

Fairness and Rationing Implications of Medical Necessity Decisions

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Abstract

When healthcare coverage entails medical necessity review, patients, providers, payers, and government agencies must confront issues of fairness and rationing. To explore the ethical ramifications of medical necessity decisions, we provide 2 illustrative cases. In the first case, we discuss the implications of rule-based rationing and in the second we consider the influence of a medical group's internal review council on decisions of medical necessity. Both case examples illustrate why there are no agreed-on rules for setting a threshold for approving or denying care based on medical necessity and suggest that more complex medical cases require a more complex review process.

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To physicians and patients, many medical necessity decisions seem arbitrary and appear to be made more in response to liability and public relations issues than to considered clinical and ethical assessments. At the other extreme, "bedside rationing" by primary care physicians is ad hoc and can conflict with the physician's ethical role as

patient advocate.¹⁻⁴ In an attempt to address this conflict, payers have begun to explore external review processes for patients denied coverage.⁵

Many questions arise when healthcare coverage requires medical necessity review. How should a health maintenance organization (HMO) or at-risk group decide about coverage for complex or special cases? How is a special case defined? Who makes medical necessity decisions? What are the moral responsibilities of patients and their families, treating physicians, medical directors, and financial administrators in these organizational settings? Although rules may have a place in rationing decisions, they can never be specific or inclusive enough to capture the complexity of individual situations and therefore cannot exclusively replace the professional judgment of physicians.⁶⁻⁸ The existence of multiple and often conflicting doctrines is a fact of democratic society, and toleration of such variety is assumed to be of value. To explore the many issues related to medical necessity decisions, we provide two illustrative cases.

...CASE 1: COVERAGE DENIED ...

Mr. H. has ulcerative colitis and last had a colonoscopy 1 year ago. He now returns to his primary care physician complaining of gas and abdominal pain. After examination and a negative Hemoccult test, the physician requests authorization to refer the patient to a gastroenterologist for possible colonoscopy. The HMO referral coordinator approves the consultation with the gastroenterologist based on the diagnosis of ulcerative colitis but withholds preapproval of the colonoscopy. After evaluation, the gastroenterologist also requests authorization for the colonoscopy. Consulting the

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Ambulatory Care Guidelines,⁹ the referral coordinator notes that colonoscopy is approved for ulcerative colitis at less than 18-month intervals only when the findings will affect clinical management.

The utilization review nurse contacts the gastroenterologist's office and learns that there is no documentation that would qualify Mr. H.'s colonoscopy under the guideline requirements, and she therefore denies authorization at this time. Having already discussed with the patient his opinion that colonoscopy is indicated, the gastroenterologist requests review by the HMO medical director. After discussing the case with the gastroenterologist, the medical director feels he must stand by his guidelines, and he upholds the authorization denial.

When the physician learns that the medical director is not a gastroenterologist, he becomes angry, believing that care has been denied by a physician lacking relevant specialty training who is basing his decision on a "cookbook." When the patient learns of the medical director's decision from the gastroenterologist, he feels the HMO is withholding needed care solely to save money.

Discussion of Case 1

Both the gastroenterologist and the patient believe that *care* has been denied by the HMO medical director. The medical director, however, is convinced that his denial of *coverage* does not constitute denial of care, and, as the professional interpreter of what the policy should pay for, he believes he has properly done his job.

The disagreement between the medical director and the gastroenterologist stems directly from the conflicting roles of the 2 physicians in a situation of rule-based rationing.¹⁰ Each physician is seeking to uphold their obligation to practice ethical medicine regardless of the system in which they function.¹⁰ The medical director has a fiduciary responsibility to interpret coverage and to ensure that the patient receives everything he is entitled to under the contract, but not more.^{11,12} The treating physician has fulfilled his responsibility to advise the patient of a course of treatment without regard to cost,^{13,14} but he has not performed the additional "economic advocacy" role¹⁵ required in the current healthcare system. For example, the gastroenterologist could ask Mr. H. if he wanted to pay for the colonoscopy himself or he might suggest alternative diagnostic procedures.

