Medical Coverage Policy | Mental Illness and Substance Abuse Mandate

EFFECTIVE DATE: 05|01|2001
POLICY LAST UPDATED: 04|19|2016

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.

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

PRIOR AUTHORIZATION
For information regarding Prior Authorization requirements, please refer to the BCBSRI Behavioral Health Vendor at 800-274-2958.

POLICY STATEMENT
Commercial Products
The treatment of mental illness and substance abuse is a covered benefit.

BlueCHiP for Medicare
Not applicable

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 abuse/chemical dependency coverage/benefits.

BlueCHiP for Medicare
Rhode Island-mandated benefits do not apply to BlueCHiP for Medicare plans, unless noted in Policy Section. Self-funded groups may or may not choose to follow state mandates.

BACKGROUND
§ 27-38.2-1. Coverage for the 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 be no 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 therapy, including methadone maintenance services, for the treatment of substance use disorders, opioid overdoses and chronic addiction is included within the appropriate classification based on the site of the service.

§ 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 health care 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.*

Mental Health Parity and Addiction Equity Act of 2008 (the "Act")
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
Not applicable

PUBLISHED
Provider Update, June 2016
Provider Update, November 2015
Provider Update, November 2014
Provider Update, January 2013
Provider Update, February 2012
Provider Update, December 2010
Provider Update, November 2009

REFERENCES
RIGL Mandate 27-38.2. http://webserver.rilin.state.ri.us/Statutes/TITLE27/27-38.2/INDEX.HTM

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This medical policy is made available to you for informational purposes only. It is not a guarantee of payment or a substitute for your medical judgment in the treatment of your patients. Benefits and eligibility are determined by the member's subscriber agreement or member certificate and/or the employer agreement, and those documents will supersede the provisions of this medical policy. For information on member-specific benefits, call the provider call center. If you provide services to a member which are determined to not be medically necessary (or in some cases medically necessary services which are non-covered benefits), you may not charge the member for the services unless you have informed the member and they have agreed in writing in advance to continue with the treatment at their own expense. Please refer to your participation agreement(s) for the applicable provisions. This policy is current at the time of publication; however, medical practices, technology, and knowledge are constantly changing. BCBSRI reserves the right to review and revise this policy for any reason and at any time, with or without notice. Blue Cross & Blue Shield of Rhode Island is an independent licensee of the Blue Cross and Blue Shield Association.