IROs

Independent Review Organizations:
Consumers Gain Needed Care When Unaffiliated Medical Experts Review Health Plan Denials

A Report on the Texas Independent Review Process Prepared by Consumers Union SWRO
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Executive Summary

In 1997 the Texas Legislature created an independent review process that consumers could use when their Health Maintenance Organizations (HMOs) denied coverage for treatments and procedures.

It has been close to five years since the Texas Legislature passed the law, and Consumers Union believed that it was time to evaluate its effectiveness. In general we find that Texas consumers benefit from independent review because the reviewers overturn the worst kinds of insurer denials but also hold doctors to a standard of medical necessity that discourages unnecessary hospitalization or therapies.

Consumers Union evaluated 263 review decisions (without any information identifying a patient). We divided the cases into various categories based on the medical issue in question and looked for patterns of care denied or care made available as a result of independent review.

Findings

Overall, the independent review system appears to work for both consumers and the larger health finance system. Consumers receive an independent assessment of their individual medical needs, but reviewers do not approve care that is not supported by the medical record or where reasonable alternatives are available.

- The reviewers overturned slightly more than half of the HMO denials. Out of the 263 cases reviewed by Consumers Union, 144 (55 percent) were either completely or partially overturned and 119 were upheld. We call this the "overturn rate." In all the overturned cases, consumers were able to get more care covered by their health plan.
- About 74% of the requests for review handled by the Independent Review Organizations (IROs) consistently concerned: a handful of contested prescription drugs (19 cases), surgical treatment for obesity (16 cases), mental illness (46 cases), substance abuse (54 cases), and the number of days (if any) required for hospital care for physical illness (60 cases).
- HMOs consistently deny and are overturned on the same issues—mental illness treatment, gastric bypass for obesity, and substance abuse treatment. This raises concerns about HMOs' practices with respect to these conditions, especially when there are clear guidelines that indicate how an IRO will decide.
- Mental health and substance abuse treatment constitute only 8% of the nation's medical care costs, and private insurance only pays 27% of the price. Yet, these conditions together accounted for 38% of care denials sent for independent review in our sample. Mental health treatment denials were overturned much more frequently than the general overturn rate (70 percent overturned or partially overturned).
- Independent reviewers only rarely overturned an HMO's decision not to pay for certain drugs. For the most part, reviewers supported alternatives proposed by the plan.
- Envoy and Independent Review Inc. (IR) overturned HMO denials more frequently than Texas Medical Foundation (TMF). The variance could reflect material differences in approach to treatment worthy of additional investigation.
- Despite the strong likelihood of additional treatment, the number of reviews remains relatively small. Insurance companies make thousands of coverage decisions each week, yet only 587 cases were settled by independent review last year.

This may be because health plans are making better coverage decisions now that someone can take an independent look. The same statute that created independent review also authorized consumers to sue a health plan for care denials.

But the low level of use could be because few consumers have the time and energy to pursue independent review after a discouraging internal review process. (They must be denied twice before accessing an independent reviewer.) Other consumers (those covered by employer based ERISA plans) are not guaranteed access to the system at all. Federal changes to ERISA proposed in the Patient Protection Act would ensure that more consumers could get an unbiased look at their health plan's treatment decisions.

A closer look at POS

Many decision-makers and interest groups, including the growing pharmaceutical industry, now intervene in the medical care delivery process. Consumers may be subject to medical judgement by their doctor, their health plan or Health Maintenance Organization (HMOs), and their Utilization Review Agent. Consumers also seek to make their own decisions and respond to advertising by drug companies.

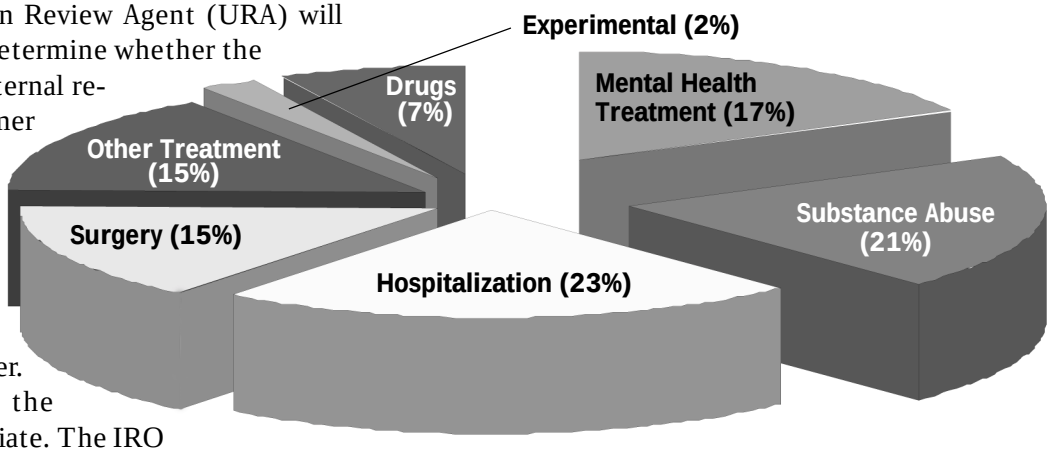
Most of the decision-makers are subject to financial incentives. These include incentives to doctors to reduce referrals. Utilization review agents get paid to reduce over-utilization of services by denying treatments that are not "medically necessary." But overly aggressive denials may become a barrier to the care people really need.

In 1997, the Texas Legislature made an effort to provide consumers a system to address this dilemma.[1] The law devel-

oped a system of accountability for HMOs and health care professionals completely independent of financial incentives. The independent review process allows patients to question their HMOs' determinations and offers insight into doctors' decisions. Similar legislation is currently a topic of debate in Congress.[2]

When a health plan denies access to care, the consumer must first appeal the decision to the HMO itself before seeking a ruling by an Independent Review Organization (IRO). (See "How it Works, p. 6.) A Utilization Review Agent (URA) will conduct an "internal review" and determine whether the original denial was valid. If the internal reviewer also denies care, the consumer may then request an independent review.

TDI assigns the case on a rotating basis to one of three independent review organizations in Texas and checks for any conflict of interest between the IRO and the insurer. The IRO then decides whether the HMO's original finding was appropriate. The IRO decision is binding.[3]



Consumers Union read 263 independent review determinations filed with the Texas Department of Insurance during a six month period between March 22, 2001 and September 26, 2001. The sample represents about half the review decisions in that year. We compared the subject matter of decisions in our sample to simple TDI coding for all decisions and believe our sample is representative of the general independent review activity.

Consumers Union Study

The Texas Department of Insurance (TDI) receives about 500 requests for independent review each year, and distributes them among three independent review organizations (IROs). Consumers Union analyzed every IRO decision completed during a six-month period, from March 22 through September 26, 2001. The sample (263 decisions) included all three review organizations and 63 health plans. We compared this time period to statistics maintained by TDI and found that the sample we

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The Texas independent review law

The 1997 Legislature passed sweeping managed care reforms. Among these, the legislature established an independent review process for persons denied care by their health plan because a utilization review agent made an "adverse determination."[1] An "adverse determination" is a finding that certain health services are not "medically necessary or appropriate."[2] After appealing the adverse determination once within the health plan, the law allows a person to seek an *independent* review from the Texas Department of Insurance (TDI). TDI contracts with three independent review organizations (IRO) to actually perform the reviews.

The bill creating independent review also inaugurated a patient's right to sue his or her health plan, and it quickly became tangled in a lawsuit filed by Aetna.[3] The lower court ruled that the Texas independent review process was preempted by the Employee Retirement Income Security Act (ERISA) and not subject to state law. ERISA regulates employer-based health plans. This ruling put the independent review process out of reach for most people who get health coverage through their jobs. The court ruled similarly regarding some health care provider rights included in the legislation, but said that the liability provision (a person's right to sue) was not preempted.

