# MICROFILM DIVIDER

OMB/RECORDS MANAGEMENT DIVISION
SFN 2053 (2/85) 5M

ROLL NUMBER

DESCRIPTION

2331

2001 SENATE HUMAN SERVICES

SB 2331

2001 SENATE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. SB 2330-2331

Senate Human Services Committee

☐ Conference Committee

Hearing Date February 5, 2001

| Tape Number | | Side A | Side B | Meter # |
|---|---|---|---|---|
| | 1 | X | X | |
| | 2 | X | | |
| February 7, 2001 | 2 | X | | 35.3 |
| February 7, 2001 | 2 | | X | |
| Committee Clerk Signature | | Carol Kolodychuk | | |

Minutes:

The committee was called to order by SENATOR LEE with all Senators present.

The hearing was opened on SB 2330 and 2331. The bills were heard together.

SENATOR MATHERN, sponsor of SB2330, introduced the bill with written testimony.

SENATOR MATHERN, sponsor of SB2331, introduced the bill with written testimony and presented proposed amendments.

DEB ISSACSON, speech pathologist, supports the bill. SENATOR LEE: What is the difference of evaluating the devices as medical or school. The physician recommends and prescribes. It is a team setting. Devices are used in schools and in community. Most school districts are good about allowing the device home at night or on the weekend. I can only speak for the school districts I am familiar with. If the device is covered by insurance it will be the child's. It goes with the child at all times.

SADY PAULSON, student using voice device, spoke through the device to the committee. (Written testimony).

KATHY SCHULTE presented a letter from DR. KERSTIN SOBUS, Altru Health Services, Grand Forks, supports bill.

CONNIE LILLIARD presented testimony from parents in Wimbleton, who have a daughter using a device. They support the bill. DAVE and BARB BURSTEAD. (Written testimony)

SENATOR MATHERN: When someone has a device only at certain times, how does this affect the child? MS. LILLIARD: In school devices are used; they are not available at home and they must change communication patterns. It is potentially harmful.

ANNE ALBRIGHT, Anne Carlson Center, Jamestown, supports bill. The earlier you can get the child a device, the better. If only in school, the social, more motivating situations are outside of school and they don't have the communicating ability. What the children get is what they have on their shelves already and it is not the proper device for that child. The device should fit the child rather than the device fits the child's needs. Therapists do not know exactly what is out there and further assessment is needed. SENATOR ERBELE: What cost is there involved. How many people need this in ND. MS. ALBRIGHT: The cost ranges from $400-600 for low tech devices. We are trying to get a device funded just for our evaluation and that device is about $9400. I'm not sure what the numbers are.

Opposition:

MICHELLE RAGAN, occupational therapist, urges amendments to include occupational therapists. (Written testimony)

This ended testimony specifically on 2330.

The chairperson called for testimony in favor of SB 2331.

SENATOR KILZER took the Chair position.

ERICA PELISHEK supports the bill (Written testimony)

JODI PELISHEK, mother, supports bill, (Written testimony)

ANNETTE KAIP, parent of a son with Cerebral Palsy, supports bill. (Written testimony)

Presented pictures to the committee.

HEATHER PHILLIPS, licensed physical therapist, supports bill. (Written testimony)

SENATOR KILZER: How long have you been practicing? MS. PHILLIPS: 2 years.

DEB HOUDEK, PA-C, Medcenter One, supports both bills. Written testimony on 2330 and 2331.

DR. KEVIN MURPHY supports bill in written testimony.

KEVIN VAN ECK, parent, supports bill. His family was denied several physical helps. My son needs to be strapped in chairs, walkers, standers.

MJ AJLOUNY, RN, BSN, supports bill, (Written testimony)

DR. MYRA QUANRUD, MD FAAP, supports bill (Written testimony).

LEON KELLER, Director of Rehabilitation Services at Medcenter One, supports bill. (Written testimony)

KAREN HIPSAK, supports bill in written testimony.

KATHY SCHMIDT read testimony from DONENE FEIST. (Written testimony)

COLLEEN STOCKERT, parent and employee of Dept. Of Human Services, supports bill. (Written testimony)

DARLENE WEIGEL supports bill in written testimony.

KEVIN OLSON, parent, supports bill in written testimony.

CONT

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RICK PELISHEK, Executive Director of the ND Disabilities Advocacy Consortium (NDDAC), supports bill. (Written testimony)

GRANT WILZ, Jordan's father, supports bill. Gave example of son's progress without therapy.

JON RICE, BCBS medical doctor, supports both bills with written testimony.

SENATOR LEE: How many children are covered in ND? DR. RICE: About 40% or 1.2 million per year. SENATOR KILZER: How long has language been in policy? DR. RICE: It is an exclusion; the procedure is not denied. SENATOR MATHERN: Please explain. DR. RICE: We will not cover because of it being an exclusion which means it is not medically necessary. SENATOR KILZER: Does the Board at BCBS have any activity on the issue? DR. RICE: No, I am not aware of any. SENATOR MATHERN: Is BCBS willing to cover part of costs if the school board will cover part or what is meshing? DR.. RICE: We are open to considering that; there is some legal obligation to the school system to provide these devices. If there is an opportunity to share these, what happens to the child who is uninsured, or the child covered by Medicaid, who covers these devices better than we do at BCBS. SENATOR MATHERN: Have you considered the possibility that schools might contract with you and the families to provide this by each of you putting in part of it. DR. RICE: It may be considered. It has not been a discussed item in the past.

Opposition:

DR. RICE, BCBS, opposes bill. (Written testimony on 2331). SENATOR MATHERN: Do you make similar decisions about coverage as in the care of the heart? DR. RICE: Yes, we make decisions. Adult medicine is different from kids. There are instances that are unallowable. SENATOR MATHERN: Are these experimental? DR. RICE: There are not good studies and that is one of the difficulties we have. How much therapy does a child need or how many

changes will take place. A lot of these things revolve around how often, how frequent, how long should we continue the therapy. What is maintenance and what is progress. Children change all the time. How much is due to the therapy or the growing and developing. SENATOR MATHERN: You talked about working together with groups. If you are able to offer more payment for more therapy; how would that impact your place in the market. Would it be useful in the Century Code so all insurance companies are treated the same. DR. RICE: You make a good point. Will it get financially out of hand? Employers would not be able to handle it. ARISA would not be affected. It is out of state, high risk.

ROD ST. AUBYN, BCBS, continues discussion. BCBS is providing for children. We need to go back. 92 cents goes for claims, 8 cents for administration. Expanded services are not objectionable. Subscribers are saying we can't afford it. We have to keep in mind 2331 would be millions of dollars. SENATOR LEE: What time frame do we need for working on problems. MR. ST. AUBYN: You have established a 4 month time frame for a task force to work on this. DPI indicated they may do something about the speech devices to be with the child at home.

BRENDA BLAZER, Health Insurance Association of America, opposes 2330 and 2331 in written testimony.

The hearing was closed on SB 2330 and SB 2331.

February 7, 2001, Tape 2, Side A, Meter 35.4

The Human Services committee was called back to order. SENATOR MATHERN presented amendments to SB 2331. He explained these amendments are to correct the problem as to how these issues are dealt with by the Insurance Commissioners Office, and to eliminate the 70% issue of providers and narrow down the physical and speech therapy. Discussion followed. It was decided that the amendments would not make this a good bill.

SENATOR MATHERN moved the accept the amendments. SENATOR POLOVITZ seconded the motion. Roll call vote carried 6-0. SENATOR FISCHER moved a DO NOT PASS. SENATOR KILZER seconded the motion. Roll call vote carried 6-0. SENATOR LEE will carry the bill.

Discussion continued on SB 2330. SENATOR FISCHER present some amendments.

MR. GRONBERG, Dept of Education, explained the departments involvement with assistive technology devices or service. These serve communication as well as physical. The conjunction of school board and insurance would certainly contribute help to the parent needing the device for the child. A task force of the Department, insurance payer, insurance company, and not-for-profit organizations could come together to finance these devices. SENATOR FISCHER moved the amendments. SENATOR MATHERN seconded the motion. Roll call vote carried 6-0. SENATOR FISCHER moved a DO PASS AS AMENDED. SENATOR MATHERN seconded it. Roll call vote carried 6-0. SENATOR FISCHER will carry the bill.

# FISCAL NOTE

**Requested by Legislative Council**
01/24/2001

Bill/Resolution No.: SB 2331

Amendment to:

1A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

| | 1999-2001 Biennium | | 2001-2003 Biennium | | 2003-2005 Biennium | |
|---|---|---|---|---|---|---|
| | General Fund | Other Funds | General Fund | Other Funds | General Fund | Other Funds |
| Revenues | | | | | | |
| Expenditures | | | | | | |
| Appropriations | | | | | | |

1B. **County, city, and school district fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

| 1999-2001 Biennium | | | 2001-2003 Biennium | | | 2003-2005 Biennium | | |
|---|---|---|---|---|---|---|---|---|
| Counties | Cities | School Districts | Counties | Cities | School Districts | Counties | Cities | School Districts |
| | | | | | | | | |

2. **Narrative:** *Identify the aspects of the measure which cause fiscal impact and include any comments relevant to your analysis.*

PERS referred this bill to our actuaries Deloitte and Touche. They indicated that it would not be possible to do a traditional actuarial analysis on the bill due to its scope in terms of waiving plan limits and not having any historical demographic information on potential utilization. However they did indicate that the bill would clearly increase costs to the plan as a result of waiving plan limits. Depending on the resulting utilization that cost could add several dollars or more per contract per month to the projected premiums. PERS presently has about 22,000 contracts on the plan. A one dollar increase applied across all contacts would increase costs by $22,000 per month or about $528,000 per biennium.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*
   A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

   B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

   C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, of the effect on the biennial appropriation for each agency and fund affected and any amounts included in the*

*executive budget. Indicate the relationship between the amounts shown for expenditures and appropriations.*

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|---|---|---|---|
| **Name:** | Sparb Collins | **Agency:** | Public Employees Retirement System |
| **Phone Number:** | 328-3901 | **Date Prepared:** | 02/01/2001 |

Prepared for Senator Mathern
February 7, 2001

# PROPOSED AMENDMENTS TO SENATE BILL NO. 2331

Page 1, line 3, replace "twenty-one" with "twenty-two, and to amend and reenact section 26.1-26.4-02, relating to the definition of "medically necessary""

Page 1, after line 4, insert:

"**SECTION 1.** Section 26.1-26.4-02 of the 1999 Supplement to the North Dakota Century Code is amended and reenacted as follows:

**26.1-26.4-02. Definitions.** For purposes of this chapter, unless the context requires otherwise:

1. "Commissioner" means the insurance commissioner.

