



STATE OF DELAWARE  
STATE COUNCIL FOR PERSONS WITH DISABILITIES

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**MEMORANDUM**

DATE: March 29, 2012

TO: All Members of the Delaware State Senate  
and House of Representatives

FROM: Ms. Daniese McMullin-Powell, *DMP/KMP* Chairperson  
State Council for Persons with Disabilities

RE: H.B. 216 [Insurer Denial of Tests & Procedures]

The State Council for Persons with Disabilities (SCPD) has reviewed H.B. 216 which requires State-regulated insurers to be subject to reimbursement and damages sustained by delayed treatment due to unreasonably denied coverage of tests and procedures. To obtain relief, the patient would be required to exhaust internal and external administrative appeals, pays for the test or procedure "out of pocket", and prove that the test or procedure was medically necessary based on the results. Thus, the impact of the law is restrained. If the Insurance Commissioner determined that an insurer violated the statutory standards three (3) or more times within 36 months, the Commissioner would process the denials as an unfair practice.

For background, attached please find several articles which describe highly-publicized denials by BC/BS of cardiac tests. An investigation resulted in release of a critical report in April, 2011 and a September, 2011 consent agreement between the Insurance Commissioner and BC/BS. Under the agreement, BC/BS committed to pay a \$325,000 penalty and underwrite the costs of system to guide the approval process for cardiac testing. BC/BS had earlier eliminated a system in which a screening provider had to repay BC/BS compensation if it failed to meet a 20% savings target. Although the issue with cardiac testing appears to have been resolved, the bill has broader application to non-cardiac tests and procedures. Moreover, the requirement of exhaustion of administrative review remedies offers insurers considerable protection and opportunity for correction of errors.

SCPD is endorses the concept of the bill. Thank you for your consideration and please contact SCPD if you have any questions regarding our position or observations on the proposed legislation.

cc: The Honorable Jack A. Markell  
Mr. Brian Hartman, Esq.  
Governor's Advisory Council for Exceptional Citizens  
Developmental Disabilities Council

hb 216 insurer denials 3-29-12

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**NEWS** From Insurance Commissioner  
Karen Weidin Stewart, CIR-ML

Wednesday, April 14, 2010 - For Immediate Release

**COMMISSIONER STEWART SETS  
RECORD STRAIGHT**

**Provides Timeline Of Department Action In Pre-Authorization  
Denials While Hosting Public Meeting Of Stakeholders**

Dover – Delaware Insurance Commissioner Karen Weidin Stewart hosted a meeting of stakeholders on Tuesday to discuss pre-authorization denials in cardiac and other imaging tests. The Commissioner applauded her Department's quick, professional and proactive responses to the initial complaint and praised the various stakeholders with whom she and her staff met the past year. The Commissioner, quoting a timeline (see below) drawn from internal department records and published newspaper accounts said, "The foundation of my administration's approach to health care is 'The Patient Comes First'. Our response to the initial and only complaint in two years made to the Department in connection with these denials from any source including doctors, patients, legislators and other health care agencies, a complaint made well after the patient had completed his surgery, was immediate. Our subsequent meeting with Blue Cross/Blue Shield of Delaware produced a suspension of all denials of services and was provided to a major Delaware media outlet, prior to any federal inquiry, on the condition that it not be made public."

Making available a detailed timetable that verified the Commissioner's original assertion, made last month in response to media criticism, that the care of the patient is paramount, The Commissioner said that the record clearly shows she and her staff took the initiative on every front including rapidly responding to the doctor, meeting with the carrier and securing an agreement on a moratorium. The Commissioner continued, "Since I took office, I and my staff have been consistently meeting with cardiologists, pulmonologists, oncologists, emergency room doctors as well as with insurance carriers, while visiting their facilities and hospitals in order to fully understand the many complexities that characterize health care and its delivery."

The Commissioner concluded, "I will continue protecting you as I have successfully done in my first year whether it is on Worker's Compensation litigation, regulating health insurance rates, securing over \$600,000 in refunds to policyholders, increasing policyholder coverage in the case of an insolvency or the many other actions I have taken that will benefit all Delawareans."