Both parties appealed the Aetna case to the 5th Circuit, which upheld the lower court decision about independent review. The case eventually landed before the U.S. Supreme Court. The Supreme Court heard arguments in January 2002 on an Illinois case instead (*Rush Prudential HMO, Inc v. Debra Moran, et al)*. In Illinois, the federal court of appeals reversed the judgement of the area's district court, declaring that ERISA did not preempt the state's independent review law. At the time of this report, the Supreme Court had not yet made a decision on the issue.[4]

About 75% of Texans have health insurance, and nearly half of these are covered by an ERISA plan. The court's decision regarding this law removed the state guarantee to an independent review for an estimated 3.9 million Texans covered by ERISA or "self-funded" employer health plans.[5] Since the first court decision, health plans have claimed they like the independent review process and will continue to use it on a voluntary basis until the case is finally settled. However, in ERISA situations, the health insurance company is typically only acting as a third party administrator and employers designing an ERISA plan have the right to accept or reject access to independent review for employees. TDI has no way of knowing how many ERISA covered consumers actually have access to this process.

In 1999, the legislature required that any voluntary participants in independent review must comply completely with the law and regulations governing this process.[6] The law makes the IRO decision binding on the health plan; an ERISA plan that voluntarily adopts independent review cannot decide it doesn't like an IRO decision and refuse to comply with it.

How it works

Utilization review agents (URAs) decide the medical necessity or appropriateness of services for health plans. Some health plans do their own utilization review and others contract out these services.

Whether a consumer asks for approval for a certain treatment up front, or gets the treatment then files a claim later, the utilization review agent must determine that the requested treatment is "medically necessary." If the URA denies access to the care (finding that it is not medically necessary), then the consumer must first file an appeal to the health plan, and someone else in the health plan looks at the case. If again denied, the health plan must send a notice to the consumer with instructions about the independent review process.

When consumers tell the health plan they want an independent review, the URA must forward the request with the necessary background information to TDI. TDI assigns the cases to a certified independent review organization (IRO) after verifying that the IRO is financially independent from the health plan and URA making the original decisions. The IROs don't actually have a finite "panel" to review the cases, but rather they contract with various health care providers and physician specialists so the cases can be reviewed by persons with appropriate expertise. One health care provider typically reviews each case.

The law requires the health plan to pay for the review ($650 for a physician review and $460 for a review by other health care providers such as dentists or podiatrists). The IRO bills the plan.

The health plan must comply with the IRO decision. An IRO is not liable for damages arising from a review decision, unless it stems from an act or omission made in bad faith or gross negligence. *(Texas Insurance Code, 21.58C, Sec. 2 (g))*

Footnotes

[1] Texas Insurance Code 21.58C.

[2] 22 TexReg 11366, November 21, 1997, adopting the initial Chapter 12 rules on the independent review process added the term "or not appropriate" in the definition of "adverse determination" in §12.5. TDI explained "the department believes that the use of the term 'appropriate' is consistent with the intent of the Legislature to ensure that the utilization review process not be used to ration health care by denying treatments which may be appropriate, simply because they are costly."

[3] *Corporate Health Insurance Inc. v. Texas Department of Insurance*, U.S. Court of Appeals for the Fifth Circuit, 215 F 3rd 526, June 20, 2000.

[4] *Rush Prudential HMO, Inc. v. Debra C. Moran, et al.*, U.S. Court of Appeals for the Seventh Circuit, 230 F 3rd 959, October 19, 2000.

[5] "Health Insurance Regulation in Texas: The impact of mandated health benefits," Texas Department of Insurance, Report to the Legislature, December 1998, p. 64-65.

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used is representative of the kinds of disputes reviewed over the past five years.

With all identifying information about consumers and physicians removed, Consumers Union read the reviewer's narrative for every decision, categorized them by illness and procedure, and summarized the relevant medical issues in dispute. The amount of information varied. Some IRO decision letters offered great insight into the medical condition and the decision-making process, while others only included a few sentences with few details. Despite these limitations, Consumers Union could determine the key medical issues in most cases, as well as the standards used by IROs when evaluating these issues.

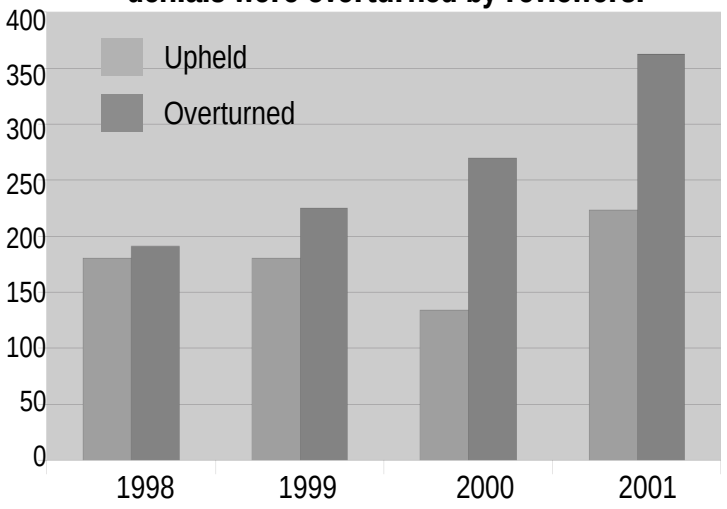
The "overturn rate" is the number of cases where treatment denials are overturned compared to the total sample. We use the term "partially overturned" for cases where the IRO agrees with the health plan on some issues but disagrees on others or where the IRO approves coverage for some additional treatment days but fewer than requested by the consumer.

General Findings

Five years after the law's passage, Consumers Union found that the independent review process is working for consumers. More than half of those who presented their case to an independent reviewer received some additional treatment (55 percent of denials were fully or partially overturned). This is a slightly higher rate than found in nationwide studies of independent review, and slightly lower than the overturn rate in Texas since inception of the system (59 percent overall).[4]

About 74 percent of the requests for review handled by the IROs consistently concerned: a handful of contested prescription drugs (19 cases), surgical treatment for obesity (17 cases), mental illness (46 cases), substance abuse (54 cases), and the number of days (if any) required for hospital care for physical illness (60 cases). The remaining disputes involved a wide array of other treatments (including chiropractic, physical therapy, occupational therapy, durable medical equipment, experimental treatments, and miscellaneous surgeries) from which it was difficult to discern any patterns of care.

Consumers' use of independent review increases each year. In 2000 and 2001 more than 60% of denials were overturned by reviewers.



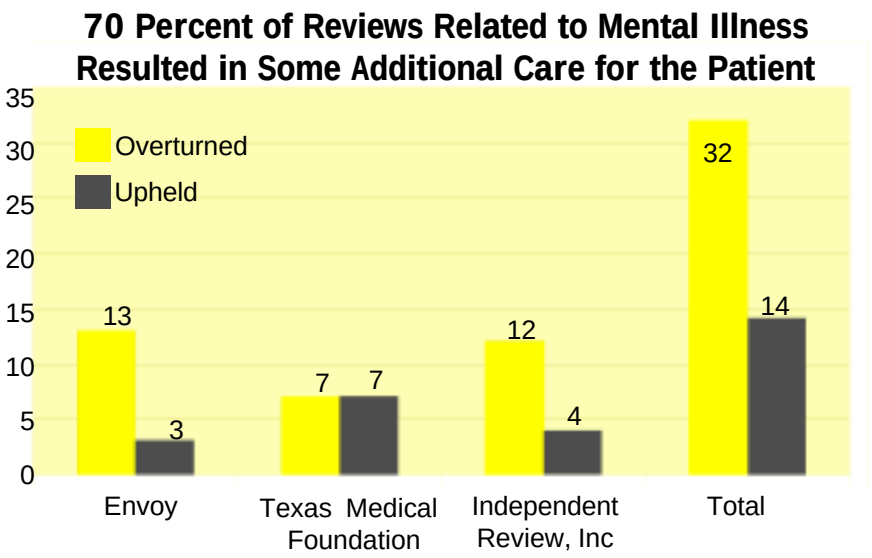
For some conditions--including mental health and severe obesity--IROs consistently overturned treatment denials. This raises concerns about HMOs' practices with respect to these conditions, especially when there are clear guidelines that indicate how an IRO will decide.

Mental health and substance abuse treatment constitute only 8 percent of the nation's medical care costs (and private health insurance pays very little of that cost).[5] Yet, these conditions together accounted for 38 percent of care denials sent for independent review in our sample. Mental health treatments denials were overturned much more frequently than the general overturn rate (70 percent overturned or partially overturned).

