

Parity Resource Guide for Addiction and Mental Health Consumers

**The Paul Wellstone and Pete Domenici Mental Health
and Parity and Addiction Equity Act (MHPAEA)**

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Parity Law Background and Overview

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) was passed in 2008 in an effort to end discriminatory health care practices against those living with mental illness and/or addiction. The statute provides that plans cannot apply financial requirements or treatment limitations to mental health or substance use disorder (MH/SUD) benefits that are more restrictive than as applied to medical/surgical benefits. In addition, plans cannot apply separate treatment limitations to MH/SUD benefits alone. Most notably, the law aims to remedy both the financial and non-financial ways that plans limit access to addiction and mental health care, more so than plans do for other physical conditions. Individuals with mental illness and/or addiction, their families, professionals in the field and employers all worked together to pass the law.

Importantly, MHPAEA does not require a plan to offer mental health and/or substance use disorder (MH/SUD) benefits; but if the plan chooses to do so, it must offer the MH/SUD benefits equivalent to the medical/surgical benefits it covers. For example, if a plan allowed an individual to have as many appointments with an immunologist as he or she needs but only covers five appointments with a psychiatrist, this limitation would violate the parity law.

The Affordable Care Act (ACA) expanded MHPAEA's protections. As a result, qualified health plans (individual and small group health plans offered in and outside the health insurance exchanges) and the benefits offered to the Medicaid expansion population must include MH/SUD benefits as an essential health benefit, and thereby, must comply with the parity law.

MHPAEA also guarantees new rights to individuals with mental health and substance use disorders that will make coverage rules more transparent and improve the appeals process. In order to preserve these rights, plans are required to:

1. Provide medical necessity criteria (see "Terms to Know") upon request to plan participants and providers.
2. Provide a reason for the denial of any claim to the insured and providers.
3. Disclose their parity compliance review and testing process in the event a parity law challenge is initiated.

Enforcement

States have primary enforcement authority over health plans that offer insurance coverage in the state-licensed group and individual markets. As such, states are intended to be the primary means of enforcing implementation of MHPAEA.

Compliance Issues

There are a number of parity compliance issues that must be addressed by plans:

- Financial requirements (e.g., deductibles, co-payments, coinsurance or out-of-pocket expenses) imposed on MH/SUD benefits may NOT be more restrictive than those imposed on medical/surgical benefits.
- Treatment limitations (e.g., frequency of treatment, number of visits, number of days or similar limits on scope or duration of treatment) imposed on MH/SUD benefits may NOT be more restrictive than those imposed on medical/surgical benefits.
- Plans that provide out-of-network coverage under the medical/surgical benefit must provide equivalent out-of-network coverage under the MH/SUD benefit.
- Plans cannot require a patient to go to a MH/SUD facility in their own local or state area if the plan allows plan members to go outside of local or state areas for other medical services.
- Plans are prohibited from using “separate but equal deductibles.” In other words, **MH/SUD and medical/surgical benefits must add up together towards the same, combined deductible, as illustrated in the example.**
- **Plans cannot exclude specific types of MH/SUD facilities or provider types while covering a full range of medical/surgical facilities and provider types.**
- Criteria for medical necessity determinations must be made available to any potential or current enrollee or contracting provider upon request. MHPAEA also requires that the reason for the denial of coverage or reimbursement must be made available to the plan participant or beneficiary.
- **The reason for any denial of reimbursement or payment must be made available to the participant or beneficiary.**
- Where there is a similar state parity law or regulation, the federal parity law serves as the minimum requirement. State regulators must enforce the federal requirements along with any additional state requirements.
- State laws that offer more consumer protections than the federal law are NOT preempted by MHPAEA.
- Additionally, under both federal and state laws, health plans must make meaningful disclosures of plan documents and clinical guidelines to enable a parity appeal, as well as other types of medical necessity or administrative appeals.

Additionally, parity requirements apply to the following facility types and services:

- Inpatient in- and out-of-network, outpatient in-and out-of-network, emergency care and prescription drugs) was never intended to exclude intermediate levels of care (intensive outpatient, partial hospitalization or residential) and,
- Intermediate levels of care (e.g., intensive outpatient, partial hospitalization and residential).

Parity Violations

What does parity look like?

The term parity means “equal to”³. The parity law is fundamentally grounded in ensuring equal access to treatment services under both the behavioral health and medical benefits offered by a health plan. Thus, the parity law requires that a health plan’s policies and practices to cover behavioral health services cannot be more restrictive than policies and practices for medical or surgical services. The comparisons between behavioral and medical/surgical benefits are made according to the same classes of benefits, such that:

- If inpatient medical/surgical benefits are provided, inpatient MH/SUD services must also be provided.
- If outpatient medical/surgical benefits are provided, outpatient MH/SUD services must also be provided.
- If in-network medical/surgical benefits are provided, in-network MH/SUD services must also be provided.
- If out-of-network medical/surgical benefits are provided, out-of-network MH/SUD services must also be provided.
- If emergency care medical/surgical benefits are provided, emergency care MH/SUD services must also be provided.
- If prescription medical/surgical benefits are provided, prescription MH/SUD services must also be provided.

