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CASE AND COMMENTARY
Conflicting Views of Medical Necessity: The Moran Case
Commentary by Ben Berkman

Ann Smith participates in an HMO through her husband's employer. Suffering from pain, numbness, and loss of strength in her right shoulder and arm, she decides to visit her primary care physician (PCP), who diagnoses her with carpal tunnel syndrome and recommends a conservative course of physical therapy. Ann completes the physical therapy, but does not see any improvement in her condition. In fact, her condition has worsened to the point that she can barely use her right arm.

Fearing that she was misdiagnosed, Ann researches other possible medical explanations for her condition. She finds an out-of-network specialist and self-pays for the consultation. The specialist believes that Ann has thoracic outlet syndrome, a condition where a bone compresses nerves in the neck, slowly damaging the nerve. There is an inexpensive treatment to relieve pressure on the nerve, but this method only provides temporary relief. The specialist has developed an unconventional treatment called "microneurolysis" where, in addition to relieving the pressure, the surgeon repairs the patient's injured nerve. Based on the likelihood that microneurolysis would provide a more permanent solution with a better chance of preventing irreversible nerve damage, the specialist recommends the $98,000 microneurolysis surgery to Ann.

After extensive review of Ann's medical record and the neurosurgeon's procedure and results, Ann's PCP is convinced that the microneurolysis procedure will provide the best remedy for Ann's disorder. The HMO medical staff decision makers do not concur that the surgery is medically necessary and authorize only the cheaper surgery provided by an in-network physician. Ann challenges the ruling, but after an internal appeal her claim is still denied.

Questions for Discussion

1. As the PCP, how do you balance your responsibilities to the patient with your obligations as an HMO employee? If you believe that the HMO decision is incorrect, how can you best advocate for your patient?
2. Is "the best remedy" synonymous with "medical necessity?" Who should answer that question, the patient's physician; or the organization that is paying the bills?
3. When the treatment plan entails financial and perhaps legal decision making, what is the physician's role?

Subsequent Legal Proceedings
This scenario is based on the facts of *Moran v Rush Prudential HMO*, on which the Supreme Court recently rendered a decision.[1] After her HMO refused to pay for the most effective treatment, Debra Moran demanded an independent review of the HMOs decision, a right granted by Illinois law.[2] The HMO refused to comply with her request for an independent review of its decision, citing the Employee Retirement Income Security Act (ERISA), a federal law that preempts state laws concerning certain employee benefits.[1, 3]

The case spent many years in court. While it was pending, Ms Moran decided to have the microneurolysis operation. She borrowed $94,000 to pay for the treatment, and amended her complaint to include a demand for reimbursement.[1]

The 7th Circuit Court of Appeals eventually ruled in favor of Ms Moran, ordering the HMO to submit to an independent review regarding the medical necessity of the microneurolysis surgery. Based on the specifics of Ms Moran's medical condition, the independent third-party reviewer decided that microneurolysis surgery was medically necessary. The Court of Appeals subsequently ordered the HMO to reimburse Ms Moran for the surgery.[4]

The HMO then appealed to the Supreme Court. Previously, federal circuit courts had demonstrated a regional split on the issue of independent review, so the Supreme Court accepted the case as a means to clarify the state law – ERISA controversy.[1, 5, 6] In June 2002, the Supreme Court, in a 5-4 split, affirmed the 7th Circuit Court's decision.[1]

Legal Analysis
The federal law, ERISA, was enacted in 1974 with the intent of protecting pension plans from fraud and mismanagement. Although 38 states currently have laws requiring HMOs to submit to an independent third-party review to resolve disagreements about the medical necessity of a procedure,[5] HMOs have avoided complying with these laws by arguing that ERISA preempts them from state laws that allow third-party reviews.[7] ERISA set forth minimum standards for administration of employee benefits, particularly pension plans, but it also included the statement that ERISA "shall supersede any and all State laws insofar as they may now or hereafter **relate to any employee benefit plan**…" (emphasis added).[8] Adding to the ambiguity of the law, the preemption was limited by an exception that preserved state power to regulate insurance, banking, or securities businesses.[9]

The broad language, "any employee benefit," has led to much debate and controversy about the intended scope of the ERISA preemption.[7] Congress allowed ERISA to preempt state laws out of a desire to create a national standard for the administration of employee pension plans, which is exactly what ERISA provided. ERISA's main objective was not to regulate health benefits.

HMOs argued that ERISA exempted them from complying with state laws, a view supported by a series of court decisions.[7] This exemption from state legislation and the absence of federal laws created a void in the regulation of HMOs.

Moran represents a move away from this judicial trend. In *Moran*, the Supreme Court held that a state law requiring HMOs to submit to an independent third-party review was not preempted by ERISA. The Court argued that a third-party independent review law was exactly the kind of state power that ERISA preserves by allowing states to regulate the insurance business.

The *Moran* decision allows each state to decide how to regulate the independent review procedure. This poses a problem for HMOs because it requires them to comply with a complex assortment of regulations across states, adding layers of management and possibly raising costs. It is possible that this decision will prompt Congress to pass a federal law to set a national standard for independent review laws, overruling this decision.[5, 7]

Ethically, the *Moran* decision also allows doctors to act as stronger advocates for their patients. If a doctor truly believes that a certain treatment is the best course of action for a patient, he or she can now act with the knowledge that the HMO does not have final decision making power. In at least 38 states, patients and physicians can be secure in the knowledge that disagreements between physician treatment recommendations and HMO decisions can be taken to an objective, third-party review board.

References

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2. 215 *Ill. Comp. Stat*., ch. 125, sec 4-10 et seq.
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8. Employee Retirement Income Security Act (ERISA). 29 U.S.C sec 1144(a).
9. ERISA. 29 U.S.C sec 1144(b)(2).

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