In contrast, independent reviewers only rarely overturned an HMO's decision not to pay for name brand drugs. For the most part, reviewers supported alternatives proposed by the health plan.

TDI is distributing the cases evenly among the reviewers as required by law, but Envoy and Independent Review, Inc. (IR) overturned HMO denials more frequently than Texas Medical Foundation (TMF) in our sample. Envoy and IR overturned 54 cases each, about a 62 percent overturn rate. TMF overturned only 36 of its 89 cases, an overturn rate of 40 percent. TMF is the oldest review company, but Envoy joined the system in February, 1998. TDI added IR in December, 1999.[6]

Within certain condition categories, Envoy and IR overturned more health plan decisions than TMF. For example, of the 54 reviews dealing with substance abuse issues, Envoy reviewed 17 and overturned 13. IR, which looked at 21 of these, overturned 13. Of the 16 TMF reviewed, only six were overturned. These differences are only suggestive however, because the number of cases in a specific



treatment category is small, and the specific case histories differ. But the variance could reflect material differences in approach to treatment worthy of additional investigation.

Finally, we find that the number of independent reviews remains low, although the system is now in its sixth year of operation. In 2001, consumers requested only 587 decisions. Since inception in November, 1997, IROs have conducted only 1,864 reviews.[7]

This is consistent with national findings on the use of the available independent review systems around the country. A recent Kaiser study of the 41 states with independent review laws found that only about 4,000 patients appeal HMO treatment decisions each year nationwide.[8]

People may get discouraged. A patient must be denied twice (an initial denial, then an internal review that upholds the first denial) before accessing independent review. Moreover, the independent review process is no longer available for all denials.

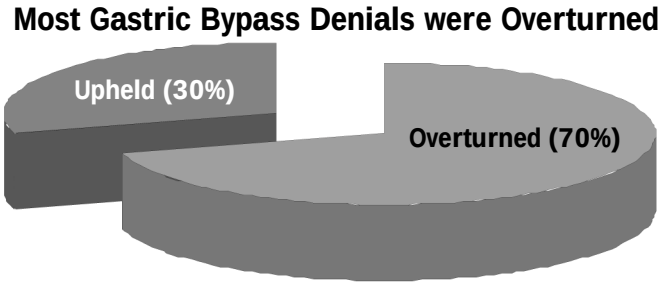
In early 1999, TDI began sending letters to certain patients requesting independent review. The letters said, "if the first time your health benefit plan performed a review of medical necessity or appropriateness was after health care was received, the IRO process is not available to you." TDI interpreted the statute to only cover "prospective" or "concurrent" denials and not those done "retrospectively."

Retrospective review may represent a significant share of the requests for review. In the workers compensation system, now being incorporated into the TDI process, 82 percent of reviews in the last four months of 2001 were "retrospective" reviews. Since some of the cases cited in this report appear to address care retrospectively (care that has already been provided), it is unclear how TDI determines which requests are appropriate to send on to independent review.[9] Without the benefit of independent review, many people end up having to pay for care they believe should have been covered by their health insurance.

More than half of appeals are fully or partially overturned. Consumers who cannot access or who do not pursue their full appeal rights may not be receiving adequate health care. Without either encouraging more consumers to challenge their HMOs' decisions or making some structural changes within the HMO industry itself, patients may fail to get medically necessary treatment and their frustration with the health care industry will only continue to grow.

Gastric Bypass Surgery

HMOs repeatedly denied surgical treatments for morbid obesity, largely gastric bypass. Of the 263 cases studied by Consumers Union, 17 involved morbid obesity and gastric bypass. When consumers fought through the whole review process, the IROs overturned most of these denials (12 overturned, or 70.5 percent), and they did so for essentially the same reasons.



According to the National Institutes of Health 1991 Consensus Conference on "Gastrointestinal Surgery for Severe Obesity," a man with a Body Mass Index (BMI) 40 kg/m^2 and over is "morbidly obese." At this level mortality rates increase. Patients whose BMI exceeds 40 kg/m^2 may be surgery candidates if they strongly desire substantial weight loss. The NIH Consensus Conference also determined that patients with a BMI between 35 and 40 kg/m^2 may also qualify for the procedure if it looks as though they will greatly benefit and it is apparent that they will face health complications if they do not lower their weight.[10]

The IRO upheld the HMO denial if the patient had not participated in a medically-supervised weight loss program prior to requesting surgery.[11] However, one IRO held that the patient had attempted several weight loss programs and qualified for the gastric bypass despite the fact that the diets had not been medically supervised. The reviewer added that the National Institutes of Health Consensus Conference does specify that patients' prior diets be medically supervised in

HOSPITAL CARE STRICTLY LIMITED

Increasingly unwilling to pay for hospital care, HMOs, utilization review agents, and finally independent reviewers struggled to define the minimum amount of inpatient care absolutely necessary to the wellbeing of the patient. Fifty-two cases involved denials of some portion of a person's hospital stay, while in eight cases the hospital stay was denied altogether. Independent reviewers overturned about half (54 percent) of hospital stay denials.

IROs only overturned two of the eight cases where the HMO believed that the patient should have never been treated as an inpatient at all, and generally supported managed care efforts to promote outpatient options for all kinds of care.

IROs agreed with the HMOs' denials if it appeared that the patient had undergone testing that could have been completed and assessed as an outpatient. For example, in one case a woman was admitted into the hospital for chronic diarrhea. The procedures she underwent, such as colonscopy and an abdominal X-ray, could have been completed without hospitalization, the TMF reviewer said. Her condition and her normal X-rays, normal lab results and normal physical did not justify inpatient care.[1] In another case, a TMF reviewer maintained that because a patient admitted into the hospital with abdominal pain had a normal white blood count and his lab work produced "unremarkable" results, he should have been observed as an outpatient.[2]

Patients who received physical therapy or oral medication were directed to outpatient treatment. In one case, an Envoy reviewer, decided that a patient suffering from low back pain did not receive any treatment as an inpatient that she could not have received as an outpatient.[3] A TMF agent reached the same decision in a case where a man suffering from severe low back pain and weight loss received oral medication. The CTscans and other tests he underwent did not warrant inpatient stay.[4]

Patients could stay in the hospital if their conditions required medical observation and IV management. In one case a woman suffering from severe pain had unsuccessfully tried outpatient therapy, and was on IV medication difficult to administer as an outpatient, the Envoy reviewer wrote.[5] In the other case a TMF reviewer found that a patient admitted with acute pancreatis could only be appropriately cared for as an inpatient. "It is the standard of care to admit patients with this diagnosis," the reviewer wrote, adding that the patient needed to be monitored because of diet modifications, lab tests and the necessity of IV fluids.[6]

Hospitals were once a one-stop shop for the tests, treatments and services needed to diagnose and manage illness. There are efficiencies for the patient as well as the doctor when tests and treatments are all integrated in one location. But increasingly, patients must navigate the medical system to make appointments and get results on their own because hosptial care may be a luxury we can no longer afford.

order to qualify for gastric bypass.[12]

HMOs denied gastric bypass to numerous patients who appeared to meet NIH standards. For example, Aetna denied (and TMF overturned) a gastric bypass for a 34-year-old woman with a BMI of 42.2 kg/m^2 who demonstrated commitment to long term after care.[13] Aetna denied (and Independent Review Inc overturned) a gastric bypass to a 450 pound, 5'8" woman with a long history of failed diets. The reviewer found it "extremely unlikely" that the patient could lose any significant weight without the surgery.[14]

HMO Blue had five gastric bypass cases referred to an IRO, and reviewers overturned all of these. In these cases, the reviewers said consumers had met standards necessary to undergo the surgery.

