MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Distribution: Community Mental Health Services Programs 00-01
Hospitals 00-11
Practitioners 00-07
Qualified Health Plans 00-08

Issued: December 1, 2000

Subject: Clarification of the Mental Health Services Responsibilities of Health Plans and Community Mental Health Services Programs for Medicaid Beneficiaries Enrolled in Health Plans

Effective: Upon Receipt

Programs Affected: Medicaid, Children's Special Health Care Services

Effective October 1, 1998, Community Mental Health Services Programs (CMHSPs) assumed responsibility for authorizing, providing/arranging, and reimbursing for necessary specialty mental health services for all Medicaid eligible individuals (see MSA Bulletin 98-06). Qualified Health Plans and Children's Special Health Care Services Special Health Plans (herein referred to as "health plans") contracting with the State of Michigan for comprehensive health care for Medicaid beneficiaries are responsible for providing up to 20 outpatient mental health visits per calendar year for beneficiaries enrolled with the health plan who need such services.

This bulletin clarifies the responsibility of health plans and the CMHSPs for the provision of mental health care. Specific guidance is furnished regarding:

- The scope and extent of the outpatient mental health benefit included in health plan contracts;
- Types and levels of Medicaid mental health benefits managed by CMHSPs;
- Guidelines for coverage determination responsibility;
- Coverage determination decisions and dispute resolution for beneficiaries enrolled in health plans who need mental health services;
- Responsibility for other services related to the provision of mental health care.

Scope and Extent of the Outpatient Mental Health Benefit Managed by Health Plans

The mental health coverage included in the health plan contracts is a limited benefit, both in terms of scope and duration, and is selective in regard to the types of conditions appropriate for this level of care. In general, the health plan is responsible to provide outpatient mental health care when the beneficiary has mild to moderate psychiatric signs and symptoms with minor or temporary functional limitations or impairments. The following services may be provided by a physician or licensed mental health professional within their scope of practice under the health plan benefit for beneficiaries with mild/moderate mental health conditions:

- diagnostic evaluation and management visit to assess mental health status;
- psychotherapy or counseling with drug management when indicated;
- family psychotherapy or counseling
- group (other than family group) psychotherapy or counseling;
- pharmacological management, including prescription, use, and review of medication with minimal psychotherapy or counseling;
- interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist the beneficiary.

Types and Levels of Medicaid Mental Health Benefits Managed by CMHSPs

CMHSPs are responsible for the provision of covered specialty mental health services necessary for the treatment of Medicaid beneficiaries with more significant, persistent, complex and/or serious psychiatric conditions who generally require multiple, intensive, and sustained mental health interventions and supports. Covered services include:

- inpatient psychiatric care for beneficiaries (including health plan enrollees) with a mental illness and who require care in a 24-hour medically structured and supervised facility;
- partial hospitalization services for a mentally ill beneficiary who requires a program of intensive, highly coordinated multi-modal care with active psychiatric supervision;
- specialized community mental health clinical and rehabilitation services, which include various mental health professional treatments and therapies, case management services, psychosocial interventions, and other community supports.

Specific coverage requirements related to these services for Medicaid beneficiaries are described in the Medicaid State Plan and are further explained in the MSA CMHSP Provider Manual Chapter III. Medicaid beneficiaries are entitled to medically necessary mental health services.

Beneficiaries with a current or recent serious mental illness (adults) or serious emotional disturbance (children) with substantial and/or extended functional impairments (disability) necessitating specialized mental health rehabilitative services and supports **should be referred directly to the CMHSP**, without the health plan having to provide the 20 outpatient mental health visits per member per year.

Guidelines for Coverage Responsibility

The severity of the beneficiary's illness, as exemplified by the intensity of psychiatric signs and symptoms, the degree of functional impairment (disability), and the extent of support needs, is the major consideration in determining whether the beneficiary should be treated under the health plan scope of coverage or should be referred to CMHSP for specialty mental health services. A diagnosis of a mental illness in a beneficiary is necessary but is not, by itself, sufficient to indicate whether or not a beneficiary should receive outpatient mental health care through the health plan or covered specialty services available through the CMHSP (although some diagnoses, by their very nature, imply the probability of a severe condition, substantial impairments, and intensive treatment needs).

The health plan's mental health consultant and/or the beneficiary's primary care physician makes the initial determination regarding whether or not the beneficiary's mental health condition should be treated through the health plan. The decision must be consistent with the required written agreement the health plan has signed with the CMHSP. If the physician and/or consultant conclude that the patient's condition or circumstance falls outside the coverage responsibility of the plan they should refer the patient to CMHSP. The referral should briefly describe the beneficiary's condition or circumstances and the rationale for referring the person for specialized mental health services. The health plan's formal referral of the beneficiary to the CMHSP is an event that triggers a CMHSP duty to conduct a face-to-face clinical assessment of the beneficiary's mental health condition and the need for specialty mental health services. If the CMHSP, based upon all clinical information and assessments available and in conjunction with the advice of the CMHSP medical director, disagrees with the health plan regarding the required services and settings needed to treat the beneficiary, they should immediately inform the health plan and dispute resolution processes described below ("Coverage Determination Decisions and Dispute Resolution") should be invoked.

