

PARITY TOOLKIT FOR ADDICTION & MENTAL HEALTH CONSUMERS, PROVIDERS & ADVOCATES

*SIMPLIFYING THE APPEALS PROCESS: STRATEGIES FOR
WINNING DISPUTES WITH YOUR HEALTH PLAN*

PARITY
IMPLEMENTATION
COALITION

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The Parity Implementation Coalition developed this toolkit to help you to understand the law, to file complaints and to appeal denied claims. We may update it as regulations are clarified and additional FAQs made available. The information included in this toolkit is meant to be helpful, but should not substitute for legal counsel. If you need help with the toolkit or have questions about parity send an email to info@mentalhealthparitywatch.org.

ACKNOWLEDGEMENTS

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DEDICATION

This toolkit is dedicated to the millions of individuals, families and providers who work tirelessly at fighting addiction and mental illness and ensuring equal rights under the law.

1. INTRODUCTION

The Parity Implementation Coalition provides this toolkit as an aid for individuals in and seeking recovery from addiction and mental illness and their families, providers and advocates to help them understand their new rights and benefits under the parity law. The toolkit is designed to be a resource in how to better communicate with plans, how to ably prepare and document information should disputes arise with a health plan over coverage or reimbursement and better understand your basic appeals rights and procedures. Clearly, every plan has its own appeals policies and procedures and each plan participant must become informed about his or her own plan's appeals process.

As health care costs have increased, public and private health plans have imposed stricter cost containment techniques on health benefits. Many plans have subjected addiction and mental health benefits, often called "behavioral health" benefits, to an even stricter form of cost containment, often in the form of higher co-pays and deductibles, shorter day and visit limits, pre-approval or "prior-authorization" for these services and other forms of "medically managing" these benefits that are more stringent than how other medical benefits are managed. Common types of discriminatory medical management for mental health/addiction benefits may include, but are not limited to:

- Prior authorization (pre-approval)
- Utilization review (the plan must authorize how the care is being delivered in advance)
- "Fail first" policies (having to fail at one drug or treatment before another is approved)
- Denials or exclusions of coverage for particular treatments or levels of care
- Medical necessity criteria (denials of care because a service or treatment is not "medically necessary" to treat an individual's medical condition)

When cost containment is used by plans to achieve quality and accountability, its impact can be beneficial to patients, providers and payers in the health system. When it is used simply as a means to delay or deny medically appropriate care, it can have devastating consequences on individuals, families and the health system at large.

It is important to note that the Mental Health Parity and Addiction Equity Act (MHPAEA) was not intended to eliminate cost containment or medical management. The law's aim is to create equality between medical benefits and addiction/mental health benefits.

The Parity Implementation Coalition includes the American Academy of Child and Adolescent Psychiatry, American Psychiatric Association, American Society of Addiction Medicine, Betty Ford Center, Faces and Voices of Recovery, Hazelden, Mental Health America, National Alliance on Mental Illness, National Association of Psychiatric Health Systems, National Council for Community Behavioral Healthcare and The Watershed Addiction Treatment Programs. The organizations advanced parity legislation for over twelve years in an effort to end discrimination against individuals and families who seek services for mental health and substance use disorders and remain committed to its effective implementation.

2. HOW TO USE THIS TOOLKIT

Model Appeals

The templates in **Section 5** provided in the toolkit MUST be customized. Individuals and families, their advocates and providers must carefully review each template, its introduction and make the best use of the templates given your own unique set of interactions you have had with your plan.

Every place in the “templates” or model appeal letters containing a [] must be filled in by an individual, advocate or provider filing the appeal. Each template contains the legal justification from a nationally recognized law firm, Patton Boggs, to provide the legal support for the argument included in the template. We encourage you to use this legal justification to increase the chances for a successful appeal, along with any additional information you can include tailored to your specific case such as clinical guidelines.

Helpful Tips for Consumers, Families and Providers

The authors of this toolkit provide individuals and families with a series of “**Helpful Tips**” that are included throughout the toolkit. These tips are based on our own hard-won experience in fighting our own appeals of denied coverage and reimbursement of mental health/addiction claims. After several years and numerous attempts, we were successful in winning our appeals and we urge you to use the toolkit’s techniques for organization, documentation and perseverance that were critical to our success.

HELPFUL TIP

We want to hear from you and help you if we can.

If you do file an appeal, we would appreciate receiving a copy of it at info@mentalhealthparitywatch.org

COMMON ABBREVIATIONS

MH/SUD – mental health/substance use disorders

MHPAEA – The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act; “parity;” the new law; “the statute;” or “Wellstone Domenici”

Checklists for Providers

For providers, we have included helpful checklists that experienced provider legal advocates have included based on their years of experience in resolving disputes that have arisen with plans. Providers should pay particular attention to the managed care appeals checklist on page 10.