2. "Emergency medical condition" means a medical condition of recent onset and severity, including severe pain, that would lead a prudent layperson acting reasonably and possessing an average knowledge of health and medicine to believe that the absence of immediate medical attention could reasonably be expected to result in serious impairment to bodily function, serious dysfunction of any bodily organ or part, or would place the person's health, or with respect to a pregnant woman the health of the woman or her unborn child, in serious jeopardy.

3. "Emergency services" means health care services, supplies, or treatments furnished or required to screen, evaluate, and treat an emergency medical condition.

4. "Enrollee" means an individual who has contracted for or who participates in coverage under an insurance policy, a health maintenance organization contract, a health service corporation contract, an employee welfare benefit plan, a hospital or medical services plan, or any other benefit program providing payment, reimbursement, or indemnification for health care costs for the individual or the individual's eligible dependents.

5. "Health care insurer" includes an insurance company as defined in section 26.1-02-01, a health service corporation as defined in section 26.1-17-01, a health maintenance organization as defined in section 26.1-18.1-01, and a fraternal benefit society as defined in section 26.1-15.1-02.

6. "Medically necessary" for individuals under age twenty-two has the same meaning as stated under section 2 of this Act.

~~6.~~ 7. "Provider of record" means the physician or other licensed practitioner identified to the utilization review agent as having primary responsibility for the care, treatment, and services rendered to an individual.

~~7.~~ 8. "Utilization review" means a system for prospective and concurrent review of the necessity and appropriateness in the allocation of health care resources and services that are subject to state insurance regulation and which are given or proposed to be given to an individual within this state. Utilization review does not include elective requests for clarification of coverage.

~~8.~~ 9. "Utilization review agent" means any person or entity performing utilization review, except:

a. An agency of the federal government; or

b. An agent acting on behalf of the federal government or the department of human services, but only to the extent that the agent is providing services to the federal government or the department of human services.

Page 1, line 12, replace "at least seventy percent of the relevant specialty" with "three or more licensed practitioners actively practicing in the area of pediatric medicine or therapy"

Page 1, line 13, remove "practitioners'

Page 1, line 23, replace "a medical treatment, medical service, medical therapy" with "medically necessary therapy (physical, occupational, speech/language) and equipment as"

Page 1, line 24, remove "medical equipment, or medical supply"

Page 2, line 1, replace "professional" with "physician"

Page 2, line 2, replace "twenty-one" with "twenty-two"

Page 2, remove line 3

Page 2, line 4, replace "medical supply" with "medically necessary therapy (physical, occupational, speech-language) and equipment"

Page 2, line 5, replace "psychiatric" with "mental"

Page 2, line 8, replace "or reduce, alleviate, or" with "or pain management as related to the treating diagnoses"

Page 2, line 9, remove "prevent pain"

Page 2, line 10, replace "professional" with "physician or physical therapist, occupational therapist, or speech/language therapist currently practicing in the field of pediatrics"

Page 2, line 11, replace "medical treatment, medical" with "medically necessary therapy (physical, occupational, and speech/language) and equipment"

Page 2, line 12, remove "service, medical therapy, medical equipment, or medical supply"

Page 2, line 13, replace "psychiatric" with "mental"

Page 2, line 14, replace "or will not reduce, alleviate, or prevent the individual's pain" with "or pain management as related to the treating diagnoses"

Page 2, line 21, replace "1" with "2"

Renumber accordingly

Date: 2/7/01

Roll Call Vote #: 1

**2001 SENATE STANDING COMMITTEE ROLL CALL VOTES**
**BILL/RESOLUTION NO. 2331**

Senate HUMAN SERVICES Committee

☐ Subcommittee on _____

or

☐ Conference Committee

Legislative Council Amendment Number _____

Action Taken Amendments

Motion Made By Sen Mathern Seconded By Sen Polovitz

| Senators | Yes | No | Senators | Yes | No |
|---|---|---|---|---|---|
| Senator Lee, Chairperson | ✓ | | Senator Polovitz | ✓ | |
| Senator Kilzer, Vice-Chairperson | ✓ | | Senator Mathern | ✓ | |
| Senator Erbele | ✓ | | | | |
| Senator Fischer | ✓ | | | | |
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Total (Yes) 6 No 0

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Sen Mathern & Soc. Dept.

Date: 2/7/01

Roll Call Vote #: 2

**2001 SENATE STANDING COMMITTEE ROLL CALL VOTES**
**BILL/RESOLUTION NO.** 2331

Senate HUMAN SERVICES Committee

☐ Subcommittee on _____
or
☐ Conference Committee

Legislative Council Amendment Number _____

Action Taken Do Not Pass as amended

Motion Made By Sen Fischer Seconded By Sen Kilzer

| Senators | Yes | No | Senators | Yes | No |
|---|---|---|---|---|---|
| Senator Lee, Chairperson | ✓ | | Senator Polovitz | | ✓ |
| Senator Kilzer, Vice-Chairperson | ✓ | | Senator Mathern | | ✓ |
| Senator Erbele | ✓ | | | | |
| Senator Fischer | ✓ | | | | |
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Total (Yes) 4 No 2

Absent 0

Floor Assignment Sen Lee

If the vote is on an amendment, briefly indicate intent:

## REPORT OF STANDING COMMITTEE

**SB 2331: Human Services Committee (Sen. Lee, Chairman)** *recommends* **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO NOT PASS** (6 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). SB 2331 was placed on the Sixth order on the calendar.

Page 1, line 3, replace "twenty-one" with "twenty-two; and to amend and reenact section 26.1-26.4-02 of the North Dakota Century Code, relating to the definition of medically necessary"

Page 1, after line 4, insert:

"**SECTION 1. AMENDMENT.** Section 26.1-26.4-02 of the 1999 Supplement to the North Dakota Century Code is amended and reenacted as follows:

**26.1-26.4-02. Definitions.** For purposes of this chapter, unless the context requires otherwise:

1. "Commissioner" means the insurance commissioner.

2. "Emergency medical condition" means a medical condition of recent onset and severity, including severe pain, that would lead a prudent layperson acting reasonably and possessing an average knowledge of health and medicine to believe that the absence of immediate medical attention could reasonably be expected to result in serious impairment to bodily function, serious dysfunction of any bodily organ or part, or would place the person's health, or with respect to a pregnant woman the health of the woman or her unborn child, in serious jeopardy.

3. "Emergency services" means health care services, supplies, or treatments furnished or required to screen, evaluate, and treat an emergency medical condition.

4. "Enrollee" means an individual who has contracted for or who participates in coverage under an insurance policy, a health maintenance organization contract, a health service corporation contract, an employee welfare benefit plan, a hospital or medical services plan, or any other benefit program providing payment, reimbursement, or indemnification for health care costs for the individual or the individual's eligible dependents.

5. "Health care insurer" includes an insurance company as defined in section 26.1-02-01, a health service corporation as defined in section 26.1-17-01, a health maintenance organization as defined in section 26.1-18.1-01, and a fraternal benefit society as defined in section 26.1-15.1-02.

6. <u>"Medically necessary" for individuals under age twenty-two has the same meaning as stated in section 2 of this Act.</u>

<u>7.</u> "Provider of record" means the physician or other licensed practitioner identified to the utilization review agent as having primary responsibility for the care, treatment, and services rendered to an individual.

~~7.~~ <u>8.</u> "Utilization review" means a system for prospective and concurrent review of the necessity and appropriateness in the allocation of health care resources and services that are subject to state insurance regulation and which are given or proposed to be given to an individual within this state.

Utilization review does not include elective requests for clarification of coverage.

~~8.~~ 9. "Utilization review agent" means any person or entity performing utilization review, except:

a. An agency of the federal government; or

b. An agent acting on behalf of the federal government or the department of human services, but only to the extent that the agent is providing services to the federal government or the department of human services."

Page 1, underscore lines 7 through 11

Page 1, line 12, underscore "routinely accepted by" and replace "at least seventy percent of the relevant specialty" with "three or more licensed practitioners actively practicing in the area of pediatric medicine or therapy."

Page 1, remove line 13

Page 1, underscore lines 14 through 22

Page 1, line 23, underscore "provides coverage for" and replace "a medical treatment, medical service, medical therapy," with "medically necessary therapy, including physical, occupational, speech, or language therapy and equipment as"

Page 1, line 24, remove "medical equipment, or medical supply" and underscore "prescribed by a licensed medical"

Page 2, line 1, replace "professional" with "physician" and underscore "acting in the scope of that licensure for any individual under age"

Page 2, line 2, replace "twenty-one" with "twenty-two", underscore "who is covered under the policy. The purpose of prescribing", and replace "this" with "the medically necessary therapy, including physical, occupational, speech, or language therapy and equipment"

Page 2, remove line 3

Page 2, line 4, remove "medical supply" and underscore "must be to improve or prevent deterioration of a physical or"

Page 2, line 5, replace "psychiatric" with "mental" and underscore "illness, injury, or condition; achieve, prevent deterioration of, or mitigate"

Page 2, underscore lines 6 and 7

Page 2, line 8, underscore "or aggravate a disability, physical deformity, or malfunction; or" and replace "reduce, alleviate, or" with "address pain management as related to the treating diagnoses"

Page 2, line 9, remove "prevent pain" and underscore ". Coverage is not required under this section if a similarly"

Page 2, line 10, underscore "credentialled medical", replace "professional" with "physician or physical therapist, occupational therapist, or speech or language therapist currently

practicing in the field of pediatrics", and underscore "presents an opinion supported by a consensus"

Page 2, line 11, underscore "in the relevant medical community, that the prescribed" and replace "medical treatment, medical" with "medically necessary therapy, including physical, occupational, and speech or language therapy and equipment"

Page 2, line 12, remove "service, medical therapy, medical equipment, or medical supply" and underscore "will not improve or"

Page 2, line 13, underscore "prevent deterioration of the individual's physical or", replace "psychiatric" with "mental", and underscore "illness, injury, or"

Page 2, line 14, underscore "condition", remove the first comma, underscore the first "or", remove "will not reduce, alleviate, or prevent the individual's", underscore "pain" and insert immediately thereafter "management as related to the treating diagnoses", and underscore the period

Page 2, underscore lines 17 through 20

Page 2, line 21, underscore "under section", replace "1" with "2", and underscore "of this Act."