Imposing limits outside the physician-patient relationship raises the concern that rules will be applied in uniform and categorical ways that do not

respect the nuances of medical illness, the complexities of medical knowledge, and the varying values that patients bring to decisions about their medical risk and benefits.⁸ Rule-based rationing might also undermine medical professionalism, with treating and authorizing physicians feeling absolved of moral responsibility for implementing rationing decisions. In the case of Mr. H., discussion between the medical director and the gastroenterologist revealed no compelling medical reason for performing the colonoscopy earlier than dictated by the guidelines. However, there are several possible patient-related reasons why the test was requested at this time.

Mr. H. has experienced increased discomfort and is worried about his condition. In response to Mr. H.'s anxiety and in the interest of building confidence with this new patient, the gastroenterologist may have decided to order the test. By doing the test now, a time-consuming follow-up visit might be avoided, with its requisite additional referral requests and authorizations. Also, the gastroenterologist might be concerned about malpractice, especially because he does not have an established relationship with the patient. Finally, if the patient requests the colonoscopy, the specialist might not want to engage in a potentially long and perhaps contentious discussion with a patient with whom he may not establish an ongoing relationship.

The reasons for requesting the colonoscopy at this time reflect physician-patient relationship factors rather than the narrow definition of medical necessity. Physicians with different approaches to patients and different levels of experience would be expected to have different responses to Mr. H. Thus authorization requests can stem from sources other than pure medical necessity. A test might be important primarily as a means of building trust or relieving a patient's anxiety.

Rule-based rationing itself might have had a negative effect on the gastroenterologist's attitude toward the colonoscopy. Hall⁸ and Mechanic¹⁶ have both observed that the values of medical professionalism are inconsistent with the imposition of external rationing decisions and, as such, are universally resented. Mr. H.'s gastroenterologist was trapped between the historical directive to deliver unrestricted resources to his patient and his inability to do so in the face of an authorization denial. His frustration resulted in an unprofessional response and an additional cost to Mr. H., his physicians, and the HMO.

Because most of the incurred costs are indirect, it is easy to overlook them. For example, by implying

that the medical director is not competent to make a judgment regarding the colonoscopy, the gastroenterologist provoked Mr. H.'s distrust of the HMO, potentially undermining the patient's continued comfort with the care he receives from its providers. As Morreim notes, "Physicians owe what is theirs to give: their professional competence and loyalty as always and, in the new era of resource restrictions, their best efforts at advising and advocacy."¹⁵ Advising and advocacy represents an evolution in medical professionalism and requires a new understanding of the limits of what can be promised in the physician-patient visit. Physicians now have a moral responsibility to engage in advocacy when authorization decisions are considered harmful to patient care.

The patient's responsibilities must also be considered. In effect, Mr. H. made a rationing decision for himself by choosing an HMO as his provider. He chose what portion of his income he is willing and able to expend on health benefits. By choosing an HMO, he consented to rules governing or limiting his access to certain procedures. However, this is true only if Mr. H. had more than one choice of insurance plan if he obtains coverage through his employer and if he was provided accurate and complete information about his benefits.

Our point here is that each of these issues carries value and cost. The most easily measured cost is the dollar price tag of the colonoscopy. The costs of administrative time to obtain a second visit are indirect. The relationship cost if the gastroenterologist is unable to find another way to build trust with Mr. H. can lead to expensive "doctor shopping" or even "HMO hopping," as well as low physician morale and staff burnout. Each organization is likely to assess its willingness to confront each of these costs differently, according to a perception of their needs at the time. For consumers, it may become part of their informed healthcare buying to evaluate insurers based on their approaches to such issues.

In the case of authorization for the colonoscopy, the medical director acted based on his responsibility for husbanding the resources of the organization and used a population-based ethic for his judgment. The gastroenterologist made decisions based solely on his judgment concerning the needs of his patient, including the need to build the physician-patient relationship, as well as pragmatic concerns regarding office and procedure scheduling.¹⁷ The consequences to Mr. H.'s health are not severe enough to engage a non-rule-based process (such as the process described in the next case), although

interpersonal and operational issues clearly come into play.