3. OVERVIEW OF THE MENTAL HEALTH PARITY AND ADDICTION EQUITY LAW

Background on Parity

Most Americans with health insurance face greater barriers in accessing services for mental illness and addiction than they face for accessing care for other medical conditions. The majority of health plans impose higher out of pocket spending requirements and more restrictive treatment limitations on addiction and mental health benefits.

Today, with new technologies like MRIs and PET scans that allow scientists to look inside the brain, the evidence that mental illness and addiction are brain diseases is more compelling than ever before. Unfortunately, reimbursement policy has not kept up with science.

HELPFUL TIP

Webster's Dictionary defines "parity" as "the quality or state of being equal." Compare your health plan's medical/surgical benefits to your health plan's "behavioral health" or addiction/mental health benefits. Are they roughly equal? If not, your plan may not be in compliance with the new parity law.

Since 1992, advocates like you have fought for health care equality for those with addiction and/or mental illness. A partial mental health parity law was passed in 1996 that was a significant step forward.

The *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act* (MHPAEA) was passed in 2008 to correct discriminatory health care practices against those both with a mental illness and/or addiction. Significantly, the law aims to curb both the financial and non-financial or "non-quantitative" ways that plans limit access to addiction and mental health care. Individuals

with mental illness and/or addiction, their families, professionals in the field and employers worked together to pass the law.

In the end, turning a law into REAL lifesaving addiction and mental illness benefits means we have to fight for our new rights and benefits. This is OUR responsibility.

Brief Summary of the Parity Law

The parity law was signed into law on October 3, 2008.

The law went into effect for plan years beginning on or after October 3, 2009.

The law applies to self insured and large employer group plans, but not to individual or small group plans.

The law does not mandate plans to provide mental health or addiction coverage, but when they are provided, they must be provided "on par" with medical benefits covered under the plan.

"Substantially all" Example:

If 70% of the inpatient, in-network medical/surgical benefits are subject to a 20% co-insurance requirement...

...then...

No inpatient, in-network mental health/addiction benefits could be subject to more than 20% co-insurance requirement

Here are ways the law requires addiction/mental health and medical benefits to be no more restrictive:

- Lifetime or annual dollar limits imposed on mental health/addiction 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 on par Out-of-Network coverage under the addiction/mental health benefit.
- Financial requirements (e.g., deductibles, co-payments, coinsurance, out-of-pocket expenses) imposed on mental health/addiction 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 addiction/mental health benefits may NOT be more restrictive than those imposed on medical/surgical benefits.
- There can be NO separate cost-sharing requirements or treatment limitations that are applicable only to mental health/addiction benefits.
- Plans are prohibited from using “separate but equal deductibles.” In other words, mental health/substance use disorder and medical/surgical benefits must add up together towards the same, combined deductible.
- Criteria for medical necessity determinations and the reason for any denial must be made available to contracted providers or the plan participant or beneficiary upon request.
- Where there is a state parity law or state mandate, the Federal Parity law serves as the floor and state laws must be enhanced to reach the federal floor.
- State laws that require more than the federal law are **NOT** preempted.

Deductible Example:

If your annual deductible is \$500, you can meet that deductible by paying \$250 for medical/surgical services and \$250 for mental health/substance use disorder services.

A plan CANNOT make you pay \$500 towards a medical/surgical deductible and \$500 for a mental health/substance use disorder deductible.

Brief Summary of the Regulatory Process

Regulations are the written rules by which agencies implement law.

Interim final regulations (IFR) implementing parity were issued February 2, 2010. The regulations give specific instructions for implementing the parity law.

“Interim final regulations” have the effect of binding law when they are issued. Parity regulators have said they will issue additional regulations, but we do not know when or if they will definitely come out. Until additional regulations are released, plans must comply with the existing regulations.

The regulations are effective for plan years beginning on or after July 1, 2010. Many plans start their plan year in January so the full effect of parity will not begin to be experienced in many markets until January 1, 2011.

6 classifications of benefits

The regulations define a 6 part classification scheme for benefits:

- Inpatient, in-network
 - Inpatient, out-of-network
 - Outpatient, in-network
 - Outpatient, out-of-network
 - Emergency care
 - Prescription drugs
- ▶ If a plan provides medical/surgical benefits in any or all of the above categories it must provide mental health/addiction benefits in the same categories.

