

**INSURANCE
DEPARTMENT OF BANKING AND INSURANCE
DIVISION OF INSURANCE**

**Actuarial Services
Mandated Benefits for Biologically-Based Mental Illness**

Reproposed New Rules: N.J.A.C. 11:4-57

Authorized By: Holly C. Bakke, Commissioner, Department of Banking and Insurance.

Authority: N.J.S.A. 17:1-8.1,15e and 26:2J-43h; P.L. 1999, c. 106.

Calendar Reference: See Summary below for explanation of exception to calendar requirement.

Proposal Number: PRN 2004-426

Submit comments by January 14, 2005 to:

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The agency proposal follows:

Summary

P.L. 1999, c. 106 (the Act) (codified at N.J.S.A. 17:48-6v, 17:48A-7u, 17:48E-35.20, 17B:26-2.1s, 17B:27-461v, 17B:27A-7.5, 17B:27A-19.7, 26:2J-4.20 and 34:11A-15) was approved on May 13, 1999, and became effective on August 13, 1999. The Act requires that all health insurance carrier policies and contracts delivered, issued, executed, or renewed in New Jersey that provide hospital or medical expense benefits or services also provide coverage for biologically-based mental illness under the same terms and conditions as are applicable to the coverage provided for any other sickness under the policy or contract.

The Department of Banking and Insurance (Department) has received complaints that some carriers have been denying coverage for certain conditions that clearly are covered under the Act's mandate (for example, pervasive developmental disorder and autism). Among the reasons offered in support of those denials have been assertions that the carriers' contracts or policies exclude coverage of physical, speech and occupational therapy for chronic conditions, and/or therapy which does not restore a previously possessed ability or function, such as speech. Relying on the first type of exclusion, the chronic condition exclusion, carriers have refused to cover speech, physical and occupational therapy for children with autism and pervasive developmental disorder even though such therapy is a key component of the treatment of such conditions. Carriers have invoked the second type of exclusion, the nonrestorative exclusion, to deny therapy to the same children, arguing that because these children did not previously possess the ability to speak such therapy is not required to be covered. The Department believes the use of these exclusions to deny treatment for persons with biologically based mental illnesses (BBMI) undermines the intent and purpose of the Act.

In response to certain carriers' use of these exclusions to deny treatment for persons with BBMI, the Department proposed new rules on May 19, 2003 (see 35 N.J.R. 2158(a)) that implemented the Act by establishing standards regarding carrier preauthorization requirements and exclusions from coverage relative to BBMI. The proposed rules also clarified that BBMI parity means that carriers may impose a preauthorization requirement for services used to treat BBMI only if preauthorization is also required when those same services are provided to treat other illnesses. The Department has determined that preauthorization is a benefit limit within the meaning of the Act because the requirement has been applied to reduce or deny benefits for services that would otherwise be covered simply because the covered person did not get the carrier's approval before the services were rendered. Additionally, under current regulations for

general contract provisions (N.J.A.C. 11:4-42.8(a)1 and 11:22-6.4), insurers must state that "benefits will be reduced" for noncompliance with preauthorization requirements, which clearly shows that preauthorization can be used to limit benefits.

To illustrate the use of preauthorization as a benefit limit, the Department is aware that some carriers are imposing a preauthorization requirement on outpatient treatment for BBMI, such as office visits, while not requiring preauthorization for outpatient treatment for other illnesses. Again, the Department believes that imposition of a preauthorization requirement on services only when used to treat BBMI, and not when used to treat other illnesses, is contrary to the intent of the Act. Based on the foregoing, it is clear that preauthorization is effectively being used by insurers to limit or restrict benefits for BBMI that would otherwise be available for other illness.

The Department's original proposal included the following provisions:

N.J.A.C. 11:4-57.1 set forth the purpose and scope of the new rules.

N.J.A.C. 11:4-57.2 contained definitions for terms used throughout the subchapter.

N.J.A.C. 11:4-57.3 set forth standards concerning benefit limits in the treatment of BBMI, which included preauthorization requirements.

N.J.A.C. 11:4-57.4 established standards regarding exclusions of treatment for chronic conditions and of nonrestorative therapy.

N.J.A.C. 11:4-57.5 indicated that noncompliant forms would be deemed withdrawn as of December 31, 2003.

