NEW YORK STATE OF OPPORTUNITY. Office of Mental Health

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MEMORANDUM

TO: Hospitals that provide inpatient mental health care for individuals under the age of 18;
All Commercial, Child Health Plus, and Medicaid Managed Care Health Plans

FROM: Thomas E. Smith, Chief Medical Officer, New York State Office of Mental Health

DATE: December 30, 2019

SUBJECT: Prohibition Against Preauthorization and Concurrent Review During First 14 Days of an Inpatient Admission for a Mental Health Condition for Individuals Under 18

Chapter 57 of 2019 added new provisions to the Insurance Law that prohibit an insurer from requiring preauthorization or from performing concurrent review during the first 14 days of an inpatient admission for the treatment of a mental health condition of an individual under the age of 18 (see Ins. Law §§ 3216(i)(35)(G), 3221(l)(5)(G), and 4303(g)(8)). The law applies to health insurers that provide comprehensive health insurance coverage, including insurers participating in the Medicaid Managed Care, Child Health Plus, and Essential Plan Programs, and their utilization review agents that perform utilization review (collectively, "insurers"). The law is effective on January 1, 2020 and applies to policies and contracts issued, renewed, modified, altered, or amended on or after such date. The new law is similar to provisions in effect for inpatient substance use disorder treatment.

Insurers are prohibited from requiring preauthorization or performing concurrent review for treatment occurring in a psychiatric inpatient hospital that participates in the insurer's provider network. In order for the provisions to apply, the hospital must notify the insurer in accordance with the notification method established in their provider agreement, or if not specified therein, by a mutually agreed upon method, such as in writing, via email, fax, or letter, of both the admission and the initial treatment plan within two business days of the admission. OMH has developed a Notification and Initial Treatment Plan Form (see Addendum A) that must be completed and submitted to the insurer within two business days of the patient's inpatient admission for mental health treatment. If an

inpatient hospital fails to provide an insurer with notice of an admission and an initial treatment plan within two business days of admission, the insurer may begin concurrent or retrospective review immediately, if parity compliant, upon learning of the admission during the initial 14-day period. Notwithstanding the applicability of these provisions, coverage determinations for inpatient treatment shall be made using evidenced-based and peer-reviewed clinical review criteria which has been approved for use by OMH.

While an insurer may not require preauthorization or perform concurrent review for the first 14 days of the admission, the law requires the insurer and provider engage in periodic consultation regarding the patient during this time. During such consultations, the parties may discuss the patient's diagnosis, prognosis, and the current course of clinical care and any care coordination or care management needs of the patient.

During the first 14 days of admission, the inpatient hospital shall review the patient daily and determine whether continued inpatient treatment remains appropriate. Inpatient teams and insurers must communicate periodically throughout the admission to ensure that clinical care and discharge planning are coordinated with the patient's outpatient providers and plan care managers. The frequency of communication should reasonably reflect the complexity of the patient's treatment and care coordination needs. The insurer shall be required to work collaboratively with the inpatient hospital to share any relevant information that support an individual's treatment and discharge planning.

Insurers are permitted to review inpatient care provided during the first 14 days of treatment retrospectively, though they must apply clinical review criteria for mental health service coverage determinations that are appropriate to the age of the patient and have been approved by OMH. Insurers must share their medical necessity review criteria with providers to allow both parties to adequately assess their retrospective review risk.

If the insurer denies the inpatient care retrospectively, the patient shall not have any financial obligation to the hospital for the treatment other than any copayment, coinsurance or deductible otherwise required under the policy or contract.

Questions can be directed to OMH-Managed-Care@omh.ny.gov .