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TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 407
A-18

Subject: Medical Necessity Decisions Are the Practice of Medicine

Introduced by: Harris County Medical Society

Referred to: Reference Committee on Socioeconomics

Whereas, Payer peer-to-peer (payer physician to practicing physician) utilization reviews regarding prior authorization adverse determinations have increased in recent years; and

Whereas, Peer-to-peer utilization reviews are predominantly decisions on medical necessity; and

Whereas, Practicing medicine, according to Texas Occupations Code Chapter 151.002 (13), "means the diagnosis, treatment, or offer to treat a mental or physical disease or disorder or a physical deformity or injury by any system or method, or the attempt to effect cures of those conditions, by a person who: (A) publicly professes to be a physician or surgeon, or (B) directly or indirectly charges money or other compensation for those services;" and

Whereas, Based on the above definition, medical necessity decisions are the practice of medicine by virtue of the fact that they effect cures; and

Whereas, To be a physician or surgeon in Texas you must have a Texas medical license; and

Whereas, At times, the 'payer peer' in the peer-to-peer review is not of the same or similar specialty as the practicing physician, not licensed in Texas, and not a physician or surgeon; and

Whereas, The Texas Occupations Code (Medical Practice Act) currently does not have clear language stating that a medical necessity decision is the practice of medicine and therefore must be made by a physician licensed to practice in Texas, and

Whereas, Texas Insurance Code Title 14, Chapter 4201, Subchapter A, Section 4201.002 (1), regarding utilization review, allows a "utilization review agent" to determine that health services provided or proposed to be provided to a patient are not medically necessary or are experimental or investigational; and

Whereas, Texas Insurance Code Title 14, Chapter 4201, Subchapter A, Section 4201.002 (14) defines a "utilization review agent" as an entity that conducts utilization review for (A) an employer with employees in this state who are covered under a health benefit plan or health insurance policy; (B) a payer; or (C) an administrator holding a certificate of authority under Chapter 4151; and

Whereas, Texas Insurance Code Title 14, Chapter 4201, Subchapter A, Section 4201.002 (13) defines "utilization review" as including a system for prospective, concurrent, or retrospective review of the medical necessity and appropriateness of health care services and a system of prospective, concurrent, or retrospective review to determine the experimental or investigational nature of health care services. This term does not include a review in response to an elective request for clarification of coverage; therefore be it

RESOLVED, That the Texas Medical Association work to align the Texas Occupations Code, Texas Insurance Code, and Texas Administrative Code with clear verbiage that medical necessity decisions are the practice of medicine and can only be performed by a physician with an active license in the state of Texas; and be it further

RESOLVED, That the Texas Medical Association work to align the Texas Occupations Code, Texas Insurance Code, and Texas Administrative Code with clear verbiage requiring that those making peer-to-peer medical necessity decisions be in the same or similar specialty as the treating physician seeking authorization.

Related TMA Policy:

145.024 Medical Decision Makers Licensed in Texas: The Texas Medical Association will (1) support legislation that would amend the Texas Insurance Code to require utilization review agents to be supervised by physicians licensed to practice medicine in the State of Texas and all denials of care based on medical necessity to be made by physicians licensed to practice medicine in the State of Texas and in the same or similar specialty as the treating physician seeking authorization of medical care; and (2) work to amend the Medical Practice Act to clearly include the supervision of persons performing precertification or preauthorization based on medical necessity as the practice of medicine; and include any denial of precertification or preauthorization of medical services based on a determination of medical necessity as the practice of medicine (Amended CL Rep. 1-A-08; amended CSE Rep. 5-A-16).

160.017 Utilization Review: The Texas Medical Association will pursue legislation to ensure that adverse utilization review determinations be made only by physicians who are fully licensed by the Texas Medical Board and monitor proposed legislation to maintain the Texas Medical Board's current authority to enforce the Medical Practice Act in regard to utilization review decisions (CL/CSE Rep. 2-A-09).

225.019 Criteria for Physicians Conducting Peer Review: The Texas Medical Association advocates that physicians who conduct review for health care decisions in Texas should (1) be in an active practice; (2) possess a nonrestricted license to practice in Texas; and (3) be experienced in the procedures or treatment under review. (For example, not all orthopedic surgeons perform spinal surgery.) (Res. 410-A-11).

265.005 Clinical Competence: Quality, appropriateness, and necessity of medical decisions are clinical decisions to be based on clinical data judged by clinically competent persons. In addition, the Texas Medical Association supports legislation and regulations which stipulate that only persons with demonstrable clinical competence for the clinical decisions under review may make the review decisions concerning quality, appropriateness, and/or medical necessity of care related to a specific patient. In addition, TMA supports legislation and regulations requiring any managed care plan wishing to deny coverage or alter a clinical decision for care based on quality, appropriateness, and/or necessity of that care may do so only through clinically competent peer review of all pertinent clinical data (Substitute Res. 28AA, p 182C, A-94; reaffirmed CSE Rep. 3-A-04; reaffirmed CSE Rep. 2-A-14).

