood of additional care, the number of reviews remains relatively small. Health plans/HMOs make thousands of coverage decisions each week, yet only 587 cases were settled by independent review in 2001. Health plans/HMOs may be making better coverage decisions now that someone can take an independent look.

But the low level of use is more likely due to discouraged consumers who must be denied twice by their health plan/HMO before accessing an independent reviewer. When care is denied the first time, the patient must first ask the HMO to review its own decision. Once the HMO denies again, the patient can ask for an *independent* review.

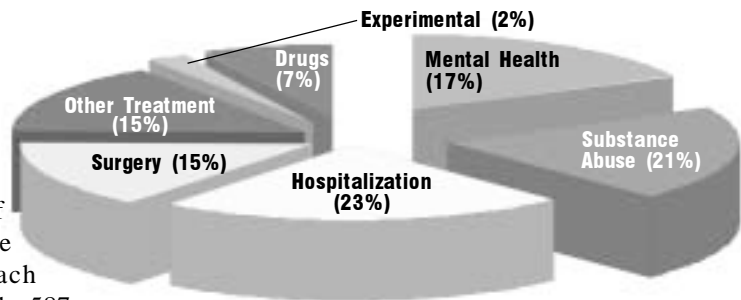
Also, people with PPO and employer-based ERISA coverage have not been guaranteed access to the system until recently. In December 2002 the Fifth Circuit Court determined that Texas's independent review is not pre-

empted by ERISA, a federal law regulating employer benefit plans. This decision reversed the Court's previous determination, guaranteeing millions of Texans who get their health coverage through their employer the right to use the independent review process.

Now, the Texas Legislature should make the process available to all Texans by clarifying that the law applies to retrospective reviews.

The independent review process helps both consumers and the managed care system because gets medically necessary care to patients before damage has been done. Once patients have the care they need and know it will be properly covered by their insurance, they are less likely to seek redress through the courts.

IRO CASES BY TYPE OF TREATMENT: MENTAL HEALTH AND SUBSTANCE ABUSE DENIED DISPROPORTIONATELY



INDEPENDENT REVIEWERS OVERTURN HMO DENIALS MORE THAN HALF THE TIME

