Connecticut State Medical Society

[illegible] (203) 865-0587 FAX (203) 865-4007

FTR

Connecticut State Medical Society
Testimony in Support of Senate Bill 1082 An Act Concerning Utilization Review
Insurance and Real Estate Committee
March 1, 2011

Senate Crisco, Representative Megna and members of the Insurance and Real Estate Committee, my name is Ken Ferrucci and I am the senior vice president of legislation and society affairs for the Connecticut State Medical Society (CSMS). On behalf of our more than 7,000 physicians and physicians in training, thank you for the opportunity to present this testimony to you today in support of Senate Bill 1082 An Act Concerning Utilization Review.

We appreciate the effort of the committee to clarify the requirements and standards for utilization review companies and the reviews such companies perform tied to medical care provided to patients. CSMS believes that for the most part, this bill assists physicians, and more importantly their patients, in the quest to have treatment determinations made in a prompt fashion, and to ensure that treatment assessments are not overruled after medical care has been provided, as long as appropriate information is provided at the time utilization review is performed.

This bill redefines "utilization review" to include *retrospective* assessments of the necessity and appropriateness of the allocation of the health care services given or proposed to be given to a patient. Under the current definition, utilization review includes prospective and concurrent assessments. We believe that this further protects the patients receiving the care and the physicians who provide the medically necessary care.

Furthermore, this bill creates a rather straightforward definition for "adverse determination" tying it to a utilization review company's decision as to whether or not an admission, service, procedure or extension of stay being provided is medically necessary, which should provide further benefit to the patient wishing to receive the medical care in question. The language also contains a clear definition of Medical Necessity as was passed in Public Act No. 07-75.

The bill also clarifies that after a prospective determination that authorizes a procedure has been communicated by the utilization review company to the provider/enrollee, the company <u>shall</u> not reverse such determination if such procedure has taken place in reliance on such determination, unless the determination was based on inaccurate information from the provider.

If a physician requests a concurrent determination, the bill would require the utilization review company to provide, if requested by the physician, an opportunity for such physician to discuss the request for concurrent determination with the health care professional making the determination. This is very important when dealing with time-sensitive and medically necessary patient care.

The bill requires any adverse determination to be made by a licensed health care professional. We strongly recommend adding language to clarify that the licensed health care professional must have

experience in providing the medical care in question or at least expertise in the clinical area in question.

The bill shortens the timeframe within which a utilization review company must notify the enrollee and physician of its determination from no later than thirty days to no later than fifteen days. Despite this shorter time period, nothing appears to prevent the companies from "gaming" the system through delay tactics (e.g., repeated requests for additional information). We recommend that a company be entitled to no more than two requests for information, and that the fifteen-day response period be extended by no more than five days in the event a second information request is necessary.

The bill would require utilization review companies to use clinical criteria and review procedures consistent with the amended definition of "medical necessity" which further supports patient care and a physician's medical necessity determination.

Under present law, utilization review companies may include, but do not have to include, a reasonable period within which a patient or physician can file an appeal for an adverse determination. This bill imposes a specific time period of not less than ninety days after the issuance of an adverse determination within which to file an appeal. We believe that this allows the patient and the patient's physician to more effectively and appropriately appeal any adverse determination.

This bill also shortens the time period within which the utilization review company must complete the adjudication from two days to not later than one business day after the date the appeal is filed and all information necessary to complete the appeal is received by the company. Given our concern for continued gaming of the system of utilization review, we recommend that the same "anti-gaming" provision suggested above be included in this section to safeguard the process and prevent abuse.

Finally, if adjudication upholds an adverse determination, the company shall notify the enrollee/enrollee's provider. In the case of a final adjudication, the notice shall contain the procedure to appeal to the commissioner pursuant to Conn. Gen. Stat. § 38a-478n. Under the current law, an enrollee or provider acting on behalf of the enrollee who has exhausted all internal appeal mechanisms, may appeal an adverse determination to the commissioner within sixty days after receiving final written notice of the determination.

The bill before you today, with the suggested amendments would appropriately strengthen our current Utilization Review law, providing a more equitable system for both patients and physicians. Please support SB 1082 with our recommended changes that go toward improving patient access to medically necessary care.