Exemptions

- ▶ Small employers who employ 50 people or fewer are exempt from the law (the new health care reform law expands parity to new small and individual plans with fewer than 50 people).
- ▶ Local and state government plans may apply for an exemption from the Centers for Medicare and Medicaid Services. To see if your plan is exempt, go to: <http://www.cms.gov/selffundednonfedgovplans/>
- ▶ MHPAEA does not apply to Medicare plans.
- ▶ MHPAEA does not apply to Federal Employees Health Benefits Plans (FEHBP) and TriCare/DOD plans.

Cost exemption

- ▶ Plans whose costs increase more than 2% in the first year and 1% in the following year may file for an exemption.
- ▶ Plans that drop coverage because the plan meets cost exemption criteria must inform plan participants of a reduction in benefits.

HOW TO GET ANSWERS TO INSURANCE-RELATED QUESTIONS

Questions about insurance coverage often come up 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 and 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). See **Section 8** in this toolkit for helpful links.
- Learn about the laws regarding insurance that protect the public. See **Section 8** in this toolkit for helpful links.

4. THE APPEALS PROCESS

Overview

Challenging a coverage denial by a health plan is a legal right guaranteed to all insured people. All plans— including Medicaid managed care, private individual and group insurance policies, and employer sponsored health plans— must provide a process to reconsider or appeal denial of coverage by a health plan.

Individuals with addiction and mental illness who are insured also have these rights to appeal denials of claims. MHPAEA also guarantees new rights to individuals with mental health and substance use disorders and their providers that will make coverage rules more transparent and improve the appeals process. These new rights are:

1. Plans are required to provide the medical necessity criteria (see **"Terms to Know"**) upon request to plan participants and providers
2. Plans are required to provide a reason for the denial of any claim to the insured and providers

For people with addiction and mental illness, denials seem to be most common for:

- Residential care for adolescents and adults;
 - Partial hospitalization and intensive outpatient care for addiction;
 - Any care that exceeds the period necessary for, among other things, "short term; evaluation, diagnosis or crisis stabilization;"
- Care that exceeds 20 visits to an office based clinician;
 - Tests, services or drugs that are not deemed "medically necessary;" or
 - Failure to secure preauthorization as required for every visit by a patient's psychiatrist, psychologist or social worker.

HELPFUL TIP

More than 50% of appeals of denials of coverage or reimbursement by health insurers are successful in favor of the covered individual. Just because this process can be long and complicated does NOT mean it should not be done. **Individuals should keep all of the plan's coverage information and correspondence in a notebook 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 politely persistent appeals.

MANAGED CARE APPEALS CHECKLIST

- Identify the type of insurance policy (fully insured, self-insured)
- Understand the terms of the policy (and what it does and does not cover)
- Obtain the medical necessity criteria for both the mental health/addiction and medical benefit so you can compare how coverage decisions are made
- Obtain the reason for the denial of care
- Obtain documentation from the plan that the criteria was applied no more restrictively

CRITICAL INFORMATION FOR FILING AN APPEAL

As a patient, provider or advocate, there are certain steps you **MUST** take to ensure the greatest likelihood of successfully appealing a claim.

BEFORE DOING ANYTHING ELSE, MAKE SURE YOU:

Know what type of insurance plan you have

It is critical you know what *type* of insurance plan you have.

INDIVIDUAL COVERAGE

Individual plans are purchased by the individual themselves, rather than by an employer. Today, individual plans are **exempt** from the new parity law requirements. In 2014, under the new health care reform law, newly issued individual plans will have to comply with both parity and the health care reform law, which **MANDATES** that plans provide mental health/addiction coverage.

EMPLOYER SPONSORED COVERAGE

Most people have employer sponsored insurance. An employer sponsored plan is one that you and your family enroll in at work. Your employer generally contributes a portion of the cost of the coverage.

When it comes to how you appeal your plan's coverage reimbursement decisions, you must know whether your plan is "**insured**" or "**self-funded**" or "**self-insured**." These last two terms are interchangeable.

Insured plans:

What they are: An employer plan is **insured** if your employer purchases health coverage from any insuring organization such as a commercial insurer like Blue Cross Blue Shield or Kaiser Permanente.

Who regulates them: Insurers of such plans are regulated by state insurance commissioners. (See **Section 8** for links to each state's appeals process.)

Self-Insured Plans/Self-Funded Plans

What they are: An employer plan is "self-funded" if the employer pays for the health care costs of its employees directly rather than purchasing insurance from a commercial insurer. Often, large self-funded employers contract with insurance companies like Aetna or Cigna to simply process the claims or to serve as a "third party administrator" for your employer's health plan.