265.010 Medical Care Guidelines: The Texas Medical Association opposes the use of so-called medical care guidelines (including, but not limited to, those published by Milliman & Robertson) that are based on economic data rather than evidence-based, scientifically sound medical data (Res. 402-A-00; reaffirmed CSE Rep. 1-A-10).

265.018 Evidence-Based Medicine: Recognizing that the primary purpose of evidence-based medicine and evidence-based guidelines is to improve patient care, the Texas Medical Association advocates the use of the most current, best clinical research evidence in all determinations and assessments of

appropriate medical care. A strong source of evidence must be documented in peer review journals and endorsed by specialty societies or nationally recognized medical organizations. Evidence-based guidelines must be patient-centered, recognizing that the integration of the physicians' clinical skills and experience, along with the patients' unique needs and preferences, must be at the core of every clinical patient care decision.[1]

TMA recognizes there are many classifications of levels of evidence in the literature but supports the use of Class I/II, Level A/B, or an equivalent, as being the most clinically sound. Additionally, TMA maintains that observational studies generally should not be the foundation of evidence-based medicine.[2]

TMA strongly supports the standardization of a national set of evidence-based measures that are clinically meaningful and lead to performance improvement while improving both patient outcome and patient satisfaction. Accordingly, TMA supports the American Medical Association-convened Physician Consortium for Performance Improvement through participation in workgroups and ongoing measure development review.

Recognizing that evidence-based medicine is continually evolving, measures should be evaluated and subject to regular review (1) at intervals in accordance with consortium standards, (2) whenever there is a major change in scientific evidence, or (3) when results from testing arise that materially affect the integrity of the measure.

TMA supports the focus of the AMA policy in its efforts to (1) work with state and local medical associations, specialty societies, and other medical organizations to educate the Centers for Medicare & Medicaid Services, state legislatures, third-party payers, and state Medicaid agencies about the appropriate uses of evidence-based medicine and the dangers of cost-based medicine practices; and (2) through the Council on Legislation, work with other medical associations to develop model state legislation to protect the patient-physician relationship from cost-based medicine policies inappropriately characterized as "evidence-based medicine" (CSA Rep. 3-A-08).

[1]TMA's description of evidence-based medicine substantially reflects the work and definition as outlined by Sackett, David L., Sharon E. Straus, W. Scott Richardson, et al. Evidence-Based Medicine: How to Practice & Teach EBM. 2nd edition. London, England: Churchill Livingstone, 2000.

[2] AACVPR/ACC/AHA 2007 Performance Measures on Cardiac Rehabilitation for Referral to and Delivery of Cardiac Rehabilitation/Secondary Prevention Services. Circulation 2007;116;1611-1642.

Related TMA Board of Councilors Current Ethics Opinions:

MEDICAL NECESSITY. The determination of medical necessity is the practice of medicine; it is not a benefit determination. Whether or not a proposed treatment is medically necessary should be decided in a manner consistent with generally accepted standards of medical practice that a prudent physician would provide to a patient for the purposes of preventing, diagnosing or treating an illness, injury, disease or its symptoms. This is true even if the physician making the medical necessity determination is making those decisions on behalf of a managed care organization. That physician must not permit financial mechanisms to interfere with his/her determination as to whether a treatment is medically necessary. Although the physician may take cost considerations into account, the physician may not refuse to approve the medical necessity of a treatment simply based on cost, and must approve the treatment if it is clearly more therapeutically effective than other treatment options that may be covered under the plan, even if those treatment options are less expensive than their more costly counterpart.

UTILIZATION REVIEW. The physician who performs prospective and/or concurrent utilization review is obligated to review the request for treatment with the same standard of care as would be required by the profession in the community in which the patient is being treated.

MEDICAL DIRECTORS. Simply because a physician is not providing direct patient care does not mean that the physician is not practicing medicine or obligated to adhere to the principles of medical

ethics. Whenever physicians employ professional knowledge and values gained through medical training and practice, and in so doing affect individual or group patient care, they are functioning within the professional sphere of physicians and must uphold ethical obligations. This is true not only if the physician is making determinations of medical necessity or coverage, but also if the physician is involved in developing a health plan's general policies that affect patient care, e.g., utilization guidelines.

Related AMA Policy:

Definitions of "Screening" and "Medical Necessity" H-320.953

(1) Our AMA defines screening as: Health care services or products provided to an individual without apparent signs or symptoms of an illness, injury or disease for the purpose of identifying or excluding an undiagnosed illness, disease, or condition.

(2) Our AMA recognizes that federal law (EMTALA) includes the distinct use of the word screening in the term "medical screening examination"; "The process required to reach, with reasonable clinical confidence, the point at which it can be determined whether a medical emergency does or does not exist."

(3) Our AMA defines medical necessity as: Health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is: (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate in terms of type, frequency, extent, site, and duration; and (c) not primarily for the economic benefit of the health plans and purchasers or for the convenience of the patient, treating physician, or other health care provider.

(4) Our AMA incorporates its definition of "medical necessity" in relevant AMA advocacy documents, including its "Model Managed Care Services Agreement." Usage of the term "medical necessity" must be consistent between the medical profession and the insurance industry. Carrier denials for non-covered services should state so explicitly and not confound this with a determination of lack of "medical necessity".

