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Guiding Principles for the Review and Approval of Clinical Review Criteria for Mental Health Services

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Chapter 57 of the Laws of 2019 added a new provision to the utilization review program standards in Insurance Law § 4902 and Public Health Law § 4902. The new provision requires that, when conducting utilization review for purposes of determining health care coverage for a mental health condition, health maintenance organizations and insurers, and their contracted utilization review agents (collectively, “UR Agents”), utilize evidence-based and peer reviewed clinical review criteria that are appropriate to the age of the patient and which have been deemed appropriate and approved for use in determining health care coverage for the treatment of mental health conditions by the Commissioner of the NYS Office of Mental Health (OMH), in consultation with the Commissioner of Health, and the Superintendent of Financial Services. These provisions are effective January 1, 2020 and apply to health insurance policies issued or renewed on and after that date.

OMH is committed to reviewing UR Agent clinical review criteria to ensure coverage determinations for mental health services are made in a manner consistent with accepted medical practices and Federal and State behavioral health parity laws. In all instances, the health maintenance organization or insurer authorized to issue coverage in New York State will be responsible for ensuring it or any contracted UR agent coordinates to submit all requested documents to OMH in a timely manner, communicates with the state review team, and responds to state review team’s recommendations regarding submitted materials. Ultimate responsibility for the use of approved clinical review criteria to make coverage determinations for mental health services may not be delegated to a subcontracted UR Agent.

The following guiding principles shall apply to OMH’s review and approval of clinical review criteria submitted by UR Agents pursuant to the Insurance and Public Health Law:

- 1) The State will only approve clinical review criteria for mental health services that are comparable to and are not applied more stringently than criteria for medical or surgical services within the same categorical classification of services, as required by Federal and State laws. UR Agents that submit clinical review criteria and/or policies and procedures regarding the application of clinical review criteria which appear to be designed to inappropriately limit coverage for generally accepted and appropriate mental health treatment will be required to revise or replace their clinical review criteria or policies and procedures to meet the standards outlined in this document prior to obtaining approval.
- 2) The State will review clinical review criteria used to determine inpatient treatment for mental health conditions for both adults and children to ensure utilization review of mental health care is performed in a clinically appropriate and parity-compliant manner. Clinical review criteria or associated policies containing any of the following requirements whether explicitly stated, implied, or used in practice, will not be approved:

- a) Requirement for prior authorization for admissions to inpatient mental health care for adults or children presenting in hospital emergency departments and determined by an emergency department physician to need inpatient care to stabilize and treat an emergency condition, as such term is defined in the Insurance Law. **See** Insurance Law § 4902(a)(8) and Public Health Law § 4902(1)(h);
 - b) Requirement that providers demonstrate or provide evidence that an adult or child presents an imminent danger to self or others as a prerequisite for approving admission to or continued inpatient mental health care. Absence of imminent danger must not preclude admission or continued inpatient care, although presence of imminent danger must be sufficient for admission or continued inpatient care;
 - c) Requirement that providers demonstrate or provide evidence of the adult or child's active participation in treatment and/or benefit from treatment for authorization of continued care in any setting;
 - d) Requirement that all inpatient treatment for mental health conditions is subject to concurrent utilization review unless the health maintenance organization or insurer demonstrates that it also requires concurrent review for all continued inpatient medical or surgical care. Instead of a blanket policy requiring concurrent review for all continued inpatient mental health treatment, which may be a parity violation, the State will require insurers to conduct utilization review only when predefined, clinical and/or quality improvement-based triggers are met (see below).
- 3) UR Agents may propose to employ quality improvement approaches to support utilization review, subject to state review.
 - 4) UR Agents must use a single set of criteria for admission, continued stay, discharge determinations and retrospective review of mental health services. Different mental health services may have different clinical review criteria, but for each mental health service, the clinical review criteria for admission, continued stay, discharge determinations and retrospective review must be the same. The State will not approve a UR Agent's criteria for acute care services, residential services, or outpatient services if they contain separate clinical review criteria for admission, continued stay, and discharge of patients (for each mental health service).
 - 5) UR Agents must include in their policies and procedures a description of clinical or quality triggers for review and how such reviews are to be conducted. Such policies and procedures must include specific triggers for retrospective review of inpatient psychiatric hospital treatment for children, which may not be subject to preauthorization or concurrent review pursuant to State law. UR Agents are strongly encouraged to adopt the approach, including numerous patient-level triggers for utilization review, as described in the "OMH Best Practices Manual for Utilization Review for Adult and Child Health Services," which is available on the OMH website.