HELPFUL TIP

Self-funded group health plans provided by state and local governments, churches and some school districts are regulated by the U.S. Department of Health and Human Services and may be exempt from the parity law. [Click here for a list of exempt plans.](#)

To find out whether your plan is self-funded or insured, ask the person who handles the benefits where you work. You can also look in your Plan Summary Description that you received from your employer when you enrolled. However, since it can be confusing, it is best to ask.

Who regulates them: The federal [Department of Labor's Employee Benefits Security Administration](#) (EBSA) regulates these plans under the terms of the Employee Retirement Income Security Act (ERISA). There are special rules governing ERISA plans. For the purpose of this toolkit, the most important rule is that self-insured ERISA plans are NOT subject to state laws, but they are subject to the new parity law.

Managed behavioral health organizations (MBHO)

What they are: Often, your plan's mental health and addiction benefits are managed by a "managed behavioral health organization (MBHO). Approximately two-thirds of Americans with health insurance are enrolled in some type of MBHO.

Employers and state Medicaid plans can choose to "carve out" mental health and addiction services from the rest of the medical benefits and contract directly with the MBHO for behavioral healthcare services. On the other hand, plans can purchase addiction and mental health coverage along with the general medical benefits from the managed care organization such as United, Aetna, Cigna or Blue Cross Blue Shield.

MEDICAID MANAGED CARE PLANS

What they are: Medicaid managed care plans deliver Medicaid benefits through an agreement between a state Medicaid agency and a managed care organization. If covered under a Medicaid managed care organization, you are guaranteed certain grievance and fair hearing rights under federal law. See helpful links in **Section 8**.

HELPFUL TIP

Keep a log of every telephone call you make with the plan. Be sure to record the date and the name of the person you spoke to and take notes about the conversation.

Ask what will happen next and when it will happen. If the plan representative says they will have to find out the information and get back to you, ask when you can reasonably expect a reply and put a reminder on your calendar. Set a reminder on your computer if you use one.

If you don't hear from the plan, it's time for another call!

CHECKLIST FOR MY HEALTH PLAN COVERAGE

My health plan coverage is through:

- My employer – Check if:
 - my plan is an insured plan; any plan denials are eligible for state external review
 - my plan is a self-funded 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. MHBO) 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: _____

My primary care physician can refer me to specialists who:

- Are part of his or her group practice

- Are on the health plan network list

- Are outside of the health plan network *only if there are no similar specialists within the network*

- Are outside of the health plan network

I have reviewed the Exclusions and Limitations section in my Evidence of Coverage. My health plan will not pay for or limits the following mental health/addiction services:

- [] _____
- [] _____
- [] _____
- [] _____
- [] _____

Is my provider in my health plan network? _____

My plan will cover services at the following hospitals:

What should I do if I need care while I am outside of my plan's service area?

For non-urgent care: _____

Phone: _____

In an urgent situation: _____

Phone: _____

In an emergency: _____

Phone: _____

If you have a PPO or POS plan:

If I use in-network providers, I will pay:

[] \$_____ annual deductible

[] _____ % coinsurance for charges that exceed the deductible

If I use out-of-network providers, I will pay:

[] \$_____ annual deductible

[] _____ % coinsurance for charges that exceed the deductible

Understand the insurance policy and benefits

Knowing what your plan will and will not cover, prior to a procedure or doctors appointment, allows you to make more informed decisions about your healthcare. Depending on your plan and your benefit, this information will be outlined on the insurance company's website or is available from your HR department or in your summary plan description that is included with your health policy. Ask your agent or your human resources person where to find it if you cannot locate it.

Know when you need to obtain pre-authorization

It is your responsibility to know when you need to obtain pre-authorization for a procedure or treatment, or specialist, and to make sure you and/or your provider receives approval. You can also find this information in the benefit plan documentation or by calling your insurance company's customer service.

What to do if a claim is denied

It is not unusual for some claims to be denied or for insurers to say they will not cover a test, procedure or service that doctors order. If this happens, it is important to have a working relationship with a customer service representative or case manager with whom you can talk about the situation. A first step should be to re-submit the claim with a copy of the denial letter. You may need the doctor to explain or justify what has been done or is being requested. Sometimes the test or service will only need to be "coded" differently. If questioning or challenging the denial in these ways is not successful, then you may need to:

- Delay payment until the matter is resolved
- Re-submit the claim a third time and request a 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 & conversations you had about the denial
- Get help from a customer service from a state or federal agency (see **Section 8** for helpful links)
- Do not back down when trying to resolve the matter
- Formally appeal the denial in writing, explaining why you think the claim should be paid.

CRITICAL INFORMATION

You may have to file your appeal within a specified time period; it is vital that you do so.

For example, depending on the health plan, it may require that it receive your appeal within 1 year of the date of treatment, or within 60 days of the date the plans tell you it's not paying your claim, whichever comes first.

