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BULLETIN 2009-11

TO: Commercial Health Insurers, Blue Cross and Blue Shield of Massachusetts, Inc. and Health Maintenance Organizations

FROM: Nonnie S. Burnes, Commissioner of Insurance
Barbara A. Leadholm, Commissioner of Mental Health

DATE: September 4, 2009

RE: Access to Intermediate and Outpatient Mental Health & Substance Use Disorder Services

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The purpose of this Bulletin is to clarify mandated benefits for intermediate and outpatient services for mental health and substance use disorders as required by Chapter 80 of the Acts of 2000 and Chapter 256 of the Acts of 2008. Please refer also to Division of Insurance Bulletins 2000-10, 2002-07, 2003-11, and 2009-04.

Mental Health & Substance Use Disorders[1]

In accordance with the above-noted Acts, health plans offered under M.G.L. chapters 175, 176A, 176B, and 176G (hereinafter referred to as insured health plans[2]), must include coverage for a range of inpatient, intermediate and outpatient mental health services for the treatment of mental health disorders so that medically necessary and active, noncustodial treatment may take place in the least restrictive clinically appropriate setting.

As used above, "mental health disorders" means mental health disorders as described in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association ("DSM").

Mental health services required to be covered by insured health plans are those that diagnose and/or treat an illness, disease or health condition in order to reduce or alleviate symptoms and/or improve an individual's emotional or behavioral functioning. Educational services to improve an

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[1] For purposes of this Bulletin, all subsequent references to mental health disorders and services includes substance use disorders and services.

[2] An insured health plan is one that is offered by a licensed health carrier through which the carrier assumes the risk to pay the cost of specified medically necessary health treatment(s) in return for the receipt of premiums.

individual's academic performance or developmental functioning are not required services under the benefit mandate for mental health services. *For example, mandated services for a child who has frequent tantrums would include coverage for treatment sessions with appropriate mental health professionals to address the child's emotional issues in order to reduce symptoms and improve the child's emotional functioning.* The treatment sessions could be with the child and/or with parent(s) and/or other caregivers.

Medical Necessity

Pursuant to M.G.L. c. 176O, §16(b), insured health plans are required to cover health care services if (1) the services are a covered benefit under the insured's health benefit plan; and (2) the services are medically necessary. Insured health plans that are accredited by the Division of Insurance as managed care companies under M.G.L. c. 176O may employ utilization review systems in making decisions about whether services are medically necessary. Utilization review is defined in M.G.L. c. 176O as "a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings."

An insured health plan must consider the individual health care needs of the insured in applying such guidelines. In accordance with M.G.L. c. 176O, an individual may appeal a decision by his or her health plan to reduce or modify a request for authorization of covered intermediate care based on the health plan's medical necessity criteria.

Levels of Service

Inpatient Services - 24-hour services, delivered in a licensed general hospital, a psychiatric hospital or a substance abuse facility, that provide evaluation and treatment for an acute psychiatric condition or substance use diagnosis, or both.

Intermediate Services - A range of non-inpatient services that provide more intensive and extensive treatment interventions when outpatient services alone are not sufficient to meet the patient's needs. Intermediate Services, include, but are not limited to, the following:

> *Acute and other residential treatment*[3]– Mental health services provided in a 24-hour setting, with clinical staff and appropriately trained professional and paraprofessional staff to insure safety for the individual, while providing active treatment and reassessment.
>
> *Clinically managed detoxification services* – 24 hour, seven days a week, clinically managed detoxification services in a licensed non-hospital setting that include 24 hour per day supervision, observation and support, and nursing care, seven days a week.

[3] Community Based Acute Treatment (CBAT) is an example of a program that falls within this definition.

Partial hospitalization - Short-term day/evening mental health programming available five to seven days per week. These services consist of therapeutically intensive acute treatment within a therapeutic milieu and include daily psychiatric management.

Intensive Outpatient Programs (IOP) – Multimodal, inter-disciplinary, structured behavioral health treatment provided over the course of two to three hours per day for multiple days per week in an outpatient setting. Includes, but is not limited to, diagnosis, evaluation and treatment of mental health and substance use disorders.

