Wednesday, October 17, 2012

Ms Victoria Veltri, JD, LLM
Healthcare Advocate
PO BOX 1543
Hartford, CT 06144

Dear Ms Veltri:

My name is Rista Luna M.A., Director of Admissions and Utilization Review at Silver Hill Hospital. I am presenting this testimony on behalf of both Silver Hill Hospital and myself.

Silver Hill Hospital is a nationally recognized, non-profit hospital for the treatment of psychiatric and addictive disorders, a place that people have relied on since 1931. When Silver Hill Hospital was founded, its guiding principles were established: Patients were to be treated with dignity and respect. They were to be active participants in their own treatments and agents of their own recovery. They were to be afforded both the best standard treatments of the day and the most innovative new treatments. They might remain at Silver Hill until they were ready to resume their normal lives. And all of this would take place in a tranquil and dignified setting designed to foster the process of recovery. The vision of our founders remains as healthy, vital, and relevant to us today as it was when it was conceived.

Today, 95% of our patients receiving acute services for mental health and substance abuse are covered by a managed care company. Most of these patients have commercial plans that adhere to the new parity regulations. However this does not ensure that they will have access to the services they need.

Most mental health services need to be reviewed for "medical necessity" before they are approved. The clinical criteria that managed care companies use is widely available to providers and consumers. However the use and interpretation of those criteria on the part of the insurance reviewers often results in denied coverage for patients that not only need the services, but would be at imminent risk if discharged to the community. It is our experience that patients that meet commitment criteria, dual diagnosis patients that require acute psychiatric services, and patients that are failing at a lower level of care are often denied access to their benefits based on the managed care company subjective application of their own medical necessity criteria.

We also want to emphasize that these kinds of denials create much extra work for patients, their families, and hospital staff. Not all patients and families have the resources or drive to pursue multiple levels of appeal or navigate the system in order to obtain coverage. These denials seem to ultimately result in insurance companies not having to pay for services that are covered under the consumer's benefit plan and are medically necessary.

Here are some situations and examples to illustrate our point:

- The cases of K. G. and E. R. illustrate how acutely mentally ill patients who meet the commitment standard could be denied insurance coverage for inpatient acute care:

    - **K.G.** – was a 23 year old female with Bipolar disorder (rapid cycling) and Opioid dependence referred from another facility with the presumption she was stable enough to transition to Residential Care. She presented to us debilitated with protracted depression, unable to get out of bed, despondent, despairing, unable to sustain herself in groups, overwhelmed, over-stimulated, distraught, hopeless, and unable to participate, engage, or process information. Her attending physician found that past medication trials had not been successful in abating her unrelenting depression. On admission and throughout her hospitalization, multiple medication changes were made while also working towards a trial of ECT. The patient began to lapse into intrusive thoughts of overdosing and could not contract for safety reporting ongoing ideas of suicide as she stated that she wanted to inject herself and “end it”. Subsequent to a number of alternate medication regimens, the patient was finally able to safely transition to Residential level of care.

Adverse Determination: K.G. was denied upon admission and her denial was upheld on a peer review and expedited appeal. The denial letter sent to the patient stated "she does not demonstrate a clear and reasonable inference of imminent serious harm to herself or others." And it also mentioned "There is insufficient evidence to support that her condition requires an acute psychiatric assessment/ intervention that unless managed in an inpatient setting, would have a high probability to lead to serious and imminent risk of serious harm or deterioration of her general medical and mental health".

- **E. R.** – was a 15 year old admitted during the December school break due to concerns of his psychiatrist and parents about his increasing psychosis. The father reported that E. R.s behavior was deteriorating immediately prior to admission. He had been talking to people who were not there and giving his father more and more aggressive responses to simple questions. E. R. stated that his father was intruding on his world and he was being more secretive and uncommunicative. The patient's psychiatrist reported that she became aware of E. R.'s psychosis when his Prozac was increased from 10mg to 30 mg. She stated that he had become increasingly paranoid, was hallucinating and his smoking marijuana had exacerbated the situation. E. R. described hearing voices of people giving a constant commentary on him and his psychiatrist feared that this could quickly escalate into command hallucinations or his acting out aggressively based on his history of impulsivity, aggression, and violent behaviors. The patient was denied coverage from the day of admission in spite of his acute presentation.
  Adverse Determination: The denial letter sent to the patient stated "You went to the hospital because of possibly hearing voices and having paranoid thoughts. You were keeping to yourself more than usual. You did not have any aggressive or dangerous behavior. You were not suicidal. You were still able to function at school. Your behavior and condition did not represent any risk of danger to the extent that you needed to be in a hospital. You had no plans or intent to harm yourself and you were in control and able to take care of yourself enough to be treated with outpatient services".

