Prospects For Improved Decision Making About Medical Necessity

A group-process approach to demystifying decisions of medical necessity in managed care plans.

by Sara J. Singer and Linda A. Bergthold

With the backlash against managed care, medical necessity has become the focus of increasing controversy. California’s health care marketplace has provided some unique opportunities to understand the role of medical necessity in managed care decision making, as the legislature and stakeholders have discovered how little consensus there is on its meaning, ownership, and application.

Nevertheless, many decisionmakers agree that medical necessity decisions generally involve authorizing treatment for an individual patient. These differ from coverage decisions, which set organizational policies regarding the coverage of treatments for populations of patients with similar conditions. Both types of decisions require medical judgment, and thus both mix considerations of payment and clinical factors. Differences in coverage policies and in the application of those policies to individual decisions contribute to variation in managed care decision making.

Previous research has found considerable variation in the process and criteria used for decision making in both public and private plans. The aim of our research was to understand more precisely what type of variation exists and whether more clarity and consistency in medical necessity decision making could make a difference to consumers and providers. We sought to document differences in decision-making criteria and to explain the relationship between contractual definitions and the way decisions are made in practice. Given the lack of existing information on how medical necessity decisions are made in managed care organizations, we believed that describing “best practices” as well as unacceptable variations could play a powerful role, along with consumer choice and regulatory fiat, in improving the process.

Finally, we sought to produce, with stakeholders’ involvement, a model contractual definition and decision-making process based on best-practices models.

Study Methods

We conducted interviews in 1998–1999 with the medical directors of thirty-four health plans, medical groups, and integrated delivery systems in California, representing more than 88 percent of the commercial managed care enrollment and 84 percent of managed Medi-Cal enrollment. Structured interviews included four case examples to test decision-making approaches. We also requested data on plan or group characteristics and relevant documents. In addition, we interviewed other stakeholders, including consumer representatives, treating physicians, purchasers, plan legal directors, and regulators, repre-
senting a total of ninety-four organizations. To understand the legal context in which medical necessity has been interpreted, we analyzed twenty-seven published California court cases. To determine the degree of variation in the interpretation and application of medical necessity by the Department of Corporations (DOC), California’s managed care regulatory authority, we analyzed a sample of twenty-two consumer Requests for Assistance cases related to reconstructive surgery.  

We then presented our preliminary findings at a three-day workshop in March 1999 involving twenty of our respondents, cosponsored by the Integrated Healthcare Association.  

Research Results

Our research addressed several central questions: (1) Who makes medical necessity decisions? (2) What are the variations in process and contractual definitions of medical necessity? (3) Can more information and better communication improve the process for consumers and providers? (4) What role should legislation and regulation play in promoting best practices and reducing unacceptable variation?

Medical necessity decisionmakers. Many consumers believe that nonclinical personnel make most of the decisions in managed care, including decisions to deny care. Consumers interviewed were unaware that both the National Committee for Quality Assurance (NCQA) and the Knox-Keene Act, which regulates managed care plans in California, require that only licensed physicians can make medical necessity decisions or denials, and that the NCQA audits the plans for compliance with these requirements.  

Although only physicians appear to be making denials based on medical necessity, in fact, nonphysician personnel do participate in initial reviews of eligibility and coverage. A clerk may have authorization to rule on a clearly excluded service. A nurse may evaluate a request against a coverage policy and recommend a denial or modification to a medical director. However, criteria and policies guiding these decisions are vague, uncertainty is present, and differences of opinion easily arise. Delays in referring such cases to medical directors leave consumers with the impression that “bean counters” are truly in charge.  

Although medical directors are physicians, the fact that the patient’s treating physician is not the final decisionmaker in all requests continues to trouble physicians and their professional associations. Recent plan decisions to give treating physicians more autonomy may alleviate this concern, although most plans will retain authority over decisions such as coverage of transplants or experimental/investigational treatments.  

California’s reliance on the delegated medical group for decision making has further obscured the source and process for making these decisions. California’s health maintenance organizations (HMOs) generally capitate medical groups (for example, independent practice associations, multi/single-specialty medical groups, and management services organizations) for professional and often for hospital services. In doing so, they also delegate initial decision-making authority for coverage to these groups.

