

Date: June 27, 2007
To: Members of the KHS provider network
From: Michael Goldberg
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Subject: Medical Necessity Criteria

It has come to my attention that there has been discussion within the provider community regarding GAF scores and their use in determining whether a member is eligible for services or whether services are medically necessary. As you may know, the Utilization Management section of the Provider Manual quotes specific GAF and/or CAFAS/PECFAS scores to be used in making determinations.

The GAF or CAFAS/PECFAS scores and other functional scales are useful tools in guiding determination of need; however, these scores will not be relied upon as the sole determinant of need by KHS. The points that appear in the paragraph below are the criterion that KHS will use to determine medical necessity. While KHS intends to guide providers to carefully evaluate treatment plans based upon the numerical measures of GAF or CAFAS/PECFAS, medical necessity determinations should be, and will be based upon the complete picture of the needs of the individual, including the GAF or CAFAS/PECFAS, in relation to the treatment under consideration. Do not, therefore, use the currently available forms to prohibit access to care based upon the scores. The forms had been designed to use scores to determine eligibility; however, new forms will be issued by mid-July.

Dr. Michel Sucher has joined KHS as Chief Medical Officer. Michel and I spoke this evening regarding this issue and he is in agreement that a flexible approach to these determinations is appropriate. Michel will continue to assist and guide KHS as we continue to develop the Utilization Management program for the PAHP.

Dr. Sucher's private practice includes administrative medicine, addiction medicine, and emergency medicine. He has provided Medical Director Services for Cenpatco and the Division of Behavioral Health Services of the State of Arizona, including supervision of the KHS equivalent vendors in that state. He has extensive experience in both outpatient and inpatient settings. I'm confident that Dr. Sucher will help bring clarity and improvement in Medicaid mental health care delivery in Kansas including joint efforts in developing practice guidelines and refinement of criteria. Please join me in welcoming him to KHS and to the service of our members and providers.

Also, I wish to thank the members of the provider community and KHS staff who worked long and hard to develop medical necessity criteria which could serve to guide treatment planning. Mental health care delivery in Kansas will, no doubt, continue to evolve based upon the good work in the utilization management plan.

MEDICAL NECESSITY means that a clinical intervention for an otherwise covered category of service, is not specifically excluded from coverage, and is medically necessary, according to all of the following criteria:

a) Authority. The clinical intervention is recommended by the treating clinician and is determined to be necessary by the Secretary or the Secretary's designee.

b) Purpose. The clinical intervention has the purpose of treating a medical condition/mental illness.

c) Scope. The clinical intervention provides the most appropriate supply or level of service, considering potential benefits and harms to the client.

d) Evidence. The clinical intervention is known to be effective in improving health outcomes. The scientific evidence for each existing intervention shall be considered first and, to the extent possible, shall be the basis for determinations of medical necessity. If no scientific evidence is available, professional standards of care shall be considered. If professional standards of care do not exist, or are outdated or contradictory, decisions about existing interventions shall be based on expert opinion.

Coverage of existing interventions shall not be denied solely on the basis that there is an absence of conclusive scientific evidence.

Existing interventions may be deemed to meet this regulation's definition of medical necessity in the absence of scientific evidence if there is a strong consensus of effectiveness and benefit expressed through up-to-date and consistent professional standards of care or, in the absence of those standards, convincing expert opinion.

e) Value. The clinical intervention is cost-effective for this condition compared to alternative interventions, including no intervention. The term "Cost-effective" shall not necessarily be construed to mean lowest price. An intervention may be clinically indicated and yet not be a covered benefit or meet the definition of medical necessity. Interventions that do not meet the definition of medical necessity may be covered at the choice of the Secretary or the Secretary's designee.

An intervention shall be considered cost-effective if the benefits and harms relative to costs represent an economically efficient use of resources for members with this condition. In the application of this criterion to an individual case, the characteristics of the individual member shall be determinative. "Medical necessity in psychiatric situations" means that there is medical documentation that indicates that the person could be harmful to himself or herself or others if not under psychiatric treatment or that the person is disoriented in time, place, or person.