The letter sent to me by Dr. Richardson in response to the NCQA complaint starts on page 6 of this document.

Mark A. Wolgin, MD
Orthopaedic Associates
619 Pointe North Blvd.
Albany, GA 31721
229-883-4707, fax 229-435-1038
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March 27, 2023

James Richardson, MD
Chief Medical Director
Peach State Health Plan
1100 Circle 75 Parkway, Suite 1100
Atlanta, GA 30339

Hello Dr. Richardson,

Please excuse the delay in my responding, but I feel there are a number of points that warrant clarification. I am sure that you and I and the patient in question (DB) are operating from different sets of information, but I am hoping you might want to know how your program affects the lives of patients your plan covers.

I am going to assume that you have never met the patient DB, but I have. She notes that both she and her husband were caught unaware of her policy being terminated until the request for surgery was denied.

You note in the second paragraph of your letter that the request was denied "based on the supplied clinical information." This phrase highlights a major problem in the relationship of Ambetter with providers, as there is apparently little correlation between the clinical information supplied and the denials, with no rationale given for the denials. In fact, the "clinical information" that was referenced as the reason for the denial is the same as it was when I had the peer-to-peer conversation with Dr. Charles Mick, a previous president of North American Spine Society, where Dr. Mick and I agreed that the proposed surgery was appropriate. In case you want to see more details, I have information on a webpage **drwolgin.com/ambetter** showing normal and DB's spinal anatomy. In light of the phrasing in your

letter, I am left with the question: how can the "supplied clinical information" be simultaneously not enough to approve the surgery and yet be enough to approve the surgery? The clinical information has been the same the whole time. If there was some detail your team needed, why didn't they ask for it instead of giving a denial with no explanation? Dr. Mick and I discussed one detail of the coding that was changed. If that code change was the reason for the denial, that information was not conveyed. Therefore, on my end as a provider, I have patient who is literally getting paralyzed from her spinal cord compression, and the requested surgery is again denied, with no explanation. With justifications like this for the denials, your letter might have just as well said, "Dear DB, your surgery was denied because the sky is blue."

The impression I have which is shared by other providers in our community is that denials are made regardless of the clinical details. Many providers here in Albany, GA (myself included) shared stories about how poorly Ambetter covers what patients need, including denials of labs, imaging, and even of antibiotics in cases of infections. While I don't have the details of all these inappropriate insurer actions, and while documenting them is difficult to due HIPAA issues, they do occur.

The net effect of these inappropriate denials, made with essentially no clear rationale, made by an insurance company that cannot be held liable for their decisions, an insurance company that is in effect practicing medicine without a license, is to erode any relationship that might lead to better patient outcomes. I am left wondering if providing quality care is even a priority, as though you may talk the talk, you don't walk the walk. The resultant erosion of the doctor patient relationship also led to my complaint to the GA Insurance Commissioner about Ambetter and Turning Point of operating in **bad faith**.

However, no need for you to worry, as apparently every organization to whom I have complained has disregarded the issues I have raised. Even in this particular case, for example, your explanations do not address my complaints about how you all operate (with opaque explanations for your denials). Not even the National Committee on Quality Assurance (NCQA), which has the words "quality assurance" right in their name, had any interest in assuring quality. I am writing simply to set the record straight with no expectation that we will agree on anything I might mention here.

In the attached copy of the letter you sent me, your group also denied the request for inpatient rehab, which is another example of an inappropriate denial. The fact is (and I would not expect you to know this detail) that the patient walks like a drunk (balance issues) due to the proprioceptive deficit that results from cervical spondylotic myelopathy (spinal cord compression). The physical therapists recommended rehab, but the patient, who is not comfortable in hospitals, chose to go home despite the risk and her inability to walk safely. From a business standpoint, however, any denial is another cost saving result for the insurer, regardless of what is best for the patient.

For the record, however, if I knew the rules, I could and would work within your parameters to be able to deliver care to the patients who have Ambetter or Peach State insurance, the population least able to fight for themselves (lower education level, can't afford lobbyists), but the problem I have with this potential partnership is that your decision making process is not transparent.

If you offered a medical rationale for your coverage decisions that made sense to me (a doctor), I could work with you.

If you had certain criteria that had to be met, to which I could refer (easily available online) and which could guide me, I could work with you.

If the actions of anyone in your organization demonstrated the slightest interest in helping patients (not leaving my staff on hold 45 minutes waiting to talk to a rep, for example), I could work with you.

If those in the utilization review department recognized that surgeons look at films themselves, I could work with you. When I talked with Dr. Mick, he relied more on the reading of the radiologist instead of my reading of the MRI scans, admitting he himself had never seen the images, and also that he knows of no surgeon (that he has met in his entire career), who will operate on a patient without seeing the films themselves. Therefore, if your review process will allow that a surgeon has valid input on interpreting images they see themselves, I could work with you.

