Litigating health-care claims

What to do when a claim is denied as not being medically necessary

BY DAVID LILIENSTEIN

The cost of health care keeps going up. A recent report issued by an industry consulting firm pegs the annual cost for a family of four at more than $20,000 – the first time the total cost has exceeded $20,000.[1]

As the cost of health care increases for individuals, the cost to health insurers of providing health care has also increased. This results in greater scrutiny of health care claims, more limited coverage, and, inevitably, more claim denials.

Health care claim denials come for many reasons. The treatment may be experimental. It may be "out-of-network." The insured may not have followed the proper preauthorization procedures. Since most health-care policies only guarantee coverage for medically necessary treatment and care, insurers regularly deny claims on the basis of medical necessity.

Who determines medical necessity? Sometimes the term is defined in the policy or health-care plan. Even so, the answer should be obvious – the treating physician determines what care is medically necessary for a given patient. He or she is presumably a specialist in the relevant medical area; has treated or examined the patient, often on an ongoing basis; and is familiar with the patient's medical history. Who else is in a better position to recommend the proper course of treatment?

Or not! Insurers regularly deny medically necessary treatment for their insureds. Rarely are these claim denials scrutinized. Regulatory agencies have limited resources to address the many complaints they receive, and most claims are so small that the insured cannot find an attorney to assist them. As a result, improper claims-handling practices continue, with impunity. However, whether on an individual or class action basis, the time is right to take these cases. The sad reality is that the plaintiff's bar is the last line of defense against health insurers that engage in unfair and unlawful claims-handling practices.

Learning to live with utilization review

There is no question that insurers are entitled to review the recommendations of treating doctors. It would be an overreach, one that courts will easily reject, to contend otherwise. Thus, there is no "treating physician rule," under which the treating physician's recommended care is sacrosanct, unchallengeable.

The process of evaluating "whether health care services are medically necessary, consistent with acceptable treatment patterns care requests," is commonly referred to as "utilization review," or "utilization management."[2]

In the workers compensation context, utilization review:

> is the system used to manage, assess, improve, or review patient care and decision-making through case by case assessments of the medical reasonableness or medical necessity of the frequency, duration, level and appropriateness of medical care and services, based upon professionally recognized standards of care. Utilization review may include, but is not limited to, prospective, concurrent, and retrospective review of a request for authorization of medical treatment.[3]

Utilization review comes in many forms. Sometimes it is conducted by the health insurer itself. Some health insurers contract directly with an outside entity such as a local or regional medical group. Under a "capitated" contract arrangement, the insurer remits a fixed payment to the medical group, based on the number of subscribers and regardless of the amount of care provided. The group then approves and pays for the subscribers' medical care. The practitioner must understand which entity does makes the initial claim decision, which one decides the

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appeal, and how many levels of appeal are available.

A utilization review is the ultimate second opinion. But when generated by an insurance company (or third party) that is more concerned with its financial results than sound medical analysis, the result is the withholding of legitimate medical care and treatment, with often tragic consequences. The irony of this is that when an insurer or medical group denies a claim through utilization review, it is rejecting the considered opinion of a doctor it chose to include in its own physician network. What is the point of having health care coverage when your insurer rejects its own doctors' treatment recommendations?

Reasonableness and the medical necessity standard

When the utilization review process results in a denial based on lack of medical necessity, it is imperative to explore what standard operating procedures the decision was based upon. Indeed, there is no statutory definition of "medical necessity." It is an "objective standard to be tried by the trier of fact."[4]

Medical necessity analysis often begins with the doctrine of reasonable expectations. This doctrine, which can come into play in any insurance context, holds that when considering coverage and evaluating potential breaches of the covenant of good faith and fair dealing, the "'reasonable expectations of the insured'" must be upheld.[5] In health care, the insured's reasonable expectations are that he or she will receive the care recommended by the treating physician. That is the promise that the insurer makes to its insureds – that they will receive the care they require. This does not mean that a treating physician has "an unreviewable power to determine coverage," but that the policy language regarding medical necessity should be construed liberally "so that uncertainties about the reasonableness of treatment will be resolved in favor of coverage."[6]

The key word here is reasonable, and although the case law is scant and decades old, the accepted standard is that unless the treating physician's judgment is "plainly unreasonable, or contrary to good medical practice," the treating physician's recommendation cannot be rejected.[7] Any jury instruction should incorporate this language.