Federal ERISA regulations require that employer-sponsored health plans (both insured and self-funded) must give you at least 180 days to file an appeal.

Know your plan's timetable for all stages of an appeal.

If your dispute involves an urgent need for health care, make sure that you understand and follow any special procedures and timelines that apply in such cases.

You may be eligible for a response within 1 – 3 days if you have an urgent need. Know your rights!

HELPFUL TIP

Make sure you have these important items when speaking with an insurance representative:

- ✓ Original Bill
- ✓ Explanation of Benefits (EOB)
- ✓ Insurance Card (group number)
- ✓ Customer Service Phone Number
- ✓ Reason for Denial letter if available

How does the appeals process work?

In general, the appeals process is similar in all plans, except for Medicare prescription drug plans, which have their own rules.

There are usually two, but sometimes three, levels of appeals available to plan members depending on the type of plan. An appeal **MUST** be denied at the first level before a second level appeal can be sought.

The first and second levels are often called “internal appeals” because they are performed by the health plan. These internal appeals **MUST** be exhausted before an “external review” (see “**Terms to Know**”) may be requested.

If in the judgment of the clinician or provider a delay in treatment poses a threat to the patient’s life, an expedited review should be requested and should be provided in 2 – 3 days. Health plans may have expedited process to deal with requests for medical services that your doctor feels are urgent. If your appeal involves an urgent need for care, make that clear to the health plan so it can expedite your appeal. Federal ERISA regulations require employer-sponsored health plans to respond to an urgent care claim within 72 hours.

Response times vary from plan to plan depending on the type of dispute. The plan will usually act more quickly if the service has not been provided, or if the patient is already in the hospital. Some health plans say that they handle the first level of reviews within 1 business day for service not yet provided, but others may take longer. The federal ERISA regulations applicable to employer-sponsored health plans set maximum response times for different types of appeals: 30 days if the service is not yet been provided, or 60 days if it has been provided. State law may establish response times for appeals to individual purchased health plans.

If you do not agree with the result of the plan’s initial review, most plans allow you to appeal the decision to a panel of individuals who were not involved in the initial decision. In some cases, you will be asked to appear at a hearing to discuss your case; in others you will not. Each health plan has its own rules about who will be members of the review panel. It may include physicians, consumers or sometimes representatives of the health plan. Federal ERISA regulations applicable to employer-sponsored health plans require that if the appeal involves a medical judgment, the reviewers must consult with a qualified health care professional.

If your plan is subject to state external review requirements, the plan will usually notify you that it has denied your appeal and tell you how to file for an external appeal.

Arbitration

Your health plan may offer or, in some cases, require that you resolve your dispute through a process called arbitration. Arbitration is a process in which 2 parties present their views of a dispute to a neutral 3rd party – an arbitrator – who will then decide how to resolve the dispute. Arbitration may be binding, in which the parties agree ahead of time to abide by the arbitrator's decision. Or, it may be non-binding, in which case the arbitrator's decision is simply advisory.

Federal ERISA regulations provide that if an employer-sponsored health plan uses arbitration as part of its internal review, the arbitration must follow the same federal rules that apply to any internal appeal, including one that says you cannot be charged a fee for the arbitration.

If your employer-sponsored health plan requires that you enter into mandatory arbitration, it must be one of the 2 allowed levels of internal appeal, and you may challenge the arbitrator's decision in court (in other words, the arbitrator's decision cannot be binding).

Your employer-sponsored plan may offer you voluntary arbitration (including binding arbitration), but only if you have completed the plan's internal review and the plan has provided you with enough information to enable you to make an informed decisions about whether or not to use voluntary arbitration. If your health plan has voluntary arbitration, your decision to use this or not, does not affect your rights to any other plan benefits such as payment for other covered treatments. If you decide not to use voluntary arbitration, your health plan cannot use this against you in subsequent appeals.

Also, your state may have rules that regulate how your plan can use arbitration. If your plan requires that you agree to arbitration to settle disputes over claims for benefits, you may want to contact your state insurance commissioner to determine what your rights might be.

HELPFUL TIP

KEEPING GOOD RECORDS IS CRITICAL

Helpful suggestions for record-keeping:

- ✓ Decide who in the family will be the record-keeper or how the task will be shared
- ✓ Get help from a friend or relative if needed
- ✓ Set up a file system in a cabinet, drawer, box or loose-leaf notebooks
- ✓ Review bills soon after receiving them
- ✓ Check all bills and explanations of benefits to make sure they are correct
- ✓ Save and file all bills, payment receipts & canceled checks
- ✓ Keep a daily log of events & expenses
- ✓ Maintain a list of addiction/mental health care team members & all other contact persons with their phone & fax numbers. Keep filed in a notebook or file for easy access.