The Department received a number of comments on its original proposal. Based on some of those comments, the Department determined that the rules as initially proposed did not adequately address certain issues and should be revised to more accurately reflect the Department's original intent to enforce the Act and assist consumers in securing the benefits and

protections afforded to them by its provisions. However, some of these changes are substantive in nature and, pursuant to the Administrative Procedure Act (N.J.S.A. 52:14B-1 et seq.) and rules promulgated thereunder, could not be made upon adoption of the original proposal. Accordingly, the Department has decided to repropose the new rules implementing the Act. The issues raised by the commenters on the Department's initial proposal appear below as summarized comments, along with the Department's responses to those comments. The responses also indicate how this reproposal differs from the initial proposal.

The Department received comments on its initial proposal from the Carrier Clinic, New Jersey Occupational Therapy Association, New Jersey Association of Mental Health Agencies, Inc. (NJAMHA), State of New Jersey Health Benefits Program (SHBP) and the Division of Pensions and Benefits, New Jersey Business and Industry Association (NJBIA), Nitta Casings Inc., Health Net of the Northeast, Inc., New Jersey Association of Health Plans (NJAFP), AmeriHealth HMO, Inc. and AmeriHealth Insurance Company of New Jersey (AmeriHealth), Magellan Behavioral Health, Horizon Blue Cross and Blue Shield of New Jersey, and Oxford Health Plans.

1. COMMENT: Three commenters expressed support for the Department's proposal. The commenters indicated that carving out BBMI as requiring special authorization in order to access benefits under a plan that does not otherwise require pre-authorization for any other medical condition is discriminatory in nature, and refusing to cover services for these illnesses or creating additional barriers to accessing care by labeling illnesses as "chronic" or "non-restorative" is unconscionable.

The commenters additionally indicated that untreated mental illnesses often result in more costly inpatient and emergency room visits, and that there is a significant offset to medical costs when mental illnesses are treated. Discouraging mental health treatment by limiting

access to services and benefits does not make good clinical or business sense, and clearly violates the intent of P.L. 1999, c. 106.

1. RESPONSE: The Department appreciates the commenters' support.

2. COMMENT: One commenter stated that, in order to provide protection for all those in need, the term "biologically-based mental disorders" used in P.L. 1999, c. 106 should be changed to "mental health disorders as defined in the most current edition of the Diagnostic and Statistical Manual (DSM) of Mental Disorders published by the American Psychiatric Association."

RESPONSE: The commenter's request would necessitate a change in legislation, and cannot be accomplished by the regulatory process.

3. COMMENT: One commenter stated that the Department's authority to promulgate regulations related to P.L. 1999, c. 106 is not at all clear. According to the commenter, the terms of the law are quite detailed, and the Legislature did not give authority to the Executive Branch to enact regulations. The commenter stated that the Department cited a 1958 law setting forth procedures to be followed for the Department's general insurance rulemaking as its authority to promulgate these rules. At the very least, it would seem that the Department should consult with the Department of Health and Senior Services (DHSS) since the BBMI law governing HMOs is part of the HMO Act, DHSS has the authority to adopt rules to implement that Act, and the matter at issue very much concerns the medical management practices of HMOs. The commenter also stated that if the State means to mandate the provision of certain services as medically necessary for the treatment of certain BBMI, it would have to do so through new legislation. The commenter added that two identical bills were introduced in 2002 in the Assembly and the Senate (A-2578 and S-1693) that would require carriers to provide certain therapies as medically necessary in the treatment of certain BBMI.

RESPONSE: The Department disagrees with the commenter with respect to its authority to adopt regulations to implement the mandate that coverage for the treatment of biologically-based mental illness (BBMI) be provided under the same terms and conditions as are applicable to coverage provided for the treatment of physical illness. The Department of Banking and Insurance is responsible for reviewing health insurance policies issued by health insurance companies and health service corporations, as well as the contracts issued by health maintenance organizations (HMOs), to determine, among other things, whether benefits mandated by law are being provided. Moreover, the HMO Act at N.J.S.A. 26:2J-43h specifically authorizes the Commissioner of Banking and Insurance to promulgate regulations relating to the requirements for HMO contract forms. However, the Department agrees that the language in N.J.A.C. 11:4-57.4 as originally proposed should have referred to the medical necessity requirement that applies to all covered services. The Department has therefore clarified this language at N.J.A.C. 11:4-57.3(a) as reposed herein to refer to medical necessity, and has also added “so long as such services or supplies are not experimental or investigational.” This additional language was added because the exclusion for experimental and investigational services or supplies is typical in all health contracts, and the Department did not intend to override that exclusion in these rules. The Department has also deleted the reference to limits because reposed N.J.A.C. 11:4-57.3(b) permits visit limits that are applied to both physical illness and BBMI.

