

Behavioral Health

Benefit Coverage

Outpatient behavioral health services performed by the PCP, within their scope of practice, are covered benefits. Coverage includes outpatient psychotherapeutic medications prescribed by the PCP subject to the IEHP Formulary. Patients who need specialty behavioral health services (including outpatient therapy, rehabilitation, crisis intervention and stabilization, medication and inpatient hospital services) will be referred to the appropriate county department of mental/behavioral health. The physical health of the patient will remain the responsibility of the health plan.

Benefit Exclusion

Specialty behavioral health services including Short-Doyle Medi-Cal (SD/MC) and Medi-Cal Fee-For-Service (FFS) (inpatient and outpatient) services and designated antipsychotic drugs are “carved out” from the Medi-Cal Managed Care Health Plans. Services are provided through the county departments of mental/behavioral health.

Examples of Covered Benefits

1. Outpatient behavioral health services performed by the PCP within his/her scope of practice.
2. Psychotherapeutic drugs prescribed by the PCP.
3. Non-carve out psychotherapeutic drugs prescribed by psychiatrists (IEHP responsibility).

Examples of Non-Covered Benefits

1. Behavioral health services provided by psychiatrists and psychologists whether inpatient or outpatient services.
2. Inpatient and outpatient rehabilitation, crisis intervention and stabilization and medications.
3. Atypical antipsychotic drugs covered through Medi-Cal Fee-For-Service.

Biofeedback

Definition

Biofeedback therapy provides visual, auditory or other evidence of the status of certain body functions so that a person can exert voluntary control over the functions and thereby alleviate an abnormal bodily condition. Biofeedback therapy often uses electrical devices to transform bodily signals indicative of such functions as heart rate, blood pressure, skin temperature, salivation, peripheral vasomotor activity, and gross muscle tone into a tone or light, the loudness or brightness of which shows the extent of activity in the function being measured.

Benefit Coverage

Not a covered benefit under Medi-Cal Managed Care.

Benefit Exclusion

Biofeedback is not covered through the Medi-Cal Managed Care Program.

Examples of Non-Covered Benefits

1. Biofeedback, inpatient or outpatient.

Blood and Blood Products

Benefit Coverage (Medi-Cal Regulations – Cal. Code Regs., tit. 22, § 51325)

Blood is covered as ordered by a physician and only upon certification of the blood bank supplying the blood or the facility where the transfusion is given, that voluntary blood donations cannot be obtained. Blood derivatives are covered as prescribed by a physician when appropriate to the diagnosis and condition of the patient.

Examples of Covered Benefits

1. The cost of whole blood and blood products to include, but not limited to:
 - a. Plasma
 - b. Platelets
 - c. Packed cells
 - d. Antihemophilic factor
 - e. Cryoprecipitate
2. Factor VIII for hemophiliacs.
3. Cell Saver (Intraoperative autologous blood transfer) during emergency surgeries such as trauma or vascular surgery.
4. Autologous (self-donated blood) - IEHP responsibility

Examples of Non-Covered Benefits

1. Blood that is stored, but not used when a patient cancels or reschedules an elective surgery.
2. Blood charges incurred by IEHP Members for services and supplies in conjunction with donating blood for another individual.
3. Blood charges associated with non-authorized or non-covered procedures.
4. Procuren or other similar blood products used in the repair of chronic non-healing cutaneous ulcers.

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Breastfeeding Support Services

Benefit Coverage (Medi-Cal Regulations – Cal. Code Regs., tit. 22, §§ 51321 & 51521)

All postpartum Members are entitled to breastfeeding counseling, education and support immediately after delivery. The first newborn visit after delivery should include assessment of breastfeeding support needs.

Referrals for professional lactation consulting services will be provided through the IPA as the need is identified. Local Women, Infants and Children (WIC) Program agencies will be used as resources for education and counseling.

Lactation management aids, such as breast pumps and breast pump kits, must be provided to Members when determined medically necessary. Lactation management aids are classified as DME, and as such are the financial responsibility of the IPA. Specialized equipment, such as electric breast pumps, must be provided to Members as medically indicated.

Manual Breast Pumps (code E0602) and personal grade electric pumps (code E0603) are available for purchase. Hospital grade electrical pumps (code E0604) are covered for daily rental only.

Benefit Exclusion

Any breastfeeding support service that is not medically indicated, or does not meet the criteria below, is not covered.

Example of Covered Benefits

1. Manual Breast Pumps will be covered for Members who meet the following criteria:
 - a. Short-term separations from their infants due to work, school, or respite services.
 - b. Engorgement.
2. Electric Breast Pumps will be covered for Members who meet one or more of the following criteria:
 - a. Separation of mother and infant due to hospitalization of either.
 - b. Infants with medical conditions that prevent nursing at the breast.

Breastfeeding Support Services (continued)

Example of Covered Benefits (continued)

- c. Premature or multiple births.
 - d. Medical conditions of the mother, which prevent the infant from latching onto the breast, such as flat or inverted nipples.
 - e. Medical conditions of the mother, which preclude her from using a manual, pump, such as carpal tunnel syndrome.
3. A hospital grade electrical breast pump will be covered for daily rental if direct nursing at the breast is established during the neonatal period (the period immediately following birth and continuing through the first 28 days of life) and nursing is interrupted and the personal grade electric breast pump fails to meet the mother's or infant's medical needs (four day minimum trial is required) and the existence of any of the following:
- a. The mother has a medical condition that requires treatment of her breast milk before infant feeding.
 - b. The mother is receiving chemotherapy or other therapy with pharmaceutical agents that render her breast milk unsuitable for infant feeding.
 - c. The infant developed a medical condition or requires hospitalization that precludes direct nursing at the breast on a regular basis.
4. If direct nursing at the breast is not established during the neonatal period, medical necessity for the hospital grade electrical breast pump is defined as the existence of any of the following:
- a. The mother has been discharged from the hospital but continues to be treated for postpartum complications that preclude direct nursing at the breast.
 - b. The infant continues to be hospitalized for a neonatal illness and/or prematurely and the mother is no longer an inpatient.
 - c. The infant has a congenital neuromotor or oral dysfunction, or other congenital or neonatal acquired condition that precludes effective direct nursing at the breast.

Examples of Non-Covered Benefits

1. Manual Breast Pumps will not be covered for Members who do not meet the above criteria.
2. Electric Breast Pumps will not be covered for Members with engorged breasts who do not have any other qualifying condition.