COMMENTARY

MEDICAL-NECESSITY DECISIONS AND THE TEXAS HMO STATUTE

Editor's note: This is the second part of a two-part commentary. Part one, "New Health Plan Proposals Doomed Under ERISA's Umbrella," was published April 11 on page 20.

Group health plans known as health maintenance organizations (HMOs) in theory involve a simple relationship

HEALTH CARE
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between the organization and its contracting physicians. In reality, however, the relationship is extremely complicated, leading to complicated liability questions.

The confusion arises because the HMOs' certificates of coverage allow them to make crucial medical-necessity determinations. Practical considerations involved also contribute to the complication, with the HMOs' powers to make medical-necessity decisions often interfering with the contracting physicians' ability to practice medicine. This interference violates the Texas HMO statute (Insurance Code articles 20A.01-20A.35) and is contrary to the Texas Medical Practices Act.

When a health plan is not governed by federal regulation (namely, ERISA), and an HMO interferes with a contracting physician's practice of medicine by making medical-necessity determinations, patients and their attorneys should analyze the facts of each case under state laws that govern the business of insurance. Potential claims could arise under the Texas Insurance Code and DTPA, common-law negligence and breach of contract for conflicting or ambiguous policy provisions.

THE HMO STRUCTURE

When an individual contracts with an insurance company to provide health insurance benefits, the company has, to an extent, a right to determine the medical necessity of a procedure covered under the policy. The insuring agreement will always provide that payments will be authorized for covered procedures that are determined to be medically necessary. Obviously, when individual insurance contracts are involved, there may be differences between the insured and the insurance company as to what constitutes medical necessity. Nevertheless, few would argue that the insurance company does not have a right to express its opinion.

HMOs present different considerations because of their structure. HMOs contract with independent physician associations (IPAs) to furnish the doctors who provide the medical services. Since the doctors inherit a pool of patients and receive payment directly from the insurance company, they agree to perform services at reduced rates. In exchange for a reduction of costs in receiving medical

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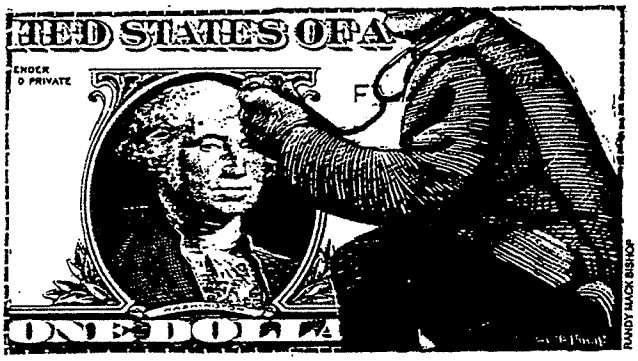
When the medical-necessity determination made by an HMO comes between the doctor and patient, the result is interference with the practice of medicine, which violates the HMO statute and possibly the Texas Medical Practices Act.

care, the insureds give up their right to see the doctor of their choice.

We believe that medical-necessity decisions made by Texas HMOs should be subjected to much greater scrutiny than in the case of individual insurance contracts.

If a person is insured through an HMO, it is much more likely than not that the health plan will be governed by ERISA. If the health plan is governed by ERISA, all state laws that regulate the insurance industry, including the Texas HMO statute, will be pre-empted by federal regulation.



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If a health plan is not federally regulated, however, the Texas HMO statute contains two provisions that are relevant. First, the act strictly prohibits an HMO from interfering, *in any manner*, with the practice of medicine. Second, the act requires that all doctors who furnish services to HMO members *must* be independent contractors. These provisions are necessary because the Texas Medical Practices Act prohibits the practice of medicine by a corporation comprised of lay persons. If a corporation employs rather than contracts with physicians to treat patients, and the corporation receives the fee, the corporation has unlawfully engaged in the practice of medicine.

MEDICAL-NECESSITY DETERMINATIONS

HMO plans are often referred to as "health insurance." In reality, however, the HMO structure allows HMOs to retain physicians to treat their insureds. The insureds' premiums are used to pay physicians directly rather than to reimburse the insureds. This structure brings an HMO dangerously close to allowing it to practice medicine and share fees with physicians in violation of Texas law. To compensate, the HMO statute imposes a theoretically simple solution: It requires that the treating physicians be totally independent from the HMO, and that the HMO not interfere with the treatment of the patients.

Although the theory is simple, in reality, the relationship between HMOs and their contracting physicians is extremely complicated and confusing. Practical aspects of the relationship contribute, but the primary reason for the confusion is the insuring agreement between HMO members and the HMO. Insuring agreements are commonly referred to as "certificates of coverage." These contracts typically contain the following provisions: (1) all physicians are independent contractors; (2) the health plan is not liable for claims; and (3) the medical director determines what services and supplies are medically necessary.