What does a parity violation look like?

A parity violation can take many forms. Some policies and practices covered under the parity law are easily measured by a dollar amount or a number; for example, financial requirements such as co-payments or deductibles and quantitative treatment limits (QTLs) such as day and visit limits, deductibles, co-pays and coinsurance. Under the parity law, financial requirements and QTLs cannot be more restrictive for behavioral health services than for medical services in the same class of benefits.

Other health plan practices or policies are called non-quantitative treatment limitations (NQTLs) because these limitations cannot be measured by a dollar amount or number. The basic rule is that a health plan cannot impose an NQTL that is not comparable or that is applied more stringently to MH/SUD benefits than to medical/ surgical benefits. Examples of NQTLs include, but are not limited to:

- Limits on the quantity or frequency of treatment: If a health plan places caps on the number of inpatient days or outpatient behavioral health visits allowed each year, but does not have the same caps on inpatient days or outpatient medical visits, the health plan is likely in violation of the federal parity law. Similarly, if a health plan limits outpatient behavioral health visits to once a week or every other week, but does not limit the frequency of medical outpatient visits, there is likely a parity violation.
- More restrictive prior authorization policies for behavioral health: Many health plans

require prior authorization for non-emergency inpatient facility or hospital services, both medical and behavioral health. However, if in practice a health plan's prior authorization routinely approves up to seven inpatient days for medical services but just three inpatient days for behavioral health inpatient services, the plan is likely in violation of the federal parity law. The parity violation is the result of the health plan applying the prior authorization process more stringently to behavioral health services.

- **Excessive concurrent review policies:** When a patient is admitted to an inpatient or residential treatment facility or to day treatment, or is in need of long-term outpatient counseling, health plans may periodically review the medical necessity of the treatment in a process known as concurrent review. If health plans require concurrent review too frequently or impose overly burdensome requests on behavioral health care providers as compared with medical care providers to justify continued treatment, the plan may be in violation of the federal parity law.

Plan Compliance with the NQTL Rule

In order for plans to comply with the parity law, they are required to do their own parity compliance testing. In terms of NQTLs, plans must demonstrate that “any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to MH/SUD benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical surgical/benefits in the classification.”

What is the test to determine whether a parity violation has occurred?

When coverage for behavioral health services has been denied, or when behavioral health services have not been paid for at the same level as medical services, there are two types of parity tests to help determine whether a violation has occurred:

1. **Quantitative Treatment Limitation (QTL) Test:** a parity violation may have occurred in relation to a QTL under one of the following types of scenarios for each class of benefits:
 - Are the patient's behavioral health benefits subject to higher out-of-pocket spending than at least 2/3 of the medical benefits in the same class?
 - Are the patient's behavioral health co-insurance amounts higher than the co-pay or co-insurance amounts applied to at least 2/3 of the medical benefits in the same class?
 - Are the patient's behavioral health day and visit limits applied more restrictively than the day and visit limits applied to at least 2/3 of the medical benefits in the same class?
 - Does the overall effect of the plan's limitation result in zero days of coverage for MH/SUD care? Does the plan:
 - Exclude levels of care for behavioral health services, while covering a full continuum of care for medical/surgical services? For example, does the plan cover inpatient treatment for medical/surgical services but not for behavioral health services?
 - Offer out-of-network coverage for behavioral care that is more limited than out-

of-network coverage for other medical conditions?

- Require the patient to receive in-state treatment for MH/SUD treatment while permitting medical/surgical patients to receive care out-of-state?

2. Non-Quantitative Treatment Limitation (NQTL) test: A parity violation may have occurred in relation to an NQTL under one of the following types of scenarios for each class of benefits:

- Is a comparable treatment, service or medically necessary item provided by the plan to covered individuals with medical/surgical conditions?
- Is the plan requiring the patient to “fail first” at MH/ SUD lower cost treatments or medications but not requiring “fail first” for comparable medical/surgical treatments or medications?
- Are there differences between behavioral health and medical/surgical coverage regarding:
 - Formulary design for prescription drugs? For example is there a wider variety of medications for medical/surgical conditions, both by type and by category?
 - Standards for provider admission to participate in a network, including reimbursement rates?
 - Plan methods for determining charges?
 - Exclusions based on failure to complete a course of treatment?
 - Restrictions based on geographic location, facility type, provider specialty or other criteria that limit the scope or duration of benefits?

In addition, are there any separate treatment limitations applied to the behavioral health benefit that are not applied to the medical/surgical benefit?

What should a person do if the pre-authorization request is denied?