However, I am again reminded about how the interests of business and medicine in reality have little overlap.

The business side needs to make a profit, so collecting premiums and then withholding care is a great business model, especially since insurance companies, which have de facto control over medical care, cannot be held liable for their decisions or actions.

On the provider side, as you are probably aware, we are in front of a patient who needs our help, but not every patient fits neatly into the insurance company "guidelines." My experience is that in the last few years, denials are becoming more frequent and more often than not, are inappropriate.

While I recognize there are some providers who might be more aggressive and operate on anyone with insurance and a pulse, that segment of the physician population is a minority, and in fact the pendulum has swung too far in the direction of denying care.

Maybe I need to be more aware that Ambetter, and Peach State, and other insurance companies, are actually teaching organizations, teaching me a lesson. I am coming to the impression of a new world order where someone like me, a doctor who went to medical school, residency, and fellowship, who has years of practice, knows less about what is best for the patient than an insurance company, where the folks there will never meet, nor ever care about the patient, with no plan advanced for alternative treatment options.

I would be glad to be proven wrong.

Sincerely,

Mark Wolgin, MD

p.s. As I discovered online, Ambetter has the resources to sponsor NASCAR in Atlanta in 2023, but apparently not enough to provide acceptable medical care. Maybe PR isn't an issue when you are servicing a patient population that has no other choices.

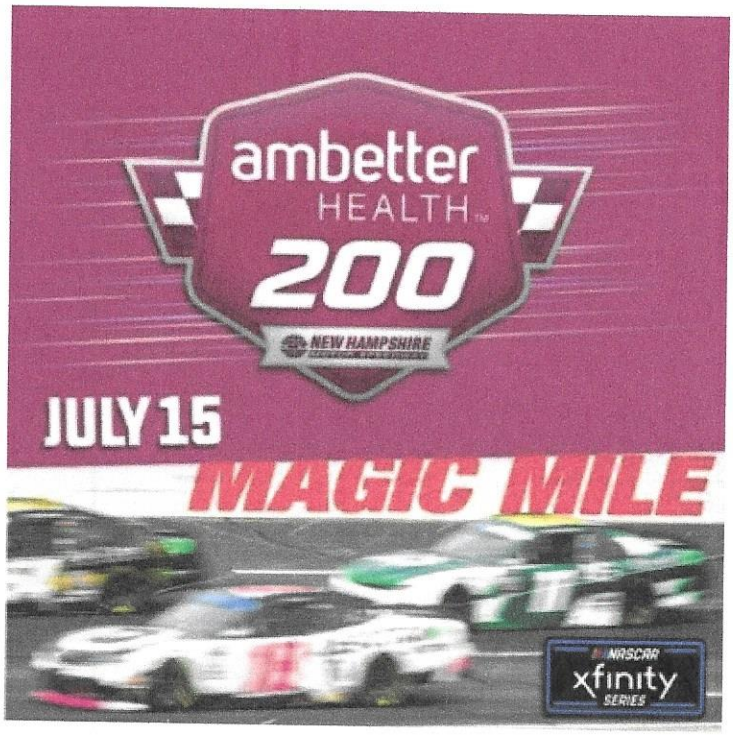
NASCAR 2023: Final results for Ambetter Health 400 at Atlanta Motor Speedway

By Yash Soni | Modified Mar 20, 2023 11:42 IST

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

ambetter. FROM peach state health plan

March 2, 2023

Mark A. Wolgin, MD
Orthopaedic Associates
619 Pointe North Blvd.
Albany, GA 31721

RE: NCQA Complaint – Orthopaedic Associates (NPI: 1295709178)

Dear Dr. Wolgin,

We are in receipt of the above-referenced complaint as of 02/20/2023. This complaint was filed by you on behalf of [redacted] In 2022, Ambetter from Peach State Health Plan ("Ambetter") insured [redacted] with an Ambetter Balanced Care 32, silver level, on-exchange plan effective 01/01/2022 – 12/31/2022. This policy terminated on 12/31/2022 due to the ending of the policy year.

We received an authorization request (CEN405890) on 12/27/2022 from Orthopaedic Associates regarding outpatient cervical spinal fusion surgery for Ms. [redacted] The request was denied on 1/4/2023 for medical necessity based on the supplied clinical information. Also Ms. [redacted] Ambetter insurance was not in effect after 12/31/2022, which was not shared. Ms. [redacted] insurance was active again on 2/1/2023. After a discussion between you and our doctor on 1/12/2023, the requested services were approved on 1/25/2023, to be performed on or after 2/1/2023. The codes approved were 22854, 20936, 22846, 22853, 22552, 22551, 22554 and 63081.

