DAUPHIN COUNTY MH/MR PROGRAM
POLICY AND PROCEDURE

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MR
Admin
Crisis
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Policy: The Dauphin County MH/MR Case Management Unit shall respond to service requests by persons who have third party behavioral healthcare insurance coverage by directing the requests back to the third party insurer for all managed care plans and indemnity plans. Decisions on public funding for mental health services will necessitate prior case specific review and approval by the County MH/MR Administrator’s Office, pursuant to procedures set forth in this policy.

Legal Base: Mental Health and Mental Retardation Act of 1966 Article V, Section 503(a);(50 P.S. §4201 (2)), Section .01(2); PA Code, Title 55. Public Welfare, Chapter 4300, Fiscal Regulations; §4300.158 (b).

Procedure:

1. Intake Assessment Requests for Persons Enrolled Privately with Managed Care Insurance Plans

   a. If, at the time an intake assessment is requested, it is determined that the person has a managed care plan, the person should be directed to the private carrier and their primary care physician for the procurement of services, without public system enrollment.

   b. If the person indicates that they are seeking services which have been rejected by their insurance carrier or are insistent that they want to seek services through the county system, an intake assessment should be scheduled.

   c. Intake staff must conduct the entire normal and customary phone screening to assure that it is clear what the person is requesting and how best to provide assistance. At no time should the contact be discontinued solely on the basis that the person indicates that they have a managed care insurance plan.
2. Requests for County Funding for Mental Health Services not Covered by Private Insurance Programs

Some types of needed mental health services may not be among those covered by a person's private insurer but may be available through the MH/MR program to case active persons (structured residential programming and psychosocial rehabilitation may be examples).

On hearing a request for County sponsorship of costs for such services, the following should be applied:

a. If the privately insured person is actively registered with the Dauphin County MH/MR Program, the County MH/MR Case Management Unit (CMU) determines whether the person's insurance carrier, given the medical necessity, can cover the costs of the traditionally uncovered service. The CMU will solicit and maintain in the person's file the written documentation from a declining carrier that will not meet the costs in question. All grievance or appeal mechanisms must be pursued by the insured individual.

b. If the privately insured person is not active with the CMU at the time such an inquiry is made, the CMU will advise the person or the person's representative to negotiate directly with the carrier, returning to the CMU for assistance only in the event that the carrier declines in writing to meet the special cost. All grievance or appeal mechanisms must be pursued by the insured individual.

c. If an insurer declines to meet an atypical cost for service, the CMU so advises the County Administrator's office, forwarding a copy of the carrier's written rejection document.

d. On review of the rejection, the County MH/MR Administrator or his designee shall render a decision within three days of the request as to the administrative approval to fund the requested service(s).

e. If so guided by the County Administrator's office, pursuant to a determination of medical necessity through the CMU's disposition meeting process, the CMU may arrange the service for the person. It is imperative that the person understands that there may still be a financial liability for the service based on the person's income.
3. Requests for County Payment of Costs for Beneficiaries of Private Insurance Programs who have Exhausted Maximum Stated Yearly or Lifetime Benefits

a. The CMU shall first direct the consumer or the consumer’s representative back to the private insurer to appeal for an extension of the maximum benefit. Consumers active with the CMU may receive case management support in lodging such appeals. All grievance or appeal mechanisms must be pursued by the insured individual.

b. If the person is actively receiving treatment from an MH/MR provider when they reach their maximum benefit allowance and the provider determines that it is medically necessary that the person continues treatment, the provider is responsible to advocate on behalf of the consumer documenting their determination of medical necessity as part of the appeal.

c. The CMU should advise the appealing party to secure from the insurer written documentation of denial, in the event that the appeal for benefit extension is rejected for non-clinical reasons. The CMU also should invite the appealing party, in the event of a denial, to forward a copy of the insurer’s rejection notice to the CMU.

d. On receipt of a rejection notice, the CMU in turn shall forward the document to the Dauphin County MH/MR Administrator’s office.

e. On review of the rejection, the County MH/MR Administrator or his representative shall make a determination within three days. The MH/MR Administrator or his representative may choose to make direct contact with the insurer to further discuss resolution.

f. Key indicators which the Dauphin County MH/MR Program will consider for public funding of service when a private behavioral healthcare plan benefits have been exhausted are as follows:

The person meets the OMHSAS’s adult state priority group I and for children they meet priority group I or II; and

A treating mental health professional documents in writing to some significant probability that the person will regress to acuity or be hospitalized psychiatrically if continuous services are not made available during the non-covered period; or
A treating mental health professional documents in writing risk of job loss (hence, loss of private insurance) or out-of-home placement for children, secondary to regression for want of needed service, resulting in likely long term and more costly reliance by the consumer on the public system; and

The carrier's benefit policy reflects no contractual obligation to meet the costs of treatment that the carrier declines to sponsor as provided by the consumer; and

Written verification is produced, confirming that the insurer's appeal process has been fully exhausted; and

The interval for which MH/MR sponsorship has been proposed is clear and brief unless sponsorship is the result of reaching a person's life time benefits; and

The type and quantity of service for which the MH/MR sponsorship has been proposed are also clear and are subject to adjustment based on MH/MR medical necessity review for the least restrictive and cost effective service; and

The amount of the initial MH/MR authorization does not exceed $1,000; and

The consumer or his/her parent or guardian when a minor, agrees to participate in a formal intake and liability determination, and to meet whatever determined personal share of costs as assessed; and

For those cases in which funding is suspended solely due to exhausting yearly sessions or benefits, that the insurer agrees to resume funding for treatment upon the new year eligibility

4. Request for Co-payments, Deductibles and County MH/MR Payment

a. The County does not participate in meeting consumer costs of insurance co-payment, deductibles or any financial liability for the person's private insurance.

b. A consumer's responsibility to meet the costs of insurance co-payment is unaffected by the person's financial liability, as determined by the County Program.