Medica

UTILIZATION MANAGEMENT POLICY

TITLE: BEHAVIORAL HEALTH SERVICES

EFFECTIVE DATE: June 15, 2023

THIS POLICY APPLIES TO MEDICA HEALTH PLAN SOLUTIONS (MHPS) MEMBERS WHOSE GROUP-SPONSORED PLANS ARE HEADQUARTERED IN MINNESOTA AND WISCONSIN.

FOR OTHER PRODUCTS, CONTACT MEDICA BEHAVIORAL HEALTH (MBH).

IMPORTANT INFORMATION – PLEASE READ BEFORE USING THIS POLICY

These services may or may not be covered by all Medica plans. Coverage is subject to requirements in applicable federal or state laws. Please refer to the member's plan document for other specific coverage information. If there is a difference between this general information and the member's plan document, the member's plan document will be used to determine coverage. With respect to Medicare, Medicaid, and other government programs, this policy will apply unless these programs require different coverage.

Medica may use tools developed by third parties, such as MCG Care Guidelines®, to assist in administering health benefits. Medica utilization management (UM) policies and MCG Care Guidelines are not intended to be used without the independent clinical judgment of a qualified health care provider taking into account the individual circumstances of each member's case. Medica UM policies and MCG Care Guidelines do not constitute the practice of medicine or medical advice. The treating health care providers are solely responsible for diagnosis, treatment, and medical advice.

Members may contact Medica Customer Service at the phone number listed on their member identification card to discuss their benefits more specifically. Providers with questions may call the Medica Provider Service Center toll-free at 1-800-458-5512.

PURPOSE

To promote consistency between utilization management reviewers by providing the criteria that determines the medical necessity.

MEDICAL NECESSITY CRITERIA

For medical necessity criteria, Medica uses MCG™ Care Guidelines, 27th edition, 2023: Behavioral Health Care Guidelines (BHG)

BENEFIT CONSIDERATIONS

1. Notification **is required** for in-network and out-of-network inpatient mental health, inpatient substance use disorder or detoxification.
   Note: health services may be reviewed concurrently or retrospectively to determine if medical necessity criteria were met. Denial may result if criteria were not met.
2. Prior authorization **is required** for some in-network and all out-of-network services: (Please see the prior authorization list for product specific prior authorization requirements)
   - Mental health and substance use disorder residential treatment.*****
   - Acute inpatient mental health, inpatient substance use disorder or detoxification rendered by an Out-of-Network provider******
3. Members who meet criteria for inpatient behavioral health admission are approved for continued stay based on medical necessity.
4. Clinical records, when requested by Medica, must be submitted by providers to Medica within 24 hours or 1 business day.
5. Coverage may vary according to the terms of the member's plan document.

6. Refer to the following Medica coverage policies for technologies that may have investigative indications. Services determined to be investigative are not covered.
   - *Cranial Electrotherapy Stimulation (CES)*
   - *Craniosacral Therapy*
   - *Outdoor Behavioral Healthcare*
   - *Sensory and Auditory Integration Therapies*
   - *Quantitative Electroencephalogram (qEEG) and Referenced Electroencephalogram (rEEG)*
   - *Cognitive Rehabilitation/Remediation*✚
7. For patients not meeting criteria for acute inpatient level of care, alternative levels of care may be appropriate such as residential treatment, or outpatient services such as partial hospitalization, or intensive outpatient.
8. If the Medical Necessity Criteria and Benefit Considerations are met, Medica will authorize benefits within the limits in the member's plan document.
9. If it appears that the Medical Necessity Criteria and Benefit Considerations are not met, the individual's case will be reviewed by the medical director or an external reviewer. If services are denied, related claims will be denied as provider liability, unless the member has signed a pre-service payment consent form indicating that the member understands that the specific health services were not covered and that the member is financially liable. Practitioners are reminded of the appeals process in their Medica Provider Administrative Manual.

* For Mayo Clinic providers serving Mayo Medical Plan members, this Prior Authorization requirement is waived.

** This is only applicable for Mayo Medical Plans Members.

✚This coverage policy may not apply to Mayo Clinic providers serving Mayo Medical Plan members; contact Provider Service Center for confirmation.

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

- For Medicare members, refer to the following, as applicable at: https://www.cms.gov/medicare-coverage-database/new-search/search.aspx

MINNESOTA HEALTH CARE PROGRAMS (MHCP)

- For MHCP members, refer to Behavioral Health Home Services at: https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=DHS-290481
- For MHCP members, refer to Mental Health Services at: https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=ID_058037

DOCUMENT HISTORY

Original Effective Date	January 1, 2016
Began use of MCG™ Care Guidelines	1/1/2016 (19th edition)
MCG Care Guidelines Edition Updates *(Medica Effective Date)*	20th edition: 10/10/2016; 21st edition: 08/31/2017; 21st edition reaffirmed: 08/20/2018; 23rd edition: 09/09/2019; 24th edition: 09/30/2020; 25th edition: 06/15/2021; 26th edition: 06/29/2022; 27th edition: 06/15/2023
Administrative Updates	06/20/2018, 01/01/2019; 01/01/2021 – product specific updates made; 01/01/2023 – product specific updates made; 04/19/2023 – Benefit Considerations Updated; 01/01/2024 – Benefit Considerations Updated