For example, three cases in which HMO Blue denied coverage for a gastric bypass involved consumers with a BMI of 40 kg/m^2 or more.[15] In yet another case, Envoy concluded that the patient met the "standard criteria for morbid obesity, as well as the insurance guidelines which require gastroplasty first." In this instance, the insurer disregarded medically-recognized guidelines for gastric bypass as well as the consumer's compliance with its own additional requirements.[16]

Mental Illness

Like gastric bypass cases, IROs frequently arrive at different conclusions than the HMOs concerning mental illness. Out of the 263 reviews studied, 46 involved treatment for mental illness. Eleven of the 46 cases all related to eating disorders (see separate discussion, page 13). Of these 46, 32 (70 percent) were either fully or partially overturned. For the most part, the dispute centered on the duration of an inpatient or residential treatment facility stay. Without access to the underlying documentation, Consumers Union could not fully evaluate the HMOs' denials, but there are some basic standards that come into play regularly during the IROs' reviews of these cases.

IROs upheld HMO denials that involved patients undergoing a change in medication that could have been

handled on an outpatient basis. In addition, if the patient showed obvious improvement and demonstrated a desire to get better, the IRO was likely to uphold the HMO's denial of continued inpatient care. Lastly, a few decisions were upheld simply because the patients' medical records were inadequate. For example, in one case, a reviewer held that while it did appear that the patient had "significant medical and psychiatric problems, including dementia with memory impairment, a history of depression, substance abuse, and violent threats and behavior," there was "grossly inadequate documentation" supporting the need for inpatient care.[17]

Most HMO denials were at least partially overturned, but the standards are a little cloudier. If the patients' records indicated they were still having suicidal thoughts, had undergone many medicine changes within a short time period, were lethargic, confused, violent, or showed no interest in committing to an unsupervised situation, the IROs overturned all or part of the HMOs' denials.

BCBS denied residential treatment for an adolescent female with an IQ of 64 who had assaulted her mother. The reviewer concluded that the patient's history of violence toward her family and self-destructive acts clearly indicated that she was entirely out of control. In this instance, as in many others, the reviewer could find no responsible explanation for the HMO's denial of residential care.[18]

During a woman's hospitalization for severe depression, United Healthcare refused to grant her a therapeutic pass. The independent reviewer found it unfortunate that "the insurance that covered her hospitalization conveyed to me that, 'If she were healthy enough to go on a pass, then she was healthy enough to be discharged.'" The pass had enabled the patient to spend time with her mother, the reviewer held, an essential step in her recovery.[19]

Sometimes the HMO wanted to move the patient to a lower level of care (residential treatment, partial hospitalization). TMF issued a decision concerning a young boy who had previously tried a long term program. He complained of voices telling him to harm others and had a plan to murder his mother and stepfather as they slept and then kill himself. TMF found that because the boy was so young, the HMO should have allowed a longer hospitalization. "It is a well known fact among child psychiatrists that children have more difficulty dealing with transitions than adults and need more preparation time for discharge," the reviewer concluded.[20]

In another example, Private Healthcare Systems agreed to cover only four days of inpatient treatment for a patient admitted by police in four point restraints with bipolar, seizure and cognitive disorders. At the time of proposed discharge, the patient was still suffering from seizures, was agitated and required restraints. An Envoy reviewer found that this patient could not be safely

SUBSTANCE ABUSE AND TEENAGERS

HMOs, the healthcare industry, and the nation as a whole all struggle to find a solution to teenage substance abuse. This study highlights 25 families who turned to their insurance policies for help and hit a wall--denied either inpatient care (ten cases), residential treatment (12 cases) or intensive outpatient (3 cases).

According to a report by the Committee on Child Health Financing and the Committee on Substance Abuse of the American Academy of Pediatrics (the committees), access to substance abuse services decreased during the last 10 years while the numbers of children, adolescents, and families affected by substance abuse increased. The decrease in access to treatment is probably due to inadequate insurance coverage, managed care controls, and low reimbursement rates, the committee said. In cases where coverage is available, it is usually short and capped at an inadequate number of visits, the report found. Moreover, a larger problem arises when dealing with inpatient care, for this service is usually excluded or covered only for "acute detoxification purposes."[1]

IROs in Texas overturned more than half of the cases involving teenage substance abuse, but rarely overturned a recommendation that teens try outpatient treatment before an inpatient admission. Eight out of the ten opinions on inpatient care agreed that the patients should be treated in an outpatient program. Reviewers recommended outpatient care because the patients had either shown insight into their illnesses, had not changed their medication or attitudes, or had inadequate records. The two denials the IROs overturned involved patients whose additional psychiatric problems complicated their recovery.

About half of the appeals concerned access to residential treatment rather than inpatient care. In these instances, if the patient had already tried an outpatient program and failed, the reviewer was likely to overturn the denial. For example, an Envoy reviewer held that a 16-year-old boy's residential treatment was medically necessary. The boy was described as a polysubstance abuser who also suffered from major depression. The reviewer noted that the severity of the boy's substance abuse had become dangerous. In addition, the boy had already attempted outpatient treatment and failed, prompting the reviewer to determine that he should remain in a residential treatment facility.[2]

Additionally if it appeared that the teenager was at a "high risk" of relapse, the reviewer would overturn the HMO's denial. An Envoy reviewer overturned a Magellan Behavioral denial of residential treatment coverage for a 17-year-old girl, who had been running away from home as well as prostituting herself for drugs. The reviewer maintained that she was at a high risk for relapse since she indicated a strong desire to use drugs, proved resistant to treatment, and had depressed and irritable mood swings. The reviewer concluded that the girl should remain in a residential treatment facility until her physician determined she was stable enough to leave.[3]

In addition, if the teen had a history of running away or had serious conflict with other family members, reviewers would determine that the patient's enrollment into a residential treatment facility was medically necessary. According to a TMF reviewer,

cared for at any other level than "acute inpatient care," and should not be transferred. Still in the hospital at the time of the review three weeks later, the reviewer felt that she should remain an inpatient until her physician was ready to move her.[21]

Patients covered by PacifiCare of Texas appealed five decisions related to mental illness. The IROs overturned three of the five. The reviewer upheld one of these because the psychiatrist did not provide enough information.[22] All of the overturned cases involved records that the reviewers believed demonstrated that the patients were still in the midst of treatment and had not shown much improvement. In one case, a patient was admitted on suicide watch and the HMO wanted her transferred to residential treatment two days later. The reviewer believed that her two unsuccessful prior admissions indicated that it was not safe to discharge her.[23]

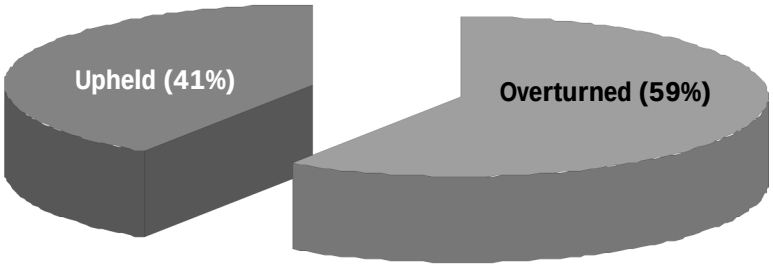
Some advocates for people with mental illness contend that managed care companies have gone too far in their efforts to wring unnecessary inpatient care out of the mental health system. Studies based on the national household survey, Health Care for Communities, find that respondents seeking treatment for mental health and substance abuse problems report delays in treatment or less treatment, but are less likely to report no treatment under managed care plans.[24] Although we could not review and categorize a large number of cases, our research identified several individual examples of overly aggressive discharge from inpatient mental healthcare that were corrected through access to the independent review process.

Substance Abuse

More than a fifth of all the cases related to substance abuse treatment (54 cases). IROs overturned more HMO denials related to substance abuse than the average "overturn rate" (60 percent or 32 cases).

Like mental illness cases, these appeals dealt mostly with the patient's length of stay in an inpatient care or residential treatment facility, or their removal from inpatient care to a lower level of care (outpa-

Substance Abuse Treatment Denials Are Often Overturned for Serious Detoxification and for Patients Who have already Failed in Outpatient Treatment



a 17-year-old girl's stay was necessary for her recovery because she was impulsive and did not completely grasp the program. Furthermore, the girl's family conflict and the presence of drug paraphernalia at home did not provide an ideal environment for recovery.[4]

Families with teenagers that have court orders to obtain treatment for their substance abuse, but whose insurance will not cover that cost, face an extra burden. Not only could the teenagers fail to meet their court orders, but they may also fail to get the treatment necessary to combat their present substance abuse problem and prevent future use and criminal behavior.