UR Agents must develop procedures that allow for greater care coordination and care management of members who meet such clinical or quality triggers to ensure these members are receiving appropriate wrap-around services in the community and that inpatient and outpatient providers have the information necessary for accurate formulation and optimal treatment planning.
 - 6) The State will not approve clinical review criteria which only take into consideration current symptoms and current level of risk in determining the appropriate level of care. Level of care

determinations must take into consideration multiple domains as well as the availability of existing services in the patient's community. UR Agents' criteria must provide for the selection of the safest and most effective level of care to treat the patient's overall condition. When there is doubt between two different levels of care, the criteria should provide for referral to or continued care in the level of care that is safer and more effective. Typically, this is a more intensive level of care. The criteria and policies and procedures must not determine that a less intensive level of care is acceptable when the appropriate level of care cannot be offered by a provider in a timely manner—a more intensive level of care should be authorized pending availability of the most appropriate level of care.

- 7) The State will require that clinical review activities and criteria for mental health services take into consideration patient need and risk factors in all the following domains:
 - a) For adults:
 - i) Risk of harm;
 - ii) Functional status;
 - iii) Co-morbidity;
 - iv) Level of stress and support in the recovery environment;
 - v) Treatment and recovery history; and
 - vi) Engagement and recovery status.
 - b) For children/adolescents (information from all of the following domains must be considered in a developmentally appropriate context):
 - i) Risk of harm;
 - ii) Functional status;
 - iii) Co-morbidity;
 - iv) Environmental stress and support in recovery environment;
 - v) Resiliency and treatment history; and
 - vi) Acceptance and engagement in child/adolescent AND caregivers.
- 8) UR Agent submissions must describe if, when, and how utilization review staff are permitted to deviate from written clinical review criteria when making coverage determinations. If permitted, UR Agent policies and procedures must specify triggers for when this is permitted and require training for utilization review staff regarding how to make coverage determinations in these situations.
- 9) The State will not approve UR Agent submissions which indicate an impermissible disincentive to providers filing appeals regarding coverage determinations, such as including rates of provider appeals or grievances in performance metrics for providers. The State will review these policies to ensure they strike a fair balance in permitting UR Agents to track and profile providers and pursue adverse actions against providers who file routine, frivolous appeals.
- 10) The State will require that UR Agent submissions describe requirements for the performance of inter-rater reliability (IRR) testing of clinical review criteria at least annually and which require a minimum pass rate of 85 percent. UR Agent policies shall provide for the remediation of poor IRR results and IRR testing for all new staff before they can conduct utilization review without supervision.
- 11) If a UR Agent intends to implement new or revised clinical review criteria for a mental health service, the UR Agent must submit such criteria to OMH no later than 60 days prior to the

date of implementation. New or revised review criteria may not be implemented without prior approval from the State. UR Agents must ensure utilization review is conducted in a manner that comports with provisions of the Insurance and Public Health Laws pertaining to in-network inpatient hospital admissions for psychiatric treatment for children.

- 12) UR Agents must ensure utilization review is conducted in a manner that comports with recently enacted provisions of the Insurance and Public Health Laws pertaining to the qualifications and experience of clinical peer reviewers. When performing utilization review for mental health treatment, the clinical peer reviewer must be:
 - a) A physician who possesses a current and valid non-restricted license to practice medicine and has experience in the delivery of mental health courses of treatment, or
 - b) A health care professional other than a licensed physician who specializes in behavioral health and has experience in the delivery of mental health courses of treatment and, where applicable, possesses a current and valid non-restricted license, certificate, registration or, where no license, certificate or registration exists, is credentialed by the national accrediting body appropriate to the profession.

Clinical peer reviewers must have professional, clinical experience relevant to the mental health treatment that they are reviewing. For example, a clinical peer reviewer making determinations regarding mental health treatment for children should have professional, clinical experience providing mental health services to children.

Utilization review must be performed on a peer-to-peer basis to the greatest extent practicable. This does not mean that the clinical peer reviewer must have identical credentials to the treating provider in every case, but that the clinical peer reviewer is a similarly trained and experienced health care professional and should have the opportunity to engage in a meaningful dialogue about the insured's needs and the objectives of treatment with the treating health care provider as often as needed.

- 13) The State supports practices intended to encourage UR Agents and in-network inpatient providers to work collaboratively throughout the entire course of inpatient admissions to ensure quality of care and coordinated care and discharge planning.
- 14) In addition to the forgoing, HMOs certified pursuant to Article 44 of the New York State Public Health Law that provide comprehensive health services through comprehensive health services plans to Eligible Persons, as defined in Title 11 of the Social Services Law, must also adhere to applicable contracts and all New York State-issued guidance regarding utilization review for ambulatory Medicaid Managed Care benefit package services (e.g. Assertive Community Treatment (ACT), Personalized Recovery Oriented Services (PROS), Adult Behavioral Health Home and Community Based Services (HCBS), Community Oriented Recovery and Empowerment Services (CORE), Children and Family Treatment and Support Services (CFTSS), and Children's HCBS).
- 15) In the event additional information is required to assess the adequacy of a UR Agent's clinical review criteria and utilization management practices, OMH may issue conditional approvals, which shall be communicated in writing. UR Agents may continue to use criteria which has been conditionally approved. Conditional approvals may not be extended if UR Agents fail to cooperate with the State in the review and approval of submissions.