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March 27, 2023

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National Committee for Quality Assurance (NCQA)
1100 13th St. NW, Third Floor
Washington, DC 20005

To NCQA:

I am writing not knowing if you are sympathetic, indifferent, or hostile to my issues with Ambetter, as my first foray contacting your organization produced a response that I consider unhelpful. (see response from 2/17/23 from Gloria Strickland). Maybe the issues I am raising here (Ambetter's systemic obstruction of the delivery of medical care with inappropriate

denials and lack of transparency) are beyond your ability to have any influence, but for what it's worth, not knowing if Ms. Gloria shared my issues, I am sharing them more broadly with this letter, especially since another similar denial of an indicated surgery just occurred with no comprehensible reason (as can be seen at **drwolgin.com/ambetter**). From the standpoint of the micro-details of whether the patient in question DB got her surgery approved,, she did eventually, but only after Herculean efforts (way beyond an acceptable level of time and attention from me and my staff). If knowing that DB got her surgery is the end of your involvement in certifying quality of health insurance programs, then read no further. I don't want to waste your time.

However, I am going to assume for the moment that the part of your name that is literally "quality assurance" means that your organization has something to do with quality assurance. The issue here is that, at least for Ambetter and their parent company Centene, and their contractor Turning Point whom they use to have plausible deniability for denials of requested services, based on my experience trying to care for patients with Ambetter insurance, their approval infrastructure is designed to be obstructive to the path of delivering care to patients. No clear explanation for the denials is offered, to allow me a chance to address their objections. This lack of transparency is unacceptable, and in my opinion is also systemic obstruction. It would take a further investigation to find out if the issues I am raising are a result of incompetence, indifference, or bad faith.

As noted on my webpage, from a pure money making standpoint, Ambetter's behavior actually makes total sense when you think about the business model of insurance. The company's revenue comes in the form of insurance premiums, money paid for the promise of covering medical expenses for their customers. However, these medical expenses, when approved, are their expenditures. More revenue and less expenditures means more profit for the company. Basic. A more liberal policy of approving suggested surgeries would mean less profits for the company. Therefore, insurance companies are highly incentivized to use any available methods to be as obstructive as possible regarding approving any expenditures that might be significant. As it happens, spine surgery is expensive, so it would make sense for them to obstruct in any way possible.

If Ambetter wanted to help patients, they would define for their providers (like me for example) whatever criteria they are using, so we could work

within their parameters to provide appropriate, cost effective care to their covered patients, or at least be clear to their covered lives what their insurance does and does not cover. However, they don't. Their denials are inappropriate, and their clinical policies are effectively hidden. Though I did get a copy of one of their policies (discussed below, about medical records, and probably sent to me by mistake since the document says "Proprietary and Confidential"), the criteria are essentially impossible to meet. Trying to contact their offices means prolonged times on hold. I have to wonder if their system was designed that way so that providers would get discouraged and stop trying to get imaging or treatments approved.

However, I stilI don't know if you want to or are able to delve into these issues.

I also understand that the relationship between the insurer and the insured is a contract, but the devil is in the details. My hope, and it might be false, is that an organization like yours, or some regulatory body can assess if these contracts were written in a manner to misrepresent what is covered, which to me would clearly be **bad faith**.

Whether you realize it or not, the patient population served by Ambetter is the least able to negotiate, and is likely also the least sophisticated in understanding an insurance contract. Aside from the fact that these days, whether it's buying an airplane ticket, opening a checking account, or signing up for iTunes, you either check the box that says you agree to the terms and conditions or you don't go forward. I am quite sure that Ambetter has in their contract verbiage all kinds of details allowing them to function as they do so probably they can't be criticized. **But morally they can be**.

It might be just my opinion, but I think that a reasonable expectation of a person who buys health insurance coverage would be that they have health insurance coverage. In my experience with Ambetter, the insurance coverage provided, in the context of actually covering health related costs, is woefully inadequate.

I have yet to find one patient or provider (doctor or advanced practice provider) who has anything positive to say about their dealings with Ambetter. If the Ambetter coverage were at least decent, shouldn't I find at least one provider who likes it?