In two cases, the HMO denied coverage because the teenagers experienced a period of enforced sobriety just prior to admission. A 15-year-old female with a two-year substance abuse problem tried an outpatient program from Aug. 3 through Sept. 9, 2000. In March 2001 she entered a juvenile detention center for a probation violation. A judge in May ordered her directly into a residential treatment facility for her polysubstance abuse problem. The HMO denied coverage based on the fact that she had remained sober for two months. The reviewer disagreed, stating that she was only sober because she had been in juvenile detention. "Apparently, communication from the insurance company non-certifying her stay led to a precipitous discharge...with the parents angry at the insurance company," wrote the reviewer. "It is disappointing that her progress was terminated by this non-certification, which was clearly medically justified."[5]

A different IRO upheld an HMO denial in a similar case. The teenager had been clean for seven weeks prior to the time he would have had to fulfill his court order by enrolling in a residential treatment program. The review decision does not state whether he spent those weeks in detention, but most residential treatment programs will not accept court ordered patients who are not sober upon entry. But the period of sobriety appeared to disqualify the teen for coverage.[6]

HMOs will sometimes deny residential treatment ordered by the court even if outpatient treatment has already failed. A judge ordered a 15-year-old boy into a 24-hour residential treatment program, but the HMO denied coverage for this level of care. Because his attempts at sobriety had failed in outpatient care, an Envoy reviewer ruled that this residential treatment was medically necessary.[7]

The committees of the American Academy of Pediatrics concluded that:

- states should extend substance abuse treatment services for those on Medicaid or the State Children's Health Insurance Program (CHIP);
- private insurance companies should reduce cost-sharing requirements for substance abuse services and widen benefits to include substance abuse prevention, assessment, and treatment services;
- insurers should also improve pre-authorization and utilization review criteria to be consistent with national standards on the treatment of substance abuse among youth developed by the American Academy of Pediatrics, the Substance Abuse and Mental Health Services Administration, the National Institute on Alcohol Abuse and Alcoholism, and the American Society of Addiction Medicine.[8]

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tient, residential, partial hospitalization). Reviewers identified a number of criteria when they examined cases—level of documentation, level of home support, level of patient commitment to drug treatment, years of drug addiction, and level of withdrawal—and frequently overturned HMO decisions for the most severe cases.

Of the 22 HMO decisions *upheld* by the IROs, some supported the HMOs' determinations primarily because the patients' families appeared supportive and non-chaotic.[25] They tended to uphold the HMO if the patient showed little or no withdrawal or had no complications.[26] Finally, reviewers tended to uphold an HMO determination if the patient was making good progress with good motivation (and therefore could successfully move to outpatient care) or if the patient was making little or no progress.[27]

On the other hand, reviewers approved additional treatment time (or a higher level of care) for patients with other complicating mental illness, those with a severe detoxification, and those with serious family conflicts at home.[28] In some cases, we were surprised at how little inpatient treatment time a managed care company would provide for severe addictions. An alcoholic of 20 years with a history of depression entered the hospital for detoxification. After two days, he was discharged to finish his detoxification as an outpatient. The HMO denied coverage for the two days of inpatient care. The reviewer determined that his severe withdrawal symptoms warranted his two-day stay.[29] Another patient with combined cocaine and alcohol dependence was granted only four days for inpatient detoxification, then moved. The reviewer noted his additional diagnoses of hypothyroidism and depression, and added another 5 days.[30]

Reviewers overturned several denials because the patients had already been unsuccessful in outpatient treatment.[31] For example, one patient addicted to multiple substances, complicated by chronic pain, entered inpatient detoxification. The HMO denied the care, and the reviewer overturned the decision because the patient's prior attempts to withdraw from opiates on an outpatient basis had failed. Inpatient detoxification was medically necessary.[32]

These cases indicate a strong tension between the need to cut unnecessary hospital costs and the need to protect patients whose condition may not be fully diagnosed.

At least 25 of the 54 substance abuse cases (46 percent) involved teenage abusers. About half these HMO decisions were overturned (13 of 25 or 58 percent).[33] In most cases, the substance abuse was coupled with juvenile crime, running away, family conflict and other problems. In response, families most frequently requested residential treatment—programs designed to give the teens 24-hour supervision apart from other substance-abusing friends or family conflicts. Each of these cases presents a snapshot of a very troubled family seeking some kind of help that they believe is covered under their insurance—and not necessarily getting it. (See Substance Abuse and Teenagers, p. 10.)

These cases also illustrate the importance of a family advocate when faced with insurance denials for mental health and substancse abuse care. Parents, or some other advocate within the system, took the time to make sure their child got the care covered under the insurance plan (first asking for internal review, then for independent review). Individuals without strong family or other support may find this process difficult to navigate on their own.

Number of Inpatient Days

A large portion of the cases reviewed by IROs dealt specifically with the number of days a patient spent as an inpatient for a wide variety of physical ailments. In all, there were 60 such disputes: 52 disputes over the number of days needed, and eight where the HMO denied coverage altogether. In about half of the cases, disputed treatment was partially or fully approved by the reviewers. Because the conditions vary considerably, our conclusions are limited.

Of the eight cases denying the need for any hospital care, IROs overturned only two. The reviewers tended to agree that patients did not need to stay in the hospital for physical exams, tests, oral medication, and physical therapy.[34]

When doctors admit a patient with an unknown problem for testing, an HMO will sometimes deny part of the stay if serious conditions are ultimately ruled out. A woman took a stress test for chest pain. Because she experienced serious chest pain during this test, doctors admitted her as

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EATING DISORDERS

Review decisions relating to eating disorders, a subset of mental health appeals in our study, illustrate some of the dangers of an over-reliance on outpatient treatments in today's managed care environment. During the six month period of our study, IROs considered 11 eating disorder appeals and overturned seven of them.

According to the American Dietetic Association (ADA), more than 5 million Americans suffer from eating disorders. Five percent of females and one percent of males have anorexia nervosa, bulimia nervosa, or binge eating disorder. An estimated 85 percent of all eating disorders, now the third most common chronic illness in adolescent females, begin during adolescence.[1]

Eating disorders involve both physical deterioration and mental illness, such as depression, anxiety, and obsessive behavior. As a result, treatment for these disorders must focus both on mental and physical health. The ADA recommends an interdisciplinary team composed of professionals from medical, nutritional, and mental health disciplines to manage and assess eating disorders. According to the ADA, medical nutrition therapy and psychotherapy are two integral parts of treating eating disorders, especially since the patient may require continued psychological support even after recovering medically in order to sustain the change.[2]

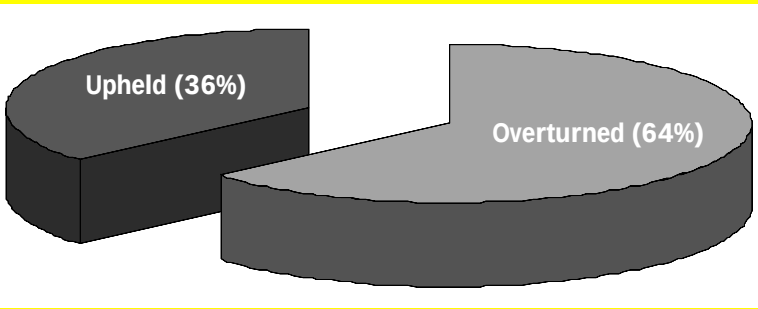
Like those appeals involving mental illness or substance abuse cases, reviewers based their decisions heavily on the patients' history and chance of recovery outside an inpatient or residential treatment settings. If the patients showed insight into their illnesses, improved mentally and physically during their time spent as inpatients, and had supportive families, the reviewer would uphold the HMO's denial.

