Policy:

Differentiating between non-certifications based on medical necessity and those based upon benefit limitations, exclusions, or lack of information.

Responsibility:

Clinical Services Department (Clinical Services) team members, Medical Director.

Procedure:

1. Clinical Services team members forward reviews that cannot be approved based on medical necessity to the medical director for review. (See *Policy and Procedure # MBH 6: Initiated Physician Review*.)

2. Clinical Services team members review all requests related to benefit coverage issues (i.e. exclusions, limited number of days/visits covered, etc.)

3. If the request is a non-covered benefit, the Clinical Services team member informs the requesting party that the request cannot be approved.

4. The Clinical Services team member consults the Clinical Services leader and/or medical director if the determination for coverage is dependent upon certain diagnosis exclusion. This is to ensure that the diagnosis is truly a non-covered benefit.

5. If the Clinical Services leader and/or medical director think extra-contractual benefits are a possibility; the process outlined in *Policy and Procedure # MBH 8: Extra-Contractual and Substituted Benefits* is followed.

6. If there is insufficient information to make a fair determination, the Clinical Services team member follows the process outlined in *Policy and Procedure # MBH 7: Lack of Information* is followed.

7. All applicable regulatory timeframes apply. (See *Policy and Procedure # MBH 911: Turnaround Timeframes*.)