Policy and Standards

The below corporate policy has been customized for **New Mexico commercial accounts** using the *modification* (text changed within the body of the corporate policy) customization method.

Policy Number:	**CO.297.02.NM**
Policy Name:	**Prior Authorization Determination: Behavioral Health**
Review Type:	Substantive (Material changes or initial documentation of current processes)
Contract or Regulatory Reference: (include citation if applicable)	NMAC 13.10.31.8 & 13.10.31.11; 2023 NM SB 273, Sections 1, 11, & 12

Product Applicability: *(For Health Insurance Marketplaces, policies and procedures are the same, unless contractual requirements dictate a more stringent variation in which case customized documents are created.)*

Commercial
Medicaid
Medicare Part: C (Medicare Advantage)
Federal (Applies to Magellan Federal, Magellan Healthcare, non-Medicaid or Medicare, Federal contracts)

Business Division and Entity Applicability:

Magellan Healthcare

Magellan Healthcare (Behavioral)

Policy Statement

The properly licensed affiliates and subsidiaries of Magellan Health, Inc., (Magellan) require prior authorization for certain procedures and services.

Purpose

This policy outlines the process by which procedures and services are determined to require prior authorization.

Policy Terms & Definitions Glossary

Key Terms *(as used in this policy)*

Per NM SB 273, Section 14 :

Generally Recognized Standards

> Standards of care and clinical practice established by evidence-based sources, including clinical practice guidelines and recommendations from mental health and substance use disorder care provider professional associations and relevant federal government agencies, that are generally recognized by providers practicing in relevant clinical specialties, including psychiatry, psychology, social work, clinical counseling, addiction medicine and counseling, or family and marriage counseling.

Mental Health or Substance Use Disorder Services

> Professional services, including inpatient and outpatient services and prescription drugs, provided in accordance with generally recognized standards of care for the identification, prevention, treatment, minimization of progression, habilitation and rehabilitation of conditions or disorders listed in the current edition of the American psychiatric association's Diagnostic and Statistical Manual of Mental Disorders, including substance use disorder; or Professional talk therapy services, provided in accordance with generally recognized standards of care, provided by a marriage and family therapist licensed pursuant to the Counseling and Therapy Practice Act."

Policy Terms & Definitions are available should the reader need to inquire as to the definition of a term used in this policy.

To access the *Policy Terms & Definitions Glossary* in C360, click on the below link: *(internal link(s) available to Magellan Health employees only)*

Policy Terms & Definitions Glossary

Standards

I. Magellan identifies certain procedures and services as requiring prior authorization to:

A. Prior authorization includes:

1. Pre-certification to determine medical necessity prior to provision of the service or procedure; or
2. The notification of an admission to the service.

B. Identification criteria for pre-certification or notification of an admission includes but is not limited to:

1. Significant drivers of cost trend;
2. Disproportionate utilization trends, such as length of stay, denial activity (clinical and administrative), appeals overturns, etc;
3. Variation in the delivery of care by diagnosis, level of care and/or by provider/facility;
4. Gaps in care that negatively impact quality and/or utilization;
5. Outlier performance against performance benchmarks such as value-based arrangements, HEDIS metrics, etc;
6. Services that have a high likelihood of inappropriate use;
7. Services that may require greater management; and
8. Services identified through utilization and administrative cost analyses.

C. The list of services and procedures that require prior authorization is reviewed at least annually by the Behavioral Health (BH) Taskforce, including Medical and Quality leadership.

1. Magellan works with each customer health plan or account to ensure that the plan's certificate of coverage accurately reflects services that require prior authorization.
2. Unless otherwise advised by the health plan or account, Magellan then confirms the list of services and procedures that require prior authorization based on contractual and/or regulatory requirements and/or the plan's certificate of coverage.
3. For health plans subject to the Mental Health Parity and Addiction Equity Act (MHPAEA), health plans are advised to review how prior authorization is applied for medical/surgical benefit versus behavioral health benefits for compliance with MHPAEA. Magellan has a tool available to assist the plans with this review and will respond to any documentation or data requests regarding prior authorization to assist the health plans in analyzing prior authorization for compliance with MHPAEA.

D. The list of services and procedures that require prior authorization is reviewed and finalized with each health plan customer during the implementation process.

E. The list of services and procedures reviewed and approved by the BH Taskforce is submitted to Magellan Quality Improvement Committees (QIC) for inclusion in appropriate QI Trilogy documents.

F. Per NM SB 273, Section 12:

1. Magellan will not require prior authorization and referral requirements for the following mental health or substance use disorder services:
    a. acute or immediately necessary care,
    b. acute episodes of chronic mental health or substance use disorder conditions, or,
    c. initial in-network inpatient or outpatient substance use treatment services.
2. Prior authorization will be determined in consultation with the member's mental health or substance use disorder services provider for continuation of services in chronic or stable conditions, or additional services.