4. COMMENT: Six commenters stated that as initially proposed N.J.A.C. 11:4-57.4 would immeasurably expand the mandate for parity beyond the scope intended by the statute by prohibiting any kind of exclusion, requirement or limit to restrict benefits for BBMI.

The commenters expressed concern that this provision seems to contradict the rest of the proposal, as well as the statute, because it prohibits carriers from applying the provisions of its benefit policy equally to physical illnesses and to biologically-based mental illnesses, and

instructs carriers to ignore the conditions of the availability of particular benefits when applying the terms of a benefit plan to a member with a biologically-based mental illness.

Specifically, a few commenters indicated that the initially proposed rules would prohibit carriers from applying any exclusions, including exclusions for the treatment of chronic conditions and for physical, speech and occupational therapy that is non-restorative, and from making medical necessity determinations. One commenter questioned whether it is necessary for someone with bipolar disorder or schizophrenia to receive physical therapy. The commenters stated that the initial proposal would result in utilization abuse of physical, speech and occupational therapy benefits, and does not achieve "parity."

RESPONSE: As stated in the prior Response, the Department agrees that the language in N.J.A.C. 11:4-57.4 as originally proposed was unclear. The text of repropoed N.J.A.C. 11:4-57.3 has been revised to refer to medically necessary services and benefits and to permit utilization of visit limits that are applied to treatment for both BBMI and physical illness. The Department has also added at N.J.A.C. 11:4-57.3(a) a list of exclusion proscriptions that carriers cannot invoke to deny services or supplies to persons with biologically-based mental illness because the Department discovered that other types of exclusions, in addition to those appearing in the original proposal, were being used by carriers to deny services or supplies. Additionally, the Department has added language in this reproposal at N.J.A.C. 11:4-57.3(a) clarifying that limitations of therapy services to a fixed number of days after an injury or illness constitutes an exclusion of a chronic condition that is not permitted for BBMI.

5. COMMENT: Four commenters indicated that the cost implications of the rules as initially proposed would be far reaching. By stipulating that health plans must treat BBMI the same as any other illness, and by allowing unlimited treatments for BBMI, the proposed rules would have a severe fiscal impact on all health plans and cause health insurance to become too

costly for many employers at a time when they are already facing double-digit rate increases in their health benefits costs and are struggling to survive in a weak economy.

One commenter stated that it may need to consider imposing limits on the number of visits and the services these rules require to be provided. Additionally, the commenter stated that Medicare recently imposed a \$1,500 per year cap on physical therapy services, and that secondary payers would be responsible for services rendered beyond the Medicare maximum.

One commenter questioned what the State will put in place to provide mental health and substance abuse treatment for those covered under this mandate following exhaustion of their benefits.

RESPONSE: As stated previously, the language in N.J.A.C. 11:4-57.4 as originally proposed has been clarified in this reproposal at N.J.A.C. 11:4-57.3(a) to address the concern that the original proposal required unlimited benefits for covered persons with BBMI, rather than parity. Moreover, in a coordination of benefits situation where Medicare is primary, the secondary payer is never required to pay more than it would have paid if it were the primary payer. Since the repropose rules clarify that visit limits that apply equally to physical illness and BBMI are permitted, the covered person will be entitled to medically necessary services up to the limits of the secondary plan.

The comment about sources of mental health and substance abuse treatment after exhaustion of benefits is beyond the scope of the proposal. The Department only has responsibility to ensure that the level of benefits mandated by P.L. 1999, c. 106 is provided.

6. COMMENT: One commenter stated that the initially proposed definition of "preauthorization" does not differentiate between "pre-authorization" (prior to treatment) and "concurrent review" (during treatment). The commenter stated that its concurrent review process requires a pre-authorization prior to the continued provision of services, yet under this proposal

the member will have already begun treatment when the request is submitted. The commenter added that all of its utilization management decisions are based on medical necessity criteria. Without a pre-authorization requirement in place, the benefits of managed care are not realized, and there would be no process in place to determine whether parity actually applies. Moreover, if the process were retrospective, the required financial adjustments would be cumbersome, difficult and very impractical for the member and provider. The commenter requested that the definition be revised to allow preauthorization for initial care and review for medical necessity of outpatient continued care.