But some HMO guidelines appear to rely primarily on weight gain as the trigger to end inpatient care. Independent reviewers looked at both physical and mental capacity to return to a more normal life. In one case, a IR reviewer wrote that while the patient had gained weight and maintained caloric intake, she remained "extremely anxious" about this weight gain, and continued to have obsessive and "distorted illness thoughts." Leaving inpatient care would have been very detrimental to her recovery.[3] According to the ADA, "weight restoration alone does not indicate recovery, and forcing weight gain without psychological support and counseling is contraindicated."[4]

Patients released prematurely from inpatient treatment may land right back in the hospital, even more ill. A 21-year-old woman entered an inpatient care facility on Nov. 21, 2000 due to complications resulting from her eating disorder and depression with suicidal thoughts. The HMO covered nine days of inpatient treatment then discontinued her certification. A TMF reviewer upheld this decision, claiming that due to lack of documentation of her suicidal intent and the fact that her eating disorder was no longer acute, any days after Nov. 30 were not medically necessary.[5]

Within two months the woman was readmitted. According to a new assessment of her case, after leaving the inpatient setting for residential treatment the first time, she felt anxious and overwhelmed when seeing food in the refrigerator and pantry. Her anxiety continued to grow as she gained weight over the next few weeks. Her practice of binging and purging resurfaced, her depression increased, and she attempted suicide in the shower. The residential facility determined that she should return to an inpatient setting on Jan. 30, 2001. The HMO denied the request, but this time the independent reviewer overturned the denial.

Reviewers Overturned Seven of Eleven Treatment Denials for Eating Disorders, particularly if HMOs denied care based primarily on physical weight gain



"Insurance companies, in general, have failed to recognize the seriousness of eating disorders, which have mortality rates in chronic patients, of up to 20 percent," said the reviewer. This particular patient probably should have stayed longer in her initial inpatient treatment program, as she "manifested most of the risk factors associated with bad outcome and death in this patient population," according to the reviewer, adding that she was unsafe in a residential care facility.[6]

One indicator of inadequate hospital treatment or discharge planning is rapid hospital readmission after discharge. According to a 1996 study of quality indicators in the managed behavior health care industry (and cited by the U.S. Surgeon General), rapid readmission occurred in 2 percent to 41 percent of discharges depending on the managed care plan. Despite methodological problems, the Surgeon General warned in 1999 that these kind of indicators "raise concerns about real differences in quality" among managed behavioral health plans.[7]

One HMO denied inpatient care to three different women with eating disorders. All three denials were overturned. The IRO found that these patients

feared returning home and being around food, continued to express compulsive desires to exercise, and remained depressed and/or suicidal. The reviewers concluded that the women needed to improve in these areas before they could successfully battle their eating disorders in an outpatient or residential setting.[8]

The ADA believes that patients with eating disorders usually progress along these stages: precontemplation, contemplation, preparation, action, and maintenance. The organization warns that "frequent backsliding" among these stages usually occur during a patient's recovery. Thus, premature release from a treatment setting, no matter what that setting may be, could be harmful to the patient.

Because relatively few patients actually pursue independent review of their insurance denials (see discussion, p. 8), we believe that the number and severity of eating disorder cases that came before reviewers during the short period of our study warrants further research, and may indicate a need to examine managed behavioral health plan utilization guidelines for this disease.

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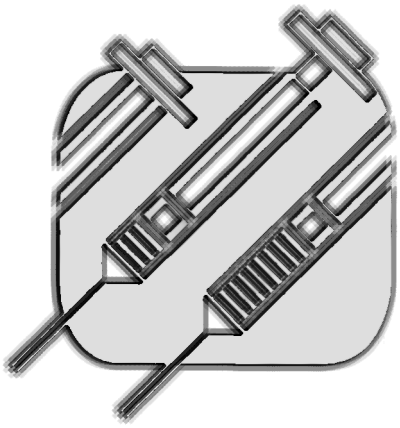
an inpatient in order to assess her condition and rule out a heart attack. Her doctors conducted a CT scan, which resulted in two more days of hospitalization. When this test came back negative, the woman underwent a heart catheterization for diagnosis, which required one more hospital day. The HMO later denied coverage for the last days of inpatient care. The IR reviewer disagreed, finding that until she received a conclusive diagnosis, her stay was necessary.[35]

A two-year-old girl was admitted to the hospital because of lethargy, vomiting, and a sudden temperature elevation of 104 degrees. When she arrived on March 7, doctors conducted tests and drew a blood culture. After admission with the preliminary diagnosis of ear infection, she started intravenous antibiotic therapy. The next day, the blood culture came back positive for gram-positive cocci. Hosptial staff drew another blood culture after receiving the first test results. She continued to have low-grade fever, and by March 9, the infection was identified as penicillin-resistant Streptococcus pneumonia. Although the child was completely stable, the physician opted to wait for the second blood culture, which came back negative on March 11, at which time the child was released. The HMO denied coverage for the child's March 10 stay, since she was stable and the infection appeared to have been identified.

The IR reviewer, however, held that the extra stay was necessary to ensure the child received the appropriate care. Because the infection was penicillin-resistant, the physician had reason to be concerned that it may be resistant to other antibiotics. Furthermore, because the child was a daycare attendee, she was at high risk for having drug-resistant pneumonia. The reviewer concluded that the child received "excellent and appropriate medical care" and the HMO should have covered her hospitalization on March 10.[36]

These cases indicate a strong tension between the need to cut unnecessary medical costs and the need to protect patients whose condition may not be fully diagnosed. While many IRO decisions supported an outpatient approach to testing, not every patient can be approached in the same way and some cases support the need for hospital based diagnostic care. They also highlight the most common feature of many utilization review decisions for hospital care—the decision to trim the hospitalization by two days, one day or even a few hours.

In at least 22 other cases, the HMOs denied coverage for two days, one day or even a few hours of inpatient care, and reviewers only overturned seven of these denials. These cases came down to patients, HMOs, physicians, and IROs grappling with how *much* inpatient care is medically needed almost down to the hour. The reviewers look at the medical records and history of each patient, taking into consideration the seriousness of their illnesses, whether they had been placed on new medication, and if their care could have been appropriately provided on an outpatient basis.



A woman, suffering from severe dizzyness, had been admitted to intensive care, and the doctors found that her diabetes was poorly controlled. The hospital, HMO, and IRO all had different opinions as to when the patient should have been released. The hospital released her on the seventh day, the HMO said she should have left on the fifth day, and the IRO determined that she should have been released on the sixth day.[37]

A managed care plan denied coverage to woman who had undergone a hysterectomy because the HMO believed that her improvement, and ability to eat and take oral medication, indicated that she was well enough to be released after dinner one evening, rather than her actual release the next morning.[38] A man who underwent surgery for sleep apnea stayed in the hospital one full day. Here, the HMO and the reviewer agreed that he should have been released the day of the surgery rather than the next morning because, by the 18th hour after surgery, he could begin drinking water and taking oral medication. In general, if the patient could begin taking oral medication and eating, then the HMO and reviewers would both deny continued inpatient care.[39]

Sometimes the HMO will deny hospital days when hospitals cannot efficiently schedule tests or deliver test results. Aetna and a reviewer agreed that a patient could have been released earlier if the doctor had asked to have test results called in to him instead of waiting for them to appear in the chart.[40] Prudential and TMF concurred that a patient who needed a cardiac catheterization should not get two days of coverage because the procedure should have been done on Saturday, rather than Monday, the day on which the hospital scheduled it.[41] But, in a similar case, when Aetna said a patient's heart catheterization should have been scheduled a day earlier, Independent Review Inc. disagreed and required the company to pay for the full stay.[42] An Aetna patient who needed a CT scan had to wait because the doctors could not immediately obtain the I.V. access needed. According to the reviewer, this *is* a "recognizable reason" for failing to perform this procedure sooner.[43]

Patients of Aetna US Healthcare asked for 26 reviews related to the number of inpatient days needed for a variety of physical conditions. Reviewers overturned almost three quarters of them (19 cases).

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WORKERS COMPENSATION LEGISLATION

The 77th Texas Legislature enacted a comprehensive law giving workers an independent review process for workers compensation claims if they are told their treatment is not "medically necessary."[1] The law requires the new independent review process to be the same as the existing process for other health insurance treatment denials. The Texas Workers' Compensation Commission (TWCC), in December of 2001, finalized regulations that turned over the review of workers comp denials to the same independent review companies currently authorized by the Texas Department of Insurance (TDI) to perform other insurance reviews.[2]

Like the HMO independent review process, TWCC will rotate these workers' compensation cases among the three IROs. In the past the commission has received about 3,000 requests for review a year, according to Bob Shipe of the Texas Workers' Compensation Commission's governmental relations division.[3] By contrast, TDI receives about 500 requests for review of HMO denials each year, giving about 150 cases to each review organization. The new workers compensation claim reviews could result in a sudden ten-fold increase in the number of cases coming before the existing reviewers.