The medical directors of medical groups reported that they approve most treatment requests (94 percent, on average). Because plans retain final legal authority, they may overturn medical groups’ decisions, often without assuming financial responsibility for the decision. Consumers generally must appeal denials first to the delegated medical group and then to the plan itself before they can seek redress from the DOC or an external review organization. This double layer of denials causes confusion and adds cost, time, and complexity to the process.

Variations in process and contractual definitions. While we found many common processes across organizations, there was much variation as well. Although variation is not necessarily negative, when consumers and employers purchase health insurance, they want to believe that Plan A will treat a given condition and patient the same way as Plan B does. We discovered variation in the contractual definitions of medical necessity and in the
application of those definitions to practice. We also found variation in the substance and application of coverage policies. By asking medical directors what criteria they used to make daily medical necessity decisions, and by comparing those criteria with the ones in their own contracts, we confirmed that contractual definitions of medical necessity vary and are not the primary driving force in practice. Instead, each medical director relies to a different extent on coverage policies, scientific evidence, expert opinion, committee consensus, personal experience, and patient characteristics and preferences when making daily decisions, while the contractual definition remains on the shelf as a reminder of legal obligations and risks.

The irrelevancy of contractual definitions is in part the result of the vague nature of the language, which lacks explicitly defined criteria or definitions of key terms. For example, most “evidence” criteria simply refer to “generally accepted or community standards of practice,” and if cost-effectiveness is addressed at all, it may be couched as “a prudent use of plan resources” or “most appropriate level of service.”

Existing definitions fail to provide guidance for decisionmakers who wish to make evidence-based decisions or explicit trade-offs between the benefits and costs of alternative treatments. Many of our respondents reported reluctance to discuss costs or cost-effectiveness with either their contracted providers or plan members. Medical directors reported that clearer evidence and cost-effectiveness criteria could improve the utility of contractual definitions.

An additional source of variation is the proliferation of multiple, overlapping, and often inconsistent coverage policies developed by plans. Coverage policies should lead to more rational and consistent decisions for patients with a particular condition. In practice, policy development and dissemination are costly and problematic, and add to unacceptable variation in decision outcomes. Medical groups in California may contract with eight to ten health plans, each with its own set of coverage policies. Medical directors and practicing physicians are left with a bewildering array of competing policies, which are neither electronically searchable nor in formats that are easily comparable.

In addition, the substance of the policies and the evidence on which they are based differ greatly, producing the dissimilar outcomes that members and purchasers fear. A case study of autologous chondrocyte transplantation (ACT) for knee pain exemplifies this variation. In three plans' coverage policies for ACT we found only three areas of consistency and many areas of potentially clinically important inconsistency. For example, Plan B recommends coverage of treatment for a member who is age fifty-five, while Plan C only recommends coverage up to age forty-five. Plan B also recommends coverage for lesions up to 20 square centimeters in surface area, while Plan C recommends coverage for lesions up to only 10 square centimeters. Lesion thickness and length requirements also differ. The degree of specificity among the coverage policies varies, with Plans B and C outlining in detail requirements for lesion size, patient age and weight, prior therapy, and surgeon characteristics, while Plan A specifies none of these. The scientific evidence upon which plans based their policies also differed. In addition, two of the medical directors contradicted their own coverage policies when asked what decision they would make in this hypothetical case. This suggests either ignorance of the policies or their irrelevance.

The collective responses from medical directors of plans and groups to this ACT case study and three others—reconstructive surgery for cleft palate, growth hormone for short stature, and high-dose chemotherapy for ovarian cancer—suggest that coverage policies for identical patients did indeed differ and that daily decisions were not necessarily based on policies. While the sample size and brevity of the cases do not permit drawing conclusive opinions, several observations can be made. First, case responses varied across medical groups and health plans, unrelated to size, geography, or populations served. Sec-
ond, there was more agreement among medi-
cal directors in the case for which evidence
was somewhat clearer (growth hormone for
short stature). This consensus may reflect the
considerable evidentiary literature on the ef-
fec tiveness of growth hormone, medical direc-
tors’ familiarity with that evidence, and the
relative comfort most medical directors have
with approving or denying this treatment
based on patient characteristics such as those
presented in the case.