Keep records of the following:

- ✓ Medical bills from all healthcare providers
- ✓ Claims filed
- ✓ Reimbursements (payments from insurance companies) received and explanations of benefits
- ✓ Dates, names & outcomes of contacts with insurers and others
- ✓ Non-reimbursed or outstanding medical and related costs
- ✓ Long-distance telephone calls related to medical or other types of medical care
- ✓ Admissions, clinical visits, lab work, diagnostic tests, procedures & treatments
- ✓ Drugs given and prescriptions filled

Internal Review: New federal rules as a result of health care reform law

If your plan is “new” (came into existence after March 23, 2010 or has made significant changes to the plan’s costs or benefits) the below processes and procedures apply.

For new plan years beginning on or after September 23, 2010 (for the majority of plans, the new plan year starts January 1), new regulations become effective as a result of the new health care law (the Affordable Care Act) that standardize the internal appeals process used by new plans that patients can use to appeal coverage or reimbursement decisions made by their health plans.

*The new rules do **not** apply to “grandfathered” health plans (plans in existence prior to March 23, 2010). Additionally, plans can lose their grandfathered status if they make significant changes to plan’s costs or benefits.*

Under the new regulations, the internal appeals process for new plans must:

- Allow consumers to appeal when a health plan denies a claim for a covered service or rescinds coverage;
- Give consumers detailed information about the grounds for the denial of claims or coverage;
- Require plans to notify consumers about their right to appeal and instructs them on how to begin the appeals process;
- Ensure a full and fair review of the denial; and
- Provide consumers with an expedited appeals process in urgent cases.

External Review

If you are not satisfied with your health plan’s decision after completing the plan’s internal review process, you may be able to appeal the plan’s denial to your state’s external review program.

External Review: New federal rules as a result of health care reform law

If your plan is “new” (came into existence after March 23, 2010 or has made significant changes to the plan’s costs or benefits) the below processes and procedures apply.

By July 1, 2011, new federal regulations as part of the new health care reform law will create one standard for how external review of denied claims would be provided by all plans instead of the confusing patchwork of state procedures individuals face today. [Click here](#) to keep informed of the new external review rights and remedies.

States are encouraged to make changes in their external appeals laws to adopt standards established by the National Association of Insurance Commissioners (NAIC) before July 1, 2011. The NAIC standards call for:

- **External review of plan decisions** to deny coverage for care based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.
- **Clear information** for consumers about their right to both internal and external appeals — both in the standard plan materials, and at the time the company denies a claim.

- **Expedited access** to external review in some cases — including emergency situations, or cases where their health plan did not follow the rules in the internal appeal.
- **Health plans must pay the cost of the external appeal** under state law, and States may not require consumers to pay more than a nominal fee.
- **Review by an independent body** assigned by the state. The state must also ensure that the reviewers meet certain standards, keep written records, and are not affected by conflicts of interest.
- **Emergency processes for urgent claims**, and a process for experimental or investigational treatment.
- **Final decisions must be binding** so, if the consumer wins, the health plan is expected to pay for the benefit that was previously denied.

If state laws do not meet these new standards, consumers in those states will be protected by comparable Federal external appeals standards.

Additionally, individuals with non-grandfathered self-insured plans will be protected by new Federal standards.

Under the new Federal standards, plans will have to:

1. Allow plan participants (claimants) to file a request for external review within 4 months after the date of receiving a notice of an adverse benefit determination or final internal adverse benefit determination;
2. Complete, within 5 business days of receiving the request for external review, a preliminary review of the request, to determine if:
 - a. the claimant is or was covered under the plan;
 - b. the denial was based on the claimant's ineligibility under the terms of the plan, thus making the claim not eligible for federal external review;
 - c. claimant exhausted internal process, if required; and
 - d. claimant provided all necessary information to process the review.
3. Then, within 1 business day after completion of the above, the plan must notify the claimant in writing if the request is not eligible or if it is incomplete. If the claim is complete but not eligible for external review, the written notice must include reasons for its ineligibility and contact information for the Department of Labor's Employee Benefits Security Administration (including its toll-free number).

If the claim is incomplete, written notice must describe what information is needed to complete the request, and also give the claimant the remainder of the four-month filing period or the 48 hour period following the claimant's receipt of the notice, to correct the problem.

4. If the claim is eligible for external review, the plan must assign the request to an independent review organization (IRO).

The IRO must notify the claimant of the request's eligibility and acceptance for external review and that the claimant can submit in writing, within 10 business days, additional information which the IRO must consider during its review. The plan must provide to the IRO within 5 business days after the IRO's assignment the documents and information considered in the plan's denial of the claim.