- The cases of J.H. and S.E. are examples of substance abuse patients that are also an imminent danger to themselves or others but are denied coverage for inpatient mental health care:

  - **J. H.** – came to Silver Hill Hospital requesting detoxification but in addition required treatment for mood symptoms. At the time of admission he reported that he felt "down" and angry towards his wife; they had been separated for over a year and she had obtained a restraining order. He had stopped taking his psychiatric medications two weeks prior to admission. He was unsure of his diagnosis but reported "ups and downs" and that he had been on Lamictal in the past. He reported not having any familial or social supports, he had been "camping out in his truck" in his brother's yard and he was working in a stressful family business. He was restarted on psych medications at the time of admission. During his hospitalization we requested that his initial authorization for detoxification be changed to a psych authorization and we were denied. That is the same day we had found out that the patient's guns were at his wife's home and that the patient had access to them. The patient's wife reported that he was "unpredictable" and that she had to call the police in the past when he had held a gun and threatened to kill her and himself. He had made numerous

similar threats often in front of their 7 and 9 year old children. At the treatment team's request she secured the guns prior to the patient's discharge.
Adverse Determination: At the time of this presentation we have not yet received a copy of the denial letter. Coverage for mental health services has been denied for J. H. at the peer review and expedited appeal levels. We only received authorization for the first 4 days of his treatment under his detoxification benefit.

- **S.E.** - age 18, came to Silver Hill Hospital from a medical facility after a 4-5 day stabilization following a near fatal overdose with IV heroin with consequent aspiration pneumonia. This overdose was the second one for the patient and it happened close to the anniversary of his father's suicide 3 years earlier just prior to the patient's 16th birthday. S.E. was admitted to our 28 day Dual Diagnosis Transitional Living Program and was being treated for Opioid Dependence and Mood Disorder. Three weeks into his stay he was given a pass with his mother so he could go to court. On the way back to Silver Hill Hospital they stopped at their home and he used five bags of heroin that he had hidden. When he returned to Silver Hill Hospital, he admitted that he was trying to sabotage his treatment. He was admitted to the inpatient unit on that date. S. E.'s history showed that he was impulsive and a high suicide risk. Like his father, S.E. was diagnosed with a Mood Disorder and while at Silver Hill Hospital he was started on a mood stabilizer and a neuroleptic to address his symptoms. He was kept on the inpatient unit until it was clinically appropriate for him to begin Naltrexone. On the last day of his inpatient stay he was given 25 mg of Naltrexone and was discharged with a prescription for 50 mg of Naltrexone daily.
Adverse Determination: We received insurance authorization for the first 3 days of S.E.'s impatient stay. The subsequent days were denied because having a chronically suicidal patient "wait" in an inpatient unit until Naltrexone could be initiated was considered "custodial care". The denial letter states "Your acute symptoms have resolved. You are not a threat to yourself…the information reviewed indicates that you have chronic problems that have not been responsive over an extended period of time to multiple acute based treatments (…) and your continued acute based treatment is not likely to change your ability to function in the community and is considered to be custodial."

The case of K.M. illustrates how inpatient care is denied, and a lower level of care (Outpatient) is recommended for patients that are already failing at an Intensive Outpatient level:

- **K.M**. - was a 53 year old female, primary caretaker for her elderly parents with whom she lives. She held an MBA and was on leave of absence from work at the time of admission. Her job was in jeopardy in relation to her psychiatric deterioration. K.M.'s depression and paranoid suspicions were interfering with her ability to function and she had very limited support from family or friends. She had taken an overdose 2 months prior to admission but she denied that it was a suicide attempt. She was referred for inpatient treatment by her IOP providers and her outpatient psychiatrist due to the patient's worsening symptoms. At the time of admission to Silver Hill Hospital, K.M. reported that "she started to feel that the people in her IOP program were not really who they said they were and it seemed to her that they were actors and everything seemed like made up". She felt that she "could not trust anyone and everything seemed just like a test for her".
Adverse Determination: The reason for denial stated in the letter sent to the patient is, "the patient was not an imminent danger to self or others. The patient was not reported to be acutely suicidal, homicidal or suffering from a treatable acute psychiatric condition, or an acute confounding medical condition requiring 24-hour

> care. It is unlikely that there was an imminent risk of serious and acute deterioration in functioning if the patient was placed in a lower level of care. It appears that the patient could be safely and effectively treated at a less restrictive level of care, such as an Outpatient Program, which is available in the patient's geographical area."

In summary, we would like to present this testimony as evidence that further changes are needed in order to insure fair coverage for patients in need of mental health and substance abuse services. We believe that as long as patients like the ones whose stories we just shared with you continue to face difficulties accessing coverage, the spirit of the parity law is not being met.

Rista Luna MA
Director of Admissions and Utilization Review
SILVER HILL HOSPITAL