As earlier referenced, I created a webpage that has further documentation (patient info redacted) at **drwolgin.com/ambetter** so any reader can assess for themselves if the denial letters offer any type of justification for the denials (spoiler alert: they don't). If Ambetter wanted to work with providers to provide appropriate services to their covered patients (a goal with which I can agree), there should be easily accessible criteria to follow. There are not. In fact, it was only after a heated conversation with one of the reps from Turning Point that I was able to get the below referenced policy on medical records with highlights of this policy noted here.

(From their own document): Acceptable medical records must meet **ALL** of the following (emphasis mine):

--If we write on the records, not acceptable.

--Patient's name and ID number should be on every page. Every note from our office is automatically disqualified. Ours has a name on the first page and then page 2 of 4, 3 of 4, etc., but doesn't have their name on every sheet of paper. They can deny any claim based on this issue alone, by their own policy.

--Documentation identical to other medical records will not be accepted. Umm...Hello! Have any of you seen an electronic medical record? They ALL have identical parts of the record that are carried over between visits. By their own criteria, they can deny any case.

--Among their requirements for detailed history, if one detail is left out (like substance abuse for example, which often not relevant), they can deny.

--Must include notes from physical therapy including initial and final visits. This requirement is another example of pure obstruction. I have been in practice 30 years and have never been asked for this additional paperwork as a requirement to approve treatments recommended by the patient's doctor, but if we don't have it, requests for eval and treatment can be denied.

--There are also other objections I have with this "proprietary and confidential" policy, which the patients with Ambetter insurance likely agreed to (or get nothing), that are clearly **bad faith**.

Then again, if you have nothing to do with insurers behaving this way, I would say I'm sorry for bothering you.

As noted on my webpage, maybe I'm the one who needs to be taught a lesson, that there are now new rules. Maybe these are them, given that insurers have all the data and the money:
--Insurers get to make all the rules, and it's not fair. We can go pound sand.
--Insurers will never see the patients I see, nor will they see that the patients often have treatable problems, and suffering can be lessened.
--Insurers, through legal loopholes, are allowed to essentially practice medicine with no liability for their actions, with more power and control than actual medical professionals, who have completed actual medical training.

As noted in various correspondences on my webpage, I would work with Ambetter if they were more transparent in their criteria, and didn't keep our staff on the phone for prolonged periods every time they called. If I had some criteria I could put on a poster in the exam rooms, or refer to on a website, I could point to it to show the patients that their insurance just doesn't cover this or that, but no such explanations are available.

I hope your group has some interest in assuring quality here, but just for the record, no other agency is interested either. On my webpage, you can see how the GA Insurance Commissioner offered no help. The GA Governor's office forwarded my complaint to the Department of Community Health, and no response. I shared the info with the Atlanta Journal Constitution thinking this issue might be a public interest story, but no response. If your group also has no leverage, then I am left with just sharing my opinions however possible. However, to use a ridiculous example to make the point, if you paid a plumber to do some work, if the plumber took your money and then said your work was not necessary (while your house flooded), you too would want a third party to set the situation right. However, I'm getting no traction on this issue.

In the meantime, I will continue to share these impressions and the documentation that proves my point with anyone who will listen. I would like to think that patients who have a choice can know about what to expect with Ambetter coverage, and might be more influenced by the issues I am sharing than by seeing the name Ambetter on an ad for NASCAR. Then again, many of the Ambetter customers don't have a choice.

Would be glad to discuss further, and again, if your organization doesn't handle "quality assurance," sorry for bothering you.

Sincerely,

Mark Wolgin, MD
drwolgin.com
drwolgin.com/ambetter
Albany, GA
mwolgin@gmail.com

Gmail

Mark Wolgin <mwolgin@gmail.com>

Re: Complaint - Ambetter

NCQA Customer Support <customersupport@ncqa.org>
To: "mwolgin@gmail.com" <mwolgin@gmail.com>

Fri, Feb 17, 2023 at 1:38 PM

Hello Dr. Wolgin,

Thank you for your correspondence expressing your concerns with Ambetter. It is unfortunate that matters have not been handled to your satisfaction.