Timeline of events related to the Department of Insurance's handling of a recent and high profile medical procedure pre-authorization case.

February 2010

The patient undergoes surgery in February. At this point in time, no complaints were made to the Department of Insurance pertaining to medical procedure denial(s) or to patient appeals related to denials.

March 10, 2010

The Department of Insurance receives a complaint letter\* from the patient's doctor informing the department that the pre-authorization process resulted in a denial of service. The doctor did not request the help of our office.

March 10, 2010

The Department of Insurance responds, in writing, to the doctor acknowledging receipt of the letter received the same day and offering the department's assistance. The letter included references to our department's legal authority and the types of services offered by our office including what information would be needed to assist with the appeal.

March 19, 2010

News Journal call results in a subsequent meeting with our Consumer Services Division. This is the first time the full extent of this case is presented and discussed. Our department immediately called and secured a meeting with BCBS.

March 21, 2010

The News Journal prints a news story about the patient who is the subject of the March 10, 2010 complaint letter filed by the doctor.

March 22, 2010

Insurance Commissioner Karen Weldin Stewart attends a meeting (previously scheduled) with BCBS executives which results in a moratorium on all denial of services relating to the medical pre-authorization process.

March 22, 2010

Insurance Commissioner Karen Weldin Stewart, in a conversation with the News Journal, informs a reporter about the denials moratorium on an "Off the record" basis. Resists public "grandstanding" on the basis that it might damage similar moratorium work in progress with other insurance carriers.

March 23, 2010

Same as above

March 25, 2010

US Senator Jay Rockefeller sends a letter to BCBS asking for information on the patient case in question and informing BCBS of his position with regard to the provision of health care service. The Senate Committee on Science, Commerce, and Transportation calls for an investigation of BCBS of Delaware (press release, below).

March 26, 2010

The News Journal publishes an editorial opinion highlighting Senator Rockefeller's newly announced investigation and critical of the Delaware Insurance Department for being reactive.

March 27, 2010

The Delaware Insurance Commissioner announces that the department will launch its own investigation into the pre-authorization process.

March 28, 2010

The News Journal publishes another news article on the subject.

March 29, 2010

Doctor responds with patient-specific insurance information.

March 29, 2010

DOI sends formal complaint to BCBS of DE. They have 21 days to respond.

\*It is important to note that up until this time there have been no pre-authorization complaints received at the Department of Insurance related to medical tests for the past two years.

**U.S. SENATE COMMITTEE ON COMMERCE, SCIENCE, AND  
TRANSPORTATION  
PRESS RELEASE, MARCH 25, 2010**

**Rockefeller Demands Transparency and Reform from Health Insurance Industry**

**Chairman Continues Push for Consumer Protection in America's Health Care Marketplace**

Jena Longo - Democratic Deputy Communications Director 202.224.7824

Mar 25 2010

WASHINGTON, D.C.— In his continued effort to hold health companies accountable for how well they cover consumers, Senator John D. (Jay) Rockefeller IV, Chairman of the U.S. Senate Committee on Commerce, Science, and Transportation, sent a letter today to Blue Cross Blue Shield of Delaware (BCBSD) requesting more information on the company's policy towards covering "stress tests." This request follows recent reports that the company has routinely refused to cover these tests for their policyholders, even when doctors have deemed them medically necessary.

According to two recent stories in the Wilmington, Delaware News Journal, BCBSD has repeatedly refused to pay for "stress tests" for their policyholders who are showing signs of coronary heart disease, including severe chest pain. Stress tests help doctors diagnose coronary disease and determine patients' risk to heart attacks and other heart-related conditions. As reported by The News Journal, BCBSD, acting through a third-party claims review company called MedSolutions, told a number of policyholders that the tests were not "medically necessary," and refused to cover them, even though the patients complained of symptoms that strongly suggested heart disease.

"While we are making history here in Washington this week, we will need to continue to make sure that American consumers get the healthcare they pay for and deserve," said Chairman Rockefeller. "As we implement health care reform, I intend to keep a close watch on the health insurance industry and will continue to ask tough questions about how they do business. Denying medically necessary services to patients showing signs of serious heart disease is not acceptable. That's not how health care should be delivered in our country. American consumers deserve better and they are going to get it as health care reforms are implemented over the coming months and years."

