

5303

Testimony of the
Connecticut ENT Society
Connecticut Urology Society
Connecticut Orthopaedic Society
Connecticut Society of Eye Physicians
Connecticut State Society of Anesthesiology
Connecticut Chapter of the American College of Surgeons
Connecticut Chapter of The American College of Cardiology
Connecticut Dermatology and Dermatologic Surgery Society

On HB 5303, An Act Requiring Reporting of Certain Health Insurance Claims Denial Data.

Before the Insurance and Real Estate Committee
On
March 4, 2010

Good Afternoon, Senator Crisco, Representative Fontana and other distinguished members of the Insurance and Real Estate Committee, for the record my name is Dr. Bill Ehlers and I am a board certified ophthalmologist practicing at UCONN medical center. I am also the legislative chair of the Connecticut Society of Eye Physicians and am here to represent over 2500 physicians in the medical fields of Ophthalmology, Otolaryngology, Dermatology, Orthopaedics, Anesthesiology, Cardiology, General Surgery and Urology to support HB 5303.

First, I would like to thank this committee for raising this important consumer advocacy bill, which looks to strengthen and continue the transparency movement this committee has long supported with regard to healthcare. As many of you know, physicians have been seeking better information on where the healthcare dollars are being spent and we agree that it is also important to report on services that are being denied coverage in Connecticut. HB 5303 takes bold steps to make this information transparent to both consumers and providers. We do believe, however that some simple amendments will go a long way toward strengthening the bill, improving full disclosure and creating the kind of transparency that will make the consumer report card a valuable consumer tool.. Medical claims often include multiple services and diagnoses on one claim. A patient may come in to have their eye pressure monitored for glaucoma and in the course of the examination is found to have a suspicious lesion on the eye lid, which is removed and sent to a lab for pathology, rather than have the patient return days later to have the procedure done. The physician bills for the glaucoma examination with a glaucoma diagnosis, and he bills for the surgical procedure using procedure and diagnosis codes specific to the removal of the suspicious lesion, all on the same claim form. Many times the Managed Care Organization will not deny the whole claim but will deny part of the claim- either the code for the exam or the code for the procedure.

We believe if we amend the language in lines 82 and 83 we can better capture these types of denials of services or procedures. The language we are suggesting is-

82 numbers of claims denied; **including claims that have multiple procedures or services where at least one service or procedure is denied coverage on the claim**(C) the total number of denials that were
83 appealed; **or partially appealed** (D) the total number of denials that were reversed upon
84 appeal; (E) (i) the **specific** reasons for the denials, including, but not limited to,
85 "not a covered benefit", "not medically necessary" "**experimental**" and "not an eligible
86 enrollee", (ii) the total number of times each reason was used, and (iii)
87 the percentage of the total number of denials each reason was used;
88 and (F) other information the commissioner deems necessary.

Additionally we would like the word specific added to line 84 and experimental added to the reasons for denial. Providers are often perplexed to see a prescribed and acceptable form of treatment get denied with an explanation from the managed care company listing "experimental" as the reason for the denial on the explanation of benefits.

In closing, we would like to support this important piece of legislation for consumers and hope that you will consider the language we offered to help address some of the issues providers are seeing when it comes to the denial of care by the industry.