It is not unusual for a pre-authorization request to be denied. In cases where prior-approval (and resulting payment) is not approved by the plan to cover a test, procedure, treatment services or provider type, it is important to have a working relationship with a customer service representative or case manager at the health plan with whom the patient or authorized representative/provider can talk about the situation. A first step should be to re-submit the request for care or the claim with a copy of the denial letter. The patient may need the treating physician to explain or justify what has been done or is being requested

Sometimes the test or service will only need to be “coded” differently, or the health plan might just need additional information. If questioning or challenging the denial in these ways is not successful, then the patient may need to:

- Resubmit the request for care or claim a third time and request a doctor to doctor (peer to peer) review
- Ask to speak with a supervisor who may have the authority to reverse a decision
- Request a written response outlining the reason for the denial

- Keep the originals of all letters
- Keep a record of dates, names and conversations about the denial
- Get help from a consumer service representative from a state or federal agency (see Appendix C for helpful links)
- Do not back down when trying to resolve the matter
- Formally appeal the denial in writing, explaining why the request for care or claim should be paid

How To Get Answers To Insurance-Related Questions

Questions about insurance coverage often arise when individuals are trying to access mental health/addiction care. Here are some tips for answering insurance-related questions:

- Speak with your insurer or managed care provider's customer service department.
- Ask for the person's name each and every time you call.
- Make a note of the person's name, the date and time of the call.
- Ask your provider for help.
- Talk with the consumer advocacy office of the government agency that oversees your plan (ask for, and write down the names of who you speak to).
- Learn about the laws regarding insurance that protect the public.

Health Plan Coverage Checklist

My health plan coverage is through:

- My employer:
 - My plan is a fully-insured plan; any plan denials are eligible for state external review
 - My plan is a self-insured plan; any denials are NOT eligible for state external review
 - My employer employs more than 50 people
 - A policy I bought myself
 - An association-sponsored policy (such as a trade or educational organization)
 - Other
-

My health plan:

- Covers mental health and addiction benefits
 - Manages mental health and addiction benefits directly
 - Contracts with an outside entity (e.g., Managed Behavioral Health Organization (MBHO)) to manage them
-

Plan phone number to call if I have a problem: _____

My primary care physician is: _____

My physician's phone number: _____

My mental health/addiction provider's phone number: _____

I need prior authorization for: _____

I do not need a referral from my primary care physician

_____ OR _____

- I need a referral from my primary care physician for:
 - Lab and x-ray tests
 - Other specialist visits
 - Other

Parity Appeals Overview

What is a Parity Appeal?

All insured people, whether under medical or behavioral health benefits have a guaranteed legal right to challenge a coverage denial by a health plan. All plans—including Medicaid managed care plans, private individual and group insurance policies provided in and outside of exchanges and employer sponsored health plans—must provide a process to appeal an adverse determination (denial of coverage) by a health plan. **Appeal timelines and deadlines vary. Each insured individual should carefully read appeal instructions enclosed with denial letters and become familiar with their plan’s appeal processes and timelines.**

Managed Care Appeals Checklist

- Identify the type of insurance policy (fully insured or self-insured).
- Understand the terms of the policy (and what it does and does not cover).
- Determine if the plan is subject to ERISA, ACA and/or MHPAEA. Your rights to plan document or external review remedies may vary depending on which law(s) govern your plan type.
- Obtain the medical necessity criteria for both the mental health/addiction and medical benefit so you can compare how coverage decisions are made.
- If there is a possible violation of MHPAEA, reference that in your appeal.
- Obtain the reason for the denial of care.
- Request an analysis from the plan of how the criteria was comparable and applied no more stringently to the MH/SUD benefits versus

MHPAEA and some state laws allow insured individuals or their providers to challenge a coverage determination if the plan does not cover the same level or scope of services for MH/SUDs as the plan covers for medical/surgical conditions. A parity appeal of denied or limited services may be based upon the insurer’s determination that the MH/SUD services requested are not medically necessary or are not a covered service under the benefit plan.

What types of appeals are there?

There are a number of types and levels of appeals that an insured individual, attending provider or advocate can utilize, some of which overlap. Internal health plan appeals can also involve parity requirements as an issue. In addition, one can appeal a determination based on parity requirements alone.

What is the most common type of parity appeal?

According to advocates, many parity appeals involve medical necessity coverage determinations (i.e. an NQTL as discussed throughout this resource guide). In addition, several court decisions have issued rulings based upon a medical necessity test of the requested service rather than delving into a parity test. In other cases, a parity appeal could be handled through the administrative process or through another avenue. Patients or their advocates should check in with the applicable regulator, plan administrator, attorney or other expert to confirm which appeals process to use.

What are the advantages of adding a parity violation to a traditional appeal?