In a case such as this, competing ethical constraints create problems for the physician-patient interaction and tensions between physicians and physician administrators. In unusual or special circumstances, interpersonal issues may become more important in medical authorizations for care. In such cases, economic, ethical, interpersonal, and social issues interact and often conflict. The relative weight of these concerns in the overall decision regarding services can vary by organization, patient, and patient situation, as illustrated in the next case.

...CASE 2: COVERAGE APPROVED ...

Ms. C., a member of a Medicare risk-contracted medical group, has multiple medical conditions, including serious heart disease and an enlarging abdominal aortic aneurysm. The group's medical director authorizes evaluation of Ms. C. by a vascular surgeon and a cardiologist. They report to her primary care physician that although she would benefit from repair of her aneurysm, the risk of surgery is too great. The vascular surgeon then discusses with Ms. C. the possibility of a new procedure (endostent) that may prolong her life. Ms. C. returns to her primary care physician to discuss her options and requests authorization for the endostent procedure. Her primary care physician refers the request to the group's medical director, who discovers that the endostent procedure is investigational and therefore not covered by the contract. In addition, the medical group does not have the expertise to perform this procedure.

The group's medical director believes the patient's situation will need to go before the group's managed care review council based on the strong convictions of Ms. C.'s treating physicians. The medical director identifies the interventional radiologist who performs the endostent procedure and requests price information. The radiologist refers the medical director to the outside hospital's contracting officer who advises him that because of a lack of guaranteed volume, the best price she can offer is a discount of 15% from customary charges. The medical director discovers that the radiologist and hospital are participating providers with the HMO and are contracted at 80% of Medicare allowable, substantially less than the offered rate of customary charges less 15%. The medical director's negotiations bring the cost of the procedure into an arguable range. After discus-

sion, the group's managed care review council authorizes the investigational procedure even though it is not covered, because it is Ms. C.'s best hope for life-prolonging treatment.

To obtain the HMO's favorable rates, the group's medical director contacts the HMO's medical director to arrange authorization through the HMO. The HMO medical director points out that investigational procedures are excluded from coverage, and he cannot authorize this service. The medical director of the provider group explains that it is the group's risk-contracted money that will pay for the procedure. Although concerned about setting a precedent, the HMO medical director issues the authorization, and Ms. C. undergoes the endostent procedure.

Discussion of Case 2

Ms. C., her treating physicians, and the medical group at risk for the cost of her care are facing 2 questions posed by Aaron: "The first is simply one of identifying when extension of life is beneficial; the second is a question of whether therapies acknowledged to be beneficial are worth the cost."⁶ Approaching the situation from Aaron's perspective, Ms. C. and her treating physicians have identified the procedure as likely to extend her life and as her most prudent option for care. Ms. C. has said she is interested in pursuing the endostent procedure but cannot afford to pay for it herself. Thus the first decision, the patient's own assessment of her best interest, has been answered in the affirmative.

There is no agreed-on, ethically superior method of managing last-chance therapies (experimental or not) that are not covered by a patient's policy. The question has been raised, in an intuitive way, whether potentially life-saving treatments have special status and value.^{7,18} Nord et al¹⁸ and Hansson et al⁷ have found that across cultures there are similarities and differences in the way people prioritize the use of limited healthcare resources in hypothetical situations. Daniels¹⁹ points out that in facing rationing decisions in which the benefits are not divisible in an equal way and competing individuals have plausible claims in principle, intuition plays a role in what ultimately "feels" fair. He notes that we have a less-developed sense of individual to aggregate comparisons than we do regarding decisions between 2 individual situations. Given the cross-cultural differences, the individualistic values of the United States, and the dramatic human appeal of last-chance therapies, there may be some subtle priority placed on such treatments that is in line with

our current social values but that could eventually change over time.