Because the independent contractor relationship has been created by statute, the HMO physician should be totally responsible for the patient's medical care. HMOs are careful to include language in their written contracts stating that the physicians are solely responsible for their exercise of medical judgment and all liability created thereby. In turn, the HMO is absolved from liability when a contracting physician or hospital is alleged to have committed malpractice.

The problems associated with these common provisions are readily apparent. While stating on the one hand that treating physicians are independent contractors who are totally responsible for the patient's medical care, the HMO declares on the other that its own medical director is responsible for determining medical necessity. Medical necessity is the foundation of medical practice. Decisions concerning medical necessity always require expert medical opinion.

Although these opinions are the responsibility of contracting physicians, HMOs routinely refuse to pre-certify procedures ordered by contracting physicians as the result of in-house determinations that the procedures are not medically necessary. When the medical-necessity determination made by an HMO comes between the doctor and patient, we believe the result is an interference with the practice of medicine, which violates the HMO statute and may be contrary to the Texas Medical Practices Act. And, though we believe reserving the medical-necessity call in the certificate of coverage conflicts with the Texas HMO statute, these decisions are made by the HMOs under the guise of favorable policy interpretation. The result is that an HMO "has its cake and eats it, too."

It is unnecessary under the statutory scheme for an HMO to reserve medical-necessity calls in the certificate of coverage. The HMO has, itself, contracted with the doctor to treat the patient. If an HMO is not pleased with the performance of a doctor, it can terminate the contractual arrangement. However, in order to be truly independent, the doctor must have the ability to make all decisions in the best interest of the patient's health care, including determinations concerning whether certain care is medically necessary.

Unfortunately, it is not just the language in the certificate of coverage that creates the inequity of the system. Certain practical aspects involving the structure of the HMO also contribute. For example, HMOs are designed to make a profit. As a result, they uniformly minimize their insureds' medical care in order to maximize their own profits. HMO medical directors and the employees who work under them are taught to scrutinize the medical necessity of procedures recommended by contracting physicians.

In a recent case against a Texas HMO, we discovered documents that stated the medical director is the "final authority" for all issues concerning medical necessity. Depositions of utilization review nurses established that they are taught to determine the medical necessity of certain procedures on their own. Other medical procedures were classified into a special group and subjected to a much greater level of scrutiny in determining medical necessity.

We also learned medical directors and utilization review personnel are taught how to "negotiate" treatment plans with health care providers. The HMO bargains for alternative courses of treatment in an attempt to shorten hospital stays and eliminate high-cost procedures. HMO employees are well schooled in explaining that patients can "make do" with something less than what their doctor prescribed. We suppose this is the essence of the term "managed care," which is the euphemistic phrase used by HMOs to describe their programs.

Although they may be statutorily prohibited from doing so, Texas HMOs conduct business in this manner on a day-to-day basis. HMOs do not hide the fact that they rule the medical-necessity roost. They truly believe they have the right to do so.

The real question is whether a Texas HMO actually does or should have a right to make decisions concerning medical necessity. There is not a question these decisions are made routinely by the HMOs. To verify the extent to which HMO claims are denied on the basis of lack of medical necessity, one needs only to review the complaint files at the Texas State Board of Insurance.

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DOCTOR'S DILEMMA, PATIENT'S NIGHTMARE

In response to an argument that it has no right to make medical-necessity determinations, HMOs inevitably argue their policy language does not conflict and that they have a valid right to make medical-necessity decisions. They argue determining medical necessity does not interfere with the practice of medicine, and the treating physician is still completely responsible for the patient's health care. Their conclusion must be that the decision not to pay for a prescribed course of treatment is not the same as telling a doctor he cannot perform the procedure.

Under the current system, HMO decision-making practices put Texas doctors at risk and patients' health in jeopardy. There are too many occasions in which a procedure is not authorized for payment and the doctor is limited in the medical advice that can be given to the patient. This puts the doctor at risk for malpractice litigation. It also puts the patient at risk if a recommended procedure is postponed or eliminated due to the HMO's decision that the procedure is not medically necessary.

This can be illustrated hypothetically, with a heart patient who has been prescribed an angiogram to film the coronary arteries because of symptoms consistent with coronary artery disease. If the patient cannot afford the procedure, the doctor is handicapped. Although the patient is suspected to have coronary artery disease, the doctor cannot effectively diagnose it. Because he cannot diagnose it, the doctor's ability to formulate a treatment plan is also inhibited. For example, while exercise may be good to strengthen the heart, it could also increase the potential for complications, because the patient may be at high risk for sustaining a heart attack through exertion.

Under the current system, the doctor will fight vigorously with the HMO to obtain pre-certification. The patient will join the battle against the HMO and try to secure the necessary funds to have the angiogram. If the insurance company persists, the patient may even begin to question the judgment of his doctor.