When filing an appeal, the insured, their attending provider or advocate should take advantage of the additional requirements afforded by MHPAEA. In many respects, this gives the patient more due process to ensure that the health plan is not taking any shortcuts regarding the obligations of the insurer to cover MH/SUD services to the same extent as medical/ surgical services. For example, an appeal that includes a challenge based on MHPAEA compliance should entitle the insured or their attending provider to documents the individual would not be eligible to receive in other appeal types. In some cases, the insurer and group health plan sponsor may be two different entities with different information available under MHPAEA, so the insured or their authorized representative may need to reach out to one or both entities depending on the specific circumstances of how the coverage is offered.

Filing a Parity Appeal

Understand the Insurance Policy and Benefits

Knowing what the insurance policy will and will not cover prior to a doctor's appointment, procedure or inpatient admission allows the insured individual to make more informed decisions about their health care. Often, a Summary Plan Description (SPD) and Benefit Booklet are made available to the insured. This information should be offered through the insurance company's website, an online Exchange or in-house through an employer's HR department. The insurance broker, plan representative or human resources personnel will know where to find it if the insured individual cannot locate it.

Here are some common examples of policies and practices that may violate the federal parity law if they are applied more restrictively to behavioral health benefits:

Limits on the quantity or frequency of treatment.

If a health plan places caps on the number of inpatient days or outpatient behavioral health visits allowed each year, but does not have the same caps on inpatient days or outpatient medical visits, the health plan is likely in violation of the federal parity law. Similarly, if a health plan limits outpatient behavioral health visits to once a week or every other week, but does not limit the frequency of medical outpatient visits, there is likely a parity violation.

More restrictive prior authorization policies for behavioral health.

Many health plans require prior authorization for non-emergency inpatient facility or hospital services, both medical and behavioral health. However, if in practice a health plan's prior authorization routinely approves up to seven inpatient days for medical services but just three inpatient days for behavioral health inpatient services, the plan is likely in violation of the federal parity law. The parity violation is the result of the health plan applying the prior authorization process more stringently to behavioral health services.

Excessive concurrent review policies. When a patient is admitted to an inpatient or residential treatment facility or to day treatment, or is in need of long-term outpatient counseling, health plans may periodically review the medical necessity of the treatment in a process known as concurrent review. If health plans require concurrent review too frequently or impose overly burdensome requests on behavioral health care providers as compared with medical care providers to justify continued

Helpful Hints

Steps to take if your appeal fails:

Step #1 – Appeal again and again: Most insurance companies must offer and/or support three to four levels of appeals, and each appeal will involve new people, increasing the chance that the insurance company will agree with the proposed care plan.

Step #2 – Request an appeal review by an external party: A review by somebody who is not on the insurance company's staff will be more objective. There may or may not be a charge to you and/or your provider for such a review.

Step #3 – Enlist the help of a consumer assistance program or your employer's Human Resources Department, if applicable: Your state may have established a Consumer Assistance Program to assist you with health insurance problems, and/or your employer's Human Resources staff may be available to assist you with benefit problems you encounter.

STEP #4 – Send your appeal to your State Insurance Commissioner, Member of Congress and relevant plan accrediting body to ask them to intervene with your insurer.

treatment, the plan may be in violation of the federal parity law.

In addition, under federal and state laws, health plans must make meaningful disclosures of plan documents and clinical guidelines to enable a parity appeal.

What information does someone need to file an appeal?

MHPAEA requires that plans use QTLs and NQTLs on behavioral health conditions as imposed on other medical conditions. As a result, to better prepare the appeal, the patient should request the following from the plan:

1. A copy of the plan's Summary Plan Description (SPD), complete benefit booklet and any other evidence/ certificate of coverage documents.
2. A complete list of the medical/surgical conditions covered by the plan and the terms under which they are covered.
3. A copy of the plan's medical necessity criteria for MH/SUD services and for other medical services.
4. Any clinical guidelines used by the plan to make benefit determinations for both medical and MH/SUD conditions.
5. If the plan is subject to ERISA (large and small employer group plans), request all plan documents related to how the plan is operated.

Helpful Tips

Expect to provide the following information in your written appeal:

- Your name, address and telephone number
- Your insurance plan number or group code and member identification number or Social Security number
- Your provider's name and bill
- Referrals to specialist services (if relevant)
- Description of the service or procedure that you requested to be covered
- Information supporting why the service should be covered
- Explanation of benefits (EOB) forms
- References to the sections from the Evidence of Coverage or Summary Plan Description that apply to your situation
- Clinical information on your medical condition or treatment, such as your medical record, treatment guidelines from your plan, information from medical journal articles or studies that says the treatment is more cost-effective in the long-term
- Documentation that the services are covered by the plan or are required by state or federal law
- Legal rationale

How should an individual initiate a parity appeal?

In most cases, an individual or their authorized representative/provider will initiate the parity appeal through the clinical or administrative appeals system. Adding a parity law compliance challenge to the appeal will require a health plan to provide more disclosure of information, documents and the plan's parity compliance review and testing.