NCQA Accredited, Certified or Recognized entities must have policies and procedures in place for the thorough, appropriate and timely resolution of member complaints and appeals. We will forward this complaint to Ambetter and request, on your behalf, that this complaint is handled in accordance with its established policies and procedures. We will ask that they respond directly to you and copy us on the resolution.

NCQA will include your complaint in our quality monitoring database that tracks the performance of Accredited, Certified or Recognized entities.

Thank you for bringing this matter to our attention.

Best,

Gloria Strickland

Manager, Customer Support

NCQA

888.275.7585

Fax (secure): 202.955.3531

From: Mark Wolgin <mwolgin@gmail.com>
Sent: Tuesday, February 14, 2023 6:31 AM
To: Gloria Strickland <Strickland@ncqa.org>
Cc: Mark Kishel <mkishel@mag.org>
Subject: Re: Complaint - Ambetter

This message originated outside your organization

TurningPoint Healthcare Solutions

TURNINGPOINT CLINICAL POLICY

Last Modified: 2/11/2021

Policy Number: GN-1002
Policy Name: Medical Record Documentation

Definition: To ensure receipt of best available care, medical records should contain accurate and thorough documentation. TurningPoint will accept documentation as outlined in this policy to promote consistency and standardization.

I. **Policy statement:**
Acceptable medical records must meet all of the following: All!!??

A. Pre-operative documentation/Office visit notes
   1. Signature: Each entry should include the author and appropriate signature with date. Surgical candidates should be seen by the surgeon within 30 days prior to surgery, at which time decision for surgery should be made and documented.
      a. Established patients with a prior history and physical exam documented can have either a telemedicine or in-person visit within 3 months prior to surgery
      b. New patients should have an in-person visit within 3 months prior to surgery; decision for surgery can be made at this visit or at a later telemedicine visit if need be
      c. For both of the above scenarios in a. and b., if the visit is outside 30 days prior to surgery (but within 3 months), documentation should be included to notate the pre-op visit date; the pre-op visit notes are not required to be submitted
   2. Clean: Notes should be submitted in chronological order, with margins free from writing. Incorrect documentation should not be crossed or whited out; corrections should be made and submitted as new entries with appropriate signature and date.
   3. Legibility: If handwritten, records must be legible to someone other than the author. Unacceptable faxed information includes documentation that cannot be read because it is illegible, too light or too dark, or obscured by artifact.
   4. Identification: Patient's name or ID number should be on each page. — ours don't. Have "page 3 of 4"
   5. Patient-specific: Documentation that is identical to other medical records submitted (cloned documenting) will not be accepted. what records with ERR is completely devoid of some copied text?
   6. Clinical documentation: Must include thorough and detailed history of current problem and physical examination; most recent smoking status and BMI must also be documented. Should also include medical history, medication list, allergies and drug reactions, family history, surgical history, and social history including substance use. Comorbidities should be addressed as appropriate; clear documentation of risks versus benefits must be included.
   7. Non-operative treatment: Attempted treatments must be clearly documented in the medical record and include specific type, frequency, duration, and response for each; must also include details on who prescribed the treatment. These may include any combination of the following (see specific medical policies for further details):
      a. Medication (anti-inflammatories, analgesics)
      b. Physical therapy

Clean?? what??

So, lack of info on subst abuse is grounds for denial, apparently

more reasons for denials

i. Must include notes from physical therapist; should include initial and final visits. — who has these??
ii. Detailed home exercise program may be accepted if completed in place of PT. This should be instructed by a physical therapist, athletic trainer, PA, or MD/DO. — How to document? I have exercises on my site, drwolgin.com

Note: For total and partial knee replacements, an initial physical therapy visit will be accepted. A home exercise plan or joint class with documentation of date instructed, along with which exercises were prescribed and by whom, will also be accepted.