But the fee structure makes this unlikely. Under the HMO system, the $650/$450 independent review fee must be paid by the insurance company every time a consumer requests review. In the comp system, independent reviews of "preauthorization" or "concurrent" denials must be paid by the insurance company (the employee has not yet received any services, or the insurer denies continued care beyond a specified limit), but if the service has already been delivered, the "non-prevailing party" (either the comp insurer or the medical provider) must pay the fee. Regulations require providers to pay the fee for a retrospective review first and get reimbursed if they prevail (the independent reviewer finds the treatment to be medically necessary).[4] The statute mandates that the injured worker will never pay for the review.

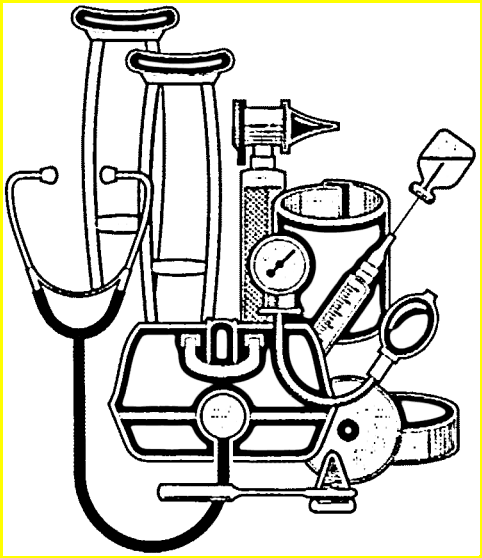
Workers compensation regulations, like many group health insurance plans, require certain kinds of procedures to be pre-authorized every time.[5] But even so, 82 percent of requests recieved in the last four months of 2001 involved services already delivered. The up-front fee may discourage many health providers from requesting reviews, Shipe said.

HB 2600 required TWCC to post de-identified independent review decisions on its web site so that all providers and workers can understand the medical basis for determinations of medical necessity.[6] Three months into the new program, no decisions have been posted. Only 68 reviews had been requested and 21 decisions completed. Given the previous volume, we would expect 8 to 10 requests for review to arrive every day. The low volume of requests so far is no doubt partially due to the implementation of a totally new system. Even so, initial startup appears slow.

Medical conditions filed under workers compensation differ substantially from the types of conditions we have identified elsewhere in this report. Workers compensation claims are far more likely to involve soft tissue damage and back problems, and the most common treatments include various therapies, durable medical equipment and "work hardening," a therapy designed to bring an injured worker slowly back to the kind of tasks required for the job. By contrast, our review of HMO independent review found the largest categories of reviews related to substance abuse, mental health, and the number of days required for inpatient care (for a wide range of illnesses).

Since the volume of reviews and type of conditions may be significantly different for workers compensation than for HMO based care, adequate oversight is critical. Regulations and the law set out a number of consumer protections that could be a model for the HMO independent review process. In addition to the requirement that TWCC post IRO decisions on the internet (without confidential information that could be used to identify the patient), workers compensation insurance companies must adjust their behavior based on the IRO decisions. If an independent reviewer determines that care is medically necessary, and the insurer based its initial denial on a particular peer review, the insurer cannot use that same basis and rationale to deny subsequent similar claims.[7]

Further, as we recommend here for all HMO reviews (see page 17), the regulations state that TWCC will monitor IRO decisions and outcomes, and establish this monitoring system through a Memorandum of Understanding with the Texas Department of Insurance.



[1] 77th Texas Legislature, H.B. 2600, Article 6, Sec. 6.04, Medical Dispute Resolution, effective January 1, 2002.

[2] 26 Texas Register December 28, 2001, Final rules and response to comment, Chapter 133. General Medical Provisions.

[3] Shipe, Bob, Texas Workers Compensation Commission, interview with Consumers Union, Feb. 22, 2002.

[4] 28 Texas Administrative Code, Title 2, Article 133.308(q)

[5] Treatments that require preauthorization include inpatient hospital admission other than emergency, spinal surgery, chemical dependency and weight loss programs, chronic pain management, durable medical equipment costing over $500, outpatient or ambulatory surgery, all myelograms, discograms, or surface electromyograms, all chemonucleolysis and much more. TWCC Fast Facts, "Preauthorization, Concurrent Review, and Voluntary Certification," February 1, 2002.

[6] 77th Texas Legislature, H.B. 2600, Article 6, Sec. 6.04, Sec. 413.031 (c).

[7] 28 Texas Administrative Code, Title 2, Article 133.308(o)(6).

ALCOHOL DETOX

Disputes about substance abuse frequently related to the necessity of inpatient care, and especially the number of days necessary for detoxification. A 40-year-old severely alcoholic woman received care at a residential treatment center from Dec. 8 to Jan. 6. The HMO approved only the first five days of her stay, denying the treatment she received from Dec. 13 onward. The Independent Review, Inc. reviewer overturned this decision, emphasizing the severity of her addiction.

The reviewer notes that the woman had been drinking a fifth of vodka every day for two years. When she came into the treatment facility she admitted to drinking daily since she was 20-years-old, with the exception of a two and one-half year period of sobriety. Furthermore, she and members of her family had a history of depression, and she also tried to commit suicide after her mother's death.

During detoxification, she suffered from hypertension, shaking, elevated blood pressure and pulse rate, and a seizure. She remained on several different medications to help her cope with these symptoms until Dec. 13, then began to think more clearly on Dec. 14.

The insurance company doctor stated her conditions could have been treated on an outpatient basis. The reviewer firmly disagreed, stating that the details of her medical report clearly indicated that she had "severe alcohol dependence syndrome." The severity of her problem was complicated by the fact that she had a dual diagnosis with major depression requiring antidepressants. The reviewer concluded that she had been discharged on "step four," a very important step for her to complete.

While she was motivated to do her work in the rehabilitation program, she continued to have much resentment that would have likely led to relapse. Therefore, the five days of treatment approved by the HMO was an inadequate time period for this patient's recovery.

Source: Independent Review, Inc., IRO Decision Letter, Prinicipal Life Insurance, April 12, 2001.

Prescription Drugs

Compared to the average "overturn rate," most HMO denials we reviewed regarding specific prescription drugs were upheld by the independent review system. IROs reviewed 19 appeals concerning prescription drugs and only overturned six (32 percent).

Surprisingly, a small number of drugs were disputed more than once. Of the 19 disputes over specific prescriptions, seven involved Lamisil, a drug that treats foot fungus, and two each concerned Lipitor and a juvenile growth hormone. The remaining seven disputes concerned a wide range of drugs.

In four of the Lamisil disputes, Aetna said that doctors should first obtain proof of the degree of their infection with either a fungal culture or PAS stain. The reviewers agreed.[44]

Lamisil, as well as similar oral fungal medications, has been linked with patients' liver problems. These problems prompted the Food and Drug Administration in June 2001 to issue a health warning, requiring that Lamisil carry stronger warnings about potential liver damage.[45] The new labels now recommend that health-care professionals obtain nail specimens for testing to confirm the diagnosis before prescribing medication for fungal nail infections.[46]

Both HMOs and reviewers were strong in their opinions that, before prescribing, doctors should demonstrate, using standard tests for fungal infection, that the patients indeed need this oral medication.

Lipitor treats high cholesterol. During the study period, Aetna removed Lipitor from its formulary and required patients to use Zocor or another drug instead. The formulary change affected Texas patients upon their plans' 2001 renewal date.[47] Given that this formulary change probably affected a large number of people, we saw relatively few appeals to independent review.

One patient was moved to other medications but wanted Lipitor again. The reviewer recommended that the patient try Zocor for at least 30 days first.[48] In the other case, the patient's doctor said she had responded well to Lipitor. She tried Zocor as required by Aetna, then was asked to try two other drugs.