While the struggle continues, the HMO will request more medical information from the patient and the doctor, often without specifying the kind of information needed. In some cases, the HMO may seek a second opinion on its own. Unfortunately, this may also be about the time the patient's medical condition deteriorates. Occasionally, the patient may even die during this period of indecision.

If a malpractice suit is brought by the patient's estate, the physician may be named as a defendant regardless of fault. And why? The answer lies within the system. Doctors who treat HMO patients are independent contractors. They are completely and totally responsible for their patients' medical care.

You can bet that the HMO, if named as a defendant, will escape liability on any theory couched in terms of medical malpractice. And why? Because HMOs are corporations, and corporations cannot practice medicine. HMOs have hired independent contractors who are completely and totally responsible for the care of their members.

The current system does not permit the functioning of a true, independent contractor relationship. To the contrary, the HMO's active participation in the patient's health care has interfered with the doctor's ability to treat the patient. What has been created is a dire liability dilemma for the physician. The doctor's dilemma, of course, is the patient's nightmare.

POSSIBLE REMEDIES

If an HMO is not governed by ERISA, then state law can be utilized in litigating claims for wrongful denials of benefits or delays in payment.

The facts of each case should be analyzed to determine whether the HMO interfered, *in any manner*, with the practice of medicine. The HMO statute incorporates the provisions of article 21.21 of the Insurance Code and makes it subject to those provisions. Under the Texas Supreme Court's analysis in *Vail v. Texas Farm Bureau Ins.*, 754 S.W.2d 129, a plaintiff could bring a claim if an HMO violates the Texas HMO statute by interfering with the practice of medicine. Because the provisions of article 21.21 are incorporated into the Deceptive Trade Practices Act, an action can also be asserted under the DTPA.

A claim for common-law negligence might also be asserted. Generally, an HMO has no duty to undertake a patient's medical care. Because the physician is in theory independent, he is liable for his own negligence. However, by making decisions that affect a patient's treatment, the HMO may have acted to undertake a portion of the patient's medical care. In Texas, one who voluntarily engages in an affirmative course of action affecting the interests of another is regarded as assuming a duty to act and must act with reasonable care. Therefore, if the HMO has failed to act reasonably in making its medical-necessity determination and the patient is injured as a result, the HMO could be held negligent under this common-law doctrine.

Another common-law negligence theory that should be considered is based on traditional independent contractor law. In Texas, one who entrusts work to an independent contractor, but who retains control of any part of the work, is subject to liability for physical harm to others when he fails to exercise his retained control with reasonable care. By reserving the medical-necessity call, the HMO has retained the right to control the doctor's work. Therefore, the HMO may be liable if it fails to exercise that control with reasonable care.

A breach-of-contract claim should also be considered. HMOs' certificates of coverage contain conflicting policy provisions that create substantial ambiguities. An ambiguity may be created by the contract when an HMO reserves the medical-necessity determination while conversely stating that physicians are independent contractors who are totally responsible for the patient's medical care.

NO CLEAR ANSWERS

There is probably not a clear-cut answer to the question of whether an HMO has the authority to make medical-necessity determinations. As a practical matter, however, an HMO's decision concerning medical necessity does interfere with a doctor's practice of medicine. Physicians we interviewed said much more of their time is spent arguing with the HMOs and supplying additional medical information when medical necessity becomes an issue. In one case we pursued, the HMO would not even tell the doctor what type of information he needed to provide to the HMO in order to satisfy its medical-necessity requirements. The clinical criteria used by the HMO to establish medical necessity were said to be "proprietary." In other words, it was a secret.

Texas doctors, as well as their patients, are caught in the middle of an unworkable system. The doctor has to explain to the patient that in her opinion, the procedure is necessary. She has to explain the health risks of forgoing the procedure. At the same time, she must explain that the HMO does not believe the procedure is medically necessary, and that the patient and her family will be financially responsible for the treatment she recommends.

Because the doctor is an independent contractor by statute, it logically follows that the doctor should have complete authority to determine medical necessity, if the procedure recommended is a covered benefit under the policy. This simple concept, however, would radically change the current approach to utilization review employed by Texas HMOs. Rather than deciding medical necessity, the utilization review department would be limited to performing part of the job it does now. The role would focus on determining whether the recommended procedure is a covered benefit under the policy, whether the doctor is a contracting physician, whether the patient is a member under the HMO and whether the facility in which the procedure will be performed is a contracting facility.

The HMO could still monitor the performance and decisions of its contracting physicians, but only as part of a review, as is implied by the term, "utilization review." The Texas Administrative Code requires all HMOs to perform this function as a part of their quality assurance programs. This procedure would achieve the goal of allowing HMOs to work with contracting physicians to increase the efficiency of their services instead of interfering with their practice of medicine. ■