An Ambetter representative contacted your assistant, LeAnne Miller, to discuss the details and informed her the procedure was approved. The representative advised Ms. Miller that since Ms. [redacted] did not have coverage with Ambetter until 02/01/2023, her procedure would need to be scheduled after 02/01/2023. Ms. Miller stated an understanding of this information.

Sincerely,

James Richardson MD

James Richardson, MD
Chief Medical Director
peach state health plan

ambetter FROM | peach state health plan

9119 Corporate Lake Drive, Suite 200
Tampa, FL 33634

carecentrix

NOTICE OF ACTION

February 27, 2023

[redacted]

ATTN: [redacted]

Para obtener ayuda para traducir o entender esta información, sírvase llamar al 1-877-687-1180 TDD/TTY 1-877-941-9231 entre 8 a.m. y 5 p.m.

Re: [redacted]
Reference ID: 1015981610

Dear [redacted]

Ambetter from Peach State Health Plan partners with CareCentrix, a leading health and wellness company, to manage our healthcare services program. CareCentrix reviews healthcare services to determine if they are medically necessary and covered by your plan.

CareCentrix looked at services requested for [redacted] received on 02/24/2023 for coverage of 0191 INPATIENT REHAB FACILITY (IRF), LEVEL 1. After review of the information received, the request was Denied.

The criteria or medical reason for this decision is the member does not meet the coverage criteria. The records we received do not show your needs are complex enough. Your care can be given at a lower level of care.

The request for admission was reviewed using the InterQual, Spinal Cord Injury (Acute Rehab) guidelines.

This decision was made on February 27, 2023. The decision was made by a Medical Director.

You, or someone you name to help you, can request a copy of criteria used in this decision.

Your doctor knows about this decision. He/she can call to talk to us about this decision.

If you disagree with this decision, you have the following option:

1. You have one hundred eighty (180) days from the date on this letter to file an appeal with Peach State Health Plan.

Once appeal decision is made; if you disagree with the decision, you have the following option

1. You may request an external Independent Medical Review (IMR) regarding this decision from MAXIMUS Federal Services, the Independent Review Organization (IRO). You have one hundred twenty (120) days from the date on the appeal decision letter to file an Independent Medical Review (IMR) request with the Independent Review Organization (IRO).

If you want your doctor or someone else to act for you, you must do this in writing. To do this, complete and return the attached "Authorized Representative Designation Form" with your request.

Authorization is based upon medical information provided. This authorization is not a guarantee of benefits or claims payment. There is at least one in-network provider available to provide the medically necessary services within a reasonable time and/or distance of your home address. If you elect to go to an out-of-network provider, you are then choosing to receive services outside of the benefits outlined in your Evidence of Coverage (EOC) & Summary of Benefits. As a result, you may be responsible for the full amount of the provider's charges for the services provided.

APPEAL:

You, your doctor, or someone that you name to act for you, can ask us to change our decision. This is called an appeal. You can ask for an appeal in writing or by calling us. If you want to appeal, you must tell us within one hundred eighty (180) days of the date on this letter. You can file an Appeal by phone, fax, or writing to us at:

Peach State Health Plan Grievance & Appeals Department
1100 Circle 75 Parkway
Suite 1100
Atlanta, GA 30339
Phone 1-877-687-1180

ambetter.
from Peach State Health Plan

AUTHORIZED REPRESENTATIVE DESIGNATION

You may have someone else act on your behalf in an appeal or grievance/complaint. The person you list below will be accepted as your representative. We cannot speak with anyone on your behalf until we receive this form. Return to us at:

Peach State Health Plan
Appeal Department
1100 Circle 75 Parkway
Suite 1100
Atlanta, GA 30339
Phone 1-877-687-1180
TDD/TTY 1-877-941-9231
Fax 1-866-532-8855 (Appeals)
Fax 1-866-532-8855 (Grievance/Complaint)

Unclear if pt's doctor (me) can be pt's rep (which I already am)

I, _____ **want the following**

(Printed Name of Member)

person to act for me in my Appeal or Grievance / Complaint. I understand that personal medical information related to my appeal or grievance/complaint may be disclosed to my representative.

1. Name of Representative (Please Print):

_____

2. Address of Representative:

_____

Street Address or PO Box **Apt #**

_____

City **State** **Zip Code**

( ) _____ ( )

Phone Number: Daytime **Phone Number: Evening**

3. Brief description of the appeal or grievance/complaint for which the Representative will be acting on my behalf:

_____

_____

_____

4. Member Signature:

_____

Signature of Member (or parent/guardian)*
Member DOB: _____
Member ID: _____
Date: _____
***Relationship to Member: Self** **Parent** **Guardian**

5. Representative Signature:

_____

Signature of Member Representative*
Date

** Relationship to Member: Parent Guardian Other – Please Specify**

??? Doctor?
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