Best practices in decision making. Consumers
and policymakers look to regulation or legis-
lation to reduce inconsistency. However, not
all inconsistencies among organizations are
negative, nor are regulation and legislation al-
ways appropriate ways of reducing them.
Some variations represent more innovative
ways of accomplishing an organizational goal,
and many best practices are those that rely on
obvious solutions: the personal touch (for ex-
ample, calling physicians directly to notify
them of a denied request); involving providers
in suggesting ideas for improvement (for ex-
ample, interdisciplinary committees); decen-
tralizing decisions (that is, moving a decision
closer to the patient and the physician); and
rewarding positive behavior over punishing
the “bad apples” (for example, “gold carding”
providers whose utilization is circumspect
and freeing them from cumbersome authori-
zation processes).

Researchers extracted around sixty “best-
practice” recommendations from the inter-
view process and asked workshop partici-
pants to rate their potential impact on
improving the decision-making process and
their feasibility of implementation (Exhibit 1).

In virtually all cases, workshop partici-
pants ranked recommendations higher on im-
 pact than on feasibility, which suggests that
while many of these best practices are poten-
tially helpful, the practical barriers to their
adoption are difficult to overcome. For exam-
ple, a recommendation for medical directors
to contact a patient’s treating physician for
comment before issuing a denial ranked high
on impact but relatively low on feasibility.
Medical directors reported that they already
try to contact physicians in most cases, but

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<tr>
<th>EXHIBIT 1</th>
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<tr>
<td>Sample Recommendations For Best Practices In Medical Necessity Decisions</td>
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<table>
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<th>Impact</th>
<th>Feasibility</th>
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<tr>
<td>High</td>
<td>Health plans should track numbers and types of denials and their reasons and use this information for quality improvement and for comparison among organizations. Plans should inform patients of requests, decisions, and reasons in a timely manner. Plans should provide consumers with timely and full information about their ability to appeal, internal and external assistance, and second opinions.</td>
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<tr>
<td>Low</td>
<td>Legislature should require plans and provider organizations to disclose their contractual definitions. Organizational policies should include references to sources.</td>
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**SOURCE:** Sample recommendations based on research project, “Decreasing Variation in Medical Necessity Decision Making” and findings from a decisionmaker workshop conducted in March 1999 at the Sierra Health Foundation, Sacramento, California.
physicians do not always return their calls.

Recommendations about streamlining authorization, enhancing communication, and providing more education were all thought to have some potential for positive impact among all stakeholder groups. Most of the recommendations that were rated highest for both impact and feasibility involved better communication. Participants, however, discriminated among communication activities, suggesting, for example, that welcome calls by health plans to new members would be neither feasible nor particularly beneficial. Recommendations expected to have the least impact entailed legislative mandates or greater purchaser involvement in the process.

- Better communication. Our findings reinforced the perception that communication with consumers and their treating providers is poor. Not enough information is disclosed or requested, and the information that is disclosed is not particularly clear, helpful, or accessible. The denial letter is a case in point. Denial letters rarely explain who made the decision, the reason for the decision, what sources of evidence were considered, what coverage policies were applied, or anything else about the process of making that decision. Although a more informative denial letter will not eliminate dissatisfaction with a decision, consumers interviewed indicated that it could increase public trust in managed care.

Lack of consistent and effective communication among multiple decisionmakers is another important source of conflict. For example, medical groups that contacted physicians and plans about questionable requests claimed less conflict and fewer appeals and overturned decisions.

- Role of legislation and regulation. There are many options for reducing variation, promoting consistency, and speeding dissemination of best practices in medical necessity decision making, only two of which are legislation and regulation. Judicial action, accreditation, market and performance incentives, and collective action also must play a role. Each of these approaches has strengths and weaknesses, whether pursued alone or in combination.

Legislation. Despite all of the attention to legislation, there has been little discussion about whether legislation is addressing the most important problems with managed care or whether it is even the appropriate vehicle for doing so. State and federal legislation have mainly addressed problems of access to providers of choice, timeliness of decision making, internal and external independent review procedures, plan accountability, and the right to sue.

Legislation can, however, promote more consistent organizational behavior. For example, California law spells out a specific process for external review of denials of experimental or investigational treatments. Our research confirmed that plans were following this mandate in similar ways. Legislation also can resolve structural debates among stakeholders, such as where the authority for various decisions should reside, and it can set standard floors below which plan performance would be considered to be unacceptable. Legislation can also require information disclosure.

The danger of detailing standards and definitions in statute, however, is that clinical practice is difficult to pin down precisely, floors quickly become ceilings, and politics almost always intrudes. Legislation is a weak strategy to effect deep systemic and organizational change of the type our research found necessary. Government regulation does not necessarily motivate providers to improve, and legislation does not necessarily make consumers more prudent purchasers.