Renumber accordingly

2001 TESTIMONY

SB 2331

Senate Bill
2330
2331

February 4, 2001

To: Members of the Senate Human Services Committee

I appreciate this opportunity to express my position regarding the direction of health care coverage for my son, Adam. Adam was born at 25 weeks gestation, weighing 1 pound 12 ounces. He surprisingly had few initial complications from this. However, due to his prematurity, general cares and size he remained in the hospital for 76 days. Within months, Adam's physician began to notice signs consistent with cerebral palsy (CP). Prior to his first birthday, CP became his official diagnosis. He began to receive both occupational therapy (OT) and physical therapy (PT) prior to his first birthday. Services continued one time each, per week until his third birthday. At the age of three, given his medical diagnosis of CP, Adam qualified for early intervention services through Fargo Public Schools. Part of his programming included PT/OT services when necessary to support his academic goals. Within one month of beginning school, Blue Cross Blue Shield (BC/BS) sent initial notification of intent to phase out PT/OT services. The reason given included "ROM (range of motion) was not a skilled service and past documentation shows minimal progress in trunk control and ADL's (activities of daily living)." We were informed that my wife and I would be trained in OT techniques in four sessions over the next three months and then OT would discontinue. From review of therapy progress notes, observation of interaction with his environment, and parental provision of ROM, it was clear that Adam was making slow but steady progress. Documentation from Adam's school based therapists identified that Adam's needs went beyond the scope of the academic setting. His physicians and private therapists also echoed this sentiment. Yet, these recommendations went unheeded. Since the denial of coverage was contrary to the therapeutic recommendations, this decision was appealed. The appeal/denial process began 5/12/00 and subsequently concluded 9/27/00. During the time of the appeal BC/BS asked for Adam's IEP. This was provided to them. We were later advised that due to his receipt of PT/OT at school his services would not be reinstated to their prior level.

We have experienced other lapses in service provision based primarily on the short coverage periods (windows). The therapy windows were designed for rehabilitative treatments from injury or some type of condition occurring after birth. Adam's condition requires a longer window period. Due to the paper reviews, shorter window periods have led to delays in services. Any delays in service could retard growth and development.

Other steps I have initiated: 1) I requested information on the qualifications of the case reviewers who grant or deny extensions or denials. I was advised that this was not available to me. 2) I have requested interactive meetings between Adam's therapists, physicians and BC/BS staff in order to articulate positions. I was told that this was not

a possibility. 3) After my son's initial denial for service coverage, I requested the criteria used in making this determination. I was advised that there were no written guidelines developed to govern this practice. I was advised that these guidelines would be developed within 6 months. This discussion took place in 5/00. I am unaware if these guidelines were developed.

BC/BS began a process (task force) on 1/24/01, intended to address some of the issues mentioned throughout the body of this letter. Prior to the initial meeting, BC/BS reinstated therapeutic services to all children at the level they were at from 12/00 thru 6/30/01. A moratorium was also instituted on denials of therapy until 6/01.

At the initial BC/BS task force meeting, I learned of the two bills now before you. Dan Ulmer, lobbyist for BC/BS, noted that these bills would likely go down to defeat. He identified that BC/BS was not equipped to handle these if passed. These are not new issues. However, they are only now coming to forefront in an official capacity due to organizational efforts of affected families, therapists and physicians each of who are stating that this practice cannot go on any longer. As regulators, you can send a strong message with your decision today. The passage of these bills will show your support for the basic needs of the most vulnerable children in our society. Thank you for your consideration of this material.

Respectfully,

Rick VanCamp

Brenda L. Blazer
Health Insurance Association of America

TESTIMONY IN OPPOSITION TO SB 2331
Senate Human Services Committee
February 5, 2001

The Health Insurance Association of America is an insurance trade association representing insurance companies who write accident and health insurance on a nationwide basis. The HIAA and its members strongly oppose SB 2331 mandating health coverage for nearly all medical services and equipment provided to individuals under age twenty-one.

SB 2331 appears to mandate coverage for any medical treatment, service, therapy, equipment, or supply prescribed by a "licensed medical professional" unless a similarly credentialed professional disagrees and is able to show that 70 percent of the "relevant medical community also disagrees.

The number of potential health benefits for which coverage would be mandated is unlimited. The only limit or restriction on coverage would be proof that 70 percent of medical professionals in the same area of practice agreed that the treatment or equipment should not be given. The logistics of how to obtain a seventy percent consensus on each prescribed treatment or piece of equipment would be complex, if not impossible.

All health benefit mandates increase costs. Higher premiums affect the number of individuals able to afford health insurance and the number of employers able to offer health insurance as a benefit to their employees. Essentially, unrestricted mandated health benefits for individuals under age 21, would clearly increase health insurance premiums.

Covered health insurance benefits should be determined by clinical effectiveness and outcomes. A coverage analysis based on whether the benefit has been proven effective cannot be performed in the setting of widespread mandated benefits.

HIAA asks the Committee to give a "do not pass" recommendation on SB 2331, which seeks to mandate insurance coverage for nearly all medical services or equipment provided to individuals under age 21.

**Testimony supporting SB 2331** Feb 5, 2001
**Judy Lee, Chairperson**
**Senate Human Services Committee**

Kevin L. Olson, parent
3141 Arizona Drive
Bismarck, ND 58503 Phone #255-5532

- Children with special needs are all individuals. Their symptoms and conditions vary greatly and you cannot lump them into one category. Their condition may not be life threatening, but their quality of life can be severely affected.
- Many children with special needs require PT or OT, and using the same set of guidelines for reviewing adult claims is not appropriate. The children's gains in gross motor and fine motor skills are hard fought. The therapists are not only training the muscles, but also helping the children overcome their muscle tone. These kids can make progress, but not if you give up on them in 3 months.
- The insurance companies will tell you they receive benefits for more than 3 months. But this is the length of the evaluation period. The therapists will spend at 30-40% of their time filling out evaluation forms for children with special needs. The continuous application and evaluation process places an unfair burden on the therapists, with the children's welfare at stake.

Senate Committee Testimony SB2330 and 2331 for 2/5/01

Committee Chair and Members,

My name is Donene Feist, from Edgeley, North Dakota. My apologies for not being present today and providing my own testimony, as I am home ill. I would like to make a few comments about SB 2330 and SB 2331.

I am pleased the Senate Committee is hearing testimony on these two very important bills for children with special health needs. I assist many families across the state find information that will assist them in the care for their child with special health needs. Many families for this population do not qualify for public insurance. For many families, whose children need augmentative communication, our private insurance considers this to be non-medically necessary. For many of these children it is medically necessary as this is their very means of communication, and further provides an avenue towards independence. How is a child to let a parent, physician, educational staff know that they are not feeling well if they have no means of communication?

Let us also examine medical necessity. For these children, it is extremely important in determining medical necessity and the services appropriate in the changing managed care systems. Existing definitions of medical necessity may lead to the denial of services required by children and youth with developmental disabilities, genetic disorders, serious mental health problems, or special health care needs. Presently, most definitions are those of which will improve health status. However many children with special health needs frequently need health and medical services that will maintain their health status. Hence, what is not understood is that if these children are denied many services to their day-to-day lives, it is very likely the may deteriorate and regress. We cannot place these children into a one-size fits all plan.

Another purpose for clearly defining medical necessity for this population is to distinguish it from rationing, or withholding of treatment on the basis of cost and outcome. Decisions about medical necessity should be based on a person's medical, health and family situation and not on cost. The key question should be "Does this person need this intervention to maintain or promote health?"

Many families have contacted me regarding the denials that they have incurred. Is this to say to them, that their children are not important? That they are too much of a liability and we have no provisions to assist you. Many of these families, once again, do not have public insurance to assist them. Nor should it matter whether premiums are self-pay or employer pay.

Medical necessity determinations must account for the reality that all situations with these children are different. Again, one size does not fit all. We should always keep into light with this population of children whether the service will help accomplish the child's overall health and functional goals.

With this vulnerable population of children it is also vital to have appropriate peer review. The plan should have in place, review that fully understands the issues of these children. You wouldn't want an OB/GYN to review something regarding Audiology or hearing concerns. You wouldn't want an Urologist to determine whether speech, physical, occupational therapy is appropriate. These children have very complex needs. The insuring provider should not scrutinize it whether the order that was written was appropriate. Our children utilize specialists and have the physicians they have for a reason. They understand the needs of these children! These specialists and physicians, write orders based on the needs of the child, and should be left in the hands of those writing the orders. Their therapies, medications, special diets, equipment, supplies and treatments have a vital purpose for the life of the child. I support the peer review provision added to this bill.

Additionally, there seems to be some confusion on "who these children are." We need to have a mechanism in place to identify these children, and provide quality assurance measures that they are receiving appropriate care. Many states have followed the Federal Maternal and Child Health Definition of children with special health needs. Which is **"Children with or at risk of disabilities, chronic illnesses and conditions and health related education and behavioral problems who require health and related services beyond that needed by most children."** This should be consistent in both the public and private service systems, to have consistency throughout the state. In our CHIP program, Medicaid, nor private insurance do we have this definition in identifying these children.

We have done a wonderful job identifying the needs of children in the general population, but we have missed a very important group with our children with special needs, and I hope this committee will do all that it can to correct this issue, by supporting these two bills.

Thank you

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February 5, 2001

To: Members of the Senate Human services Committee

From: Sherwin & Annette Kaip
307 Seventh St. NW
Mandan, ND 58554

Thank you for taking time to listen to our concerns. Our six year old son,Michael, has Cerebral Palsy. In May of 1999 Michael had a Selective Dorsal Rhyzotomy. In this surgery, about 35% of the sensory nerves in his lower spinal cord were severed in order to reduce the spastic tone in his legs. He was hospitalized for 6 weeks. Michael walked before the surgery and we knew that his walking would eventually improve due to the rhyzotomy. However, he had to start all over again. It took him three months before he could walk without a walker and is still working on improving his walk and all areas of physical mobility.

