Scott Glovsky
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Health insurance coverage denial: Medical directors

WHO THEY ARE, WHAT THEY DO AND HOW TO DEAL WITH THEM IN A BAD-FAITH CASE

A central actor in most health-insurance bad-faith lawsuits will be the medical director who reviewed the request for coverage that the insurer either delayed or denied. Therefore, it is important to understand what medical directors are, how they do their jobs, and what type of information about them you should pursue in discovery. This article explores these questions and provides a rough guide for how to address medical directors in litigation.

Who are medical directors?

Absent a clerical or coding error, most health-coverage denials result from a contractual exclusion or a purported lack of medical necessity. Common exclusions in health plans are those labeled as cosmetic procedures or treatments that are considered experimental or investigational. When an insurer or managed-care plan denies an insured's request for coverage it will employ a medical director – a doctor – to make a medical-necessity determination.

Managed-care plans, the vast majority of health coverage providers in California, are required by law to use licensed doctors when making a denial of a member's request for health care coverage. Health & Safety Code section 1367.01, subdivision (c) requires that health care service plans "employ or designate a medical director who holds an unrestricted license to practice medicine in this state . . . or, if the plan is a specialized health care service plan, a clinical director with California licensure in a clinical area appropriate to the type of care provided by the specialized health care service plan."

How do medical directors perform their reviews?

The law requires that a California doctor make the final decision to deny a request for coverage for medical necessity but many times the medical directors are family medicine practitioners or internists – even when the insured is seeking review of a claim for coverage for a specialized procedure such as brain surgery or cancer treatments. These medical directors might have no experience with a particular diagnosis or treatment, or might not have any knowledge of the service for which they are reviewing coverage.

The medical directors rely on clinical guidelines or medical policies, which are generally checklists for them to follow. Specifically, these documents have a list of symptoms or clinical findings that must be documented before the medical directors can approve or deny medical necessity. The majority of health service plan providers have these documents available to view on their websites and you can find a policy or guideline for any specific treatment with a quick internet search of the name of the treatment, the insurer and the words "medical policy" or "clinical guideline." These documents allow

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medical directors with scant knowledge of a particular treatment to reach a determination of medical necessity for an insured.

Medical directors will often use medical policies in conjunction with specific pages of an insured's medical record that can be identified and separated by a health plan's review nurse. In other cases, the medical director might not have access to medical records, relying instead on summaries of the records by the review nurse. The medical directors can then simply compare the summary or specific medical record pages to the list of requirements in the medical policies. In this way, medical directors can work in their homes or a generic office in front of a computer without the need of any other reference materials or discussions with any other person to reach a determination on claim after claim. It is no surprise that many of these reviews result in medical necessity denials.

Written discovery to investigate a medical director

In order to target relevant discovery regarding medical directors, it is important to understand a bad-faith cause of action in California. In "every insurance policy there is an implied obligation of good faith and fair dealing that neither the insurance company nor the insured will do anything to injure the right of the other party to receive the benefits of the agreement. . . . To breach the implied obligation of good faith and fair dealing, an insurance company must unreasonably act or fail to act in a manner that deprives the insured of the benefits of the policy. . . ." (CACI 2330.) Further, a health care plan must conduct a full, fair, prompt, and thorough investigation of all of the bases of a claim for coverage before it denies coverage. (CACI 2332; *Egan v. Mutual of Omaha Ins. Co.* (1979) 24 Cal.3d 809.)

Commonly, insurance companies charge medical directors and reviewing nurses with performing most, if not all of the insurer's "investigation" into a coverage request. Health service plans usually have policies that require the nurses and medical directors to document the steps that they take. Further, medical directors often review so many requests for coverage on a daily basis that often they are completely reliant on their notes to go back and determine what steps they took to reach any particular denial.

For this reason, requests for production are an incredibly important tool. First and foremost, it is important to send out requests early to seek to acquire all of the documents that illustrate the actions the insurance company took to reach the particular denial at issue. Often, these documents are described as the utilization management ("UM") file for the claim or request. Plaintiffs should seek all communications between medical directors and the reviewing nurse with whom they worked and any other communications that the medical director might have had with anyone regarding the denial at issue. It is also important to understand upon what documents the medical director relied in reaching the denial. In most circumstances, the only documents returned in response to such a request will be a medical policy and the few pages of medical records that the medical director might have reviewed. It is possible that the medical director conducted their own research before denying a claim and it is important to understand such sources to piece together the adequacy of the insurer's investigation.

Was the doctor qualified?

Another important area to investigate are documents illustrating whether the medical director was actually qualified to review and understand the treatment requested. As explained above, many times a plan member will request service for a treatment that is rare or specialized and often the medical directors reviewing such claims are not trained and do not have the experience necessary to understand medical necessity of the requested coverage. It can be useful to propound requests for the production of the medical director's resume, which should illustrate their education and specialty.

Further, it is useful to seek the documents that the insurer used to train the medical directors as to how they should review requests for coverage and to train them to understand the specialized treatment sought in any particular case. Often insurers contend that they have very little – if any – training for the medical reviewers and do not turn over many documents. This absence of training materials can be helpful as well.