Regulation. Regulation is a more flexible tool than legislation to promote consistency, but it can be a barrier to innovation. Ideology and bureaucracy often prevent regulators from moving quickly or responding to emerging problems effectively.

In our review of Requests for Assistance from the DOC, we found that the department does not have a consistent process for or a standard definition of medical necessity. The consultant the DOC used for our sample cases relied largely on his own clinical judgment
with little citation of scientific literature to support his recommendations. The DOC representative who attended the project workshop acknowledged the need to improve the department’s process.

Judicial action. Judicial interpretation and application of the law can cause organizations to change. However, the judicial system can also obfuscate rather than clarify the most troubling questions. Our review of court cases related to medical necessity decisions confirmed that judicial outcomes in such cases seem idiosyncratic and fact specific and do not provide useful guidance for medical necessity decision making.¹⁹

Accreditation. Private accrediting agencies such as the NCQA, the American Accreditation Healthcare Commission (URAC), and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) serve an important standard setting and auditing role in the managed care decision-making process. Since accreditation standards are not compulsory, they can promote incremental performance improvement. We found both consistent and inconsistent implementation of NCQA standards in our interviews. All plans and groups used physicians to make medical necessity denials, but not all plans and groups demonstrated that medical evidence was documented as part of the coverage policies they use or that plans were successfully involving practitioners in the development of policies.²⁰

Market and performance incentives. Accreditation promotes consistency, but market and performance incentives drive organizations to achieve optimum performance. We found considerable evidence of innovation as health plans attempted to improve their own decision-making processes in response to consumers’ demands and the potential for legislation. Organizations were exceeding legislated timeline requirements and were revising the cumbersome authorization system and even eliminating it for some procedures and practitioners.

Among the most intractable problems are those that do not lend themselves to correction by any of these strategies but rather require stakeholders to work collectively. Thus, to address the problem of overlapping and conflicting coverage policies, workshop participants recommended a public/private initiative to compare, evaluate, and encourage standardization.

The problems associated with medical necessity go beyond the terminology and authority for decision making. The decision-making process itself is in need of improvement. To make the process more consistent yet provide opportunity for innovation will require multiple strategies, as outlined above. Consumers, advocacy organizations, and employers can use their buying power to effect appropriate systemic and organizational change. Only then can managed care fulfill the promise of evidence-based medical necessity decision making to improve quality of care.

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NOTES
219–223.


7. Singer et al., “Decreasing Variation,” Appendix A (model process) and Appendix B (model definition).

8. The DOC was responsible for regulating “Health Care Service Plans” (that is, HMOs) in California in accordance with the Knox-Keene Health Care Service Plan Act of 1973. In 1999 a new Department of Managed Health Care replaced the DOC in this role.

9. The Integrated Healthcare Association is a group of California health plans, physician groups, and health systems, plus academic, purchaser, and consumer representatives involved in policy development and special projects around integrated health care and managed care.

10. See National Committee for Quality Assurance, Surveyor Guidelines for the Accreditation of Managed Care Organizations (1 July 1998–30 June 1999), Sec. 3.2.


12. The Permanente Medical Group allows its treating physicians to make determinations of medical necessity; more recently United HealthCare announced that it too would let contracted physicians make those decisions in some states. In California, where these decisions have been largely delegated to medical groups, the effect may not be significant. See C. Ornstein, “United Health to Let Doctors Set Treatments,” Dallas Morning News, 8 November 1999.


14. National polls and surveys show that there is a problem with managed care that the marketplace alone does not solve. “Survey of Americans’ Views on the Consumer Protection Debate,” Kaiser Family Foundation and Harvard University (17 September 1998); “Survey of Physicians and Nurses,” Kaiser Family Foundation/Harvard University School of Public Health (July 1999); and “Consumers in Managed Care: Problems, Solutions, and Lessons Learned from the Health Rights Hotline” (Sacramento: Health Rights Hotline, 30 June 1998).


16. See California A.B. 1663 (Friedman) 1996, which adds Chapter 979 to Section 1370.4 of the Health and Safety Code and Section 10145.3 to the Insurance Code.


20. NCQA, Surveyor Guidelines for the Accreditation of Managed Care Organizations, Sec. 3.2, QI 2.3, QI 8.1, and QI 8.2, respectively.