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Eliminate Second Opinion Provision for Elective Surgery (DHFS -- Medical Assistance, BadgerCare, and SeniorCare -- Eligibility, Payments and Services)

[LFB 2005-07 Budget Summary: Page 250, #14]

CURRENT LAW

The Department of Health and Family Services (DHFS) may not reimburse a provider for certain elective surgical procedures under the medical assistance (MA) program unless the MA recipient obtains a second opinion from another provider. DHFS is directed to require second opinions for selected elective surgical procedures for which second opinions disagree with the original opinions at demonstrably high rates.

DHFS has promulgated a rule [(HFS 107.065 (e)] to implement this statutory requirement. The rule lists the procedures that are subject to second opinion requirements. These procedures are: (a) cataract extractions; (b) cholecystectomy (surgical removal of the gall bladder); (c) dilation and curettage; (d) hemorroidectomy; (e) hernia repair; (f) hysterectomy; (g) hip or knee joint replacement; (h) tonsillectomy and adenoidectomy; and (i) varicose vein surgery. In addition, the rules state that the final decision to proceed with the surgery remains with the recipient, regardless of the second opinion. Further, the rules prohibit DHFS from reimbursing the physician that performs the second opinion if he or she ultimately performs the surgery. Under HFS 104.4 (2), DHFS may waive the second opinion requirement based on documentation that the surgery was urgent or emergent.

DHFS provides additional guidance regarding this requirement in its MA Physicians Services Handbook. The handbook describes the responsibilities of the recommending surgeon and recipient in obtaining the second opinion, and identifies situations where DHFS may waive the second opinion requirement based on documentation that the surgery was urgent or emergent. Second opinions can be performed by any Wisconsin MA-certified physician willing to provide them.

Finally, federal law requires that any surgical procedures be subject to medical review. DHFS currently contracts with MetaStar to continually conduct clinical and administrative reviews of elective surgical procedures for appropriateness.

GOVERNOR

Repeal the provision that prohibits DHFS from reimbursing a provider for certain elective surgical procedures without a second opinion from another provider under the state's MA program.

DISCUSSION POINTS

1. Second surgical opinion requirements are intended to assist recipients in making informed decisions about certain elective surgical procedures and to decrease costs due to overuse and inappropriate surgeries. However, under Wisconsin's MA program, the ultimate decision to undergo or forego the proposed surgery remains with the recipient. The proposed surgery is reimbursable if the recipient decides to undergo the procedure, whether the second physician agrees or disagrees with the recommending surgeon.

2. Because the recipient ultimately decides whether or not to have the procedure performed, the MA program does not realize cost savings by prohibiting procedures for which the second opinion disagrees with the initial surgical recommendation. It is possible that some recipients choose to forego surgical procedures due to the second opinions they receive, but there is no information available that suggests how frequently this occurs.

3. Repealing the second opinion requirement would likely have a minimal effect on MA benefits costs and may slightly reduce MA benefits costs by eliminating payments to physicians to conduct required second opinions. As previously indicated, it is unlikely that the current requirement results in recipients choosing not to have surgery. However, MA recipients would continue to have the option to seek second opinions, funded by MA, for making informed decisions regarding surgery.

The MA program pays physicians to perform second opinions under a range of procedure codes describing confirmatory consultations. These codes reflect increasing levels of complexity, ranging from $28.07 for the lowest level procedure to $58.56 for the highest-level procedure. However, in 2003-04, the MA program paid approximately $2,600 for 70 of these procedures that were billed with the appropriate second surgical opinion modifier or diagnosis code, out of a total of approximately $70,900 paid for 1,923 confirmatory consultations. (Since not all second surgical opinion claims include the unique modifier or diagnosis code, MA payments for these services were significantly more than $2,600 in 2003-04.)

4. Changing this requirement reduces the administrative costs to health care providers who will no longer be required to submit unnecessary paperwork or document compliance with the

requirement.

5. In an article published in the September/October, 1999, issue of Health Affairs, titled, "Who Gets Second Opinions?" Wagner and Wagner discuss the evolution of second medical opinions. The authors concluded that the effectiveness of second surgical opinions at decreasing inappropriate surgeries and costs was questionable, and that, with the increasing percentage of individuals enrolled in managed care, such requirements are no longer needed to monitor utilization. While an estimated 50 to 75 percent of provider organizations may have used them in 1992, these requirements have likely been discontinued or replaced with quality enhancement programs.

6. At the same time, five states (Florida, Indiana, Louisiana, Missouri, and New York) have passed legislation to preserve access to voluntary second opinions for HMO enrollees. Other states are considering similar legislation that is intended to protect enrollees' right to a second opinion. The national trend appears to indicate that second opinions are not required, but they are retained as an option for patients to use at their discretion.

7. None of the health maintenance organizations (HMOs) that serve MA recipients in Wisconsin has a mandatory second surgical opinion requirement. However, they may pay for a second opinion if an enrollee requests one. The MA program pays HMOs on a capitated basis, meaning they receive a fixed payment per month per enrollee. In this type of system, second opinions do not generate revenue for the HMOs. Instead, the HMOs determine the cost-effectiveness of second surgical opinions.

ALTERNATIVES

1. Adopt the Governor's recommendations to repeal the provision that prohibits DHFS from reimbursing a provider for certain elective procedures without a second opinion.

2. Delete provision.

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