RESPONSE: Neither the originally proposed nor repropoed rules would prohibit use of preauthorization (either prior to or during treatment) by a carrier for the treatment of BBMI, provided the same standards for requiring preauthorization are applied in the treatment of physical illness. Moreover, the proposed rules do not prohibit use of other case management techniques for BBMI that are applied to physical illness, including the requirement to obtain a referral prior to receiving specialty care and the requirement to have care coordinated by a primary care physician or a care/case manager.

7. COMMENT: Five commenters expressed concern with N.J.A.C. 11:4-57.3(a) as originally proposed, which characterized a carrier's preauthorization requirements as a benefits limit. The commenters stated that preauthorization is not a benefit limit at all, but a case management tool for pre-service evaluation of coverage and/or medical necessity. It is also a communication tool to alert the consumer whether he or she will incur any financial liability in advance of obtaining services. One commenter questioned how a carrier would determine whether a member has a BBMI without pre-evaluating the diagnosis.

The commenters indicate that, under the Department's original proposal, carriers would be required to either preauthorize all hospital admissions and outpatient services, or waive

preauthorization for hospital admissions and outpatient services related to BBMI services. According to the commenters, both options contradict legislative intent and increase health care costs and administrative burdens. Many services, especially outpatient services, do not require preauthorization. To require preauthorization for all inpatient and outpatient services would significantly increase the number of services that will have to be preauthorized, as well as costs to consumers, providers and plans. By waiving preauthorization for all BBMI services, providers would be allowed to predetermine medical necessity, clearly increasing costs. If the services provided are for non-biologically-based mental illness, claims will be denied and consumers will incur significant financial liability.

The commenters stated that the statutory language provides that the law should not be construed to change the manner in which an insurer determines whether a mental health service meets the medical necessity standard established by the insurer. Preauthorization is one method for determining medical necessity; therefore, the Department's proposal clearly conflicts with the statute. One commenter added that the Department's stated concern is not with the prior authorization requirements, but rather with the practice of denying reimbursement in all instances where it was not obtained. Accordingly, the commenter suggested that the Department narrow its focus and engage in a dialogue with the State's managed care providers about how to best implement the prior authorization tool.

RESPONSE: The Department disagrees with the commenters. Preauthorization is a benefit limit because failure to obtain preauthorization of a medically necessary service that would otherwise be covered results in a benefit reduction of up to 50 percent of the benefit, which amount must be paid by the covered person (see N.J.A.C. 11:4-42.8(a) and 11:22-6.4). In other words, failure to get permission in advance results in a financial penalty of up to 50 percent of the fee that would be paid by the carrier for the service. Such increased financial

responsibility is clearly a benefit limit since it is a reduction in a benefit. Accordingly, the Department's reproposal has retained this requirement at N.J.A.C. 11:4-57.3(b).

8. COMMENT: Two commenters expressed concern with the language in N.J.A.C. 11:4-57.3(a) as originally proposed, stating that "carriers shall not impose benefit limits, including limits involving preauthorization requirements, on services for the treatment of biologically-based mental illness unless the same benefit limits are imposed on services for the treatment of physical illness." One commenter stated that this provision presents an impossible standard because the same services are not provided to treat mental and physical illnesses, so the same services could not be required to be preauthorized. One commenter stated that there are certain mental health services (for example, partial day hospitalization or intensive outpatient programs) that are not typically used in the care of physical illnesses. Accordingly, limits should be allowed on the coverage of these types of services even though there is not a comparable service for physical illness. The commenter requested that the Department confirm that the use of limits would be acceptable in such instances.

RESPONSE: The Department recognizes that certain treatments may be unique to BBMI and are not used to treat physical illness. However, the criteria that are used to determine what BBMI treatments are subject to preauthorization must be the same as the criteria used to determine what treatments for physical illness are subject to preauthorization. For example, if a carrier requires all treatments that are expected to cost more than \$10,000 to be preauthorized, then any BBMI treatment expected to satisfy that criteria should be subject to preauthorization. Again, the focus is on parity, and BBMI treatments cannot be subject to different criteria or standards than are treatments for physical illness.