If the plan does not provide documents and information, the IRO may terminate its review and reverse the claim denial. If this happens, the IRO needs to notify the claimant and the plan within 1 business day of its decision to reverse, then the plan has to carry out the IRO's decision.

The IRO reviews the claim de novo (brand new), and will not be bound by any decisions or conclusions reached during the plan's internal claims and appeals process. It can consider additional information and documents to the extent available and appropriate, beyond what was provided as part of any earlier review. This includes materials outside of the plan's claims file. The IRO must complete its review and provide notice of the decision to the plan and the claimant within 45 days of its receipt of the external review request.

New Expedited Federal External Review Process

Effective July of 2011, the regulations set out procedures for expedited review in the following situations:

1. Following an adverse benefit determination involving a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum.
2. An admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services but has not been discharged from a facility.

If the plan gets one of these appeals, it must "immediately" conduct the preliminary review previously described above, and then "immediately" provide a written notice to the claimant detailing whether the claim is eligible for external review and, if not eligible, why not and what materials are needed to complete the request. "Immediately" probably means within 24 hours, but the regulation does not specify.

If the appeal meets the criteria for an external review, the plan will assign it to an IRO which has to, in turn, decide the external review request as expeditiously as the claimant's medical condition requires but in no event more than 72 hours after the IRO receives the request for expedited review.

External Review: Grandfathered Plans Process and Procedures

*If your plan is "**grandfathered**" (was in existence before March 23, 2010 and has not made significant changes to the plan's costs or benefits) the below processes and procedures that are part of your state law today apply.*

External Review: Who can appeal?

Most states have external review programs, but the details of these programs vary considerably. External review programs differ from state-to-state in the types of disputes that are eligible for appeal, the process used to resolve the appeal, and the time limits imposed at each step of the process. This section describes the variations found in states' external review programs. [Click here for state by state processes](#)

In most states, state external review requirements apply to all types of health plans. In a few states, they apply only to managed care plans (such as HMOs, PPOs, or POS plans), or just to HMOs.

You can use your state's external review program if your health plan is an insured employer-sponsored plan or a private plan that you have purchased on your own. Remember, state external review laws do not apply to employer-sponsored health plans that are self-funded, so if you are in a self-funded plan, you cannot use your state's external review procedure. At this time, your only recourse is to sue in court if your plan is grandfathered. State external review programs also do not apply to Medicare and Medicaid beneficiaries. If you are a Medicare beneficiary, you must follow the Medicare review process described in your Medicare handbook. If you are a Medicaid beneficiary, you can ask your state or local Medicaid office about their appeals procedure.

In most states, you can give someone else written authorization to appeal for you. In many states, your provider may appeal on your behalf with your written authorization.

External Review: What types of problems can you appeal?

Most state insurance departments will review your request to be sure that it is eligible for external review before sending it on to an external reviewer. Most states require that the issue at stake involve "medical necessity." That means that you and your doctor must believe a particular procedure, treatment or prescription drug is essential for your health and recovery. Your health plan, for a variety of reasons, may disagree. For example, your plan may believe a particular treatment is ineffective for your condition, so it will not pay for it.

You and your doctor may want a medical treatment, but your health plan will not cover the cost because it considers the treatment experimental or investigational. Most states will allow you to submit this type of dispute to external review.

Many states explicitly exclude disputes over coverage issues, such as whether you can use a non-network provider because no qualified network provider is available or whether you were actually enrolled in the health plan, although some states have a separate process for reviewing these non-medical necessity denials.

Several states require that your dispute involve a minimum amount of money, usually from \$100 to \$500. In other states, your right to appeal a claim is limited by the amount of money involved.

External Review: When you can appeal

If you have a dispute over whether your health plan will pay for a particular treatment, you may have to proceed with treatment before knowing if the plan will pay for it. In many states, you will be able to submit your dispute for external review even if the services have been provided; in others you may submit your case only if services have not been provided.

Most states require you to complete all the steps in your plan's internal appeals procedure before requesting external review. Some states specify time limits for the internal review, and some allow you to file for external review if you have not received a response from your plan within the required time. At least one state, New Mexico, allows you to file for external review at the same time you appeal to the health plan if your case is an emergency.

If you have completed all the steps in the internal appeals process, and you have not won your case, you should receive a note of "adverse determination" or "adverse decision" from your health plan, along with instructions on how to file with the state for external review. Usually you must file within a specified period, say 30 to 90 days, after receiving the adverse determination in order to be eligible for external review.