Day treatment[4]- Services based on a planned combination of diagnostic, treatment and rehabilitative approaches to a person with mental illness or substance use disorder who needs more active or intensive treatment. Day treatment programs encompass generally some portion of a day or week rather than a weekly visit to a mental health clinic, individual provider's office or hospital outpatient department. The individual does not need 24-hour hospitalization or partial hospitalization.

Crisis stabilization –Short-term psychiatric treatment in structured, community-based therapeutic environments. Community Crisis Stabilization provides continuous 24-hour observation and supervision for individuals who do not require Inpatient Services.

In-home therapy services[5]– An intensive combination of diagnostic and treatment interventions delivered in the home and community to a youth and family designed to sustain the youth in his or her home and/or to prevent the youth's admission to an inpatient hospital, psychiatric residential treatment facility, or other psychiatric treatment setting.

The following are not considered intermediate services and are not required to be covered by an insured health plan;

- Programs in which the patient has a pre-defined duration of care without the health plan's ability to conduct concurrent determinations of continued medical necessity for an individual.
- Programs that only provide meetings or activities that are not based on individualized treatment planning.
- Programs that focus solely on improvement in interpersonal or other skills rather than treatment directed toward symptom reduction and functional recovery related to amelioration of specific psychiatric symptoms or syndromes.
- Tuition-based programs that offer educational, vocational, recreational or personal development activities, such as a therapeutic school, camp or wilderness program. The health plan must provide coverage for medically necessary outpatient or intermediate services provided while the individual is in the program, subject to the terms of the member's evidence of coverage including any network requirements or co-payments/coinsurance provisions.
- Programs that provide primarily custodial care services.

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[4] Structured Outpatient Addiction Program (SOAP), SOAP/Enhanced and Psychiatric and Enhanced Psychiatric Day Treatment are examples of programs that fall within this definition.

[5] Family Stabilization (FST) is an example of a program that falls within this definition.

Outpatient services[6] - Services provided in person in an ambulatory care setting. Outpatient services may be provided in a licensed hospital, a mental health or substance abuse clinic licensed by the department of public health, a public community mental health center, a professional office or home-based services. Such services delivered in such offices or settings are to be rendered by a licensed mental health professional (a licensed physician who specializes in the practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a licensed mental health counselor, or a licensed nurse mental health clinical specialist) acting within the scope of his/her license.

Services Provided in an Intermediate Care Setting

In a particular case, a health plan may determine that a specific level of intermediate care is not medically necessary but instead the plan indicates it would provide coverage for outpatient services or a different level of intermediate care. If, despite such determination, the patient elects to receive the originally requested intermediate care, the health plan must provide coverage for any medically necessary outpatient services or other authorized level of intermediate care provided while the individual is in the intermediate care setting, subject to the terms of the member's evidence of coverage including any network restrictions or co-payment/coinsurance provisions. Medically necessary outpatient or other intermediate services may not be prohibited by a health plan simply because the patient is receiving non-authorized intermediate care. These outpatient services or other intermediate care services may be reviewed under the health plan's concurrent review system.

For example, a patient requests coverage in a residential facility. The health plan determines that residential treatment is not medically necessary but would cover outpatient therapy or partial hospitalization. If the patient chooses to proceed with the residential placement, the health plan must cover any authorized medically necessary outpatient therapy or partial hospital sessions if the care is billed separately and otherwise meets any network requirements.

Level of Benefits for Intermediate Care Services

The duration of intermediate care services authorized for any particular individual will vary according to that person's individual needs. Because Chapter 80 of the Acts of 2000 and Chapter 256 of the Acts of 2008 do not specify a minimum benefit for intermediate care, authorizations for intermediate care should be based on medical necessity rather than any arbitrary number of days or number of visits. Additionally, the authorization of benefits for intermediate care shall not affect the minimum benefits mandated for inpatient care (60 days) or outpatient visits (24) for non-biologically based conditions.

If you have any questions regarding this bulletin, please call Nancy Schwartz at (617) 521-7347.

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[6] Ambulatory detoxification services, cognitive behavioral therapy, and dialectical behavioral therapy are examples of services that fall within this definition.