During the first six weeks following surgery, the pediatric neurologist prescribed physical therapy two times a day and occupational therapy once a day while he was in the hospital. He received the therapies prescribed and improved quickly. We returned to North Dakota. The pediatric physiatrist and pediatric neurologist both prescribed physical therapy five days a week for the first six months. Michael was learning to walk all over again. There were many variables that affected Michael's ability to improve his condition. This learning was 'NEW" learning. His brain had already imprinted old patterns of movement that needed to be erased, while at the same time learning new patterns that he was now physically capable of because of the surgery. Due to the nature of the surgery and the recovery, Michael had not used his muscles for six weeks. They were very week and took a long time to build up. Growth spurts changed the length of Michael's legs and muscles became tighter. Movements that may have been mastered once had to be re-taught and re-practiced due to these changes.

When coverage for the therapy was requested from BCBS, it was reviewed by a person who had no training or experience with pediatric rehabilitation and no understanding of what a selective dorsal rhyzotomy is. Michael was treated as though he was an adult who underwent a minor knee surgery and fifteen days of therapy over a six week period were approved. We had no choice but to use the therapy up in 3 weeks and fight the insurance company. Letters from Shrine Hospital doctors and therapist as well as Med Center One were sent to the Insurance company. A detailed description of the surgery was also sent. Michael's therapist tried to reach the BCBS employee reviewing our request. Initially, she was denied the opportunity to talk with him and was not allowed to even know his name or have any contact with him. She was persistent and spent many hours trying to find a way to get the therapy approved. Eventually we were granted three months of therapy. Every three months therapy has to be re-applied for and re-approved. Every three months the therapist has to spend more time to get approval on therapy

that has been prescribed by pediatric doctors. It has been almost twenty months since the surgery. BCBS has reduced Michael to two sessions per week. His progression has slowed considerably. Recovery for the selective dorsal rhysotomy is approximately two years according to professionals in this field.

Michael also receives occupational therapy. He initially received OT once per week according to BCBS policy on his initial evaluation and follow-up therapy. After three months BCBS reduced OT to two times per month. Michael's progression slowed or stopped in most areas. Learning at this age requires repetition. A child with a disability requires more repetition for the same learning. With persistence and time, Michael's therapist was eventually able to convince BCBS to increase the therapy to once per week. His is once again progressing.

Insurance companies argue that therapy should be used for consultation and intense home programs should take the place of professional therapy. As the parents of a child with a disability, we want you to know that we love him very much and would not trade him for any kid in the world. But the reality is that everything we do, every activity, bath time, dinner time, outings, getting dressed, getting ready for bed, picking up toys, ...everything we do takes longer. We spend time almost everyday stretching Michael. We try to do as much of his home therapy program as we can. When we run out of time we feel guilty. Another reality is that a disability in a family puts more stress on everyone in that family. When the insurance company tells us that we have to take the place of the professional therapist, stress increases. What Michael really needs from us is time when his mom is just being his mommy and his dad is just being his daddy.

We strongly encourage you to support Senate Bill 2330 and 2331. This Bill will allow children to receive the services they need. It will also allow therapists and doctors to spend their time doing the jobs they were trained to do without having to constantly argue with insurance companies on what constitutes "medical necessity." It will unburden parents who are forced to take the place of the professional therapists when not adequately trained to do so. Please do everything you can to get these Bills passed. Thank you for your time.

# FACTS SHEET Re: SENATE BILLS 2330 AND 2331

## Reason for Action

Senate Bills 2330 and 2331 were written in response to the inappropriately justified authorization of insurance benefits for children in North Dakota with special needs as related to augmentative communication devices, therapy services, and medically necessary equipment.

## Purpose of Legislation

Senate Bill 2330 will require insurance companies of North Dakota when deemed medically necessary by a child's physician and therapist to provide coverage for augmentative communication devices and the speech therapy required to use them.

Senate Bill 2331 will require insurance companies of North Dakota when deemed medically necessary by a child's physician and treating therapist to provide therapy service and equipment for a child under 21 years of age.

## Current Problems

1. If a child cannot speak, BCBS of ND has a zero payment policy for purchase of an augmentative communication device and the speech therapy service to learn utilization of the device.

2. Of a multitude of different private and public insurance organizations identified by our task force, including Medical Assistance of North Dakota, BCBS of ND remains the only one with a zero payment policy on augmentative communication.

3. BCBS of ND has no documented definition of medical necessity as it pertains to children with special needs.

4. BCBS of ND is consistently denying therapy services and equipment to children with special needs when the treating physician(s) and therapist(s) have recommended the services.

5. BCBS of ND has no consistent peer review process for children with special needs. Because of this, adult health care providers with little pediatric specialty experience often deny therapy services and equipment determined medially necessary by the pediatric based treating physicians and therapists.

6. BCBS of ND has implemented inappropriate episodes of therapeutic treatment for children with special needs often based from an adult model.

7. BCBS of ND has recently demonstrated a "cook book" type of approach when authorizing benefits for therapy services for children with similar diagnoses but very different levels of functioning. The focus, thus, is on diagnoses versus the individual medical needs preventing the child from reaching his or her maximal functional ability.

8. BCBS of ND has on several occasions, when reviewing the need for medically based services, requested information regarding current educationally based services to justify their authorization of benefits, even though medical instead of educational needs have been justified by the treating physician and therapist. In compliance with the IDEA Act, this information is completely separate and should in no way affect their ability as North Dakota citizens to obtain medically based services through a private insurer.

**Senators:**

1. Chairperson – Judy Lee (R) – West Fargo, ND
2. Vice Chairperson – Ralph L. Kelzer (R) – Bismarck, ND
3. Robert S. Erbele – (R) – Lehr, ND
4. Thomas Fischer – (R) – Fargo, ND
5. Tim Mathern – (D) – Fargo, ND
6. Michael Polovitz – (D) – Grand Forks, ND

**RE: Senate Bill #2330 & Senate Bill #2331**

- Introduced by Senator Tim Mathern (D) – Fargo, ND; Senator Russell Thane (R) – Wahpeton, ND; and Representative Gail Fairfield (D) – Eldridge, ND

My name is Leon D. Keller. I am the Director of Rehabilitation Services at Medcenter One. One of the areas that I manage is the Pediatric Therapy services to include physical therapy, occupational therapy, and speech therapy. I am supporting these two pieces of legislation, because I believe that insurance companies of North Dakota have not implemented the appropriate insurance coverage for children with special needs. As manager, I have seen the tremendous amounts of documentation that the therapists have to submit to Blue Cross Blue Shield of North Dakota (BCBS) in order to get extensions for services and/or pre-authorization for services. This documentation is required because BCBS of North Dakota consistently denies services and equipment for children with special needs even though the treating physicians and therapists have recommended the services as medically necessary.

It appears to me the reasons for the denials of services stem from the fact that BCBS of North Dakota has:

1. No documented definition of medical necessity as it pertains to children with special needs;
2. And, no consistent peer review process for children with special needs. Because of this, the adult health care consultant will deny services and equipment that the pediatric specialist has found to be medically necessary.

Other reasons for requiring this documentation is that BCBS of North Dakota has implemented inappropriate episodes of therapeutic treatments for children with special needs often based upon an adult model at BCBS. Recently, BCBS of North Dakota has demonstrated a "cookbook" approach when authorizing benefits for therapy for children with similar diagnoses but very different levels of functioning. The focus is on the diagnosis versus the individual's medical needs, which prevents the child from reaching his or her maximal functioning ability.

When the therapists have to spend time writing letters, faxing, and re-faxing notes to BCBS, it takes time away from providing services to the children. This is time that would also be spent on developing new programs that could possibly educate parents and prevent disabilities. It also takes time on BCBS's part to review all of this information. This is a gross inefficiency of time for the therapist, and I would suspect for BCBS of North Dakota as well.

As a manager who is also a physical therapist, I have always believed that the physician working with the patient and therapist must determine the medical need of the patient. The mainstay of both of these bills relies on the determination of medical necessity by a pediatric specialist and the peer review process by a similar pediatric specialist.

**Prepared testimony for the hearings related to Senate Bills 2330 and 2331**

As a mother of a developmentally delayed child with the diagnosis of "microcephaly", translated into lay terms as "small head", I come here today seeking a resolution for all children. I am not a stranger to health care, I have been a registered nurse for over twelve years now. The information that I present here today was obtained by my own personal experiences and is my own perception of the issues at hand.

The disillusionment faced by parents of children with disabilities is partially caused by the disbelief that this is happening to them as a family but more prevailently by the red tape involved in the procurement of services for their children. I have never been blind to the needs of compromised children having worked in maternal child areas most of my career, however prior to my own experiences I have been guilty of seeing the world through rose colored glasses. In January of 1997, with the birth of my daughter Bryce the glasses came off. I was awakened to the struggle of parents dealing with meeting the needs of their compromised children. **The most debilitating aspects of our circumstances as parents of these children is our inability to fight for their rights with insurance companies**. I was completely ignorant in my understanding of insurance and the role it would play in the quality of life for my child. My mistake in all this was the trust I placed in the fact that I was insured and therefore felt I was protecting and gaurding my family from any health misfortunes that may occur. I could not have imagined or anticipated the amount of time and energy that would be required in battling for services my daughter Bryce would need to achieve the best quality of life possible. Services that physicians directly involved in my daughter's care deemed medically necessary for her to achieve the best quality of life possible. Since her birth, Bryce who is now four years old, has seen the same pediatrician, the same pediatric neurologist, the same pediatric physiatrist and the same pediatric opthalomologist. They have all said verbally and in written documentation that she needs and would subsequently substantially benefit from various theraphies. Yet, my insurer BCBS of North Dakota in numerous letters of response to letters of appeal for denied services, without ever laying a hand or eyes on Bryce continued to dictate medical necessity for services. One of their standard responses: **PLEASE KEEP IN MIND THAT BENFITS ARE ONLY AVAILABLE FOR MEDICALLY APPROPIATE AND NECESSARY SERVICES.** In my mind these services were medically indicated according to the experts that had worked with Bryce throughout her short life. Finally after numerous phone calls and persistant resubmittance of documentation from these health care professionals a second statement: **PLEASE KEEP IN MIND THAT BENFITS ARE ONLY AVAILABLE FOR MEDICALLY APPROPIATE AND NECESSARY SERVICES, SUBJECT TO THE CONDITIONS, LIMITATIONS AND EXCLUSIONS OF THE PATIENT'S BENEFIT PLAN.** The reality of all this came down to one conclusion, having medical insurance means absolutely nothing if the insurer continues to deny claims first under the premise that the service is not medically indicated and second when the letters of appeal continued to surface under the exclusion of the patient's benefit plan. In your consideration of the issues at hand, please consider the level of frustration in dealing with this absurd paradigm. My belief is that when in comes to children medically appropriate and necessary services should never be subject to the conditions, limitations and exclusions of the patient's benefit plan. Insurance companies **should and could** formulate a product that meets the needs of these children. Our children should never face a day where they are denied an opportunity for best quality of life possible on a slight technically, oh by the way it's not covered!