"It seems onerous to force a patient to try two agents (Baycol and Lescol) that are well known to be less effective than either Lipitor or Zocor," wrote the reviewer when finally approving the Lipitor.[49] In these two cases, the independent review fullfilled its purpose by providing the patient an individualized (and independent) needs assessment when faced with formulary restrictions.

While Pfizer's Lipitor is one of the best-selling pharmaceutical drugs worldwide, it is newer than Merck's Zocor. Lipitor entered the market in 1997 and quickly became a popular cholesterol-lowering drug.[50] Lipitor and Zocor are both among the top 25 drugs used by state employees and teachers.[51]

The battle of the efficacy studies rages unabated between Lipitor and Zocor. Research on Zocor in 1994 prompted growth in the use of statins (cholesterol-lowering drugs), after a study showed that it could greatly a patient's risk of dying from a second heart attack.[52] A study presented at the 49th Scientific Session of the American College of Cardiology in March 2000 found that Zocor increased levels of both "good" cholesterol (HDL) and apolipoprotein more than Lipitor.[53] At the same time, a 1999 European study found Lipitor more effective than Zocor at lowering "bad" cholesterol.[54]

While only a small number of consumers appealed a formulary decision regarding a specific name brand drug, the details of these reviews indicate that reviewers will uphold insurer formulary rules unless the patient demonstrates a strong need and alternatives are less effective. In this way, independent review may help control escalating costs related to direct-to-consumer marketing of expensive name brand drugs.

Conclusions and Recommendations

Our assessment of the independent review process indicates that it works to balance the fiscally motivated decisions of insurers and helps consumers gain access to their health benefits. In areas where independent reviewers generally agree with HMO determinations, the process helps to manage high cost care like the prescription drugs identified in this report.

- The Texas experiment with independent review of medical necessity has helped consumers and provided a balancing influence in the spectrum of care. The independent review system should be expanded to include ERISA plans through final passage of federal legislation, and should cover consumers in all states. (The U.S. Supreme Court could rule to make independent review available to ERISA insured.)

- The Texas Department of Insurance should regularly conduct a substantive review of Independent Review decisions and identify procedures or conditions where the reviewers tend to overturn HMO decisions. TDI should direct HMOs to review their internal guidelines for these conditions and correct them to avoid unnecessary requests for review. Workers Compensation rules already prohibit insurers from denying care once an underlying rationale has been discredited by reviewers.

- Health plans should review and modernize their guidelines for approval of gastric bypass, eating disorders, and substance abuse care. Patients who meet medical standards (including severely addicted individuals needing inpatient detoxification) should be granted access to a higher level of care (surgery, inpatient treatment). Not all conditions can be adequately treated using outpatient methods, although they might be less expensive initially.

- Independent review decisions, with all information that would identify the individual redacted, should be posted on the internet as now required only for independent review of workers compensation claims.

- The Texas Department of Insurance should review all "adverse determination" notices that are sent to persons who are denied services and should revise them to be more understandable to consumers.

- The independent review statute should be amended to clearly apply to retrospective reviews. In the meantime, TDI should clarify by rule the criteria used to determine whether a denial is a "concurrent" review or a "retrospective" review for purposes of denying consumer access to the independent review process.

- Employer groups covered by ERISA are not subject to this law, but employees would benefit from this process if it were provided voluntarily. The Texas Department of Insurance should survey employers and Third Party Administrators to determine whether they use the independent review process.

- Workers denied treatment under workers compensation will have access to the same review process as other managed care patients for the first time this year. The changes may significantly affect the way the IRO system works and should be monitored carefully. So far, few reviews have been requested. Once the system is well started, TWCC should assess whether the fee requirements create too great a disincentive for the provider to fight for patient care.

Footnotes

[1] Texas Insurance Code, Art. 21.58A, Section 6A, effective Jan. 1, 1998.

[2] H.R. 2563, Sec. 104, Ganske, introduced 7/19/2001 and S. 1052, Sec. 104, McCain, introduced 6/14/2001.

[3] Title 28, Texas Administrative Code, Chapter 12; Texas Insurance Code, Article 21.58A, Sec. 6A(3).

[4] Texas Department of Insurance, "IRO Monthly Report," February, 2002. Albert, Tanya, "Few Patients Opt to Appeal HMO Denials," AM News, April 8, 2002.

[5] U.S. Department of Health and Human Services, Office of the Surgeon General, "Mental Health, A Report of the Surgeon General," 1999, p. 412.

[6] Texas Department of Insurance, "IRO 2001 Report," "IRO 2000 Report," "IRO 1999 Report," "IRO 1998 Report."

[7] Texas Department of Insurance, "IRO 2001 Report," 2001.

[8] Albert, p. 2.

[9] Texas Department of Insurance, "Sample Letter Regarding No Right to IRO if Only a Retrospective Review Was Performed," April 20, 1999. Memo to Kathy Mitchell, Consumers Union SWRO, from Jon Schnautz, Research and Oversight Council on Workers' Compensation, April 29, 2002.

[10] Consensus Development Conference Panel, "Gastrointestinal Surgery for Severe Obesity," Annals of Internal Medicine, Vol. 115, No. 12, December 15, 1991, pp. 197-202.

[11] Texas Medical Foundation, IRO Decision Letters, Aetna, 9/17/2001 and 6/16/2001. Envoy, IRO Decision Letter, Aetna, 5/24/2001. Independent Review Inc., IRO Decision Letter, Prudential, 4/4/2001.

[12] Independent Review Inc., IRO Decision Letter, Blue Cross Blue Shield, 6/19/2001, overturned.

[13] Texas Medical Foundation, IRO Decision Letter, Aetna U.S. Healthcare, 5/10/2001.

[14] Independent Review Inc., IRO Decision Letter, Aetna U.S. Healthcare, 9/17/2001.

[15] Independent Review Inc., IRO Decision Letter, HMO Blue, 5/29/2001 and 6/7/2001. Texas Medical Foundation, IRO Decision Letter, HMO Blue, 5/23/2001.

[16] Envoy, IRO Decision Letter, HMO Blue, 5/15/2001.

[17] Independent Review Inc., IRO Decision Letter, BCBS, 9/4/2001. The statute gives the IRO access to any medical records of the enrollee that are relevant to the review, any documents used by the plan in making its determination, the notice to the consumer explaining the determination, any documentation submitted in support of the appeal, a list of each physician or provider who may have medical records relevant to the appeal. In some cases it appeared that the documentation problem originated with the providers, whose notes or other information were insufficient to support the requested treatement.

[18] Independent Review Inc., IRO Decision Letter, BCBS, 8/15/2001.

[19] Independent Review Inc., IRO Decision Letter, United Healthcare of Texas, 6/20/2001.

[20] Texas Medical Foundation, IRO Decision Letter, HMO Blue, 4/11/2001.

[21] Envoy, IRO Decision Letter, Private Healthcare Systems, 6/6/2001.

[22] Texas Medical Foundation, IRO Decision Letter, Pacificare, 4/23/2001.

[23] Envoy, IRO Decision Letter, Pacificare, 7/23/2001.

[24] RAND Research Highlights, "Are People With Mental Illness Getting the Help They Need," download date, 3/28/2002.

[25] Texas Medical Foundation, IRO Decision Letter, Magellan Behavioral, 8/8/2001. Envoy, IRO Decision Letter, Corphealth, 6/8/2001.

[26] Independent Review Inc., IRO Decision Letter, Prudential Healthcare, 9/11/2001. Texas Medical Foundation, IRO Decision Letter, Aetna, 5/17/2001. Envoy, IRO Decision Letter, Magellan Behavioral, 8/28/2001.

[27] Texas Medical Foundation, IRO Decision Letter, Prudential Healthcare, 4/3/2001. Texas Medical Foundation, IRO Decision Letter, Unicare, 5/1/2001. Envoy, IRO Decision Letters, Magellan Behavioral, 8/15/2001, 8/28/2001. Independent Review Inc., IRO Decision Letter, Clarendon, 5/16/2001. Independent Review Inc., IRO Decision Letter, National Health Service, 5/29/2001.

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