What constitutes good medical practice was played out in *Hughes v. Blue Cross of Northern Cal*. (1989) 215 Cal.App.3d 832. There the court held that "good faith demands a construction of medical necessity consistent with community medical standards that will minimize the patient's uncertainty of coverage in accepting his physician's recommended treatment."[8] The insurer that employs a more "restricted definition of medical necessity" in opposition to the reasonable or "justified expectations of the insured," and that fails to liberally construe policy language in favor of coverage, does not act in good faith.[9]

So, while there may be no treating physician rule, "reliable evidence, including the opinions of a treating physician" cannot be arbitrarily rejected.[10] The *Nord* case was an ERISA disability case and did not involve a health-insurance claim. However, it does provide additional support for upholding a treating physician's recommended course of medically necessary action.

The insurer's duty to investigate

When litigating medical necessity claims, the insurer's investigation must be dissected. It is no secret that an insurer has a duty to investigate, and that "an insurer may breach the covenant of good faith and fair dealing when it fails to properly investigate its insured's claim."[11]

Alarmingly, medical care can be denied because a computer program rejects a treatment code. No doctor, or other licensed medical practitioner, reviews the case and renders a medical decision. Other times, claims are denied by nurses or nurse practitioners who have more claims to decide than they have time to make a reasoned decision. This can be a productive area of discovery.

Discovery into the medical doctor (or doctors) who reviewed the claim is also an important tool. Get the CV. Find out when the doctor last had a medical practice. Is he or she Board Certified in the relevant medical specialty? For example, if an insurer uses an ObGyn to review a request for back surgery, or fails to use a mental health specialist to decide a psychological claim, there may be good evidence of an unreasonable investigation.

It is also crucial to know what information was provided and or reviewed. Very often an insured has a long history of treatment that the medical reviewer never considered. The patient needing back surgery may have had back pain for years, may have tried physical therapy, may have had steroidal injections, and may have gone through multiple medications and even increasing doses of the same medication, before his doctor recommended more invasive – and more expensive – modalities. In all likelihood, the insurer's medical reviewers failed to consider the totality of this evidence.

In an era where people regularly change health plans, whether due to a change of employment, the costs of premiums, or other factors, relevant medical history may be elusive. This does not excuse the insurer from its duty to investigate. Be sure to check policy applications, as well as the insurer's underwriting files. They may contain relevant information that put the insurer on notice about an insured's conditions. If the review process is still open, either give the insurer the relevant information, or tell it where to find it. The insurer's failure to follow-up on this information will go a long way toward establishing an unreasonable, bad-faith investigation.

The ERISA bugaboo

Before filing suit against a health-care insurer, the practitioner must know whether the action will be governed by

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California law or will be governed by the federal ERISA statute.[12] Under the former, standard insurance bad-faith jurisprudence applies. This means that not only is the carrier liable for a potential breach of contract cause of action, but also in tort for the breach of the covenant of good faith and fair dealing – bad faith. An unreasonable claim denial opens the door to tort remedies, which include damages for emotional and financial distress, and attorneys' fees.[13] Where a claim denial is sufficiently outrageous, punitive damages may be proper.[14] Indeed, California's insurance bad-faith laws are among the most plaintiff-friendly in the country.

Not so much with ERISA. ERISA preempts California bad-faith remedies. It limits potential recoveries to the actual out-of-pocket damages.[15] It removes the right to a jury trial. Punitive damages are out of the question. Discovery is either limited or is not allowed. Cases are tried in federal court. Often, the standard of review is not reasonableness but whether the insurer abused its discretion. In sum, ERISA tilts the playing field in favor of the insurer, and against the insured.[16]

Figure out the ERISA question early. Generally speaking, if the policy at issue is an individual plan, California law will govern. If the plan is a non-governmental, employer-sponsored plan, ERISA will govern. If the insured initially received coverage through his or her employer, but is no longer employed, the plan can "convert" from a group, ERISA-preempted plan, into an individual plan governed by California law. Also note that arbitration clauses are unenforceable in ERISA plans.

Who is liable?

What happens when the health insurer and a third-party medical group both participate in a claim denial? The common scenario is that the medical group makes the initial determination, and the health insurer handles all appeals, with medical professionals acting as claims administrators.

