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BULLETIN NO. 05-13

TO: **ALL HEALTH INSURANCE COMPANIES, HOSPITAL SERVICE CORPORATIONS, MEDICAL SERVICE CORPORATIONS, HEALTH SERVICE CORPORATIONS, AND HEALTH MAINTENANCE ORGANIZATIONS AUTHORIZED TO ISSUE HEALTH BENEFITS PLANS IN NEW JERSEY**

FROM: **DONALD BRYAN, ACTING COMMISSIONER**

RE: **MANDATED BENEFITS FOR BIOLOGICALLY-BASED MENTAL ILLNESS**

On May 2, 2005, the Department of Banking and Insurance (Department) adopted regulations at N.J.A.C. 11:4-57 (Mandated Benefits for Biologically-Based Mental Illness) that implemented P.L. 1999, c. 106 by specifying that certain exclusions may not be applied to the treatment of biologically-based mental illness (BBMI), and that benefit limits in policies and contracts may not be applied to deny medically necessary benefits or services for the treatment of BBMI when those benefit limits are not applied in the same manner to treatments for other illnesses. Some carriers have requested that the Department clarify the application of the regulations to a carrier's case management of in-network BBMI services. The purpose of this Bulletin is to provide such clarification.

The Department reiterates its position set forth in the Notice of Adoption of these regulations (see 37 N.J.R. 1523(a)). In response to comments received on the proposed regulations relating to the issue of case management, the Department indicated that the regulations permit the use of case management techniques to manage services for BBMI provided in-network where case management or care coordination is generally applied to physical illness.

The regulations permit carriers to require that ongoing outpatient care with in-network contracted providers be coordinated by a primary care physician or a care/case manager. Case management review evaluates the member's care to make sure that members receive medically necessary services in the

appropriate setting. This case management review process should take place between the provider and the carrier and not impose any procedural requirements on the member.

A requirement to obtain a referral or to register care with a primary care physician or a care/case manager prior to receiving care for purposes of determining member benefits and eligibility is permitted by these regulations for in-network services. In cases of non-BBMI diagnoses, there may be limits on a member's available benefits, and this process serves to confirm that the member is eligible for the proposed service prior to the service being delivered.

6/9/05
Date

/s/ Donald Bryan
Donald Bryan
Acting Commissioner

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