STATE OF CONNECTICUT

DEPARTMENT OF SOCIAL SERVICES

25 SIGOURNEY STREET • HARTFORD, CONNECTICUT 06106-5033

October 5, 2005

Vicki Veltri, Staff Attorney
Greater Hartford Legal Aid, Inc.
999 Asylum Avenue, 3rd floor
Hartford, CT 06105-2465

Sheldon V. Toubman, Staff Attorney
New Haven Legal Assistance Ass'n
426 State Street
New Haven, CT 06510

Dear Ms. Veltri and Mr. Toubman:

I am writing in response to your letter of August 15, 2005 regarding the level of care guidelines under the Behavioral Health Partnership (BHP) and the application of the Department of Social Services' medical necessity definition. The Departments of Social Services and Children and Families ("Departments") share your concern with improving the quality of behavioral health care and ensuring that clinical management is conducted in a manner consistent with state and federal law. We hope that the answers to your questions in this letter provide reassurance that the Departments' approach to clinical management is appropriate and that it will set a high standard for responsiveness to providers.

The Departments' clinical management requirements under the BHP are described in the draft Administrative Service Organization (ASO) contract and will be further elaborated in policies and procedures to be developed by the BHP ASO and subject to the approval of the Departments in advance of implementation. The ASO will train care managers in accordance with the contract and the approved policies and procedures. These materials will be readily available to the public. In addition, a summary of the care management procedures will be provided in the BHP provider manual. I would be happy to make these materials available to you when they are complete.

The first concern that you raise is that "a particular level of care will not be individually reviewed under the regulatory definition of medical necessity **unless** peer review is initiated and then such review actually occurs; if it does not occur, there will effectively be an impermissible denial under the more restrictive guidelines." According to the draft ASO contract, doctoral level peer review must automatically occur for every request for a level of care that does not meet the guidelines, whether or not peer review is requested by the provider. A provider will be offered a telephonic peer review with one of the ASO's peer reviewers in every case in which a denial is under consideration. If the provider does not

wish to speak to a peer reviewer, the peer reviewer will conduct a peer desk review which entails a review of the clinical information gathered by the care manager, along with the level of care guidelines for the level of care to which the request pertains, and the Departments' medical necessity definition. A denial will only be issued in cases in which available information fails to support the need for care under the Department's medical necessity definition.

In your letter, you also raised concerns as to whether the authorization decisions would be timely. Specifically, you note that "even if the peer review is automatically triggered, there remains the fundamental problem of delay in conducting these reviews, the lack of approval in the meantime, and potential lack of approval if no contact is made." We believe that the utilization management processes that we have in place will ensure that the review and determination, including peer review, are timely with respect to the requested level of care. All requests for inpatient psychiatric care will be decided within two hours and all requests for inpatient detoxification within three hours. Requests for other intensive services such as day programs will typically be decided within one hour, although if peer review is requested, final determination will occur within one business day of the request.

We believe that the contractual requirements for timely review and determination meet or exceed those in place in the HUSKY program. In addition, the contractual requirements for timely response have been reviewed by the Behavioral Health Oversight Council's Provider Advisory Group and, with their suggested revisions, have met with their approval.

In your letter, you further note that "the peer review process should be not only an automatic process but also an **internal process only**. Providers should not be subject to having to repeat the submission of information, resulting in the delay of the onset of treatment." Feedback from providers suggests that they prefer to have the opportunity to confer directly with the ASO's peer reviewer than to have the determination made without the opportunity for further discussion. The peer reviewer will have access to the information gathered in the initial care manager review and the provider will have the opportunity to share additional information and to discuss additional clinical considerations that support the case for medical necessity. In any case, the choice as to whether to have a discussion with the peer reviewer rests solely with the provider.

We believe it is reasonable to allow for the provision of additional information after the initial care manager review and that it is essential to support an individualized authorization process. Care managers are typically masters level clinicians without the experience and expertise necessary to support in depth clinical discussion and complex clinical considerations beyond what is included in the standardized care manager review. Peer reviewers will be doctoral level child or adult psychiatrists or addiction medicine specialists with the experience and training to appreciate a wide array of factors that influence an individual's presentation and treatment needs, and to consider this information in the context of the Departments' medical necessity definition. We believe that the medical necessity definition is a general principle with broad applicability to all health care conditions and services and is best applied by these more expert and experienced peer reviewers.

In summary, the level of care guidelines are intended to operationalize the medical necessity definition and thus facilitate the conduct of reviews by masters level behavioral health clinicians. The application of the guidelines is an inclusive process, which means that any individual that meets the guidelines is presumed to meet the Departments' medical necessity definition. Any request that does not meet the guidelines will be reviewed by a more experienced peer reviewer who can consider available information within the context of the Departments' medical necessity definition. We share your concern about timeliness and believe that this second level review must not interfere with timely decision-making. For this reason, we have imposed strict contractual requirements for completing peer reviews and we have assigned significant penalties to these requirements.

Finally, we share your concern if providers seem to equate the level of care guidelines with the Departments' medical necessity definition. In the provider orientation, provider handbooks and other written materials that describe the authorization process, the Departments will emphasize that final determination of medical necessity will always be based on the Departments' definitions of medical necessity and medical appropriateness.

I hope that our response to your concerns provides sufficient assurance that reviews will be timely and that the Departments' medical necessity definition will be appropriately applied. Please contact me if you would like to meet to discuss these issues further.

Sincerely,

Mark Schaefer, Ph.D., Director
Medical Policy & Behavioral Health

Attachments:

Cc: Senator Toni Harp, Chair, Medicaid Managed Care Advisory Council, Co-Chair Appropriations Committee
Senator Christopher Murphy, Co-Chair, Behavioral Health Oversight Subcommittee of the MMCAC, Co-Chair Public Health Committee
Richard Blumenthal, Attorney General
Michael P. Starkowski, Deputy Commissioner, DSS
Karen Snyder, Chief Operating Officer, DCF
David Parrella, Director, Medical Care Administration, DSS
Patricia McCooey, Esq., DSS
Susan Walkama, Chair, Behavioral Health Oversight Council Provider Work Group
Jeff Walter, Co-Chair, Behavioral Health Oversight Subcommittee of the MMCAC
Jeanne Milstein, Child Advocate