If the denial was made in bad faith, which entity is liable? The answer is that whoever plays a role in the claim denial, whether initially or on appeal, will be liable for its conduct:

> A plan, any entity contracting with a plan, and providers are each responsible for their own acts or omissions, and are not liable for the acts or omissions of, or the costs of defending, others. . . . Nothing in this section shall preclude a finding of liability on the part of a plan, any entity contracting with a plan, or a provider, based on the doctrines of equitable indemnity, comparative negligence, contribution, or other statutory or common law bases for liability.[17]

Essentially, section 1371.25 removes vicarious liability between the plan and the provider. So if the provider is the lone decisionmaker, including all appeals, it alone will be liable.[18]

In *Watanabe*, Blue Shield contracted with a third-party medical practice association to provide medical care. Both entities participated in the disputed claim, but the medical practice group was the primary decisionmaker. The court held that under section 1371.25, Blue Shield was not vicariously liable for the actions of the medical practice association.

This is a noteworthy case not only for the vicarious liability issue, but also because the plaintiff settled with the medical practice association prior to trial for $150,000, then prevailed at trial against Blue Shield but was only awarded $65 in damages.[19] Be sure, therefore, to assess the relative liability of all parties. The health insurer may not be the most important defendant.

To file or not to file: administrative remedies

There are two state agencies responsible for regulating health care insurers: the Department of Insurance ("DOI") and the Department of Managed Health Care ("DMHC"). The DMHC enforces the Knox-Keene Health Care Service Plan of 1975.[20] In most general terms, the DMHC regulates Health Maintenance Organization plans (HMOs). Preferred provider organizations (PPOs) come under the DOI's jurisdiction.

Both agencies have an infrastructure for addressing consumer complaints. The DMHC, however, has an independent review process that is binding on insurers. Insureds, or their attorneys, can submit relevant information to an independent panel of medical reviewers.[21] If the panel finds in favor of the insured, the insurer must provide the requested treatment or be subject to statutory fines.

Whether to submit to the DMHC review process is case-dependent. The majority of DMHC appeals do not favor insureds. However, the DMHC publishes the results of its reviews, and these results show, for example, that autism-related challenges often result in overturning the claim denial, whereas insureds are less likely to be successful in challenges to a chronic pain, cancer and mental health-related claim denial.

Practitioners should be warned, however, that their bad faith case may be undermined by a review panel decision upholding the claim denial. And if the policy is governed by ERISA, the insurer will have a strong argument that it did not abuse its discretion if it can point to a supporting DMHC decision.

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Endnotes

1 For an employee-sponsored, PPO plan. See www.milliman.com.

2 *Mintz v. Blue Cross of California* (2009) 172 Cal.App.4th 1594, 1599.

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[3] 8 Cal.Code Regs. § 9770(q).

[4] *Sarchett v. Blue Shield of California* (1987) 43 Cal.3d 1, 9

[5] *Sarchett*, 43 Cal.3d at p. 10 (quoting *Gray v. Zurich Insurance Company* (1966) 65 Cal.2d 263, 271).

[6] *Ibid*.

[7] *Id*. at p. 13.

[8] *Hughes*, 215 Cal.App.3d at p. 846

[9] *Id*. at p. 845.

[10] *Black & Decker Disability Plan v. Nord* (2003) 538 U.S. 822, 833.

[11] *Egan v. Mutual of Omaha Ins. Co*. (1979) 24 Cal.3d 809, 817.

[12] The Employee Retirement Income Security Act of 1974, 29 U.S.C. §§1001 *et seq*.

[13] See, e.g., *California Shoppers v. Royal Globe Ins. Co*. (1985) 175 Cal.App.3d 1.

[14] See Civil Code section 3294

[15] The successful ERISA practitioner can also petition for attorneys fees. See *Hardt v. Reliance Standard Life Ins. Co*. (2010) 130 S. Ct. 2139,

[16] One court called ERISA a “serbonian bog.” *DiFelice v. Aetna U.S. Healthcare* (3d Cir. 2003) 346 F.2d 442, 454.

[17] Health & Safety Code § 1371.25.

[18] See *Watanabe v. California Physician’s Service (Blue Shield)* (2008) 169 Cal.App.4th 56. Also beware that a third party medical physicians group may only be liable for negligence, and not bad faith.

[19] *Watanabe*, 169 Cal.App.4th at p. 375.

[20] Health and Safety Code sections1340 *et seq*.

[21] See http://wp.dmhc.ca.gov/imr/

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