

**TESTIMONY**

**Connecticut Orthopaedic Society  
Connecticut ENT Society  
Connecticut Urology Society  
Connecticut Society of Eye Physicians  
Connecticut Dermatology & Dermatologic Surgery Society**

**In Support of**

***Senate Bill 54, An Act Concerning Uniform Preauthorization Standards for Health Care Providers and Health Insurers***

**Committee on Insurance and Real Estate - February 17, 2011**

Senator Crisco, Representative Megna and Members of the Insurance and Real Estate Committee, on behalf of the members of the Connecticut Orthopaedic Society and members of four statewide medical specialty societies, thank you for the opportunity to present this testimony to you in support of Senate Bill 54, An Act Concerning Uniform Preauthorization Standards for Health Care Providers and Health Insurers.

I am Dr. Robert Green, a board-certified orthopaedic surgeon in Hartford, member of the State Medical Examining Board, Assistant Clinical Professor at UConn School of Medicine and Past President of the Connecticut Orthopaedic Society and I am here this afternoon to strongly urge your support of this legislation.

Last year, the Connecticut Orthopaedic Society had the pleasure of meeting with Senator Crisco and Speaker of the House Representative Christopher Donovan on the necessity for pre-certification and pre-authorization standards and we appreciate the ongoing legislative commitment to correct the inadequacies associated with insurance precertification and preauthorization and subsequent reimbursement to the physician community. The physician community has long ago adhered to the specific and burdensome preauthorization and precertification procedures required by managed care organizations and utilization review companies, at significant administrative costs and sometimes delays in patient care to obtain the appropriate approval. Some contracts require us to confirm that a service is not covered in order for us to bill the patient. And while we have reluctantly incorporated these mandates into our business practice, what is not acceptable is that after the formal approval process is completed, authorization received and care is provided, the very entity that approved the

care reneges on payment to the physician and burdens the patient with the very bill they certified for payment.

Over two years ago, I had a patient who had a severely arthritic hip and in need of surgery. The surgery was pre-certified by my office per United Healthcare's mandate, the surgery performed and one month later United Healthcare denied payment not only for my services but also the hospital care the patient received. This was the impetus for our Society meeting with representatives from the Office of Healthcare Access to address the impact of this unfair and burdensome business practice on our patients.

Our patients also rely upon the process to pre-certify, pre-authorize or pre-determine a service or procedure which gives them peace of mind, during stressful times, that the insurance coverage they or their employer pay a high premium for covers the cost of that specific service or procedure. When it is retroactively taken away, the patient is forced to pay or navigate through a lengthy and oftentimes unsuccessful appeal process.

We urge you to apply a common business principle, reimbursement for service provided, be applied to the contractual relationship between physicians and health care insurers with no reversal or retroactive period.

To this end we appreciate members of the legislature for their recognition of the problem and commitment to solve the issue so patients and physicians are not left shouldering the financial responsibility of the insurer.

Our Society has developed draft language that specifically addresses this issue and we look forward to meeting with leadership and Committee members to properly and succinctly define the language of the bill to have a consistent standard for pre-certification, pre-authorization and pre-determination to ensure that common and fair principles be afforded to the physician community so patients can be assured that services and procedures pre-certified, pre-authorized and pre-determined will be paid by the health care insurer.

Thank you.

**SB 54 AN ACT CONCERNING UNIFORM PREAUTHORIZATION STANDARDS FOR HEALTHCARE PROVIDERS AND HEALTH INSURERS.**

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Sec. 4. Subparagraph (A) of subdivision (1) of subsection (a) of section 38a-226c of the 2010 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2012*):

- (A) Notification of any prospective determination and/or preauthorization by the utilization review company, by issuance of an authorization number or other method that is the standard for all prior authorizations for that insurer, shall be mailed or otherwise communicated to the provider of record or the enrollee or other appropriate individual within two business days of the receipt of all information necessary to complete the review. Any determination not to certify an admission, service, procedure or extension of stay shall be in writing. After a preauthorization for admission, service, procedure or extension of stay has been communicated to the appropriate individual, based on accurate information from the provider, the utilization review company [may] shall not reverse such authorization and no insurer, health care center, fraternal benefit society, hospital service corporation, medical service corporation or other entity responsible for paying claims shall refuse to pay for such admission, service, procedure or extension of stay if such admission, service, procedure or extension of stay has taken place in reliance on the authorization.
- (B) Providers may seek an authorized predetermination of covered procedures and services by the insurer, for procedures and services that do not require precertification or preauthorization by the insurer. If such prior determination is sought, the provider shall be notified of predetermination and coverage eligibility, by issuance of an authorization number or other method that is the standard for all prior authorizations for that insurer, of the insured within two business days of receipt of the request. Upon authorized predetermination, no insurer, health care center, fraternal benefit society, hospital service corporation, medical service corporation or other entity responsible for paying claims shall refuse to pay for such admission, service, procedure or extension of stay if such admission, service, procedure or extension of stay has taken place in reliance on such determination.
- (C) Sec. 5. (NEW) (*Effective January 1, 2012*) An insurer, health care center, fraternal benefit society, hospital service corporation, medical service corporation or other entity delivering, issuing for delivery, renewing, amending or continuing an

individual or group health insurance policy or medical benefits plan in this state providing coverage of the types specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes, that preauthorizes an admission, service, procedure or extension of stay other than through a utilization review company, as defined in section 38a-226 of the general statutes, shall not reverse such preauthorization or refusal to pay for such admission, service, procedure or extension of stay if such admission, service, procedure or extension of stay has taken place in reliance on such preauthorization.

**Statement of Purpose:**

To establish uniform standards for health care providers and health insurers for the preauthorization, certification and/or predetermination of an admission, service, procedure or extension of stay.