The following matrix has been developed to assist health plans and CMHSPs in making coverage determination decisions related to outpatient care for health plan beneficiaries. Generally, as the beneficiary's psychiatric signs, symptoms, and degree/extent of functional impairment increase in severity, complexity and/or duration, the more likely it becomes that the beneficiary will require specialized services and supports available through the CMHSP. For all coverage determination decisions, it is presumed that the beneficiary has a diagnosable mental illness or emotional disorder, as defined in the most recent diagnostic and statistical manual of mental disorders published by the American Psychiatric Association.

Mental Health Condition	Coverage
• The beneficiary is experiencing or demonstrating mild or moderate psychiatric symptoms or signs of sufficient intensity to cause subjective distress or mildly disordered behavior, with minor or temporary functional limitations or impairments (self-care/daily living skills, social/interpersonal relations, educational/vocational role performance, etc.) and minimal clinical (self/other harm risk) instability. • The beneficiary was formerly significantly or seriously mentally ill at some point in the past. Signs and symptoms of the former serious disorder have substantially moderated or remitted and prominent functional disabilities or impairments related to the condition have largely subsided (there has been no serious exacerbation of the condition within the last 12 months). The beneficiary currently needs ongoing routine medication management without further specialized services and supports.	Health Plan
• The beneficiary is currently or has recently been (within the last 12 months) seriously mentally ill or seriously emotionally disturbed as indicated by diagnosis, intensity of current signs and symptoms, and substantial impairment in ability to perform daily living activities (or for minors, substantial interference in achievement or maintenance of developmentally appropriate social, behavioral, cognitive, communicative or adaptive skills). • The beneficiary does not have a current or recent (within the last 12 months) serious condition but was formerly seriously impaired in the past. Clinically significant residual symptoms and impairments exist and the beneficiary requires specialized services and supports to address residual symptomatology and/or functional impairments, promote recovery and/or prevent relapse. • The beneficiary has been treated by the health plan for mild/moderate symptomatology and temporary or limited functional impairments and has exhausted the 20-visit maximum for the calendar year. Exhausting the 20-visit maximum is not necessary prior to referring complex cases to CMHSP. The health plan's mental health consultant and the CMHSP medical director concur that additional treatment through the CMHSP is medically necessary and can reasonably be expected to achieve the intended purpose (i.e., improvement in the beneficiary's condition) of the additional treatment.	CMHSP

The "mental health conditions" listed in the matrix above are descriptive and are intended only as a general guide for CMHSPs and health plans in coverage determination decisions. These categories do not constitute unconditional boundaries and hence cannot provide an absolute demarcation between health plan and CMHSP responsibilities for each individual beneficiary. Cases will occur which will require collaboration and negotiated understanding between the medical directors from the plan and the CMHSP. The critical clinical decision-making processes should be based on the written local agreement, common sense, and the best treatment path for the beneficiary.

The requirement for the health plan to provide up to 20 outpatient mental health visits per beneficiary per **calendar** year does not mean that each beneficiary needing outpatient mental health services is entitled to the upper limits of care (i.e., the full 20 visits). The actual amount of service or number of visits that a beneficiary receives will depend upon what is medically and clinically necessary to treat their condition.

There may be situations in which an individual begins an episode of care through the health plan but the beneficiary's mental health condition becomes more severe during the course of that episode of care. In these situations, a referral should be made to the CMHSP to acquire the more intensive or extended services necessary to treat the condition. Similarly, a beneficiary’s condition may moderate substantially and improve to the point that routine medication management or simply follow-up evaluation and management is appropriate. In this case, the patient may be referred back to the health plan for ongoing care by the primary care physician if the beneficiary is more comfortable with that arrangement.

The dimensional typology (mild, moderate, and severe) described above should not be used as a guide in determining coverage responsibility (health plan or CMHSP) for very young children who exhibit signs and symptoms of an emotional disorder or behavioral disturbance. The treatment needs of young children vary depending upon the nature of the disorder and the adaptive capabilities of the child's family or primary caretakers. Treatment needs may include both developmental support services available through the health plan (i.e., maternal and infant support services) and specialized modalities (e.g., infant mental health services) offered through the CMHSP. Medicaid-covered services for young children should also be coordinated with other available community supports for families and children funded under different auspices. Medicaid enrolled children are entitled to medically necessary services.