Who sold us, through our employers these insurance plans anyway! Insurance companies spend a great deal of man power and resources on denials of claims, would these dollars benefit children more by using these funds to create a product that genuinely cares about children all children! As a parent I ask myself this question daily....If I do not act as a voice for my child and the numerous other children who will? At this point that is why we as parent's are here today, to act as advocates for our children and the children of future generations. We need to emphasis that insurers must sell a product that is in the best interest of these children. The reality is that these services are expensive to supply but these children do benefit from these services and the focus must always be on giving them every opportunity humanly possible to grow, survive and thrive in the community. Insurance companies need to develop a suitable product that adheres to the inherent needs of children with disabilities. It is so disheartening to see parents struggle continuously for the rights of their most precious commodities. The struggles are day in and day out for most of these families, if we can alleviate any of the stress, trials and tribulations then we are obligated to do so. If we here today do not act in these children's best interest who will? If those of us who are able do not educate the general public on the lack of services covered in these plans who will? If we do not articulate the needs of the innocent children affected who will? If our elected officials do not remove the obstacles and barriers these families face with the appropriate legislation who will? **We can no longer allow the public to be lulled into a false sense of security by thinking, no problem we're insured.**

Respectfully Submitted By: M.J. Ajlouny, R.N., BSN.
February 5, 2001.

# Blue Cross Blue Shield Proposal for Compromised Children

A. **Medical Necessity:** Any service is medically necessary if it is deemed necessary by a medical physician who has seen and evaluated a patient and renders the decision that a patient would benefit from a service to improve the patient's potential for normal growth and development hence enabling the patient to achieve the best quality of life possible.

B. **Services:** Services can be defined by the physician and can be but are not exclusive to referral to another physician, professional therapies, devices which are proven tools to assist in the goal of best quality of life possible.

C. **Insurance:** Insurance is a product that is formulated, this product in the provision of services to infants/children should include full and non-restrictive criteria based on medical necessity, to aid in obtaining the goal of best quality of life possible. At no time should medical necessity be the decision of the insurer, they are not the physician who has been working directly with the patient nor have they seen and evaluated the patient.

D. **Case Managers**: One qualified case manager should work in conjunction with the professionals working with the patient on obtaining the goal of best quality of life. At no time should a child have multiple contact individuals. The child needs to be evaluated in his or her totality to maintain expert decision making to obtain the goal. These case managers should be live individuals who are readily assessable and have knowledge of the services offered the child. One or two case workers assigned to a facility may be an option and in all probability be advantageous to all parties. At no time should resources be wasted in the pursuit of discrediting the contribution that each party is able to provide in reaching the goal of best quality of life provided. A mutual relationship of trust and collaboration will be expected in order to render positive impact on quality of life.

With these guidelines it is unfortunate that a definition of medical necessity does not exist as related to children with special healthcare needs.

The above stated provision taken at face value sounds plain and simple and many of you may be wondering why Senate Bill 2331 is necessary.

The problem is currently insurance companies in North Dakota are denying a large number of benefits for therapy services especially for children with special needs because they are stating **not medically necessary**. Often times the employees of the insurance companies making these decisions have no training/expertise in the area of the service they are denying again after having been recommended by the treating pediatric specialized physician as well as the treating therapist.

I ask you now to please refer to the **Facts Sheet re: Senate Bills 2330 and 2331**, more specifically the current problems section. This will allow you to more fully understand a few of the specific examples that have lead to the writing of this bill and why your committee, in order to fully serve your constituents, who themselves or have children with special healthcare needs must pass Senate Bill 2331.

It is estimated that nationwide approximately 17% of all children have a special healthcare need. Therefore, in North Dakota based on surveys as well as national average extrapolation it is estimated that between 29,000 and 33,000 children have special healthcare needs. I would venture to guess that no legislative district goes untouched. I would ask you to think for a minute who in your district this may affect. Keep in mind that this includes the diagnoses of asthma and heart disease (up to 16,000 children), conditions typically requiring only medical care.

**BCBS of ND has no documented definition of medical necessity as it pertains to children with special needs.** The task force that was involved in the writing of this bill was unable to find a concrete documented definition of medical necessity as it pertains to children with special needs utilized by insurance companies in North Dakota.

**BCBS of ND is consistently denying therapy services and equipment to children with special needs when the treating physician(s) and therapist(s) have recommended the services.** Again these denials are coming from people without education, training, or experience in the area of children with special needs.

> Example: A child who has severe athetoid cerebral palsy is unable to walk functionally and requires the use of a power wheelchair to move throughout her environment. She is in the eighth grade and has normal intelligence. She is able to do this independently with a head switch. Her wheelchair was, however, denied as not being medically necessary. Without it she is fully dependent on others for mobility.

**BCBS of ND has no consistent peer review process for children with special needs. Because of this, adult health care providers with little pediatric specialty experience often deny therapy services and equipment determined medially necessary by the pediatric based treating physicians and therapists.**

> Example: Blue Cross and Blue Shield of North Dakota's system of review for physical therapy benefits is as follows: The therapist makes a request for additional services

1.reviewed by nurse case manager (if unanswered or denied)→ 2.reviewed by a physical therapist who is without pediatric experience and who the therapists are unable to directly communicate with (if denied) → 3.reviewed by medical director who is a family practice trained physician (if denied) → 4.reviewed by a 3 person panel of physical therapists one of which practices pediatrics and up until 2 months ago was from out of state.

Please note approximately two years ago when the physical therapist reviewer was a therapist with experience in practicing pediatrics it was felt that reviews regarding physical therapy services were fair and appropriate by treating pediatric physicians and therapists.

**BCBS of ND has implemented inappropriate episodes of therapeutic treatment for children with special needs often based from an adult model.**

Example: An 8 year old child with cerebral palsy (abnormal neurological system) who underwent 13 lower extremity surgical procedures at one time, for the intended purpose of improving the alignment of his legs and his muscles ability to work better to prevent bone deformity jeopardizing his chances of walking independently, was initially treated by his insurance company, in regard to number of physical therapy visits issued, the same as an adult who would have fallen and broken his/her wrist and requiring a surgical pinning. The 8 year old's therapy was needed to return him to his previous ability of walking independently without an assistive device (i.e. walker, cane, crutch) and climbing up and down a flight of stairs whereas the adult's therapy was needed to achieve movement back in his wrist.

Example: A 6 year old child underwent a dorsal rhizotomy (surgical procedure utilized to improve control of lower extremity muscles that requires the physician to go into the spinal cord and sever a select number of the child's sensory nerves) and was also treated by his insurance company, in regard to physical therapy benefits, the same as the adult who broke his/her wrist. His therapist then had to write a detailed letter monthly requesting continued benefits, when established protocols exist from places such as Gillette Children's Hospital and Shriner's Children's Hospital that recommend therapy at a frequency of five times per week for twelve months following this procedure.

**BCBS of ND has on several occasions, when reviewing the need for medically based services, requested information regarding current educationally based services to justify their authorization of benefits, even though medical instead of educational needs have been justified by the treating physician and therapist. In compliance with the IDEA Act, this information is completely separate and should in no way affect their ability as North Dakota citizens to obtain medically based services through a private insurer.** Medically and Educationally based services are two very different issues. Medically based services are those that are referred to in this bill meaning they are prescribed by a physician and recommended by a therapist to improve the child's ability to function independently and age appropriately in their environment including home and community. Educationally based physical therapy services as mandated by federal law are to serve the purpose only of assisting a child with a disability to fully benefit from a special education. This has been interpreted as the ability to access and participate in the educational environment.

A child could very easily require both medical and educational services, only medical, or only educational services.

Example: If a child is unable to go up and down stairs, but the school they attend does not have any stairs the school is not responsible for providing therapy that assist the child in learning to climb stairs. However, this is definitely a skill the child will need to accomplish in order to independently function in their environment and therefore it continues to remain a medical necessity.

I would also like to offer you information regarding physical therapy's role in preventing or decreasing the amount or intensity of surgical intervention required for a child with special needs.

Due to the nature of many of the conditions children with special needs have, surgery is often inevitable. However, when a trained therapist is able to intervene during appropriate windows of opportunity these surgeries can often be delayed or lessened.

A common response from insurance companies heard time and time again is that no further benefits for physical therapy will be authorized because the child is up walking. Unfortunately no regard is given to how the child is walking. A trained, experienced therapist, however, knows that because the child is walking so abnormally that they are stressing their bones and muscles in inappropriate ways, they are paving the fast track to surgical intervention. On the other hand if therapy would have been continued to alleviate this abnormality more likely than not surgery would have been delayed and possibly not needed at all.

An example of a typical surgical procedure required by children who walk with cerebral palsy costs approximately $35,000, which is typically fully covered by insurance. This without appropriate therapy may have to be repeated several times throughout a child's growing years. The other option could have been therapy during a primary window of opportunity resulting in a fraction of the cost to the insurer.

In closing I would ask you to revisit the reason Senate Bill 2331 was introduced to you today. It is requiring not that insurance companies be required to pay above and beyond those benefits outlined in their policies, but rather that they be held accountable for the benefits their employees, without relevant training and experience, are denying supposedly because they are not medically necessary when they have been prescribed by the treating specialized physician and therapist.

Unfortunately many of the children affected by Senate Bill 2331 have conditions that are life long and will never go away. Therefore, their management always focused on maximizing maximal potential also needs to be life long. It doesn't end when they're 3, 6 and start school, 18, or 21. If you would refer back to page one in regards to specifics that insurance companies cover you will note that they cover services that restore maximum function. Again Senate Bill 2331 is not asking insurance companies to implement new coverage, but rather to be accountable for their coverage. Children with special needs have a right to appropriate medical coverage the same as you and I even though they are predisposed often times since birth to requiring significantly more intervention. They are not the most cost effective policyholders. However, the world we live in is not a utopia.

I urge you to recommend the passage of Senate Bill 2331.

