March 18, 2024
RE: support for HB2834
Submitted electronically to h.insurance@house.ks.gov on 3/17/2024

My name is Courtney Younglove and I am a resident of Johnson County, Kansas. I am a practicing physician, board-certified in Obesity Medicine and Obstetrics and Gynecology. I am the founder and medical director of Heartland Weight Loss, the first insurance-based private practice clinic with offices in Johnson County and Douglas County. I opened Heartland Weight Loss in 2018 with a mission of providing affordable, evidence-based treatment for the diseases of obesity and pre-obesity/overweight. At that time, patients who desperately wanted and needed treatment either couldn't get it or were getting sub-optimal treatment from med spas or commercial weight-loss vendors with minimal to no focus on quality, which seemed wrong and in need of correction.

As I'm sure you are aware, for numerous reasons, the overhead costs of running a medical office are high. Small practices that are not affiliated with large health systems get sub-optimal contracts from payors (typically, reimbursing less than Medicare rates) yet still have similar overhead costs (malpractice, staffing, supplies, etc.). Because of this, over the past decade, most established, independent practices in the area have had to merge with large health systems to avoid financial ruin. Not surprisingly, there have been only a handful of small independent practices that have been created during this time. I have worked very hard since 2018 to stay profitable enough to keep our doors open in order to provide patients access to high-quality, evidence-based treatments for excess weight - a task that requires constant adaptation due to constantly changing regulations in the insurance industry.

From 2018 through mid-2023, over 95% of our patients used commercial health insurance to pay for some, or all, of their visits. Approximately 55% of our patients were covered by some type of Blue Cross Blue Shield plan, consistent with trends in the area. Again, in no way were we running anything close to a medical spa or boutique practice. The average body mass index (BMI) of our patients is 38 and the great majority of our patients have multiple obesity-related comorbidities such as hypertension, hyperlipidemia, obstructive sleep apnea, or diabetes/pre-diabetes.

In early 2023, Blue Cross retracted several dozen previously-paid claims and then began denying many of the claims we were submitting, citing what they refer to as an "obesity exclusion." Buried in the exclusions section of the base Blue Cross plan document is a clause that allows them to deny visits that address the treatment of excess weight - even if that treatment is part of the treatment of other illnesses. This means claims can be denied as a "non-covered service." After meeting with the team at BCBS of KC, I was informed that self-funded plans can remove the exclusion, but most don't because it drives up the cost of the plan.

I had the legal team at the American Medical Association (AMA) review the documents and they stated that it's legal for this exclusion to exist. However the team at the AMA, along with the leadership in the Obesity Medicine Association (OMA) agreed with me in stating that enforcing it is unethical when the treatment of excess weight is part of a comprehensive strategy to improve multiple related disease states. The Obesity Medicine Association went as far as to release a position statement in reaction to the "obesity exclusion" (the paper can be found at: https://www.sciencedirect.com/science/article/pii/S2667368123000165). Several months later, claim denials based upon this "obesity exclusion" were increasing by various Blue Cross plans throughout the country, the OMA, along with five other well-respected societies representing the field of Obesity Medicine released a collaborative statement that concluded by saying, "Bias and stigmatization directed at people with obesity contributes to poor health and impairs treatment. Every person with obesity should have access to evidence-based treatment." (the full position statement can be found here: https://obesitymedicine.org/about/obesity-consensus-statement/).

While I was fighting with Blue Cross for coverage for my patients' treatment in the summer of 2023, I noticed that quite a few of the denials had occurred in people who were covered under the State Employee Health Plan (SEHP). I was familiar with the 2022 guidelines that the federal Office of Personnel Management (OPM) released requiring coverage for obesity treatment and I appealed the claim denials for patients covered under the Kansas State Employee Health Plan (SEHP). I also uncovered several self-funded plans that explicitly stated that treatment of obesity was covered under the plan and appealed those as well. I was able to successfully appeal approximately seventy individual claims (out of what has now topped over a thousand claims retracted or denied) and the majority of those appeals granted were for people covered by the KS SEHP.

As you can likely imagine, dealing with a massive number of claim denials not only wreaked havoc on the finances of the business but also on the morale. Patients were irate that claims were denied and, as so often happens, took much of their frustration out on my staff as they tried to explain plan exclusions and non-covered services.

Aside from the SEHP, most Blue Cross plans explicitly exclude treatment of obesity (even while concomitantly treating other obesity-related comorbidities), so most of our patients covered under a Blue Cross plan either had to stop getting treatment or pay out of pocket. However, we continued to process claims for our patients covered under the SEHP. Several months later, we began getting dozens of claim denials for these patients, citing "insufficient documentation" as the reason the claims would not be paid.

It took my billing team several months to identify this pattern as something different than what we had been dealing with regarding the claims denied for "non-covered services" and for me to muster more energy to resume appealing claims. All the while, the denials kept coming in. As of today, I have appealed over 80 claims, have a few dozen denied claims still to appeal, and we have hundreds of visits sitting in limbo, as yet unpaid, which likely means denials are coming.