What are some tips for a successful appeal?

Appeals are only successful when they are:

- Presented according to the particular plan's appeals process and timeframe. It is important that the insured individual, their attending provider or their representative educate themselves about the particular plan's appeals processes
- Factual, and clearly state their intent to appeal the adverse determination (denial)
- Focused and remain on point even as the person jumps some of the bureaucratic hoops associated with most appeals

The most important element of an appeal letter is that it MUST be tailored to the specific patient's clinical need(s) as documented in the case/medical record and provide a clinical justification in support of the recommended treatment, item or service. Individuals filing an appeal should work with their treating provider to help get this information.

Another Helpful Tip

More than 20% of appeals of denials of coverage or reimbursement by health insurers are successful in favor of the covered individual and an even higher number at the external review level. Just because this process can be long and complicated does not mean it is not worth it. Individuals should keep all of the plan's coverage information and correspondence in a notebook or an online file to help ease the process and organize your appeals materials. Individuals often do not win at the first level of appeal. Success is more likely with ongoing and persistent appeals until all options are exhausted.

Appendix A Provider Request for Documentation

Provider request for documentation of the specific criteria applied “no more stringently than”

To: _____ From: _____
Mgd Care Co: _____ Provider: _____
Fax: _____ Fax: _____
Phone: _____ Phone: _____

Please disclose specific criteria and the processes, strategies, evidentiary standards and other factors [insert plan name] used to apply such criteria or protocols to deny coverage as detailed herein. Please document how this criteria and/or protocols are comparable to the medical/surgical criteria and/or protocols and how they were applied to the behavioral health services requested in a no more stringent manner than to similar service categories under the medical/surgical benefits provider under the plan.

Patient/Insured's Name: _____
Insurance Company: _____
Insurance Policy ID#: _____
Level(s) of care requested: _____

Should you have any questions regarding this request, please contact me at the phone number listed above

Appendix B
Patient Request for Medical Necessity Criteria for Behavioral Health

Sample Facsimile/Email Request

[Date]

Via Facsimile – [Fax No#] (or Email)

[Insurance Company and/or Managed Behavioral Health Company] [Member Services Dept. or other applicable dept.]

[Address, if needed]

Dear [Member Services or other applicable dept.]:

My name is [insured patient's name] and I am insured under policy # [insert policy #] and group # [insert group #]. My plan is governed by the Federal Mental Health Parity and Addiction Equity Act.

I am currently a patient at [insert name of provider], and I hereby request a copy of the specific reason(s) for denial of the treatment services requested and of the specific medical necessity criteria that you are relying on in denying reimbursement for my treatment services. I am also requesting a copy of the medical/surgical “medical necessity” criteria for similar service categories and the plan’s analysis of how the behavioral health criteria is comparable to and is applied no more stringently than the medical/surgical criteria for similar service categories:

- Detoxification
- Inpatient rehab
- Residential
- Partial hospitalization
- Intensive outpatient
- Outpatient
- Prescription drugs

I have paid for this benefit, and [insert name of provider] is licensed by the state of [insert state] [and nationally accredited, if applicable] to provide these treatment services. My attending physician has admitted me to this/these level(s) of care and is recommending my continued treatment. I am in dire need of these treatment services and they are covered by my benefit plan and should be paid for.

I request that you immediately fax this relevant information to me so that I may fully understand how you reached a different decision than my treating physician in refusing to cover my treatment services.

Please fax the above requested information to my attention at fax # [insert #]. If you would like to speak with me, please contact [insert name of applicable care provider contact].

Appendix C Appeal Letter Samples

1: Denial Based on Freestanding or Residential Facility-Type Exclusions

Note: Highlights facility-related adverse determinations or denials.

[Insert Date]

[If URGENT, then indicate URGENT APPEAL]

[Insert Name]

[Insert Company Name/Plan]

[Insert Address]

Re: [Insert Patient's Name]

[Insert Patient's Date of Birth]

[Insert Patient's Insurance ID Number]

[Insert Patient's Group ID Number]

[Insert Disputed Service, provider of service, and dates of disputed coverage]

Dear [Name of contact at health insurance plan]:

I have been a member of your plan since [date] and am now writing to appeal your decision to deny coverage for [state the name of the specific treatment or service denied AND if it is urgently needed to prevent harm or the inability to regain maximal function]. It is my understanding based on your letter dated [insert date of denial] that this [treatment or service] has been denied because: [Quote the specific reason given in the denial letter].

I have enclosed a letter from [name of clinician] explaining why [he/she] recommends [treatment or service], [his/her] qualifications. I have also attached a rationale for why I am entitled to this service under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). [If the treatment is urgent, then the treating professional should indicate so in the attached letter.]

