



Traumatic Brain Injuries: Challenging HMO
Guidelines – Are Patients Powerful or Powerless?
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Introduction

Fifty million Americans are affected by what in the managed health care industry are known as “practice or treatment guidelines.” Healthcare professionals and many individuals and their families have heard the term “treatment guidelines,” and this is often the term used by managed health insurers to deny or limit specific medical treatment and/or care. Unfortunately, very few people understand where treatment guidelines are created. Individuals and healthcare providers have assumed that each health maintenance organization (HMO) sets its own guidelines. The reality is that relatively unknown companies are setting up these guidelines. An HMO uses these confidential, highly detailed guidelines or directives to decide most facets of patient care, including length of in-patient rehabilitation stay for individuals with traumatic brain injury.

One of the leading publishers of healthcare management guidelines is Milliman & Robertson, a company that sells its practice guidelines to HMOs. The guidelines provide estimates of optimal recovery times for thousands of medical treatments and surgical procedures. Other companies also publish guidelines that supply information to healthcare insurers regarding length of inpatient hospitalization and the treatment of complications that a person may experience. Opponents of HMO guidelines argue that physicians are not being permitted flexibility in deciding the best care, and that the guidelines are set with complete disregard of prior medical history and overall health of the individual. This is especially true when care of individuals with catastrophic illnesses or injuries is denied because the person does not fit within the strict confines of the guidelines.

Treatment guidelines are not guidelines at all, but rather strict parameters into which patient care must fit, or the HMO will deny reimbursement. Initially, practice guidelines were intended to limit capricious or arbitrary medical practices. They were not intended to dictate every aspect of care. Rather than being “recovery recommendations,” these guidelines are now serving as “treatment barriers” for many individuals with traumatic brain injury.

Based on treatment guidelines, the rationale used by managed care insurers for denying care for persons with traumatic brain injury are as follows:

- The requested treatment is not medically necessary
- The requested treatment is experimental
- The individual has plateaued and ongoing care is custodial in nature



- Given the person's condition, the most appropriate care possible was provided
- There is a limit to what the insurers can do
- If every appeal was granted, insurers would be out of business

Examples of Restrictive Treatment Guidelines

- Unfair and unnecessary medical documentation required before approval for inpatient rehabilitation
- Overly restrictive guidelines requiring unrealistic progress before acceptance into a coma stimulation/coma awareness TBI program
- Directives limiting the number of home care visits, and type and frequency of therapies for individuals with brain injury
- Primary care providers are encouraged to limit testing and referral of persons with seriously and injury under a capitated system
- Discharge from hospital emergency rooms without treatment or admission

Studies

Numerous studies have been conducted to find the effects that restrictive treatment and treatment guidelines have on the overall health and recovery of the individual:

1. A National Cancer Institute study released in June 1998 found that women receiving outpatient mastectomies face significantly higher risks of being re-hospitalized and an increased risk of surgery-related complications, including embolisms and infections.
2. A 1997 study published in the *Journal of the American Medical Association* showed that babies discharged within one day of birth faced increased risk of developing jaundice, dehydration and dangerous infections.
3. A June 1998 study by researchers at Rand and the University of Michigan found that although most HMOs strictly limit when hysterectomies are permitted, there is little agreement among scientists to justify ironclad practice guidelines for this procedure.

Health care providers and advocates, as well as individuals with traumatic brain injuries and their families, are becoming more aware that restrictive HMO guidelines result in unnecessary complications, which may require additional costly care in the future. Moreover, many leading health care experts believe that individuals with TBI fail to reach optimal recovery when care and services are denied prematurely.



Problems with Practice Guidelines

1. The guidelines are published by health care management agencies and vary from company to company.
2. The guidelines are written so they are open to HMO interpretation
3. HMO guidelines are not provided to the insured, the treating doctor or other health care professionals.
4. Insurance companies modify the guidelines or restrict the guidelines according to their business needs.
5. Guidelines adopted by HMOs vary significantly from insurance plan to insurance plan.

Remedies For Flawed or Restrictive Practice Guidelines

Appeals: Appealing an HMO decision that is based on flawed treatment guidelines is a challenging endeavor. Most appeals are unsuccessful because of the following factors:

1. Patients, advocates and health care providers do not have the insurance policy, including the definitions, limitations, exclusions, experimental clauses and "treatment guidelines" which are the basis of the HMO decision
2. Treatment guidelines and regulations, which form the basis of the HMO's decision-making process, are not memorialized in a written document
3. The period of time in which an appeal must be filed by a patient, patient advocate, attorney and/or health care provider, is a short one, which restricts a person's ability to gather appropriate medical documentation
4. An appeal hearing is normally done over the telephone, not in person. This makes the entire process both nameless and faceless
5. There are no guarantees that any medical information or documentation that is sent to the appeals committee will be read prior to the hearing
6. During most appeals, the patient and his/her advocate are not permitted to question the reviewing appellate hearing officers to ascertain whether or not they have read the submitted information. The appeals process normally limits the presentation of testimony on behalf of the patient to 10 to 15 minutes. It is very difficult for a doctor to present testimony for a patient within that timeframe.
7. The time limits are too restrictive when appealing an adversarial decision
8. The employer and the patient's treating doctor often are unwilling to support an appeal on behalf of an individual with a disability, for fear of retribution and sanctions by the HMO



External reviews: As a response to the increasing problem of denial of benefits by HMOs, state legislators have endorsed laws for the use of external reviews. An external review allows an insured person to receive an unbiased review of utilization decisions by an impartial panel. Prior to the legislation enforcing external review, the only option an insured individual had was to appeal to the insurance carrier or the State Department of Insurance. Legislation requiring external review of utilization decisions has been enacted by four states (New Jersey, New York, Pennsylvania and Texas).

Litigation:

1. In 1999, a California court ordered an HMO to pay in excess of \$100 million for failing to provide appropriate care in a timely manner.
2. A Wisconsin court held that the tort of bad faith applies to HMOs making out-of-network benefit decisions.
3. In September of 1998, Texas passed a law allowing persons injured by treatment denials or delays to sue their health plans for damages
4. The United States Federal Court recently ruled that Connecticut citizens may sue HMOs for negligence when they fail to provide a proper standard of care.
5. In a landmark case, Pennsylvania ruled that some health maintenance organizations (HMOs) are providers of health care services, not just payors for services, and therefore may be the target of lawsuits for rendering improper medical care under the theory of "corporate negligence."

Conclusion

By promoting restrictive treatment guidelines, HMOs hope that individuals with TBI, their families and treatment providers will feel "powerless," and will accept the minimal benefits offered by their insurers. Patients, patients' advocates, doctors and hospitals, however, are becoming more successful as they challenge flawed and restrictive guidelines by using intra-insurance company appeals and the judicial process.

Mr. Romano is an attorney who represents children and adults throughout the United States who have sustained catastrophic brain, spinal cord and other serious injuries and illnesses. He is the author of Legal Rights of the Catastrophically Ill and Injured: A Family Guide, Second Edition and Cancer, Brain Injuries, Spinal Cord Injuries: Challenging HMO Guidelines - Are Patients Powerful or Powerless? Call (800) 331-4134 to receive a complimentary copy of either brochure.

