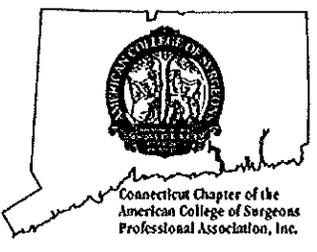
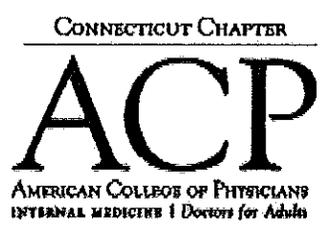


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**Testimony in Support of House Bill 6612 An Act Concerning Insurance Grievance Process For Adverse Determinations, The Office Of the HealthCare Advocate and Mental Health Determinations**  
**Insurance and Real Estate Committee**  
**March 12, 2013**

Senator Crisco, Representative Megna and members of the Insurance and Real Estate Committee, on behalf of the almost 8,500 physicians and physician-in-training members of Connecticut State Medical Society (CSMS) and the Connecticut Chapters of the American College of Physicians (ACP) and the American College of Surgeons (ACS) thank you for the opportunity to testify in support of House Bill 6612 An Act Concerning Insurance Grievance Process For Adverse Determinations, The Office Of the HealthCare Advocate and Mental Health Determinations.

We appreciate the ongoing effort of this committee, as well as the Office of Healthcare Advocate, to strengthen to process for both internal and external review when determinations of medical necessity are made. House Bill 6612 is yet another example of those activities. HB 6612 will increase protections and safeguards for physicians and patients when put in the unfortunate situation when necessary care is denied by a health insurer.

The bill rightfully adds to the definition of an "Urgent Care Request," in addition to a situation in which a covered individual would be subject to "severe physical pain, substance abuse disorders and mental disorders for both inpatient or intensive outpatient services." We consider this an integral issue of mental and behavioral health parity and an acknowledgement of the urgency often presented by emotional or psychological pain and the need for rapid coverage decisions so that patients can receive the medically necessary care as prescribed by the treating physician.

CSMS also strongly supports the inclusion of language in House Bill 6612 making significant additions to the current Utilization Review Statutes regarding reviews in which substance abuse and mental health requests are involved. In the appropriate situations, review criteria must be based on the American Society of Addiction Medicine's Patient Placement Criteria or the American Academy of Child and Adolescent Psychiatry Child and Adolescent Service Intensity Instrument.

Also, CSMS strongly supports that in situations when an urgent care request is made, the timeframe for a response from the insurer should be shortened from seventy-two hours to twenty-four hours for the benefit of the patient. Any prudent individual would consider waiting three days for a decision in an urgent situation far too long, regardless of the diagnosis, the condition being treated, or the medical treatment prescribed. In addition, CSMS believes it is

critical that the twenty four hour period also be instituted in situations where a service has been denied and a request for an "expedited review" of the denial has been made by the patient, or by the physician serving as the patient's representative.

Further, CSMS supports the language of the bill that adds protections to covered patents by clarifying that in situations in which ongoing care has been terminated by the insurer and the covered patients has appealed the decision, care must continue during the pendency of the appeals process. More importantly, no liability is placed on the patient during the time the insurer is making the appeal determination.

Finally, the language before you today seeks to provide some adjustments in the insurers' required internal utilization review process consistent with provisions of state statute. In too many situations, utilization reviews and benefits determinations are being made by individuals with no clinical experience or training in the service for which they are making critical decisions that may result in the denial of care that directly impacts the health and safety of the patient. For the physician whose clinical judgment is being questioned and overturned in this situation, the frustration is compounded by the time, resources and cost added to the system through appeals, use of the external review process, and other efforts to seek coverage for the medically necessary services of their patients. Of course, of greatest risk is the often time sensitive nature of the care being rendered to the patient and the potential affect that this disruption in care could have on the patient care and therefore the patient's recovery.

HB 6612 intends to ameliorate the situation by requiring insurers not only to have procedures in place to ensure that professionals administering the utilization review program consistently apply clinical review criteria in utilization review determinations, but also requires that the appropriate or required clinical peers are designated to conduct utilization reviews and benefits determinations by insurers or their agents.

Section 8 of HB 6612 contains language to amend the current definition of "clinical peer" with the intention of establishing that such reviews and determinations are made by professions from the same specialty as the physician providing the service in question. We appreciate the inclusion of the language in Section 8 as well as the intended outcome. However, for consistency with established state statute we ask that language be amended to state the following:

(7) "Clinical peer" means a [physician or other] health care professional who holds a nonrestricted license [in a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review] in this state or in another state that requires the same or greater qualifications for licensure, and:

(A) Is licensed by the appropriate regulatory agency of this state or another state requiring the same or greater qualifications; and (2) is trained and experienced in the same discipline or school of practice as the health care professional whose care is the subject of an adverse determination, and such training and experience shall be as a result of the active involvement in the practice or teaching of medicine within the five-year period before the incident giving rise to the claim.

(B) For a review or benefit determination concerning a child or adolescent substance use disorder treatment, as such disorder is described in section 17a-458, or a child or adolescent mental disorder, holds a national board certification in child and adolescent psychiatry or child and adolescent psychology, and has training or clinical experience in the treatment of child and adolescent substance use or child and adolescent mental disorder, as applicable.

Thank you for the opportunity to provide this testimony to you today. Please support HB 6612 with the suggested amended language.