Another important category of documents to request in discovery are documents that illustrate the percentage of reviews that a medical director approves and denies, and more specifically, the number of requests for the type of treatment at issue that the medical director has approved and denied. California law establishes that evidence of an insurer's misconduct in claim handling and the history of the reviewer central to a particular case is highly relevant to illustrating an insurer's pattern and practice of failing to investigate and handle claim processing. (See *Colonial Life & Accident Ins. Co*. (1982) 31 Cal.3d 785, 790-792; see also Croskey, Heeseman, Ehrlich & Klee, California Practice Guide: Insurance Litigation (Rutter Group 2018) § 15:751 & § 15:753 (information about other insureds relevant to proving bad faith and punitive damages).) Plaintiffs are therefore entitled to discover such documents even though they predate their specific dispute and involve third parties. (*Colonial Life & Accident Ins. Co., supra*, 31 Cal.3d at 791 [in a bad faith case "a plaintiff may establish a claim by showing either that the acts that harmed him were knowingly committed or were engaged in with such frequency as to indicate a general business practice"].)

Such information can also be relevant to a bad faith plaintiff's claims that an insurer acted with malice and is subject to punitive damages. (*Mock v. Michigan Millers Mutual Ins. Co.* (1992) 4 Cal.App.4th 306, 329 ["a central theme common to those cases which have sustained punitive awards is the existence of established policies or practices in claims handling which are harmful to insureds"]; *Hughes v. Blue Cross of Northern Calif.* (1989) 215 Cal.App.3d 832, 847 [punitive damages appropriate because insurer's objectionable practices

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were rooted in established company practice].)

To get to this information, it can be helpful to propound requests for documents illustrating the total numbers of reviews that a medical director might have conducted in any specific period of time whether it be in a given week, month, year, or five-year period. Propound requests that seek documents reflecting the number of reviews that resulted in a denial in the same time period. From the documents returned, one can then extrapolate what percentage of reviews result in denials.

Deposing a medical director

Because medical directors often rely heavily upon their written notes to remember what happened with any particular review, it is beneficial to seek such documents through requests before proceeding with a deposition. Once a plaintiff has acquired such documents, it is important to proceed with depositions as quickly as possible as the medical director's testimony can steer the rest of discovery in a bad-faith case.

In many cases, medical directors are doctors who have left the world of treating and healing patients for a less demanding and more lucrative job working for insurance companies. Due to the nature of their position, medical directors often have their employer's – and not the patient's – best interests in mind when giving testimony in a deposition. Since medical directors have an incentive to protect their employers and keep their jobs, they can be susceptible to heavy coaching by the insurance company's counsel. It is therefore important to explore the nature of their job and incentives in deposition so that later the jury will be able to understand why the medical director's testimony is less credible than the treating doctor's testimony

As in written discovery, it is important to garner information in a deposition that can illustrate the qualification (or lack of qualification) of the medical director to perform the insurance investigation. Questions about medical training, the types of patients that they have personally treated, their experience with the particular diagnosis at issue, their experience administering the particular treatment at issue, the research they have performed, the articles they have reviewed and/or written that are relevant to the coverage at issue, the conferences at which they have spoken or attended, and the classes they have taught or attended can be helpful. Questions about the training that the medical director received from the insurance company, more specifically when, how, where, by whom, and what subsequent training the insurance company has provided, can illustrate whether it was unreasonable and therefore in bad faith for the health plan to entrust the medical director with making a medical necessity determination.

A central focus of the deposition should be to nail down a complete understanding of how the medical director does his or her job. Ask where they work and if they work at home, what they use to conduct their reviews (often it is just their computer), the hours that they work, other duties they might have other than reviewing requests for insurance companies, and what their typical day reviewing requests is like. To understand whether the medical director has a pattern and practice of denying requests for coverage, you should also ask questions about the average number of reviews conducted by the medical director and how many result in denials. Medical directors are generally well trained to respond with a claim of ignorance and an inability to estimate even how many requests they have reviewed in the last week.

Another main focus of a medical director deposition should be a detailed walk-through of every step the medical director took in reviewing the request for coverage. As explained above, this will likely be an extended exploration and explanation of the notes that the medical director kept when reviewing the claim. It is important to ask where the review was done, how long the review took, each step that the medical director took from turning on the computer to submitting the final denial, and all of the people with whom the medical director talked during the review.

Conclusion

The medical director's actions are central to a health insurance bad-faith case. Therefore, it is important that a plaintiff's attorney understand everything about the medical director involved and every step that the medical director took. Whether the medical director is qualified and whether the medical director conducted a full, fair and objective investigation before reaching a denial is critical to answering whether a health service plan acted reasonably and thus whether it is subject to bad-faith liability.

Scott C. Glovsky is a trial attorney in Pasadena who frequently associates into cases as trial counsel. His trial practice often includes catastrophic personal injury and insurance bad-faith cases. He appeared in the film SiCKO and in People Magazine, and his cases have been profiled on the major networks. He is a repeat guest on AirTalk with Larry Mantle. He received the "Street Fighter of the Year Award" from CAOC in 2008, and he is a graduate of Gerry Spence's Trial Lawyers College. Mr. Glovsky received his undergraduate degree from the University of California, Berkeley and his J.D. from Cornell Law School.