Good Day, Senator Gerrantano, Representative Johnson, and esteemed members of the Public Health Committee. For the record, my name is Jeffrey Sandler, M.D. and I am a board certified ophthalmologist practicing in Bridgeport. I am also the past president of the CT Society of Eye Physicians and the current councilor for the American Academy of Ophthalmology. I am here representing over 1000 M.D.s in the specialties of Eye, ENT, Dermatology and Urology in support of H.B. No. 5529 (RAISED) AN ACT CONCERNING THE DEFINITIONS OF MEDICAL NECESSITY.

Medical Necessity is the lynchpin of every healthcare claim. Without it health insurers have a right to deny coverage of any and all procedures or services submitted by a healthcare provider. The terms “medical necessity” or “medically necessary” when used in the determination of medical coverage specifies what services and procedures are allowed or payable by a managed care organization and which services are excluded.

Unfortunately, some insurers make arbitrary and capricious decisions on medical necessity, and it is often difficult to view them as anything other than cost-saving maneuvers. In many instances, insurers base these decisions not on what is standard of care, or commonly accepted practices in the medical community but on the absence of “up to date scientific studies.” One example is the past experience of Connecticut ophthalmologists with regard to Optic Nerve Imaging. Over the past five years, optic nerve analysis by sophisticated imaging equipment has become the standard of care in the diagnosis and treatment of glaucoma. For two years, Aetna routinely paid for this service for their enrollees. Without explanation or warning, except for a notation of being “experimental” on their explanation of benefits, these tests were suddenly denied and no longer covered. At the time, all other major carriers in Connecticut except for Aetna were covering these services for the diagnosis and treatment of glaucoma. Countless hours of administrative time were spent in a battle lasting over six months to reinstate the coverage for these services, which they claimed had no scientific foundation. Ultimately with involvement of the Attorney General’s office, optic nerve imaging was again allowed as a covered service. However, physicians were never paid for the thousands of tests performed during the denial period.

To many, it is hard to understand the need to define “medical necessity”, as every physician who becomes part of a provider panel must submit evidence of their training and credentials for verification by each MCO or insurer. If this process is done properly, a strong argument can be made that anything ordered by a licensed and credentialed provider should be considered medically necessary. Insurers may argue that there is abuse in the system but there are also ways of monitoring performance. Insurers are able to easily monitor the practice patterns of individual providers and compare them to others in the state. In this way, those with unusual practices can be identified and a determination can be made of the reason for the difference. This should provide insurers with the tools to make a determination of the appropriateness of the care being rendered.
Decisions of medical necessity should be left to those in the best position to make that determination: the physician, who is the most qualified professional in determining the proper care of their patients, and not the managed care administrators who do not know the patient nor their individual and unique problems and needs.

In conclusion, we support H.B. No. 5529 (RAISED) AN ACT CONCERNING THE DEFINITIONS OF MEDICAL NECESSITY and hope this committee will keep medical decision-making in the hands of physicians.

Thank you and I will be happy to answer any questions at this time.