I also hereby request that you: 1) provide me with a copy of the SBC and/or SPD and complete benefit plan booklet for both the medical/surgical and mental health/substance use disorder benefits within 30 days; 2) explain the specific plan provisions you are relying upon to exclude coverage for this facility type and the services they provide; 3) provide me with plan documents under which the plan is established or operated, with information on the processes, strategies, evidentiary standards and other factors used to exclude coverage for [freestanding or residential treatment facilities] under the behavioral health benefit; and 4) explain how that is comparable to and applied no more stringently than coverage or non-coverage for similar provider types under the medical/surgical benefit. Should you require additional information, please do not hesitate to contact me at [phone number]. I look forward to hearing from you in the near future.

Sincerely,

[Insert your name]

Cc: [insert patient's name]

[insert State Insurance Commissioner's Name]

[insert your Member of Congress' name]

Enclosure:

Clinical guidelines where appropriate

2: Denial Based on Level of Care Exclusions

Note: Highlights adverse determinations where care is categorically limited or denied.

[Insert Date]

[If URGENT, then indicate URGENT APPEAL]

[Insert Name]

[Insert Company Name/Plan]

[Insert Address]

Re: [Insert Patient's Name]

[Insert Patient's Date of Birth]

[Insert Patient's Insurance ID Number]

[Insert Patient's Group ID Number]

[Insert Disputed Service, provider of service, and dates of disputed coverage]

Dear [Name of contact at health insurance plan]:

I have been a member of your plan since [date] and am now writing to appeal your decision to deny coverage for [state the name of the specific treatment or service denied AND if it is urgently needed to prevent harm or the inability to regain maximal function]. It is my understanding based on your letter dated [insert date of denial] that this [treatment or service] has been denied because: [Quote the specific reason given in the denial letter].

I have enclosed a letter from [name of clinician] explaining why [he/she] recommends [treatment or service], [his/her] qualifications. I have also attached a rationale for why I am entitled to this service under the

Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). [If the treatment is urgent, then the treating professional should indicate so in the attached letter.]

I also hereby request that you: 1) provide me with a copy of the SBC and/or SPD and complete benefit plan booklet for both the medical/surgical and mental health/substance use disorder benefits within 30 days; 2) explain the specific plan provisions you are relying upon to exclude coverage of these services; 3) provide me with plan documents under which the plan is established or operated, with information on the processes, strategies, evidentiary standards and other factors used to exclude coverage for [indicate level of care] under the behavioral health benefit; and 4) explain how that is comparable to and applied no more stringently than coverage or non-coverage for similar services under the medical/surgical benefit. Should you require additional information, please do not hesitate to contact me at [phone number]. I look forward to hearing from you in the near future.

Sincerely,

[Insert your name]

Cc: [insert patient's name]

[insert State Insurance Commissioner's Name]

[insert your Member of Congress' name]

Enclosure:

Clinical Guidelines where appropriate

3: Denial Based on Blanket Exclusions of Office-Based Diagnostic and Treatment Interventions

Note: Highlights adverse determinations and denials related psychological testing for diagnostic assessments or other treatment services like individual psychotherapy and family counseling.

[Insert Date]

[If URGENT, then indicate URGENT APPEAL]

[Insert Name]

[Insert Company Name/Plan]

[Insert Address]

Re: [Insert Patient's Name]

[Insert Patient's Date of Birth]

[Insert Patient's Insurance ID Number]

[Insert Patient's Group ID Number]

[Insert Disputed Service, provider of service, and dates of disputed coverage]

Dear [Name of contact at health insurance plan]:

I have been a member of your plan since [date] and am now writing to appeal your decision to deny coverage for [state the name of the specific treatment or service denied AND if it is urgently needed to prevent harm or the inability to regain maximal function]. It is my understanding based on your letter dated [insert date of denial] that this [treatment or service] has been denied because: [Quote the specific reason given in the denial letter].

I have enclosed a letter from [name of clinician] explaining why [he/she] recommends [treatment or service], [his/her] qualifications. I have also attached a rationale for why I am entitled to this service under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). [If the treatment is urgent, then the treating professional should indicate so in the attached letter.]

I also hereby request that you: 1) provide me with a copy of the SBC and/or SPD and complete benefit plan booklet for both the medical/surgical and mental health/substance use disorder benefits within 30 days; 2) explain the specific plan provisions you are relying upon to exclude coverage of these services; and 3) provide me with plan documents under which the plan is established or operated, with information on the processes, strategies, evidentiary standards and other factors used to exclude coverage for outpatient diagnostic services and treatment under the behavioral health benefit. Should you require additional information, please do not hesitate to contact me at [phone number]. I look forward to hearing from you in the near future.

Sincerely,

[Insert your name]

Cc: [insert patient's name]

[insert State Insurance Commissioner's Name]

[insert your Member of Congress' name]

Enclosure: Clinical Guidelines where appropriate

Appendix D

Terms to Know

Accrediting Body: An impartial external organization such as the National Committee for Quality Assurance (NCQA) and URAC that performs a comprehensive process in which a health care organization undergoes an examination of its systems, processes and performance to ensure that it is conducting business in a manner that meets predetermined criteria and is consistent with national standards.