c. Weight loss
   i. BMI of 30-35 requires weight loss discussion; must see documentation of discussion between provider and patient (e.g. maintaining healthy weight, acceptable BMI, lifestyle modifications, etc.).
   ii. BMI of 35-40 requires documented weight loss plan (e.g. patient joining Weight Watchers, reducing caloric intake, increasing exercise, meal planning, seeing nutrition specialist, etc.).
   iii. BMI greater than 40 requires documented weight loss on a case-by-case basis.
d. Injections
e. Assistive devices (e.g. crutches, cane, brace, splint, orthotics)
f. Thermal or cryotherapy
g. Activity modification
   i. Detailed examples should be given to show how the patient's pain interferes with their daily activities. — How detailed? Notes indic can't do their ADL's
h. Systemic therapy (e.g. medication for rheumatoid arthritis, chemotherapy)
i. Psychological and/or behavioral therapy — on whom?

8. Imaging: Must submit imaging reports for imaging done out of office. If surgeon's and radiologist's interpretations of imaging differ, addendums to the radiology report will be requested for clarification. Objective documentation from surgeon for x-rays taken and read in-house is acceptable. → Not requested. These discrepancies used as reasons for denials.
9. Treatment plan: Clear and detailed documentation of the surgical plan and rationale from the surgeon, including all procedures to be performed and specific anatomical locations. Plan should be consistent with patient's diagnosis; medical work up should be thorough and rule out other etiologies.
   a. The surgical plan should include rationale for and align with all procedure codes requested. Codes with CCI edits may be denied unless the medical record contains documentation to support separate requests.
   b. Procedures that are "possible" will not be authorized without evidence to support medical necessity in the records submitted.

→ Another arbitrary reason for denial. Reasons for "possible" procedures is that in many cases, you don't know what you are going to do until you are in there.

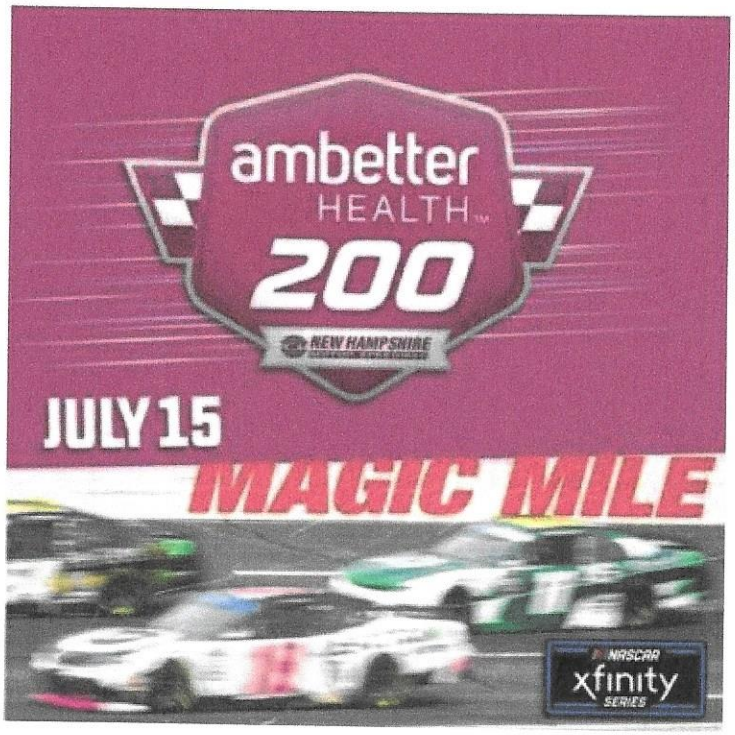
as of 2/6/23, my pt DB remains not approved, despite severe spinal cord compression

Pure bad faith.

Even though Ambetter can't find enough money to cover physical therapy and MRI exams for patients, I'm glad to see that they have enough money to sponsor NASCAR:

Ambetter Health Named Entitlement Partner for 2023 Nascar Xfinity Series Race at Nhms

Speedway Digest Staff SPEEDWAY NEWS Thursday, Feb 23 375



From: https://www.speedwaydigest.com/index.php/news/speedway-news/75576-ambetter-health-named-entitlement-partner-for-2023-nascar-xfinity-series-race-at-nhms