Coverage Determination Decisions and Dispute Resolution for Beneficiaries Enrolled in Health Plans Who Need Mental Health Services

Health plans and CMHSPs must have local written agreements with one another as required by their respective contracts with the Department. This local written agreement is extremely important for both the health plan and the CMHSP and is the basis for dispute resolution processes as well as other issues of collaboration between the two entities. The Department suggests that a team of clinical staff from both entities be convened to meet on a regular basis to address issues of mental health care coordination. Individual entities may work together or broader groups may form to benefit from each other’s expertise and perspective. In addition to regular meetings, a clinical review team should be available for expedited review and resolution on a case-by-case basis. It is critical that CMHSPs and health plans see themselves as partners in providing appropriate and timely mental health care to the beneficiaries.

The CMHSP and health plan medical directors and clinical staff should use the guidelines put forth in this document to shape the local agreement and establish protocols to address coverage determination issues, notification of service provision, coordination of care, changes in service arrangements based on the beneficiary’s condition, and other issues of mutual concern to the parties and in the best interest of beneficiary care. While the matrix above provides general guidelines for coverage determination decisions, there will be instances in which CMHSPs and health plans disagree regarding the enrollee’s condition and the required services

and settings necessary to treat the beneficiary. In such situations, the case should be immediately referred to the locally established clinical review team for timely resolution. The organizations must have joint agreements in place to ensure that adequate interim services sufficient to serve the beneficiary's needs are provided during the dispute resolution process. If the beneficiary's needs are of an urgent nature, resolution of the dispute must occur within 24 hours. All disputes should be settled within 14 calendar days. The Department of Community Health (DCH) must be notified of any coverage determination disputes not settled in the required timeframe. In instances where the parties cannot agree on coverage responsibilities within the prescribed timeframe, the Department reserves the right to utilize the DCH Office of Psychiatric Affairs and the DCH Office of Medical Affairs to make a determination of coverage responsibility.

Beneficiaries retain the option of invoking fair hearing rights under 42 CFR 431 subpart E if the request for services is not acted upon with reasonable promptness.

Responsibility for Other Services and Situations Related to the Provision of Mental Health Care.

Community Coordination: Besides the relationship that health plans and CMHSPs have with each other relative to Medicaid beneficiaries, each organization will, at times, interact with other local health programs and/or community agencies (i.e., local Family Independence Agency offices, court systems, the schools) that are also involved with a beneficiary's well being. It is important that health plans and CMHSPs collaborate (to the extent possible and consistent with applicable disclosure regulations) with these programs and agencies on issues concerning the physical and mental health of the beneficiary.

Electroconvulsive Therapy (ECT): ECT must be authorized before being provided. Either a health plan or a CMHSP may authorize the service depending on the needs of the patient. The party that authorizes this treatment is responsible for payment for the service as well as any ancillary charges such as anesthesia, outpatient facility fees and professional fees. It may be to the payer's advantage to negotiate bundled rates for this type of service when it is provided in an outpatient setting.

Inpatient Hospital Consultation Services: If a beneficiary is admitted to the hospital for a psychiatric stay that CMHSP has authorized and is responsible for, and there is a need for a medical consultation, authorization for the medical consult must be obtained from the health plan and the health plan is responsible for payment. Likewise, if a beneficiary is admitted for a medical reason which the health plan has authorized and is responsible for, and there is a need for a psychiatric consultation, authorization for the consultation must be obtained from the CMHSP and the CMHSP is responsible for payment. A consultation for the purpose of clearing a beneficiary for psychotropic drug use is considered psychiatric in nature and is the responsibility of the CMHSP. Neither CMHSPs nor health plans can deny payment for consultations on the basis of the provider being out-of-network or the condition not supporting the inpatient setting. Both health plans and CMHSPs need to be aware of the responsibility to authorize and pay for these consultation services even though they did not authorize the admission. This issue highlights the importance of coordination of care for beneficiaries receiving services in both systems.

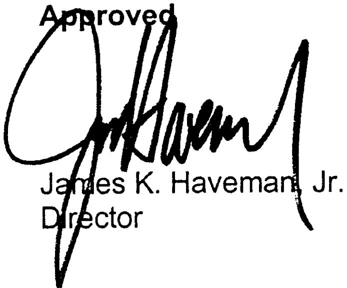
Manual Maintenance

Retain this bulletin for future reference. MSA Bulletin 95-03 is obsolete and may be discarded.

Questions

Any questions regarding this bulletin should be directed to: Provider Inquiry, Medical Services Administration, PO Box 30479, Lansing, Michigan 48909-7979. Providers may phone toll free 1-800-292-2550.

Approved



James K. Haveman, Jr.
Director

Robert M. Smedes
Deputy Director for
Medical Services Administration