In this case, Ms. C.'s physicians believe that the investigational procedure is her best option and because she is interested in the treatment, they advocate for coverage under the group's risk contract. Although a medical director tempers the rules for coverage decisions with his or her full medical experience and empathy, sometimes a patient's situation presents issues that overreach the rules and warrant a different process. To answer the second question posed by Aaron,⁶ the medical director refers Ms. C.'s case to the group's managed care review process. Ms. C.'s at-risk group had previously agreed to discuss complex utilization issues in their managed care policy-making body, a council composed of a variety of professionals, all of whom are salaried and receive no bonuses or incentive payments.

Although the financial conflict of interest is less direct than it would be under different reimbursement arrangements, the medical group's financial well-being is the direct responsibility of some members and in the interest of all. By including participants with varying ethical responsibilities, expertise, and objectives on the review council, the medical group hoped a fair judgment could be arrived at in the cases discussed. Also, creative solutions to each case were expected to emerge from these discussions. In real life, self-interest cannot be hidden behind a veil of ignorance,²⁰ but with the proper structure and procedure it can be accorded less power.²¹ (Although rotating committee membership would have provided training in the deliberative method and a broader representative function, the managed care review council's status as an organizational experiment led to non-rotating initial membership. Thus one of the possible limitations faced by the review council was entrenchment of power and evolution of subtle group-held prejudices. Involving treating physicians in the presentation and discussion of cases provides some oversight and a link to the wider group community.)

Making decisions through the deliberation process used in this case has some disadvantages, the most obvious of which is the potential for apparently inconsistent results. The review council process clearly does not eliminate the possibility of injustice, but once a fair decision-making procedure can be agreed on, the results may be fair enough^{22,23} or the decision makers might at least have some flexibility, which guarantees a more just outcome than does the imposition of rule-based rationing. The consistency and objectivity of rules sacrifices the values

of individuality and accuracy in complex situations, potentially undermining the fairness of decisions. In simple authorization decisions, such as that of Mr. H. in the preceding case, the value of objectivity often outweighs concerns for specificity (a trade-off between consistency and singularity). However, in authorization decisions regarding treatment for life-threatening conditions, these values of objectivity and specificity may interact and conflict.^{6,24}

Goold²¹ raises several questions that reflect on the effectiveness of the review council process. Was the decision based on a reasoned deliberation about the best use of available resources reflecting a greater value placed on life-saving treatment or was it a sympathetic response to a fellow human's plight, more reflective of the greater psychologic weight of the individual life over the statistical life? Has the need to restrain the use of resources been maintained or have the limitations become abstract compared with an individual's identifiable need? Have the physicians on the council, in the guise of taking the moral high road, found a way to "game" the insurance contract (even at a cost to their group), expressing their frustration in the face of decreasing control over unexamined access to medical resources on behalf of their patients?

The question of the best use of resources runs into immediate problems. As Benjamin and others point out,^{6,25,26} the US healthcare system is an open one, functioning without a definite budget. This makes it more difficult to say no to care that is costly and marginally beneficial because it is not clear that resources withheld from one patient actually go to another who is more rationally selected. (Benjamin denies we ration, stating we irrationally allocate rather than ration.²⁵) So if the group's review council elects to withhold treatment from Ms. C., what guarantee do they have that the saved resources will benefit a needier patient? If the review council is composed of academic highly specialized physicians, they value research and support colleagues involved in research. Their knowledge and values might influence their willingness to consider covering experimental treatments and actually undermine concepts of distributive justice based on utilitarian ideals.