Adverse Determination: Any action by a health plan that denies or limits payment for the requested behavioral or medical treatment or services.

Appeal: A legal right for an insured individual, their provider or an authorized representative to seek relief against a health plan or third party determination to deny or limit payment for requested behavioral or medical treatment or services.

Appealing a Claim: The process to seek reversal of a denied behavioral health or medical claim. Most insurance carriers have their own process and timeline, but are subject to state and federal regulations.

Arbitration: An often binding process for the resolution of disputes outside of courts.

Balance Billing: The amount you could be responsible for (in addition to any co-payments, deductibles or coinsurance) if you use an out-of-network provider, which may represent the fee for a particular service that exceeds what the insurance plan allows as the charge for that service.

Behavioral Health: A descriptive phrase that covers the full range of mental health conditions and substance use disorders (MH/SUD).

Carrier: The insurance company that issues your insurance policy. The term is synonymous with health plan or health insurer.

Carve-Out: An independent managed behavioral health organization that manages the mental health and substance use disorder benefits separately from the plan's medical benefits.

Claim: A bill (or invoice), typically in a standardized form, containing a description of care provided, applicable billing codes and a request for payment, submitted by the provider to the patient's insurance company (or the plan's third party administrator).

Class Action: A lawsuit certified by a court that allows a number of plaintiffs to join in one lawsuit when they are suing a common defendant or defendants under common factual and legal grounds.

Classification: One of the six categories of benefits governed by MHPAEA (e.g., in-network inpatient, out-of-network inpatient, in-network outpatient, out-of-network outpatient, emergency room and prescription drugs).

Clinical Appeal: An appeal that involves a “medical-necessity determination” or other issue related to the medical appropriateness of care.

Clinical Practice Guideline: A utilization and quality management tool designed to help providers make decisions about the most appropriate course of treatment for a particular patient.

Co-Payment: A dollar amount that an insured patient is expected to pay at the time of service.

Deductible: A dollar amount an insured patient must pay before the insurer will begin to make benefit payments.

Denial: Refusal of a request for payment or reimbursement of behavioral health or medical treatment services.

Denied Claim: Non-payment of a claim for reimbursement of behavioral health or medical services delivered to the insured patient. The insurance company must inform the patient of the non-payment of the claim and explain why the services are not being reimbursed.

Effective Date: The date your insurance coverage actually begins. You are not covered until the policy’s effective date.

Employee Assistance Programs (EAPs): Mental health or substance use disorder treatment services that are sometimes offered by insurance companies or employers. Typically, individuals do not have to directly pay for services provided through an employee assistance program. EAPs are deemed to be part of an employer’s single group plan for purposes of parity law application.

Employee Retirement Income Security Act (ERISA): A broad-reaching federal law that establishes the rights of health plan participants, requirements for the disclosure of health plan provisions and funding and standards for the investment of pension plan assets.

Exclusions: Specific conditions, services, treatments or treatment settings for which a health insurance plan will not provide coverage.

Explanation of Benefits: A statement sent from the health insurance company to an insured member listing services that were billed by a health care provider, how those charges were processed, the total amount paid and the total amount of patient responsibility for the claim.

External (Independent) Review: External review is part of the health insurance claims denial process. It typically occurs after all internal appeals have been exhausted, when a third party (that is intended to be independent from the plan) reviews your claim to determine whether the insurance company is responsible for paying the claim(s). External review is one of several steps that comprise the appeal and review process.

CAUTIONARY NOTE: Patients and providers should be cautioned that not all external appeals

are reviewed by truly “independent” organizations. In self-funded ERISA cases, IROs are hired by the health plans or their agents that issued the denials the IROs are reviewing. Many IROs are also assigned by states to review denials made by the same organizations in fully-insured cases. Since external appeals are generally voluntary, consumers and their advocates should weigh the prospect that a health plan may attempt to rely on an external review denial to justify its internal denials when future care is sought or during any court case that may arise.

Fail First: Refers to a medical management protocol used by some health plans that requires that a patient demonstrate that they failed at a lower-cost therapy or treatment before the plan will authorize payment for a higher-cost intervention. Fail-first is considered a non-quantitative treatment limitation (NQTL) and must be comparable to and not applied more stringently to behavioral health benefits than as applied to medical/surgical benefits. (Note: fail-first protocols used to deny coverage for entire levels of care under the behavioral health benefit have been found to violate the parity law, as they are not typically utilized for medical conditions, except in the prescription drug class of benefits.)

Financial Requirements: Includes deductibles, copayments, coinsurance and out-of-pocket maximums.