Having spent my entire career in private practice, I am very familiar with medical billing and coding and what is necessary to justify the various levels of medical office visits. When coding guidelines were updated in 2022, I made sure my entire team was aware of the changes and how to code their visits appropriately. Since we only do outpatient office visits (and the occasional EKG), this means we only have to be familiar with a handful of CPT codes (new patient office visits determined by complexity, return patient office visits also determined by complexity) and the ICD-10 codes that are appropriate to our specialty (codes for obesity, hypertension, hyperlipidemia, etc.).

Because the majority of our patients have a significant number of comorbidities that we are treating alongside their excess weight, the management of these patients is typically very complex. Medication use must be closely monitored - both anti-obesity medications and medications used to treat comorbidities, as when the status of the comorbidities change along with their weight, they require close monitoring to avoid adverse consequences. The medical-decision making and level of risk we assume in managing these complex patients almost always justifies a CPT code for "moderate complexity" - although occasionally, we have patient encounters that do not carry much risk or complexity and we bill these visits as "low risk" appropriately.

Most of the claims that the SEHP has denied are for visits coded as "moderate complexity" - CPT codes 99204 (new patient moderate complexity) and 99214 (established patient moderate complexity), although some claims have been denied for visits coded as "low complexity" - CPT codes 99213 (established patient low complexity). The only CPT code for a medical office visit that is less than 99213 is a code used for a nurse visit (such as a vaccination) when no medical decision-making is required beyond following up a previous order, so the fact that these 99213 codes have been denied when medical management by a physician or advanced practice provider is taking place is highly inappropriate. In addition, as part of the denials for several patients, although an EKG was documented and interpreted, the claim for the EKG was also denied, citing "insufficient documentation."

The fact that these low-risk claims and EKGs were denied for insufficient documentation speaks to some type of automatic denial process or a significant lack of training in coding guidelines for someone individually reviewing the claims. The first round of appeals I submitted to the SEHP justifying the original CPT codes were very detailed, specifying how each of the claims met the level of service originally billed. I gave specific examples of wording within the claims and submitted each individually, per their process, along with the corresponding chart notes. Every one of those claim appeals was rejected, again citing "insufficient documentation" as a reason. No mention of the detailed appeals or arguments as to why the appeals didn't change the outcome was given.

Per some (very inefficient) contract specifics between BCBS of KS and BCBS of KC, I am not allowed to speak to anyone at BCBS of KS and must go through representatives at BCBS of KC when trying to get further answers. Nobody at BCBS of KC can explain the denials of the appeals or give me any further information.

The complete lack of communication and unethical, automatic claim denials by the SEHP (along with the standard "obesity exclusion" in other plans administered by Blue Cross) have resulted in Heartland Weight Loss completely severing our contract with Blue Cross, effective December 31, 2023. Patients with any type of Blue Cross plan must find another provider or pay out of pocket for Obesity Medicine services. Since there are very few clinicians in the State of Kansas with advanced training in Obesity Medicine, this means that most patients who need treatment will not get it.

As previously mentioned, before this debacle, Blue Cross patients made up 55% of our patient population. Many patients covered under Blue Cross plans have left the practice altogether, which has resulted in a decrease in our overall volume. Although I have done everything I can to avoid it, this decrease in volume (with such a high number of outstanding, unpaid claims) means that to remain financially viable, I have had to let several of my staff members go to avoid financial ruin. It has also completely soured me on the idea of maintaining a small, independent medical practice in the state of Kansas and I am actively preparing to sell the practice.

Although some of our Blue Cross patients have stayed, opting to pay for treatment out of pocket, having two completely separate business models (self-pay and insurance-based) contained under one roof is incredibly confusing to patients and staff and is not sustainable long-term. I also have no desire to have a fully self-pay clinic as it doesn't align with my values of making care accessible to all. Our current out-of-pocket cost for medical office visits is very low, consistent with my vision, but I imagine once I am no longer the owner, that cost will inevitably rise, consistent with what happens when private equity acquires a practice.

What has happened to our patients over the past year is tragic and has resulted in a great deal of adverse outcomes. Many of our patients are afraid to go to any healthcare provider and discuss their weight, concerned that their visits will be denied there as well. I know I am not the only office experiencing these issues - the Obesity Medicine community is small and fairly tight-knit and the problem extends well outside of my office walls. I simply happen to be very outspoken about the problem. And sadly, since this bill was just brought to the table 3 days ago, I have not had time to do more than write this appeal. Advocacy takes time and energy - and making it happen over a holiday weekend when providers are away from work isn't an ideal time.

Given the adverse outcomes that have happened this year and the lack of response from those currently overseeing the SEHP, I believe it is in the people's best interest to move the leadership and oversight of this program into the hands of an organization staffed by people with experience and deep knowledge of the field of medicine and the insurance industry and how the two intersect - an organization familiar with the industry, such as the Insurance Commissioner's office, could have stepped in before a problem like this was able to adversely affect thousands of patients and will be necessary to prevent it from happening to other medical offices that have not been wise enough to stop taking Blue Cross plans yet and are still at risk.

Because this was brought to the docket only a few days ago and I have meetings already scheduled, I cannot attend the proceedings, but I hope you take the time to read this and hear from someone who has been on the front lines of healthcare in the state of Kansas for over 20 years, doing my part to make the world a better place. I can be reached on my cell phone if anyone wants to speak to me directly: 913-915-5004 and I would be happy to schedule a meeting if anyone wants to meet individually and hear more.