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# The News Journal

## Blue Cross Blue Shield of Delaware broke law, report finds

*Insurer criticized for denying tests, linking exams to savings*

By JONATHAN STARKEY • The News Journal • April 16, 2011

Blue Cross Blue Shield of Delaware violated state law by signing a contract with a company that guaranteed the health insurer would save money by denying high-tech imaging tests such as nuclear cardiac exams, according to findings of an investigation by Delaware's Department of Insurance.

MedSolutions was hired in July 2009 to review claims before doctors administered tests such as knee MRIs and CT scans of the brain. The firm stood to lose money if it did not reach its 20 percent savings target, according to the report. Such a contingency violated state law. It was removed from the contract last summer.

The report, which took 13 months to complete, also criticized BCBSD and Tennessee-based MedSolutions for making it difficult for high-risk heart patients to obtain nuclear stress tests, which doctors use to diagnose artery blockages. MedSolutions denied 27 percent of requests to pay for nuclear stress tests – 24 percent when considering those overturned on appeal. Under Blue Cross Blue Shield's pre-authorization program, the insurer forced doctors to prove a test was needed before it would agree to pay.

Contact Web  
Manager

Insurance Commissioner Karen Weldin Stewart said she is still considering whether to assess a fine or impose other penalties because of the illegal contract clause.

As Stewart's report surfaced Friday, so did a summary report concluding a parallel probe of preauthorization in Delaware by the U.S. Senate Committee on Commerce, Science and Transportation. It reviewed pre-authorization programs at BCBSD and at Aetna.

The report blamed insurance companies and doctors for confusion that often left patients stuck in the middle unable to access necessary care. Senate investigators focused on Michael Fields, an Elkton, Md., man whom The News Journal profiled in March 2010, sparking the probe.

Fields was denied nuclear tests two times in January 2010 before his doctors admitted him to Christiania Hospital and performed bypass surgery.

"In the case of Michael Fields, the pre-authorization process unnecessarily delayed care for his life-threatening medical condition," the Senate report said.

The Department of Insurance report recommends that Blue Cross implement pre-authorization standards no stricter than those recommended by the American College of Cardiology and other organizations. That recommendation resulted from findings in the report by Dr. Marc Tecce, a cardiologist at Thomas Jefferson University hired by the Department of Insurance to review BCBSD records. He said MedSolutions' standards for approving nuclear stress tests were stricter than those developed by the ACA, the American Heart Association and the American College of Radiology. He said the MedSolutions standards were inappropriate for high-risk patients.

Stewart said she intends to write a regulation compelling insurance companies to abide by those criteria.

"I feel very strongly that the criteria that the American Cardiology Foundation uses are the criteria that should be used," Stewart said. "We're not going to [let] grass grow under our feet on that one."

BCBSD said in response to the report that it is inappropriate for Stewart to impose a set of criteria.

"The health and safety of our members are vitally important to us," the statement read. "We implemented our high-tech imaging pre-authorization program to ensure our members have timely access to high-quality, safe and appropriate medical care, while minimizing the potential for duplicative and unnecessary tests."

The insurer no longer requires pre-authorizations for nuclear cardiac exams, although MedSolutions still does that for MRIs and CT and PET scans.

Aetna, which also contracts with MedSolutions, still requires prior approval for nuclear cardiac scans.

#### Later problems

Tecce's review also found that 16 nuclear exams that were denied should have been approved. Another 17 exams that were denied but overturned on appeal should have been cleared without issue. That means 12 percent of denials were inappropriate. Another 43 were denied for administrative purposes, such as insufficient information or a scan ordered without a doctor having seen the patient in more than 30 days.

Four Delaware patients who were denied a scan submitted a serious cardiac claim within about a month, according to Stewart's report. Those claims would be for services such as a cardiac catheterization in an emergency department of a hospital or bypass surgery to clear life-threatening blockages. Stewart said that number did not present an "alarming concern."

Fields was one of those patients.

"You're talking about somebody's life," Fields said Friday. "You're literally putting a price tag on somebody's life. You can't do that."

