



Connecticut Department of Social Services

Making a Difference

Medical Inefficiency: Departmental Report

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Report from the Department

- Status of implementation of the definition in policy and procedures
- Approvals and denials of requests for medically necessary services, by each category of service, before and after implementation of the revised definition
- Examples of clinical denials
- Next steps

Implementation Timeline

- Definition effective upon passage – April 14, 2010
- Departmental staff, MCOs, BHP, DHP notified of changes – April 16, 2010
- Qualidigm notified of changes – April 17, 2010
- Training of MCO staff on Notices of Action, including review of new definition – April 22, 2010
- Detailed guidance to MCO Medical Directors issued – July 23, 2010

New Definition

"Medically necessary" and "medical necessity" mean those health services required to:

Prevent, identify, diagnose, treat, rehabilitate or ameliorate an individual's medical condition, including mental illness, or its effects, in order to attain or maintain the individual's achievable health and independent functioning provided such services are:

- (1) Consistent with generally-accepted standards of medical practice that are defined as standards that are based on (A) credible scientific evidence published in peer-reviewed medical literature that is generally recognized by the relevant medical community, (B) recommendations of a physician-specialty society, (C) the views of physicians practicing in relevant clinical areas, and (D) any other relevant factors;
- (2) Clinically appropriate in terms of type, frequency, timing, site, extent and duration and considered effective for the individual's illness, injury or disease;
- (3) Not primarily for the convenience of the individual, the individual's health care provider or other health care providers;
- (4) Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the individual's illness, injury or disease; and
- (5) Based on an assessment of the individual and his or her medical condition.

Interpretation of New Definition

- 1) Within generally accepted standards of medical practice based on credible scientific evidence published in peer-reviewed medical literature, recommendations of specialty or clinical experts, and “any other relevant factors.”
 - Interpretation: A denial because the service is not indicated according to established clinical criteria, guidelines, or expert opinions.
 - Example: A request for palivizumab for a 12 month old asthmatic born at term, or BRCA testing for a 35 year old woman with breast cancer whose family history is limited to her mother who was diagnosed at age 60.

Interpretation, continued

- 2) Clinically appropriate in terms of type, frequency, timing, site, extent and duration and considered effective for the individual's illness, injury or disease.
- Interpretation: A denial because the service requested is not medically necessary in frequency, duration; or the type of therapy requested is inappropriate.
- Examples: A 4 month old with lung disease of prematurity whose provider wishes to administer palivizumab through the summer months because the child attends a large day care center, or physical therapy, where the duration of therapy prior to reassessment of need, frequency of visits, or types of therapeutic modalities used is not appropriate.

Interpretation, continued

- 3) Not primarily for the convenience of the individual, the individual's health care provider or other health care providers.
 - Interpretation: This criterion should be cited when a service requested is denied because the service, the timing or frequency of the service, or other factors leading to the request, are for reasons other than medical need.
 - Examples: Requests for home nursing services only on weekends for a child of a parent who wishes to work only weekends, or NEMT services to transport a patient for a consultation to a facility which is not the closest appropriate facility to the client's home.