Formulary: A listing of drugs, classified by therapeutic category or disease class, that are considered preferred therapy for a given population and that are to be used by an MCO’s providers in prescribing medications.

Fully Insured Plan: Employer-sponsored insurance plan where the employer contracts with another organization to assume financial responsibility for the enrollees’ medical claims and for all incurred administrative costs. These plans are regulated by state insurance commissions. The term is synonymous with “fully-funded plan.”

Grandfathered Plans: Health Plans and other designated insurance arrangements that were in existence prior to March 23, 2010.

Grievance Appeal: A complaint by the insured related to a payment issue or the four corners of the benefit plan.

Health Insurance Portability and Accountability Act (HIPAA): A federal law that outlines the requirements that employer-sponsored group insurance plans, insurance companies and managed care organizations must satisfy in order to provide health insurance coverage in the individual and group health care markets.

Independent Review Organization: A third party organization that is intended to be unaffiliated with the health plan and to have no stake in the outcome of the review. Please refer to *CAUTIONARY NOTE* under definition for External (Independent) Review.

Inpatient: A term used to describe care rendered in a hospital or non-hospital based facility (e.g.,

inpatient detoxification, residential detoxification, inpatient rehabilitation, residential treatment, skilled nursing care, inpatient physical rehabilitation), as defined by the plan.

Managed Behavioral Health Organization (MBHO): An organization that provides behavioral health services by implementing managed care techniques.

Medicaid: A joint federal and state program that provides hospital, medical and behavioral coverage to the low-income population and certain aged and disabled individuals.

Medical/Surgical Benefits: For purposes of this reference guide, the phrase refers to insurance coverage for medical and surgical (non-behavioral health) services.

Medically Necessary: Health care services that are clinically indicated for the diagnosis and/or treatment of a medical or behavioral health condition.

Medical Necessity Appeal: An appeal filed when the health plan has denied payment or reimbursement for level of care or service based on a “lack of medical necessity”. Synonymous with “UM appeal”.

Medicare: A federal government program established under Title XVIII of the Social Security Act of 1965 to provide hospital expense and medical expense insurance to elderly and disabled persons.

Mental Health Condition and Substance Use Disorder (MH/SUD): The phrase used in the Mental Health Parity and Addiction Equity Act (MHPAEA), accompanying regulations and certain state laws to describe the range of behavioral health conditions.

National Committee for Quality Assurance (NCQA): One of several accrediting bodies that performs evaluations of health plan procedures and performance.

Network: The group of physicians, hospitals and other medical care professionals that a managed care plan has contracted with to deliver medical and/or behavioral health services to its members.

Non-Quantitative Treatment Limitation (NQTL): Any non-financial treatment limitation imposed by a health plan that limits the scope or duration of treatment (i.e. pre-authorization, medical necessity, utilization review, exclusions, etc.).

Out-of-Network: Physicians, hospitals, facilities and other health care providers that are not contracted with the plan or insurer to provide health care services at discounted rates. Depending on an individual’s plan, expenses incurred by services provided by out-of-plan health care professionals may not be covered or may be only partially covered.

Outpatient Care: Treatment that is provided to a patient on a non-24 hour basis without an overnight stay in a hospital or other inpatient or residential facility.

Partial Hospitalization Services: Also referred to as “partial hospital days”, this refers to outpatient services performed as an alternative to or step-down from inpatient mental health or substance use disorder treatment.

Pre-Authorization: Confirmation of coverage by the insurance company for a service or product before receiving the service or product from the medical provider. This is also known as prior authorization.

Provider Payment: The amount of money paid to the health care provider by the insurance company for services rendered.

Quantitative Treatment Limitation (QTL): Limits based on frequency of treatment, number of visits, days of coverage or days in a waiting period. A limitation that is expressed numerically, such as an annual limit of 50 outpatient visits.

Usual, Customary and Reasonable Fees (UCR): Often defined as the average fee charged by a particular type of health care practitioner within a geographic area for a particular type of service. These fees are sometimes used by insurers to determine the amount of coverage for health care services provided by out-of-network providers. The insured may be responsible for any copayment, coinsurance and deductible, as well as any remaining portion of the provider’s fee that is not covered by the UCR fee.

Reason Codes: A letter or number system typically presented and defined at the bottom of an Explanation of Benefits (EOB) used to explain how the insurance claim was processed and why the insurance company denied all or part of your claim.

Self-Insured Plan (ERISA): A plan offered by employers who directly assume the major cost of health insurance for their employees. Self-insured employee health benefit plans are exempt from many state laws and instead are subject to federal (ERISA) law. Synonymous with self-funded plan.

Summary Plan Description (SPD): A description of the benefits included in your health plan.

URAC: One of several accrediting bodies that performs regular evaluations of health plans processes and performance. URAC, for example, has a specific standard for plan parity compliance.

Utilization Management (UM) Appeal: Synonymous with “medical necessity appeal”.