**Contract 'obnoxious'**

Dr. Timothy J. Gardner, medical director for Christiana Care's Center for Heart & Vascular Health, called the 20 percent savings provision in the BCBSD-MedSolutions contract "obnoxious." If it failed to hit the target, MedSolutions had to refund 10 percent of its fee.

"That's not right," Gardner said. "I think that's based on the assumption that the doctors aren't providing good care and are doing unnecessary tests."

The guaranteed savings provision was stripped from Blue Cross Blue Shield's contract with MedSolutions last summer, during the state's examination.

"There is absolutely no financial incentive whatsoever for the MedSolutions doctors and nurses who review these requests to do anything other than make sure that patients receive the safest and most appropriate tests for their needs," Dr. Gregg Allen, chief medical officer at MedSolutions, said in a statement.

Allen contended that specialists who own testing equipment often order expensive tests like nuclear stress exams unnecessarily, noting that cumulative radiation exposure can be harmful to patients.

A 2009 study by the American College of Cardiology and the insurer UnitedHealth that looked at almost 6,000 nuclear cardiac exams found that 14.4 percent of the scans were ordered inappropriately, based on the college's published guidelines. According to the insurance department data, which considered only requests submitted to BCBSD, more than one in 10 nuclear exams doctors ordered did not follow ACC criteria, the Senate report noted.

In a June 2010 report, the Medicare Payment Advisory Commission said a rapid increase in imaging has correlated with a shift in imaging from hospital settings to doctors' offices.

The Senate report fo- cused on the competing conflicts of doctors and insurance companies.

"A predictable result of this conflicted health care delivery system is that patients like Michael Fields and countless others do not reliably receive medically necessary services in a timely way, or they receive unnecessary -- or sometimes even harmful -- services," the Senate report said.

'Close to death'

Fields' ordeal began in January 2010, when he visited his primary-care doctor, Bruce Turner, of Newark, complaining of chest pain. Turner ordered Fields' first denied nuclear cardiac exam on Jan. 6.

Turner's secretary, Mary Wingate, handled the appeal with MedSolutions and ultimately, MedSolutions denied coverage in writing on Jan. 15, saying a staff physician, Dr. John Schottland, a neurologist, had considered and rejected the request, according to the Senate report.

In a 10 a.m. phone call on Feb. 8, Wingate pleaded with a Blue Cross Blue Shield of Delaware representative to reconsider.

"This guy needs a stress test or he's going to drop dead," Wingate said, according to phone records provided by Fields.

Fields' condition had worsened and he could not climb stairs or shovel snow without fighting for breath and suffering from chest pressure he described as feeling like a balloon was inflating inside his chest.

"We've been trying to appeal this and, and I feel myself getting weaker," Fields told an insurance company representative named Kathy, also on Feb. 8.

Fields, who has hired a lawyer and is considering legal action, said he had become "desperate" and even began "begging" Blue Cross Blue Shield of Delaware to foot the bill for his tests. He requested the phone records recently from BCBSD.

Later, Fields requested the home address of a doctor denying his request. "That way, I can send a picture of my 9-year-old son to them so he can understand who needs to be taken care of when I fall over dead with a heart attack."

On Feb. 9, Fields underwent a cardiac catheterization at Christiana Hospital, during which Dr. Andrew Doorey, of Cardiology Consultants in Newark, threaded a catheter into the blood vessels leading to Fields' heart, discovering "critical coronary artery disease," according to a letter that Doorey sent to Stewart on March 5. Doctors performed quadruple bypass surgery on Feb. 10.

In his letter, Doorey wrote that Fields was "visibly shaking" after learning he required immediate bypass surgery.

"He was shaking because he realized how close to death he had come due to the repeated refusal of Blue Cross and MedSolutions to allow him to have a stress tests," Doorey wrote.

## **SUGGESTED ACTIONS**

The Department of Insurance's recommendations for Blue Cross Blue Shield of Delaware:

1. Eliminate guaranteed savings clause in MedSolutions contract.
2. Do not use pre-authorization criteria more restrictive than those published by professional organizations, such as the American College of Cardiology.
3. Ensure denials are being conducted by health care personnel with expertise in field of medicine being reviewed.
4. Clean up claim handling and complaint reviews.



