Medical Coverage Policy | Mental Illness and Substance Use Disorders Mandate

EFFECTIVE DATE: 02|05|2024
POLICY LAST REVIEWED: 01|21|2026

OVERVIEW

This is an administrative policy to document mental illness coverage (Rhode Island State Mandate § 27-38.2). This policy also provides for the coverage of medically necessary services for the treatment of chemical dependency.

This policy is applicable to Commercial Products only.

NOTE: This policy documents services that may be covered under the Rhode Island General Law and Federal Mental Health Parity Act. The Mental Health Parity Act always supersedes a Rhode Island State mandate.

MEDICAL CRITERIA

Not applicable

NOTIFICATION OF ADMISSION

For all participating and non-participating providers, notification to Blue Cross and Blue Shield of Rhode Island (BCBSRI) within 48 hours of admission and within 48 hours after discharge is required for the following levels of care to ensure correct claims processing.

- Inpatient mental health and substance use disorder treatment
- Inpatient withdrawal management (detoxification)
- Crisis Stabilization (CSU)
- Residential mental health and substance use disorder treatment
- Partial hospitalization - mental health and substance use disorder treatment

For more information, contact BCBSRI Behavioral Health Utilization Management at 1-800-274-2958.

POLICY STATEMENT

Commercial Products

The treatment of mental illness and substance use disorder is a covered benefit.

Medicare Advantage Plans

The treatment of mental illness and substance use disorder is a covered benefit (although not subject to the Mandate).

COVERAGE

Commercial Products

Benefits may vary between groups/contracts. Please refer to the appropriate Benefit Booklet, Evidence of Coverage, or Subscriber Agreement for applicable substance use disorder/chemical dependency coverage/benefits. Self-funded groups may or may not choose to follow state mandates.

BACKGROUND

§ 27-38.2-1. Coverage for treatment of mental health and substance use disorders.

(a) A group health plan and an individual or group health insurance plan shall provide coverage for the treatment of mental health and substance use disorders under the same terms and conditions as that coverage is provided for other illnesses and diseases.
(b) Coverage for the treatment of mental health and substance use disorders shall not impose any annual or lifetime dollar limitation.
(c) Financial requirements and quantitative treatment limitations on coverage for the treatment of mental health and substance use disorders shall beno more restrictive than the predominant financial requirements applied to substantially all coverage for medical conditions in each treatment classification.
(d) Coverage shall not impose non-quantitative treatment limitations for the treatment of mental health and substance use disorders unless the processes, strategies, evidentiary standards, or other factors used in applying the non-quantitative treatment limitation, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification.
(e) The following classifications shall be used to apply the coverage requirements of this chapter: (1) Inpatient, in-network; (2) Inpatient, out-of-network; (3) Outpatient, in-network; (4) Outpatient, out-of-network; (5) Emergency care; and (6) Prescription drugs.
(f) Medication-assisted treatment or medication-assisted maintenance services of substance use disorders, opioid overdoses, and chronic addiction, including methadone, buprenorphine, naltrexone, or other clinically appropriate medications, is included within the appropriate classification based on the site of the service.
(g) Payors shall rely upon the criteria of the American Society of Addiction Medicine when developing coverage for levels of care for substance use disorder treatment.
(i) Parity of cost-sharing requirements. Regardless of the professional license of the provider of care, if that care is consistent with the provider's scope of practice and the health plan's credentialing and contracting provisions, cost-sharing for behavioral health counseling visits and medication maintenance visits shall be consistent with the cost-sharing applied to primary care office visits.

§ 27-38.2-3. Medical necessity and appropriateness of treatment.

(a) Upon request of the reimbursing health insurers, all providers of treatment of mental illness shall furnish medical records or other necessary data which substantiates that initial or continued treatment is at all times medically necessary and appropriate. When the provider cannot establish the medical necessity and/or appropriateness of the treatment modality being provided, neither the health insurer nor the patient shall be obligated to reimburse for that period or type of care that was not established. The exception to the preceding can only be made if the patient has been informed of the provisions of this subsection and has agreed in writing to continue to receive treatment at his or her own expense.
(b) The health insurers, when making the determination of medically necessary and appropriate treatment, must do so in a manner consistent with that used to make the determination for the treatment of other diseases or injuries covered under the health insurance policy or agreement.
(c) Any subscriber who is aggrieved by a denial of benefits provided under this chapter may appeal a denial in accordance with the rules and regulations promulgated by the department of health pursuant to chapter 17.12 of title 23.

§ 27-38.2-4. Network coverage.

The healthcare benefits outlined in this chapter apply only to services delivered within the health insurer's provider network; provided, that all health insurers shall be required to provide coverage for those benefits mandated by this chapter outside of the health insurer's provider network where it can be established that the required services are not available from a provider in the health insurer's network.

§ 27-38.2-6. Infant and early childhood mental wellness task force.