Senate Bill No 2331

Support for:

Children and Adolescents with developmental or acquired disabilities, for example Cerebral Palsy, Spina Bifida, Downs Syndrome, Autism Spectrum Disorders, Traumatic Brain Injury, Spinal Cord Injury, and Intra or Intercerebral hemorrhages (stroke) should receive medical coverage for medical needs and medical related services based on medical necessity related to current developmental age and ability with periodic review as to anticipated developmental or growth related changes or needs relevant to their medical disability based on appropriated expected benefit and outcome. The infant, child or adolescent's medical and developmental needs can be anticipated including growth and developmental changes in gross motor, fine motor, language, cognitive, personnel and social development and should be taken into consideration when planning and providing for medical related needs. Infants, children, and adolescents are not merely small adults but have unique developmental and medical needs related to their disability based on age and anticipated growth and developmental changes.

This bill would assist in defining medical coverage for infants, children and adolescents based on age and developmental needs as related to their medical and medical related needs.

Reference for Growth and Development:
Molnar,Gabriella, Sobus,Kerstin: Growth and Development. Chapter 2, Pediatric Rehabilitation, Third Edition. 1999, Hanley and Belfus. Pages 13 – 28.

Thank you for your time and consideration,

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Senate Human Services Committee
Testimony on SB 2331
Monday, February 5, 2001
By Colleen Stockert, Parent

Madame Chairperson, members of the committee, for the record, my name is Colleen Stockert. I am the parent of a child with cerebral palsy. I am also an employee of the Department of Human Services, and want to be clear that I am here testifying as a parent, in support of SB 2330, not as an employee of the Department. I am on annual leave this morning so I could be here to testify.

My six year old daughter, Nicole is here with me today. She has severe cerebral palsy and has received physical, occupational, and speech therapy from a local hospital since she was nine months old.

This summer, our insurance company notified us that they would no longer cover Nicole's occupational therapy at the hospital. The decision was appealed by her therapist and denied.

Nicole's pediatrician, physiatrist, and occupation therapist all recommended that she continue to receive OT services. I understand that the insurance company has an OT on staff who reviews these requests. However, that one OT's decision overruled the recommendation of three other professionals who

have worked with my daughter most of her life. They know her and her needs. The OT at the insurance company has never met my daughter, never examined her, never observed an OT session, yet her opinion of Nicole's needs outweighed everyone else's opinions.

Nicole does receive therapy services at school, but they are only required to provide services that are necessary for academic purposes, not for other reasons. The OT services she was receiving from the hospital addressed other needs that may not be academic in nature, but will affect her ability to do things and to participate in life.

The insurance company wanted copies of a home program submitted when they reviewed the OT's notes. I agree that parents need to follow-up with therapy at home, but there is not enough time in the day for us to follow through with everything she needs. If we were to do all the things she needs, we would be doing the following:

- Stander for ½ hour per day
- Range of Motion exercises everyday – ½ hour per day
- Work on feeding/drinking – ½ hour additional time at meals
- Speech exercises – ½ hour per day
- Vision exercises – ½ hour per day

- Work with augmentative communication device – about ½ hour per day

My husband and I both work full-time jobs. I usually get home with the kids around 5:30 pm. Nicole goes to bed between 8 and 8:30 pm. That gives us about 2 ½ to 3 hours per night to review school work, make supper, eat, clean up, do the three hours worth of activities listed above and get her and her sister ready for bed. It just isn't enough time. At least if Nicole is receiving PT, OT and speech once a week we can keep a handle on the areas that she needs the most work and concentrate on those.

In addition, since Nicole is not going to OT regularly, we don't even know what we should be working on. Neither my husband nor I are a therapist. We rely on the recommendations of her therapists to know what we should be trying to work on. We aren't getting that from her OT anymore because the insurance company decided it wasn't medically necessary.

Finally, without therapy, Nicole may lose range of motion, or suffer other complications of cerebral palsy, such as contractures. The cost of treating these complications, as well as the affect they have on her quality of life are not being considered in the decisions made by the insurance company.

I believe that we are responsible consumers of medical services, including therapy services. We don't agree to all the therapies

that may be recommended for Nicole, rather, we weigh the need for the therapy against Nicole's need to be a child and not spend all her time at the hospital. But, I think her physicians, therapists and parents are in the best position to determine what her needs are, not someone sitting in an office hundreds of miles away who has never even met Nicole.

Please support SB 2331 – for the sake of our children.

Thank you for listening to my testimony. I would be happy to answer any questions you may have.

SB 2331, Human Services Committee

I am Senator Tim Mathern of District 11 in Fargo. I am sponsoring Senate Bill 2331 to address problems parents have when trying to get medically necessary care for their children who have disabilities.

It is disconcerting to hear from parents that some health insurance companies refuse to cover medical care prescribed by a physician for a child with a disability.

I am distressed to hear from parents that some health insurance companies refuse to cover medical care prescribed by highly regarded and specialized physicians who regularly treat children and who are completely familiar with the needs of a specific child with a disability.

Some health insurance companies use a familiar tactic to deny these legitimate claims for medical care. That tactic is the incorect use of "medical necessity," "medically necessary," "medically reasonable," and similar terms. Some companies write health insurance policies that give the health insurance companies sole and absolute discretion to determine whether prescribed care is a "medical necessity," "medically necessary," or "medically reasonable."

Some of these companies use nurses, therapists, and allied health professionals to declare that prescribed care is not a "medical necessity," "medically necessary," or "medically reasonable." Sometimes these people have no relevant experience to the specialized treatment needs of the child.

If parents appeal the denial to the health insurance company, these same insurance companies often use a general practitioner, family practitioner, general pediatrician, or non-specialized physician to uphold the insurance company's earlier decision. These insurance company physicians may have no relevant training or experience but the insurance companies use them to veto the care prescribed by a licensed and board-certified specialist physician who is an expert in this particular medical need and who is thoroughly familiar with the entire health condition of the specific child.

Often the medical professionals are employed by the insurance company. If not, the insurance company pays them on a contract basis for each case they handle.

In virtually no case does the insurance company's nurses, therapists, allied health professionals, general practitioners, family practitioners, general pediatricians, and non-specialized physicians ever see the child for whom they make critical health insurance coverage decisions. Nonetheless, they make decisions that suggest that they know more than the licensed and board-certified specialist physician about what is a "medical necessity," "medically necessary," or "medically reasonable" for the child.

This is not a sensible way to ration health care.

Some health insurance companies recently began working to address these problems. Those companies deserve credit for their efforts. As admirable as these recent insurance company efforts may be, they do nothing for the child with a disability who needs important health care now. They also do nothing for the child harmed by a health insurance company that is not involved in this recent initiative.

This bill is a very small step toward protecting our children from the hurtful practices employed by some of the health insurance companies that do business in North Dakota.

I strongly urge a Do Pass recomendation to the Senate on this bill. Thank you.

Good Morning:

I am writing to ask your support for Senate Bill 2331.

I am a pediatrician who provides care to approximately 125 children with special healthcare needs, both in private practice at Dakota Clinic in Jamestown, as well as at the Anne Carlsen Center for Children. I am also an Executive Board member of the North Dakota Chapter of the American Academy of Pediatrics, and organization that represents most of the pediatricians in the state, and which also supports this bill.

Children with special healthcare needs in North Dakota have often been denied medically necessary services because the third party payor has used an adult model of service needs to determine reimbursement. Likewise, the approval process is frequently based upon adult injury recovery models rather than pediatric rehabilitation models.

The first rule of pediatrics is: "Children are not little adults." Children have growth and developmental needs which specifically impact the medical services they require. For example:

- An adult has sustained an injury, and through physical therapy has achieved the maximum level of function possible. At this point, the adult may only need "maintenance" therapy to preserve that level of function. This standard is applied whether the injury is of the acute type (e.g. fractured ankle) or the chronic rehabilitative type (e.g. stroke).

- In contrast, a 2 year old born with a brain injury has, through physical therapy, achieved the maximum level of function possible. However, that child will grow, and develop more muscle strength, and greater thinking abilities. Her maximum level of function at 2 years may be nothing compared to what she can achieve at 5 years. In addition, the therapy needs for her may change dramatically as her body grows into that of an adult. Her need for ongoing care is reflected by her growth and development.

The concept of "maintenance" therapy for children with special healthcare needs is not the same as for adults, either in the acute injury model or in the rehabilitation model. Unfortunately, the adult model is usually employed by third party payors in determining benefits.

In addition, insurance benefits for children frequently are reviewed by persons who have no pediatric experience. Reviewers are not currently required to have any specific experience in caring for children, and thus they have great difficulty in understanding the genuine medical necessity of services to the child with special healthcare needs.

SB 2331 requires ND insurance companies to **apply appropriate pediatric standards to services provided to children**, rather than the inappropriate adult standards. SB 2331 goes further in providing the **definition for medical necessity** **as it applies to children**---a definition which heretofore has not been available.

This legislation will make a very positive impact on the lives of those children with special healthcare needs. I ask your support for Senate Bill 2331.

MQuanrud MD

Myra Quanrud, MD FAAP
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**Senate Bill 2331**

**Testimony of**
**Deb Houdek, PA-C**
**Medcenter One**

Madam Chairman and members of the Senate Human Services Committee. My name is Deb Houdek and I am testifying in support of Senate Bill 2331. The essence of this bill is to provide for coverage of therapies and equipment necessary for children with special needs. This bill is necessary as there has been little or no consistency with the review of therapy services and their subsequent denials by Blue Cross and Blue Shield of North Dakota. This has led to countless number of letters and phone calls trying to give the case manager an accurate picture of the child's needs. Most of these case managers have had very little training regarding the ongoing changes of a child with special needs.

Here in North Dakota, we are fortunate to have state of the art facilities to provide the necessary services for these children. We also have some of the finest medical professionals and pediatric trained therapists to carry out these services. These professionals have the knowledge needed to treat children that have been diagnosed with cerebral palsy, spina bifida, closed head injury and other congenital anomalies. The purpose of this therapy is to provide these children with the necessary tools to help them regain or achieve their maximal functioning capacity. Without such services, permanent loss in range of motion occurs. When changes like this occur, the child becomes more difficult to care for causing , in some cases, institutionalization.. We want as many of these children to be able to go to college, seek employment and live as independently as their condition permits.