## Blue Cross hit with \$325,000 fine

12:23 AM, Sep. 14, 2011

**DOVER** -- Delaware Insurance Commissioner Karen Weldin Stewart on Tuesday ordered Blue Cross Blue Shield of Delaware to pay a \$325,000 fine for problems in how the company approved and paid for cardiac testing ordered by doctors.

Blue Cross, which refused to pay for testing ordered by cardiologists and primary-care physicians, also will work with the American College of Cardiology on a pilot program designed to reduce inappropriate testing. The tests in question are high-tech nuclear-imaging tests used to diagnose artery blockages that cause heart attacks. Blue Cross and the Insurance Department agreed on the program and fines in settlement negotiations.

A series of stories in The News Journal last year revealed that Blue Cross, the state's largest health insurer, was denying patients access to needed tests through a third-party claims administrator -- MedSolutions, of Franklin, Tenn.

Blue Cross used MedSolutions to prescreen requests by doctors for nuclear cardiac exams and other high-tech tests. The use of such imaging tests has boomed in recent years, and insurers across the country have turned to so-called benefits managers to rein in the ordering of unnecessary tests.

Stewart and the Commerce Committee of the U.S. Senate launched probes into the matter after the stories were published. Stewart said her office's agreement with Blue Cross "is another step on solving the complex problems of delivering the highest quality care to Delaware citizens."

Blue Cross' contract with MedSolutions included guaranteed savings targets that were tied to the company's compensation. That violated provisions in state insurance code, according to Stewart's findings, which were published in April. That report also noted that Blue Cross denials made it difficult for patients to access necessary care and pointed out six cases in which patients were treated for an emergency heart ailment after a denial.

One patient profiled in the newspaper's stories had to be admitted through an emergency room for a heart bypass operation within weeks of a Blue Cross denial of his doctor's request for a cardiac stress test that should have revealed his arterial blockage.

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Blue Cross has eliminated its pre-authorization program for nuclear stress testing. In a statement, Blue Cross said that "as part of our ongoing efforts to enhance and refine our guidelines to benefit our members, we continue to consult with cardiologists concerning cardiac testing and treatment."

The insurer agreed to enter a program run by the American College of Cardiology, which develops cardiac testing criteria. Doctors will use a computer program to determine whether tests they plan to order for patients are appropriate based on a patient's set of symptoms and medical history.

Blue Cross will underwrite the three-year program at a cost of \$100,000 a year, Stewart said. Delaware doctors are to begin using the program, called FOCUS, this fall.

Patients and physicians participating in the pilot program will not be denied any testing. It's intended as an alternative to benefits managers and should reduce inappropriate testing over time by giving doctors feedback about why a test was termed "inappropriate," said Dr. Janet Wright, senior vice president of science and quality for the American College of Cardiology. The program also allows doctors to map their own testing patterns.

"They can not only see their pattern but they can compare themselves to other practitioners," Wright said. "They don't like to be out of line with their compatriots. Just having that feedback shapes behavior like

nothing else."

Data, including some published in the Journal of the American College of Cardiology, show that doctors often do order tests inappropriately. One multi-location study last year showed that more than 14 percent of nuclear stress tests were wrongly ordered and those percentages are higher among primary-care physicians, who often refer patients to specialists.

The cardiology program should generate a wealth of Delaware-specific data about the appropriateness of testing.

"You will see that the majority of physicians are doing what's appropriate," said Gaetano Pastore, a Newark cardiologist and immediate past head of the Delaware chapter of the American College of Cardiology.

Fines paid by Blue Cross will be directed to the state's General Fund, an idea that was questioned Tuesday by state Rep. Daniel

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B. Short, a Seaford Republican.

Short, who has introduced legislation designed to punish insurance companies for wrongly denying tests, said the tests should be used to lower **healthinsurance** premiums or to expand the cardiology program to include other insurance companies. Generally, Short praised Tuesday's announcement.

"For me, this has always been about ensuring that Blue Cross Blue Shield customers can trust that they are receiving the best quality care, regardless of costs," Short said. "I am confident today's consent order will be a step in the right direction in helping to save lives."

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