3. Magellan will not limit coverage for mental health or substance use disorder services up to the point of relief of presenting signs and symptoms or to short-term care or acute treatment.
4. The duration of coverage for an insured with a mental health or substance use disorder shall be based on the mental health or substance use disorder needs of the insured rather than on arbitrary time limits.
5. Magellan may require a mental health or substance use disorder services network provider to provide notification to Magellan and submit a treatment plan after the initiation of in-network mental health or substance use disorder treatment.
6. If Magellan requires such notification by the network provider and the provider fails to do so, Magellan may perform appropriate utilization review.

II. ***Per NMAC 13.10.31.8*** General requirements:

A. Responsibility for requesting prior authorization.

1. Magellan will accept a prior authorization request submitted by a provider or by a member.
2. Should a member choose to submit a prior authorization request directly, Magellan will provide them with any assistance required to properly submit the request, including assistance with obtaining required documentation and information to meet clinical guidelines.
4. Magellan will allow non-participating providers to request prior authorizations and submit supporting documentation by all submission methods authorized, and receive confirmations and tracking numbers.

B. Requests for multiple benefits.

1. Magellan allows a provider to submit a single request for multiple benefits that will be delivered contemporaneously to the same member.
2. If Magellan doesn't grant prior authorization for all of the benefits in a multiple benefit request, it will clearly state which benefits are approved and which are denied.

C. Changes to prior authorization requirements.

1. Magellan will not expand the list of benefits for which prior authorization is required except when a new covered benefit is added to the plan, when safety or other concerns have arisen with respect to the benefit, when authorized by a state or federal regulatory agency, or as indicated by changes in nationally recognized clinical guidance.
2. Magellan will notify the network of providers before adding a prior authorization requirement.
3. If Magellan removes a prior authorization requirement it will notify the network providers of the change as soon as practicable, and no more than 60 days after the requirement is removed.

D. Retroactive denials. Magellan will not retroactively deny authorization if a provider relied upon a written prior authorization from the carrier received prior to providing the benefit, except in those cases where there was material misrepresentation or fraud by the provider.

E. Retrospective authorization requests. Magellan has written policies and guidance for the process and circumstances under which it will consider a retrospective authorization. Its policies will not unreasonably limit the ability of a provider to request or obtain a retrospective authorization.

G. Expiration of prior authorization. Magellan's prior authorization will expire no sooner than sixty (60) days from the date of approval unless an earlier expiration is warranted by the clinical criteria. Magellan will allow a request for the extension of an authorization as supported by the clinical criteria.

H. Reasonable prior authorization requirements. Magellan will not impose a prior authorization requirement that deters or unreasonably delays the delivery of medically necessary and covered benefits warranted by prevailing standards of care. Magellan will only require prior authorization for a benefit to the extent reasonably necessary to contain inappropriate or unnecessary costs or implement demonstrably effective medical management services.

I. ***Per NM SB 273, Section 11*** : Magellan will not rescind or modify an authorization for mental health or substance use disorder services that has been authorized, after the provider renders the services pursuant to a determination of medical necessity, in good faith, except for cases of fraud or violation of the provider's contract with the health insurer.

III. **Auto-adjudication (NM ADC 13.10.31.11) -** Magellan has a process to auto-adjudicate electronically submitted prior authorization requests.

A. Magellan complies with all statutory prior authorization review timelines as posted on the OSI website.

B. Magellan may reject for correction an auto-adjudicated prior authorization request for reasons other than medical necessity as long as the rejection is completed within statutory timelines.

C. Magellan may pend an auto-adjudicated prior authorization request if it requires manual review, as long as the review is completed within statutory timelines.

D. Magellan will not automatically deny an auto-adjudicated prior authorization request. It will only deny a prior authorization request based on a live review.

Cross Reference(s)

None

Corporate Policy Life History

Date of Inception: July 29, 2022	**Previous Review Date:** July 29, 2022	**Current Review Date:** August 04, 2023
Previous Corporate Approval Date: July 29, 2022	**Current Corporate Approval Date:** August 04, 2023	**Unit Effective Date:** September 04, 2023

Unit Policy Life History

Date of Inception: February 2, 2023	**Previous Review Date:** N/A	**Current Review Date:** November 29, 2023
Previous Approval Date: February 2, 2023	**Current Approval Date:** December 15, 2023	**Unit Effective Date:** January 1, 2024

Associated Corporate Forms & Attachments *(internal link(s) available to Magellan Health employees only)*

None