STATE OF CONNECTICUT

INSURANCE DEPARTMENT

BULLETIN HC- 93
September 3, 2013

TO: ALL INSURANCE COMPANIES, FRATERNAL BENEFIT SOCIETIES, HOSPITAL SERVICE CORPORATIONS, MEDICAL SERVICE CORPORATIONS AND HEALTH CARE CENTERS THAT DELIVER OR ISSUE INDIVIDUAL AND GROUP HEALTH INSURANCE POLICIES IN CONNECTICUT; ALL UTILIZATION REVIEW ENTITIES LICENSED IN CONNECTICUT

RE: Section 72 of Connecticut Public Act No. 13-3 – Behavioral Health Statutory Clinical Review Criteria Requirements

---

Section 72 of Connecticut Public Act No. 13-3 ("Act") amends section 38a-591c of the Connecticut General Statutes and requires that each utilization review program use documented clinical review criteria that are based on sound clinical evidence and are evaluated periodically by the health carrier to assure its program's ongoing effectiveness. A health carrier may develop its own clinical review criteria or it may purchase or license clinical review criteria from qualified vendors approved by the commissioner. Each health carrier shall make its clinical review criteria available upon request to authorized government agencies.

This Bulletin is to provide guidance relating to how vendors may be identified as "Qualified" by the Commissioner.

VENDOR QUALIFICATION REQUIREMENTS

To be considered a Qualified Vendor of behavioral health clinical review criteria pursuant to Conn. Gen. Stat. Sec. 38a-591c, as amended by section 72 of Connecticut Public Act No. 13-3 the company must provide the following information to the Insurance Commissioner ("Commissioner") for evaluation:

1. A description of the criteria development process. This should include discussion of the following:

- Are the target users of the guidelines clearly defined?
- Is the way the target users will use the guidelines clearly defined?
- What criteria were used for selecting the evidence?
- What are the strengths and limitations of the body of evidence used?
- Were systematic methods used to search for evidence? Describe.
- Describe the methods for formulating the guidelines.

- Were the health benefits, side effects, and risks considered in formulating the guidelines?
- Is there an explicit link between the guideline and the supporting criteria?
- What personnel/clinical staff are involved in the process?
- What is the ratio of in-house to consultant staff used in the process?
- What outside experts are used in the development process and how are they selected? Does the development group include individuals from all relevant professional groups?
- How is the proposed criteria reviewed and tested?
- Are consensus judgments from a panel with a large number of expert reviewers used? Provide the definition of "consensus" used (e.g. simple majority, majority by practice specialty, etc).
- Are structured group discussions of the panel used to share information and minimize conformity pressures? How are those conducted?
- Have competing interests of guideline development group mernbers been recorded and addressed.
- Is there a procedure for updating/reviewing the guidelines on a regular basis? How often?
- Have the views of the funding body influenced the content of the guidelines?

2. With respect to the current criteria:

- Are the overall objective(s) of the guidelines specifically described?
- Are the health question(s) covered by the guideline specifically described?
- Is the population (patients, public, etc.) to whom the guideline is meant to apply specifically described?
- Are the criteria specific and unambiguous?
- Are the different options for management of the condition or health issue clearly presented?
- Do the guidelines provides advice and/or tools on how the recommendations can be put into practice?
- Does the guideline describe facilitators and barriers to its application?
- Are the potential resource implications of applying the recommendations considered in the criteria guidelines?
- Do the guidelines presents monitoring and/ or auditing criteria?
- Do the criteria span all aspects of the continuum of care from acute to residential and community setting?
- Does it incorporate a safety risk assessment?
- Does it incorporate a level of functioning?
- Does it address dual diagnosis, co-morbidity or non-specific diagnoses?

3. What companies in Connecticut are currently using the Applicant's criteria?

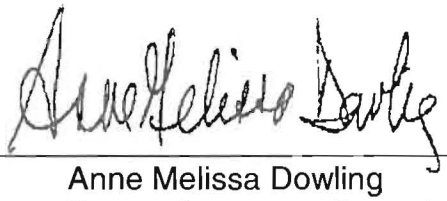
4. A copy of the company's behavioral health clinical review criteria must be submitted.

The Insurance Department ("Department") will consider the clinical review criteria to be a confidential trade secret and exempt from the Connecticut Freedom of Information Act ("FOIA"). This may be marked as a Confidential and Proprietary trade secret and exempt from disclosure under the FOIA pursuant to Conn. Gen. Stat. Sec. 1-210(b)(5)(A).

5. Qualification Period

If approved, the Commissioner will post on the Department website that the vendor is qualified for a period of two years. Companies will need to re-submit information every two years to maintain qualified status.

Please contact the Insurance Department Life and Health Division at cid.lh@ct.gov with any utilization review licensing questions. Market Conduct Division at cid.mc@ct.gov with any utilization review, grievance or appeal questions.



Anne Melissa Dowling
Deputy Insurance Commissioner