In this case, the medical director has already expended group resources (in the form of his time) to find the most cost-efficient way of obtaining services, should they be authorized. By discovering the HMO contracted rates with the hospital and directly communicating with the interventional radiologist, he can shift more of the direct cost onto the experi-

mental grant and the outside hospital, and he lowers the final hard dollar cost to the medical group. For the group, this represents a cost shifting from the direct cost of services to the indirect cost of overhead (the nonreimbursable administrative salary of the medical director). Because for-profit and not-for-profit healthcare organizations compete in the current healthcare market, the cost of educating healthcare providers, testing new therapies, and conducting research can become a competitive disadvantage to organizations performing these socially valuable functions. In Ms. C.'s case, the medical group has taken on responsibility for some of these costs in an indirect way, not only in the expenditure of the medical director's time but also in the general value placed on research and education in academic group practices. In many HMOs, the question of treating Ms. C. might not even have arisen, either because of different values or lack of information about available experimental treatments.

The presence at the council meeting of Ms. C.'s treating physicians provides the council members with expertise and the treating physicians with a procedure for patient advocacy in special situations. In addition to making the decision process explicit (thereby reinforcing accountability), this arrangement models the engagement of professional and organizational values in medical necessity decision making, creating a shared value base on which individual physicians can build when facing bedside rationing decisions. Ms. C.'s treating physicians are at the council meeting for the express purpose of sharing the moral responsibility for rationing decisions. Their presence ensures that the council members cannot feign unawareness of the real stakes for Ms. C. and that her treating physicians cannot blame abstract "others" for decisions denying coverage.

The medical group review process has as its constituency both the group's physicians and the covered patients. Through this review process, the medical group attempts to preserve fairness and to support physician morale and professionalism by reinforcing the importance of physician advocacy in medical necessity decisions. When the review council process works, it undermines regressive and nihilistic concerns on the part of patients and physicians, concerns that they will always be refused access to expensive services. The review process also undermines a belief that there are needless obstacles to care. The conviction that the system or HMO is "gaming the patient" (taking unfair advantage of the patient by exploiting ambiguity and flex-

ibility in the rules) can pressure physicians to bend the rules and circumvent restrictions.¹⁵

In care decisions that are potentially onerous, a medical group's review council ensures that a painful judgment will not fall on a single physician and negates any tendency on the part of the treating physicians to abrogate their moral accountability to their patients. The review council also prevents physicians from potentially shirking their moral responsibility to patients in situations in which the physicians become enforcers of rationing decisions made by absent and faceless others. It also prevents decision makers from becoming too distant from the patient and thereby avoiding the full human impact of their judgments. In the collegial atmosphere of the group, physicians share moral responsibility for costly resource allocation decisions (costly in terms of money or life) but do not escape from the ethical responsibilities of their role.

...CONCLUSION ...

In decisions regarding medical necessity, uncertainty is a constant. Patients have individual medical conditions and unique wishes and values regarding their treatment. Physicians also have unique values, both personal and professional. Organizations have specific missions and financial responsibilities to their boards and stockholders. Consequently, our current healthcare delivery system is an arena of conflicting values, primarily between business ethics and the traditional ethics of medical care. The businesses that own healthcare's resources sometimes are seen as intruders in the physician-patient relationship. We are cautioned by Morreim that, "Where the needed tools are costly and scarce, and are owned or paid for by third parties, then physician and patient alike have an obligation to respect these agents' legitimate interests and resource restrictions."¹⁵

At the same time, physicians' professional autonomy and the ethical precepts of the physician-patient relationship must not be violated. Attempts to resolve some of these issues through bureaucratic process and rule-based rationing have effectively managed some medical necessity decisions even as philosophical discussions continue. However, complex medical cases engender more subjective, value-laden issues and have a greater stake for all parties involved. These parties include patients making life-changing medical decisions, physicians facing challenges to their autonomy and conflicting responsibilities to patients and organizations, and

organizations facing escalating medical demand but limited financial resources. The value to society of medical education and research comes into play in many medical necessity decisions, along with the question of who pays.

We have discussed 2 cases here, one in which rule-based rationing may be fair enough and a second in which a review council process is initiated in recognition of the higher stakes and greater complexity of the situation. The allocation decisions made by a review council act as "considered moral judgments,"²⁰ informed by the principles used to arrive at them. The questions posed by Ms. C.'s case cannot be fully answered but stand as self-queries for evaluating the effectiveness and fairness of the review process.