(5) Our AMA encourages physicians to carefully review their health plan medical services agreements to ensure that they do not contain definitions of medical necessity that emphasize cost and resource utilization above quality and clinical effectiveness.

(6) Our AMA urges private sector health care accreditation organizations to develop and incorporate standards that prohibit the use of definitions of medical necessity that emphasize cost and resource utilization above quality and clinical effectiveness.

(7) Our AMA advocates that determinations of medical necessity shall be based only on information that is available at the time that health care products or services are provided.

(8) Our AMA continues to advocate its policies on medical necessity determinations to government agencies, managed care organizations, third party payers, and private sector health care accreditation organizations.

Medical Necessity Determinations H-320.995

(1) Our AMA urges: (a) health insurance carriers and government health care financing agencies to rely on appropriate medical peer review programs for adjudication and resolution of all matters concerning quality or utilization of medical services requiring professional judgment, and (b) that peer review programs have as their goal both improved quality of care and more efficient delivery of medical service.

(2) Our AMA urges health insurance carriers, government financing agencies, physicians and medical societies to explore ways of improving communications, such as the following: (a) In furtherance of past Association recommendations that policyholders be thoroughly and clearly informed as to the extent of their coverage, more detailed information explaining the "medical necessity" exclusion should be provided, especially when the exclusion refers more to the site of the service than to the service itself. (b) Insurers should develop formal protocols as to their methodology for determining "medical necessity," including distinctions between those instances where in-house medical expertise is considered sufficient and those where outside consultation is considered necessary; (c) Third party methodologies for determining "medical necessity" should be made available to medical societies and to individual physicians, as well as listings of those specific situations (such as the ordering of either experimental or outdated procedures or questionable hospital admissions) where additional data may be required; (d) In "medical necessity" decisions where the determination may be modified by additional medical evidence, there should be an opportunity for the treating physician to provide such evidence before a final decision not to pay is made.

Medical Necessity and Utilization Review H-320.942
Our AMA supports efforts to: (1) ensure medical necessity and utilization review decisions are based on established and evidence-based clinical criteria to promote the most clinically appropriate care; and (2) ensure that medical necessity and utilization review decisions are based on assessment of preoperative symptomatology for macromastia without requirements for weight or volume resected during breast reduction surgery.

Medical Necessity Determinations under Medicare D-335.994
Our AMA will urge the Centers for Medicare and Medicaid Services and Congress that medical necessity denials within the Medicare program be reviewed by a physician of the same specialty and licensed in the same state.

Utilization Review by Physicians H-320.973
1. It is the policy of the AMA to urge its constituent medical associations to (a) seek the enactment of legislation requiring that utilization review for insurers shall be conducted by physicians licensed by the state in which they are doing the review; and (b) seek enactment of legislation that would require all agencies or groups doing utilization review to be registered with the appropriate health regulatory agency of the state in which they are doing review and to have an appropriately staffed office located in the state in which they are doing the review.
2. Our AMA will continue to work with state medical associations to monitor utilization management policy to ensure that hospital admissions are reviewed by appropriately qualified physicians and promote related AMA model legislation.

Sources:
1. Texas Occupations Code, Title 3 Health Professions, Subtitle B Physicians, Chapter 151 General Provision, Subchapter A General Provisions, Section 151.002(13): Sec. 151.002. DEFINITIONS. (a) In this subtitle: (13) "Practicing medicine" means the diagnosis, treatment, or offer to treat a mental or physical disease or disorder or a physical deformity or injury by any system or method, or the attempt to effect cures of those conditions, by a person who: (A) publicly professes to be a physician or surgeon; or (B) directly or indirectly charges money or other compensation for those services.

2. Texas Insurance Code, Title 14 Utilization Review and Independent Review, Chapter 4201 Utilization Review Agents, Subchapter A General Provisions, Section 4201.002(1): 4201.002. DEFINITIONS. In this chapter: (1) "Adverse determination" means a determination by a utilization

review agent that health care services provided or proposed to be provided to a patient are not medically necessary or are experimental or investigational.

3. Texas Insurance Code, Title 14 Utilization Review and Independent Review, Chapter 4201 Utilization Review Agents, Subchapter A General Provisions, Section 4201.002(14): Sec. 4201.002. DEFINITIONS. In this chapter: (14) "Utilization review agent" means an entity that conducts utilization review for: (A) an employer with employees in this state who are covered under a health benefit plan or health insurance policy; (B) a payor; or (C) an administrator holding a certificate of authority under Chapter 4151.

4. Texas Insurance Code, Title14 Utilization Review and Independent Review, Chapter 4201 Utilization Review Agents, Subchapter A General Provisions, Section 4201.002(13): Sec. 4201.002. DEFINITIONS. In this chapter: (13) "Utilization review" includes a system for prospective, concurrent, or retrospective review of the medical necessity and appropriateness of health care services and a system for prospective, concurrent, or retrospective review to determine the experimental or investigational nature of health care services. The term does not include a review in response to an elective request for clarification of coverage.