The treatment of children is very different than the treatment of an adult. A great majority of children who need therapy services have a diagnosis of cerebral palsy. The incidence of a child being born with cerebral palsy is 2 per 1000 live births. Cerebral palsy is damage to an area of the brain caused by either lack of oxygen or rupture of a blood vessel. This results in severe tightness or spasticity in muscles which the child is unable to control. Because of this, the child needs to learn how to overcome the obstacles that their bodies present to them. The only way of doing this is to have trained professionals working with them to develop

new approaches to walking, talking, feeding and using their arms.

To make this more complicated, the child's bones continue to grow at a rate that is difficult for their muscles to keep up with. Due to this growth, the child needs ongoing therapies such as physical, occupational and speech therapy to help them accommodate for the sudden tightness they experience. A child's eyes, swallowing, talking, bowel, bladder, head, trunk and extremities are all affected.

These children need trained professionals who are specialized in their many needs. A speech therapist is needed to help them form words so intelligible speech may be possible or to assess appropriate devices to help them communicate. Assessing the risk of aspiration or chokin g on their own saliva, causing hospitalization, is monitored by the speech therapist. Helping the child use muscles around the mouth and in the neck to help them swallow and determine what textures of food the child can handle to prevent choking are all responsibilities of the speech therapist. All of this plus educating parents is a vital role speech therapists perform .

Occupational therapists provide the child with the ability to use their arms and carry out fine motor skills such as obtaining a pincer grasp, necessary to hold a spoon and other basic functions. They work with stretching and strengthening the muscles of the upper body, preventing permanent contractures at the elbow or wrist. These areas are also prone to skin breakdown which can lead to an open sore and source for infection. The occupational therapists provides splints for their hand , wrist, and/or elbows which allow the child to overcome some of the spasticity.

Physical therapists are needed to help with gross motor skills such as walking, standing, and crawling. They are responsible for stretching the muscles in the hip, legs and feet to prevent permanent contractures in these areas. They work with these children to provide them with the necessary tools to carry out safe and functioning mobility. They constantly assess common problems that can occur due to their spasticity, such as scoliosis or a dislocated hip.

In combination, the pediatric therapists evaluate equipment that is appropriate for the child such as a feeding chair, wheelchair, walker, stander and braces. Along with the recommendations of the medical provider, the child is able

to have the necessary equipment and therapy to assist with their independence.

These children need therapists who specialize in these needs. We have found that many insurance companies routinely pay for these services, but Blue Cross of North Dakota has been inconsistent in providing the necessary coverage. Although we all recognize the need for insurance companies to watch costs closely, this can't be done at the expense of necessary medical treatment. Cerebral palsy is a medical diagnosis and the families who pay for Blue Cross coverage should be able to receive treatment that is recognized as essential within the medical community.

The position of Blue Cross is to say to us: teach the parent to do all these therapies at home. This would be fine if parents were physical, occupational and speech therapists all rolled into one. But they are not and this approach simply doesn't work.

I strongly urge the passage of this bill as it would provide for a definition of medical necessity and require that coverage decisions be made by people who have the appropriate expertise.

Thank you for time. I will try to answer any questions you may have.

Good morning. My name is Heather Phillips and I am a licensed physical therapist who practices in the area of pediatrics. I graduated with my master's degree from the University of North Dakota and have practiced primarily in the field of pediatrics since that time. In order to practice physical therapy you must be licensed in the state you practice in. In order to achieve North Dakota licensure you must graduate from an accredited physical therapy school and must pass the national licensure exam. In order to keep your license you must attend 25 hours of continuing education courses every 2 years to assure you to stay abreast of all changing practices and to further your area of expertise.

I am here this morning as a concerned professional as well as a North Dakota constituent to urge your committee to recommend the passage of Senate Bill 2331. This morning it is my objective to present you with testimony for the viewpoint of a practicing professional who treats children with special needs that will allow you to become informed as to the importance of your yes recommendation of Senate Bill 2331.

Senate bill 2331 in summary if passed would require insurance companies in North Dakota to provide coverage for children under the age of 21, covered under the respective policy, for medical treatment, medical service, medical therapy, medical equipment, or medical supply prescribed by a licensed medical professional within their scope of practice; in order to improve or prevent deterioration of a physical or psychiatric illness, injury, or condition, and or facilitate maximal age appropriate developmental capacity or growth, or reduce, alleviate or prevent pain.

In essence this bill formulates a universal definition of medical necessity as related to children with special needs to be utilized synonymously by all payers and providers in the state of North Dakota.

Please note Senate Bill 2331 is not asking insurance companies in North Dakota to provide payment for services above and beyond what is stated in their policies, but rather holds them accountable to their members.

If this bill is passed in order for the above stated prescribed services to be denied (which insurance companies continue to be fully capable of with the passage of this bill) it must be denied, on the basis of not achieving the above stated, by a physician or licensed professional with like education, certification, training and experience as the one prescribing the treatment/equipment.

> **For Example:** A therapy service recommended and deemed medically necessary by the treating pediatric physiatrist and pediatric therapist can not simply be denied on the basis of not medically necessary by a licensed Registered Nurse.

**The North Dakota chapter of the Academy of Pediatrics supports this bill.**

In review of specific insurance policies I have noted that covered services specifically include: **physical therapy services performed by or under the direct supervision of a physical therapist to restore maximum function following a disease, injury, or loss of a body part if services are provided in accordance with a prescribed plan of treatment ordered by a physician. Services must be non-maintenance and medically appropriate and necessary.**

In response to Senate Bill No. 2331

Our daughter Lauren was diagnosed with a brain tumor on October of 1999. In the course of 2 biopsy retrivals, her right side became quite impaired. She couldn't sit up in a bed without being propped, she was in a wheelchair, her right arm didn't function, and also impaired were her speech and facial expression. As you can see Lauren has come a long way with the help of her rehab services. She still has a long way to go, because Lauren wants to be the best she can be!

Lauren's Physical Therapy has been cut to once a month. This is very frustrating especially since she was making significant gains and was by no means at the full potential of what she could of and can accomplish. I question the process of how these descions are made and what facts are they based upon. The information I've read is phenonemal on what the brain of a child can do to recover from injury by providing proper services. What happens down the road when there is joint, tendon, and muscle damage because denied services has led the patient to use the mechanics of the body improperly? Will services be denied to repair the damage? A body is somewhat like a car. When something is not working you fix it right away or eventually it leads to more breakdowns and higher costs to repair.

Lauren wants the opportunity to try to live a life without a brace or a gait when she walks. She wants to swim, play, jump rope, ride bike, write right handed agin etc. That is how most 9 yr. olds live! She works so very hard at therapy. We feel given the chance all these things are achievable. We've come so far! I wish we had a video of before rehab and after.

When one gets cut from therapy they say they should do a home program.. Please remember we try our hardest but we have 2 other children who need our care, we have jobs outside the home, we are mothers, fathers, husbands, wives, employees, housekeepers, volunteers, and now therapists. Believe me they don't get the therapy they would get from a professional no matter how hard one tries. In fact, most of my time is put into Lauren's education. School isn't as easy as it use to be for her, but she's working hard and keeping up. She is maintaining A's and B's without any cirriculum adjustment. She does not get services in this area that is why I spend so much time on the thinking process and we are still experiencing improvement.

I have written a letter to BC/BS asking for a response to the descion of why she is unable to get more therapy. I am still waiting to hear. It's been over a month.

When you go thru your child having an illness you wonder why. If the reason is so that today we can come forth and have a voice to make a difference and better the system not only for our child but for all children then we will accept this illness. We don't plan to die from this brain tumor. We plan to live with this brain tumor, and we plan to live the highest quality of life we can achieve with the help of rehabillitation.

Sincerely,
Darlene Weigel

Testimony before the Senate Human Services Division
Regarding SB 2330 & SB2331
February 5, 2001

Chairman Lee and members of the Senate Human Services Committee. My name is Rick Pelishek. I am the Executive Director of the North Dakota Disabilities Advocacy Consortium (NDDAC), which is comprised of 16 organizations (and growing) from around the state. One of our goals is to be a resource to you so you can make informed decisions in an effort to improve public policies and programs for individuals with disabilities.

I am testifying today in favor of SB 2330 and SB2331. I will not repeat the testimony given here this morning. As a Consortium, we have been following this issue and agree that insurance coverage for augmentative communications devices and services for our children are needed. We have had plenty of testimony on the facts of that today, and you will probably hear more in the days ahead as this issue is worked on.

We also agree , if a licensed medical professional prescribes a service, treatment, therapy, equipment or supply and it is supported by others in the relevant medical community as an appropriate treatment, therapy, equipment or supply, it should be covered. This is not a complex issue.

I personally think that we have been looking at the wrong "Bottom line" for a long time in our public policy. We have been looking at what will it cost,

and not looking at the real "bottom line" which is "will it improve the quality of life" and make this state a better place to live and work. If anything will affect the economic development in our state, this new "bottom line" will. These two bills are just a few that will bring that new "bottom line" in our state up a notch.

Chairman Lee, members of the committee. Thank you for your time. Are there any questions?

NDDAC
North Dakota Disabilities Advocacy Consortium

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*A project of People First of North Dakota*

NDDAC
Disabilities Advocacy Consortium

## Mission Statement

**The NDDAC will advocate for public policy that ensures all people with disabilities and their families are fully integrated into the mainstream of society. We will work to:**

- **Improve the quality of life through greater independence, empowerment, and self determination.**
- **Guarantee the freedom to exercise rights and responsibilities as citizens of North Dakota.**
- **Promote universal accessibility and inclusion in all aspects of community life.**
- **Uphold the values of the Americans with Disabilities Act**

## To Accomplish its Mission NDDAC will:

- **Identify and research public policy issues, develop testimony and policy recommendations, and encourage innovative solutions to public policy concerns.**
- **Educate legislators in an effort to improve public policies and programs for individuals with disabilities.**
- **Encourage people with disabilities and their families to advocate for themselves and coordinate grass roots efforts to support them.**
- **Advocate for a consumer-friendly service delivery system.**

Updated 1/5/01

Erika

TESTIMONY ON SB 2331

Madame Chairman and Members of the Committee:

I'm Erika Pelishek and I want to tell you why this bill should be passed. I have three siblings who have a variety of disabilities. My brother Karl had to be taught everything, even how to swallow. The Doctors said he might never walk. My parents worked hard to teach him, and I helped. I showed him how I ride my bike. We got a special bike for him. He learned a lot in therapy, too. He even runs track in Special Olympics.