...REFERENCES ...

1. Rosner F. The ethics of managed care. *Mt Sinai J Med* 1997;64:8-19.
2. Thomasma DC. The ethics of managed care: Challenges to the principles of relationship-centered care. *J Allied Health* Summer 1996:233-246.
3. Warner EG. Ethics and morality vs managed care. *Ohio State Med Assoc* 1996;89:275-279.
4. Bell H. Managed care ethics: A delicate balance. *Minn Med* 1996;79:11-16.
5. Jeffrey N. Aetna to set national review plan for HMO subscribers denied coverage. *Wall Street Journal*. January 12, 1999:B6.
6. Aaron HJ. Questioning the cost of biomedical research. *Health Aff* 1986;5(2):96-99.
7. Hansson LF, Norheim OF, Ruyter KW. Equality, explicitness, severity, and rigidity: The Oregon plan evaluated from a Scandinavian perspective. *J Med Philos* 1994;19:343-366.
8. Hall MA. The problems with rule-based rationing. *J Med Philos* 1994;19:315-332.
9. Ambulatory care guidelines. In: Doyle RL, Feren AP, Jacobs RJ. *Healthcare Management Guidelines*. November 1996 ed. Seattle, WA: Milliman & Robertson Inc; 1996;3:2-34.
10. Plows CW. Response to comments on the AMA report, ethical issues in managed care. *J Clin Ethics* 1995;6:318-319.
11. Sabin JE. Caring about patients and caring about money: The American Psychiatric Association code of ethics meets managed care. *Behav Sci Law* 1994;12:317-330.
12. Howe EG. Inner turmoil: An important consideration in conflicts of interest. *J Clin Ethics* 1995;6:367-371.
13. Levinsky N. The doctor's master. *N Engl J Med* 1984;311:1573-1574.
14. Churchill LR. Damaged humanity: The call for a patient-centered medical ethic in the managed care era. *Theor Med Bioeth* 1997;18:113-126.
15. Morreim EH. Gaming the system: Dodging the rules, ruling the dodgers. *Arch Intern Med* 1991;151:443-447.

- 16.** Mechanic D. Rationing of medical care and the preservation of clinical judgment. *J Fam Pract* 1980;11:431-433.
- 17.** Sabin JE, Forrow L, Daniels N. Clarifying the concept of medical necessity. *Med Interface* December 1991:35-42.
- 18.** Nord E, Erik, Richardson J, Street A, Kuhse H, Singer P. Maximizing health benefits vs egalitarianism: An Australian survey of health issues. *Soc Sci Med* 1995;41:1429-1437.
- 19.** Daniels N. Meeting the challenges of justice and rationing: Four unsolved rationing problems: A challenge. *Hastings Cent Rep* 1994;24:27-29.
- 20.** Rawls J. *A Theory of Justice*. Cambridge, MA: Harvard University Press; 1971.
- 21.** Goold SD. Allocating health care: Cost-utility analysis, informed democratic decision-making, or the veil of ignorance? *J Health Polit Policy Law* 1996;21:69-98.
- 22.** Fleck LM. A democratic decision-making approach. *University P Law Rev* 1992;140:1579-1638.
- 23.** Miles SH, Koepp R. Comments on the AMA report ethical issues in managed care. *J Clin Ethics* 1995;6:306-311.
- 24.** Daniels N, Sabin JE. Last chance therapies and managed care: Pluralism, fair procedures, and legitimacy. *Hastings Cent Rep* 1998;28:27-41.
- 25.** Benjamin M, Cohen C, Gruchowski E. What transplantation can teach us about health care reform. *N Engl J Med* 1994;330:858-860.
- 26.** Braithwaite SS. Distributive justice: Must we say yes when society says no? In: Monagle JF, Thomasma DC, eds. *Healthcare Ethics: Critical Issues*. Gaithersburg, MD: Aspen Publishers; 1994:295-304.