9. COMMENT: One commenter stated that N.J.A.C. 11:4-57.5 as originally proposed would result in all form filings since August 1999 being out of compliance. The commenter

requested that this provision be revised to allow carriers to bring forms into compliance via a rider.

RESPONSE: The commenter misunderstands the operation of deemed withdrawals. A noncompliant form will be deemed withdrawn unless endorsed to bring it into compliance. Consequently, the Department does not believe that it is necessary to revise this requirement as suggested by the commenter because, if compliance is obtained through an endorsement, the form will not be considered noncompliant, and therefore will not be withdrawn. Reproposed N.J.A.C. 11:4-57.4 now states that noncompliant forms shall be deemed withdrawn as of July 1, 2005.

In addition to the changes made in these reproposed new rules that were discussed in the comments and responses above, the Department has added a definition of "exclusion" at N.J.A.C. 11:4-57.2 because that term, used in the original proposal and the reproposal, was not defined in the original proposal.

As the Department has provided a 60-day comment period on this notice of proposal, this notice is excepted from the rulemaking calendar requirement pursuant to N.J.A.C. 1:30-3.3(a)5.

Social Impact

These reproposed new rules will have a positive impact on those individuals, and the families of individuals, with certain biologically-based mental illnesses who may have previously been, or might, in the future, be denied treatment or receive limited benefits.

Economic Impact

These reproposed new rules will have a favorable impact on those individuals who may have been paying out-of-pocket for treatment of certain biologically-based mental illnesses.

Health carriers who have been denying coverage for such treatment will likely be unfavorably impacted by these repropsoed new rules because they will be required to provide coverage for certain treatments of biologically-based mental illnesses that they had failed to provide prior to this clarification of the statutory mandate that they do so.

Federal Standards Statement

A Federal standards analysis is not required because the repropsoed new rules mandate that certain benefits for the treatment of BBMI be provided pursuant to P.L. 1999, c. 106, and are not subject to any Federal requirements or standards.

Jobs Impact

The Department does not anticipate that the repropsoed new rules will result in the generation or loss of jobs.

Agriculture Industry Impact

The Department does not believe that the repropsoed new rules will have any impact on the agriculture industry in the State.

Regulatory Flexibility Analysis

The Department believes that the repropsoed new rules will apply to few, if any, "small businesses" as that term is defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. To the extent that the repropsoed new rules apply to small businesses, such small businesses will be health carriers authorized to transact business in this State. The rules may require such small business health carriers to incur additional costs by providing benefits for treatment of BBMI

that they may not have previously provided. However, these repropose new rules do not independently impose any undue additional costs or burdens on health carriers because the rules merely implement the statutory requirements of P.L. 1999, c. 106.

The repropose new rules provide no different reporting, recordkeeping or compliance requirements based on carrier size. As indicated in the Summary above, all carriers who write policies and contracts delivered, issued, executed or renewed in New Jersey that provide coverage for hospital or medical expenses or services are also required to provide the coverage mandated by P.L. 1999, c. 106. That legislation provides no different compliance requirements based on carrier size. While some carriers who may have been denying coverage for the treatment mandated by this legislation may experience a negative economic impact, the statutory requirements do not vary based on carrier size, and the Department believes that different compliance requirements based on carrier size would undermine the intent and purpose of the legislation and would not be appropriate or feasible. The legislative mandate was intended to provide all individuals with certain biologically-based mental illnesses, and who have health insurance coverage, with appropriate treatment and benefits. Accordingly, the proposed new rules provide no differentiation in compliance requirements based on carrier size. The Department does not anticipate that carriers will need to hire additional employees or obtain professional services to comply with the rules' requirements.

Smart Growth Impact

The repropose new rules have no impact on the achievement of smart growth and the implementation of the State Development and Redevelopment Plan.

Full text of the repropose new rules follows:

SUBCHAPTER 57. MANDATED BENEFITS FOR BIOLOGICALLY-BASED MENTAL
ILLNESS

11:4-57.1 Purpose and scope

(a) The purpose of this subchapter is to implement P.L. 1999, c. 106 by specifying that certain exclusions may not be applied to treatment of biologically-based mental illness, and that benefit limits in health insurance policies and health maintenance organization contracts may not be applied to deny medically necessary benefits or services for the treatment of biologically-based mental illness when those benefit limits are not applied in the same manner to treatments for other illnesses.