Karl could only go to therapy for a few months at a time, and then Mom said the insurance would no longer pay. This didn't make sense to me -- why would they quit helping him, when he was learning so much? When they finally paid again, we had to teach him some things all *over* again.

My little sister Emily needed to learn to talk – mom & dad said she needed lots of help. But insurance wouldn't pay for speech – because she knew *some* words. We spent a lot of time teaching her. I wish I'd had more time to play with her instead. It's hard for Emily to calm down when she gets upset. The doctor thought it would help for her to have occupational therapy. Insurance only paid for three months, and then said she didn't need it anymore. She still has trouble calming down. It usually takes more than three months to learn something like *that*.

My big sister was 14 when she came to live with us. She had a hard time tying her shoes, writing and reading. The doctor thought she should have occupational therapy too, but the insurance people thought she was too old to learn. Can you *believe* that? We had to teach her ourselves. We spent lots of time trying to teach kids things they should have learned in therapy. I'm glad we had the time to help them. We still work with them a lot. Some families can't help like we do

That's why I think this bill should pass. *All* children should be able to get what they need.

Emily

Karl

Mary

Chairman Lee & Members of the Committee

My name is Jodi Pelishek, and I am here to support Senate Bill 2331. As you have heard from my daughter, denial of therapeutic services **affects** not only the child being denied, but **the entire family.**

As the parent of five children, three of whom have special needs, it has been extremely frustrating to jump through hoops to access the therapies our children need. Too often, those hoops are moved, arbitrarily it seems, and we are left not knowing what the insurance company wants. We are told that the therapy needs further justification, only to have it rejected once additional doctor's recommendations are made. We are told that the therapist must submit more detailed notes...again, to be denied.

It has been our experience that our **children made the best progress while accessing appropriate therapies** as prescribed by physicians, psychiatrists and therapists. Unfortunately, therapies are typically only approved for 90 days, if at all. At the end of the three months, there can be a gap of two to six weeks without therapy, until we know whether insurance will cover again. Often children lose ground during this time, so when insurance finally covers again,they must spend the first weeks just catching up.

**Please understand**. Recommendations for therapy are *not* made on a whim. Families have better things to do than take children to appointments, and would not do so if there was no benefit. We choose *qualified specialists* to help with our children's care, just as I'm sure you do. When those experts recommend specific treatment, either medical or therapeutic, our job as parents is to be sure that service is provided. The insurance company's responsibility is to provide coverage.

In thirteen years of advocating for our children and dealing with all kinds of medical, emotional, mental and behavioral issues, as well as adoption agencies, our largest obstacle has always been Blue Cross/Blue Shield. As parents we deal with sleepless nights, the rages, the agonizingly slow process of learning, changing & monitoring medications and day-to-day crisis. Our children often feel isolated from peers, so we provide most social interaction ourselves. In addition, **we are asked to** not only parent our children, but to **serve as therapists** when no other help can be found.

We no longer purchase toys for fun. We evaluate them to discern what will best help develop fine motor skills and eye/hand coordination. We use masking tape on our living room carpet as we work on gross motor skills and balancing. Therapists ask us to keep up with home programs when insurance denies coverage – charting how many push-ups and sit-ups are done *each* day, how many two-part commands each child can follow, and what progress they're making in self-help and calming techniques. We also work on writing skills, and monitor vocal problems by marking speech charts at home. We sort and match, count and recount money, work on measuring and other life skills, all in addition to the hours of school work they must complete

My plea is this – **PLEASE allow me to parent these children**, with their many challenges, rather than to become their only therapist. **PLEASE keep Blue Cross/Blue Shield accountable to provide the insurance coverage that we pay for, but are too often denied.**

I have tracked gains and regressions of one of our children, dependent on the acquisition of therapeutic services. After about a year of therapy, services were deemed, by insurance, as no longer necessary. Although the child was at risk, & therapy was still recommended, coverage was discontinued. Lack of progress was noted in every area:

| **Therapy** | **Score when therapy denied** | **A year later** |
|---|---|---|
| Language – receptive | 28months/34 months | 32 months/46 months |
| Language – expressive | 32/34 months | 38/46 months |
| Fine Motor skills (OT) | 32/34 months | 29-30/45 months |
| Gross Motor skills (PT) | 25/34 months | 30/46 months |
| Self-Help (OT) | 21/34 months | 32/46 months |
| Social/emotional (OT) | 33/34 months | 30/46 months |

With previous therapy, the child had made substantial gains. As you can see, without therapy the child gained less than five months in a twelve-month period. When you consider there were already delays, a no-win race develops – that of attempting to help the child not only make progress, but learn to interact with peers who continue to move ahead of them.

With ongoing, uninterrupted therapy, the child would have been supported and given the necessary tools by a qualified therapist, diminishing the need to repeat developmental stages that had at one time been mastered.

It is clear that insurance companies have an obligation to provide care deemed necessary by an attending physician.

SB 2331
TESTIMONY
SENATE HUMAN SERVICES COMMITTEE
FEBRUARY 5, 2001

Chairwoman Lee and members of the Senate Human Service Committee, my name is Jon Rice. I am a Medical Director at BCBSND. I appear before you in opposition to SB 2331.

This bill probably represents the largest and most expensive mandate ever considered by this legislative body. It significantly expands the prescribing authority of medical practitioners across the state and effectively eliminates any controls of insurance companies for evaluation of medical necessity and appropriateness.

I recently evaluated a request from a provider requesting that an injection called Synagis be administered on a monthly basis to a premature newborn because that newborn is at high risk for development of respiratory synctial virus (RSV) infection. In addition to the monthly injections with a drug cost of approximately $1,000 per month, the prescribing physician felt that it was appropriate that this be administered by home health nurses in the infant's home, at a cost of about $80 to $120 per visit. We agreed that in this situation it was appropriate to receive the protection from RSV infection, however, did not feel it was medically necessary that this be administered by home health nurses especially in view of the fact that this child has siblings at home, has parents who smoke, will be attending daycare, and will be making routine newborn visits to the physician's office. We were unable to see any reason that additional potential exposure to office children would put the child at significant risks and denied the use of home health services for this type of a situation. Under SB 2331 we would be unable to make such a determination as we view the bill.

As another example, we have recently had a situation in which an individual was seen for a hepatitis C infection and treated with a combination of medications called Rebetron therapy. This involves three times weekly injection as well as daily pills. Generally these injections are self administered at home like insulin and monitoring is done on a monthly or every other month basis. In the situation that we dealt with, the physician indicated that in his opinion it was medically necessary that these injections be given in the office and that monitoring be done on a weekly rather than a monthly or every other month basis. This resulted in a series of office visits, laboratory tests, injection fees, and drug fees over a six-month period of $50,000 for one patient. The usual amount of services and reimbursement for this situation that we have provided in North Dakota is in the range of $7,000 to $8,000 per member for a course of therapy.

Again, based on the language and 2331, we feel that it would be nearly impossible to deny reimbursement for these medically unnecessary services. Specifically, there is difficulty in the language of this bill relating it to the definition of consensus and its practical implementation. We feel that from a practical point of view, it makes denial of any services necessitate a poll of all "relevant specialty practitioners" to determine whether 70% would support the service or would deny the service and actually requires that 70% oppose the service before it could be denied. The licensed medical practitioner language does not have a definition to the best of our knowledge.

As I understand it, the concerns precipitating the introduction of this bill revolve specifically around appropriate levels of service in the physical therapy, occupational therapy, and speech therapy for children with special needs and those who undergo long term therapy with disabilities in these areas. This has been an area of difficult decision making for us for years and has become more acute during the last year. We have difficulties in regards to determining how much therapy is medically appropriate. We have problems with determining when individuals are making progress, and it is difficult to determine what is maintenance care and when additional therapies are not warranted. There are specific exclusions in our benefit plans at this time for maintenance care and it is not a covered service. Likewise, the benefits for occupational and speech therapy include a 90-calendar-day period for each year. These concerns came prominently to our attention during the public forum meetings that Mr. Unhjem held around the state during the year 2000. At his request, we met with a group of parents in the Fargo area and they expressed their needs for streamlining the authorization of additional therapies beyond the 90 days allowed in the benefit plan, the expansion of therapies, and better understanding of the appeals process. We also met twice via conference call with another group from Bismarck concerning the same issue. We have taken that information to heart. We have assigned the 100 patients that use most of the PT, OT, and ST services to specific case managers so they have a constant uniform point of contact if their questions are not able to be answered at our customer service desk. We have written out and provided to a group of the parents our appeals process in addition to the explanation in the benefit booklet. We have formed a task force and had one meeting with this task force consisting of parents, speech therapists, occupational therapists, and physical therapists, as well as representatives of DPI and the Department of Human Services to address the problems of benefits and definitions. This group met a couple of weeks ago and has formed a series of subcommittees to begin to address the benefits and definitions issues. The next scheduled meeting is the end of February. Our goal is to have the task force complete its recommendations during the next four months. They will then be assessed for inclusion in our contract rewrite to be completed in July of this year.

We feel that the language in this bill is extraordinarily broad and inclusive. We believe that the language indicating that any licensed medical professional acting within the scope of the licensure can prescribe for any individual under the age of 21 medical service, medical treatment, medical therapy, medical equipment or medical supply and it must be covered by the insurance company is exceptionally broad and unworkable. In addition, the purpose of this prescribing not only to improve one's health, but also to prevent deterioration of a physical or psychiatric illness, injury, or condition, or to prevent pain may be extremely difficult to interpret. As we look at this bill, it is certainly possible that chiropractic manipulation on a weekly basis for the purpose of preventing pain, if approved by 30% of the chiropractors, would mandate payment of therapy under this bill. While some therapies may not be appropriate and we could potentially find a significant population of the practicing providers that feel that it would be inappropriate, the methodology to do this and the cooperation of the practicing community to provide constant input into these determinations would be practically impossible to obtain.

It is our anticipation that the passage of this bill will significantly increase utilization and costs. Our subscribers are emphasizing to us that they can no longer afford the high premium increases they have experienced during recent years. If this bill passes, we will have two options; either increase premiums or reduce provider reimbursements. The second option would significantly impact our providers at a time in which Medicare reimbursements have not kept up. It is our strong recommendation that based on affordability of this bill and the total loss of all control of potential benefits to insurance companies that this bill be defeated.

I thank you for your attention and would be happy to respond to questions.

Proposed Amendment to SB 2331

Page 1, line 5, replace "26.1-36" with "26.1-26.4"

Renumber accordingly