(a) The general assembly hereby finds that:
- *(1) Infant and early childhood mental health is defined by Zero to Three as "the developing capacity of the child from birth to five (5) years of age to: form close and secure adult and peer relationships, experience, manage and express a full range of emotions, and explore the environment and learn — all in the context of family, community and culture."*
- *(2) Significant mental health challenges can and do occur in babies and young children. Epidemiological studies show a sixteen percent (16%) to eighteen percent (18%) prevalence rate of mental health disorders in children between age one and age six (6). Evidence shows that many mental health challenges occurring in the first years of life persist and increase the risk of problems related to early learning and development in all areas, and to serious long-term health and mental health challenges and poor educational and economic outcomes.*

(3) *Young children respond to and process emotional experiences and traumatic events in ways that are very different from adults and older children. Consequently, identifying and addressing mental health challenges in early childhood requires special skills and knowledge. Promoting responsive and nurturing parent/caregiver-child relationships is particularly important for babies and young children.*

(4) *It is essential to treat young children's mental health challenges in the context of their relationships within families, homes, and communities. The emotional well-being of young children is directly tied to the functioning of their parents/caregivers and the families in which they live. Thus, successful mental health treatment for young children involves working to build and strengthen consistent, supportive relationships within their families and community. Identifying and treating mental health challenges of parents and caregivers, especially maternal depression which is a common condition and can negatively impact child development, is also needed. When relationships are reliably responsive and supportive and stress is reduced, young children can thrive.*

(5) *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC: 0-5) is the only recommended diagnosis system for children under age six (6). DC: 0-5 is a system of classification of mental health and developmental disorders for infants and toddlers.*

(6) *Evidence-based and evidence-informed parent-child dyadic therapies exist that focus on the powerful influence of the parent/caregiver-child relationship to positively impact a child's trajectory. Evidence-based interventions aimed at mental health challenges are more effective when implemented during early childhood rather than school age. It is a misconception that young children will grow out of their difficulties or simply forget early traumatic experiences.*

(7) *In Rhode Island, approximately fifty percent (50%) of infants and young children have Medicaid health coverage which covers screening, evaluation, diagnosis, and treatment for children's mental health needs starting at birth. Data from 2018 indicate that less than eight percent (8%)of the Medicaid population under age six (6) received any mental health services.*

(8) *According to the National Center for Children in Poverty, at least twenty-one (21) states have adopted research-informed infant/early childhood mental health state policies and scaled initiatives. Medicaid policy in at least thirteen (13) states and the District of Columbia recommends or requires the use of the developmentally-appropriate DC: 0-5 system for the diagnosis of children under age six (6), and at least twelve (12) states require providers to use an evidence-based dyadic treatment model for children under age six (6).*

(b) *The executive office of health and human services shall establish a task force to develop a plan to improve promotion of social and emotional well-being of young children as well as screening, assessment, diagnosis, and treatment of mental health challenges for children from birth through age five (5) with Medicaid coverage.*

(c) *The planning task force shall include representation from the RI Association for Infant Mental Health and representatives from pediatric healthcare, mental health care, child psychiatry, child welfare, early intervention, family home visiting, early care and education, advocacy organizations, Medicaid managed care organizations, Medicaid accountable entities, families with young children, and other stakeholders as needed.*

(d) *The plan established in accordance with this section shall include strategies to:*

(1) *Promote use of developmentally appropriate screening, assessment, diagnosis, and evidence-based and evidence-informed parent-child dyadic therapies for children from birth through age five (5).*

(2) *Identify mental health promotion and prevention-related parenting support programs, particularly evidence-based or evidence-informed parent-child programs supporting social and emotional well-being.*

(3) *Allow for effective screening, evaluation, and treatment over multiple visits with a qualified practitioner in a variety of settings, including in children's homes, at childcare and early learning programs, in schools, and in clinical and other professional settings.*

(4) *Establish a registry of trained infant/early childhood mental health professionals that can be a resource across health care, education, and human service settings.*

(5) *Strengthen infant and early childhood mental health skills, knowledge, and practices of all providers who work with young children (birth through age five (5)) in health care, mental health care, early childhood, and child welfare service sectors.*

(6) *Address and respond to the intergenerational effects of racism, economic insecurity, and toxic stress that influence the health and mental health of parents/caregivers, babies, and young children.*

(e) *The task force shall submit a plan to the governor and general assembly on or before June 30, 2023.*

This law established parity between medical and surgical (M/S) benefits and benefits relating to mental health and/or substance use disorders (MHSA). Group health plans subject to the act cannot establish more restrictive financial requirements or treatment limitations for MHSA than those established for M/S benefits.

CODING

Not applicable

RELATED POLICIES

Behavioral Health Services Inpatient and Intermediate Levels of Care

PUBLISHED

Provider Update, March 2026
Provider Update, April 2025
Provider Update, February 2024
Provider Update, December 2023, February 2023
Provider Update, January 2022

REFERENCES

Rhode Island General Law (RIGL) Mandate 27-38.2.
https://webserver.rilegislature.gov/Statutes/TITLE27/27-38.2/INDEX.htm