(b) This subchapter shall apply to all policies and contracts providing hospital or medical services or benefits that are delivered, issued, executed or renewed in this State in the individual, small group and large group markets as follows: all hospital service corporation contracts issued pursuant to N.J.S.A. 17:48-1 et seq.; all medical service corporation contracts issued pursuant to N.J.S.A. 17:48A-1 et seq.; all health service corporation contracts issued pursuant to N.J.S.A. 17:48E-1 et seq.; all health insurance policies issued pursuant to N.J.S.A. 17B:26-1 et seq., 17B:27-26 et seq., 17B:27A-2 et seq. and 17B:27A-17 et seq.; and all health maintenance organization contracts issued pursuant to N.J.S.A. 26:2J-1 et seq.

11:4-57.2 Definitions

The following words and terms, as used in this subchapter, shall have the following meanings unless the context clearly indicates otherwise:

“Benefit limit” means any restriction, condition, or limitation (including, but not limited to, visit limits, dollar limits and preauthorization requirements) applied to the provision of health care services or benefits in a health insurance policy or health maintenance organization contract.

"Biologically-based mental illness" (BBMI) means a mental or nervous condition that is caused by a biological disorder of the brain and results in a clinically significant or psychological syndrome or pattern that substantially limits the functioning of the person with the illness, including, but not limited to, schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder and pervasive developmental disorder or autism.

"Carrier" means any insurer authorized to sell health insurance pursuant to Title 17B of the New Jersey Statutes; a health, hospital or medical service corporation; or a health maintenance organization.

"Commissioner" means the Commissioner of the Department of Banking and Insurance.

"Exclusion" means a provision in a policy or contract that limits the scope of coverage by specifying causes and conditions for which benefits are not provided.

"Form" means any individual or group health insurance policy, health maintenance organization contract, any rider or endorsement for use with such policy or contract, certificates and evidence of coverage forms.

"Preauthorization" means a carrier's authorization, using paper or electronic means, for specified services or supplies that is given prior to the date the services or supplies are provided.

11:4-57.3 Exclusions and benefit limits

(a) Notwithstanding the applicability of such exclusions to persons with physical illness, carriers shall not apply any exclusion in a health insurance policy or health maintenance

organization contract to deny benefits for services or supplies that are medically necessary for the treatment of covered persons with biologically-based mental illness, so long as such services or supplies are not experimental or investigational. This proscription shall include but not be limited to:

1. Exclusions for the treatment of chronic conditions;
2. Exclusions for physical, speech and occupational therapy that is non-restorative (that is, that does not restore previously possessed function, skill or ability);
3. Exclusions for services rendered after a fixed period of time has elapsed from an injury, procedure or the onset of illness;
4. Exclusions for the treatment of developmental disorders or developmental delay;
5. Exclusions for therapy on a long-term basis;
6. Exclusions for the treatment of behavioral problems; and
7. Exclusions for the treatment of learning disabilities.

(b) Subject to (a) above, carriers may apply benefit limits, including preauthorization requirements, to treatment of biologically-based mental illness only if those benefit limits, including preauthorization requirements, are applicable to treatments of physical illnesses. Visit limits and preauthorization requirements may be applied only to the extent stated in (b)1 and 2 below.

1. Visit limits

i. Visit limits may be applied to therapy for the treatment of biologically-based mental illness if the same visit limits are applied to therapy for the treatment of physical illness. For example, a limit of 30 speech therapy visits per year is permitted for speech therapy that is required to treat a biologically-based

mental illness (such as autism or pervasive developmental disorder), so long as the limit also applies to speech therapy that is required to treat a physical illness (such as stroke).

2. Preauthorization requirements

i. Preauthorization of all services to treat biologically-based mental illness (that is, blanket preauthorization) is not permitted.

ii. Preauthorization of particular services for the treatment of biologically-based mental illness is permitted only if preauthorization is required for the same or similar services when provided to treat physical illness. For example, a carrier may require preauthorization of partial day hospitalization for the treatment of biologically based mental illness if it also requires preauthorization of intensive outpatient treatments for physical illness such as outpatient surgery, chemotherapy or radiation therapy.

11:4-57.4 Effect on previously filed forms

Forms that have been filed by the Commissioner containing provisions not in compliance with this subchapter shall be deemed withdrawn as of July 1, 2005.

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