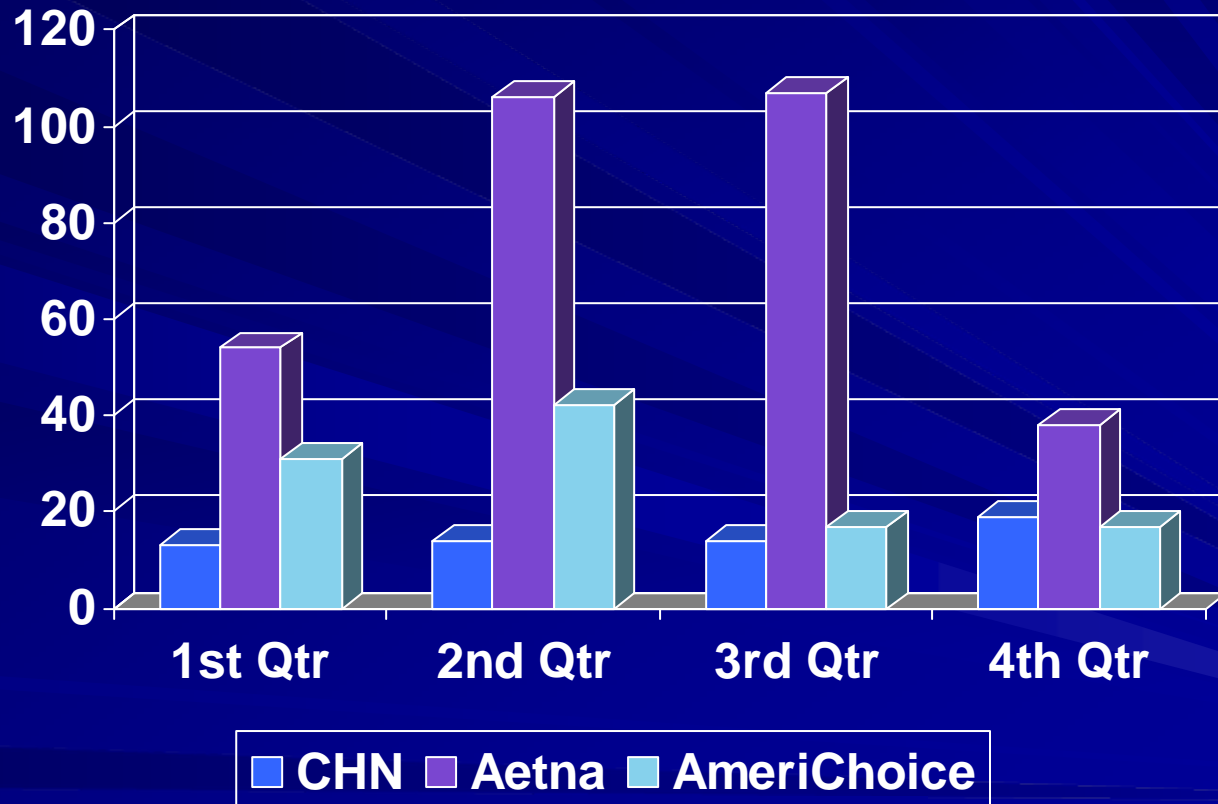
Interpretation, continued

- 4) Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the individual's illness, injury or disease.
 - Interpretation: This standard is to be cited when a decision to deny a service is made, all other factors being equal, because there is an equivalent service of lesser cost available.
 - Examples: A brand name drug with a generic equivalent, new products marketed as “gold standards” among equivalent therapies due to small but unproven alterations of established products, such as certain vacuum powered wound drainage systems, ceiling mounted patient lifts, replacement joints, etc.

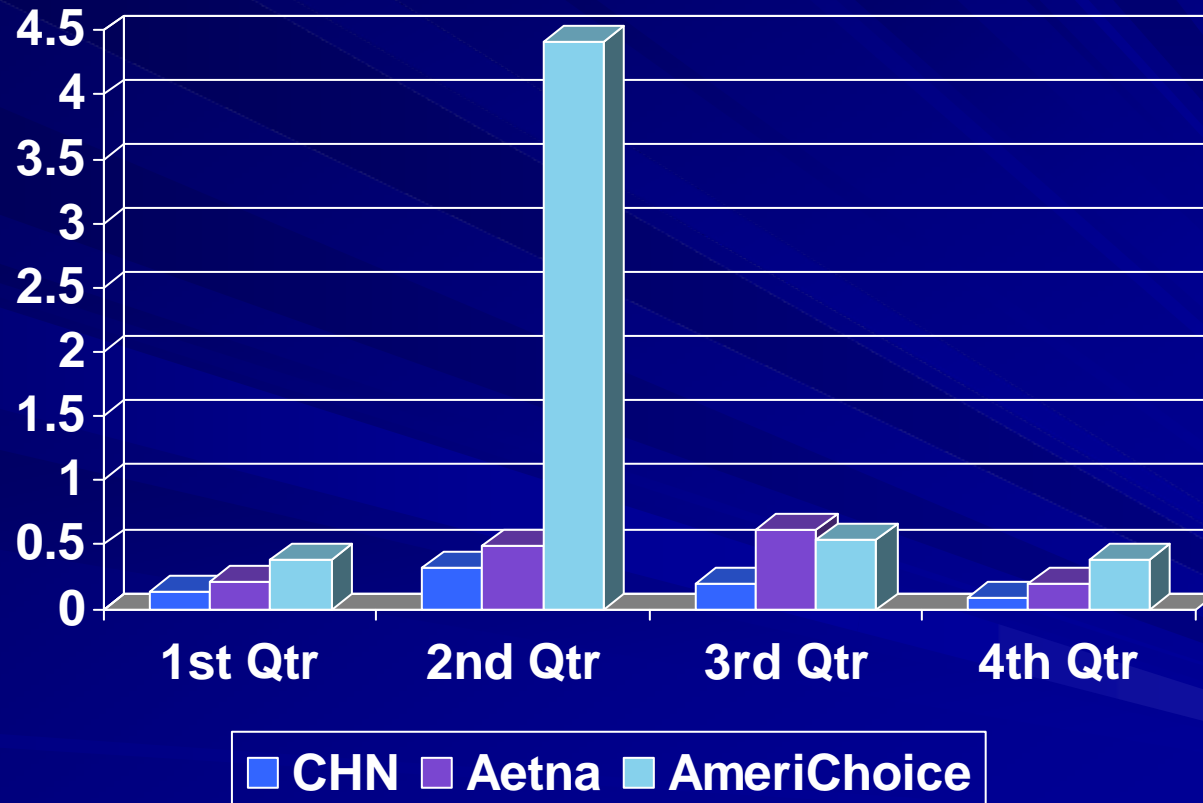
Interpretation, continued

- 5) Based on an assessment of the individual and his or her medical condition.
 - Interpretation: This standard is to ensure that the needs of the individual patient must be considered in authorization decisions, but may also be cited if a patient has not received a timely re-evaluation of their needs by the provider ordering the services.
 - Example: Renewed requests for ongoing home care for a wound which is not responding to therapy, when the ordering provider has neither reassessed the care plan nor re-evaluated the patient.

Total PA Requests per 1000 MM State Fiscal Year 2010 (HUSKY A)



PA Denials per 1000 MM State Fiscal Year 2010 (HUSKY A)



Draft baseline: denials include administrative denials; AmeriChoice 2nd quarter data is under review; no partial denials not included, but will be reported separately in the future.

Next Steps

- Continue to work with MCOs to standardize reporting – ongoing
- Redraft regulations for submission for legislative approval – early 2011
- Provider Bulletin – October, 2010