If a delay in receiving services will cause you serious harm, most states have what is called an "expedited review" which will give you a decision in a much shorter period, usually 24 to 72 hours.

External Review: How to appeal

Every state has a different procedure for handling external reviews. You will usually receive instructions for filing an external appeal when your internal appeal is denied by your health plan. In some states, you begin the external appeal by contacting your health plan again. Others required that you contact your state's department of insurance or other state agency or initial your appeal.

The actual review may be performed by the state agency itself or through an independent review organization hired by the state or selected by the plan. Usually you do not have to pay for such reviews, though some states charge a nominal amount, usually \$25 to \$50. Several states have provisions to waive these charges if you demonstrate that they would cause financial hardship.

Although some states schedule a hearing and allow you to speak directly with the reviewer, most do not. In many states, it is not clear whether you and your health plan must accept the decision made by external review. In such cases, you may be able to appeal to the court system if you are not satisfied with the result of your external review. You will likely need to contact a lawyer to determine what, if any, rights you may have if you are not satisfied with the result of an external review.

CHECKLIST FOR KEEPING TRACK OF YOUR APPEAL

Who to contact regarding a health plan appeal

Who to call: _____

Where to write: _____

How soon must I appeal? _____

How many days will it take to receive a response? (List the response times for each level of review)

1st level _____

2nd level _____

Expedited review
(for medical emergencies) _____

Note: Federal ERISA regulations for employer-sponsored health plans provide that a health plan cannot require more than 2 levels of appeals, and that if 2 levels are used, both must be completed within the response time allowed by the regulations.

Tips for successful appeals

Appeals are only successful when they are:

- Presented according to the particular plan's appeals process and timeframe. It is important that you educate yourself about the particular plan's appeals processes
- Factual
- Provide a clear purpose of the appeal letter at the beginning
- Brief

The most important element of an appeals 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 your clinician to help get this information.

Because individuals and providers of services to those with addiction and mental illnesses are guaranteed new benefits under MHPAEA, we also recommend that you include the legal justification of why the service or treatment is permitted under the law. The sample letters and legal rationale in this toolkit provide that justification.

When should you file an appeal?

When a denial of coverage has been made, patients and providers should consider the following:

1. Is the patient's care equal to care provided by the plan for other medical conditions?
2. Is the treatment, service or medically necessary item indicated for this patient at this point in time?
3. Is a comparable treatment, service or medically necessary item provided by the plan to covered individuals with other medical conditions?
4. Are the patient's benefits subject to higher out-of-pocket spending than other comparable medical conditions?
5. Are the patient's co-insurance (see "**Terms to Know**") or copayment (see "**Terms to Know**") amounts higher than 2/3 of the co-pay or co-insurance amounts applied to other medical conditions?
6. Are day and visit limits applied more restrictively to treatment services than to 2/3 of other medical conditions?
7. Does the plan impose a higher annual or lifetime limit on mental health/addiction services than it does on other medical conditions?
8. Is the patient's care subject to stricter cost containment techniques?
9. Are essential treatments excluded or does the plan refuse to pay for entire levels of care?
10. Does the plan require prior authorization for every office based visit?
11. Does the plan offer out-of-network coverage that is different than out-of-network coverage availability for other medical conditions?

What do you need from the plan to file an appeal?

MHPAEA requires that plans use the same cost containment techniques or "non-quantitative treatment limitations" (see "**Terms to Know**") on behavioral health conditions as imposed on other medical conditions. As a result, to better inform your appeal, you should request from the plan the following:

1. A complete list of the medical/surgical conditions covered by the plan and the terms under which they are covered
2. A copy of the plan's medical necessity criteria for mental health/addiction services and other medical services
3. Any clinical guidelines used by the plan to make benefit determinations for medical and mental health/addiction conditions

Sample Facsimile Request for

Provider Request of Medical Necessity Determination Criteria

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

Please disclose and/or make available the medical and behavioral health criteria used for your medical necessity determination, (as required by the 2008 Mental Health Parity & Addiction Equity Act), regarding:

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

IF THERE HAS BEEN A DENIAL OF AUTHORIZATION FOR TREATMENT, PLEASE PROVIDE THE SPECIFIC REASONS FOR DENIAL.

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

Sample Facsimile Request for

Patient Request of Medical Necessity Determination Criteria

[Date]

Via Facsimile – [Fax No#]

[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 and Addiction Parity law.

I am currently a patient at [insert name of provider] and I hereby request a copy of the medical necessity criteria and specific reasons for denial that you are relying on in denying reimbursement for my treatment services at the following level(s) of care:

detoxification

inpatient rehab

residential

partial hospitalization

intensive outpatient

I have paid for this benefit and [insert name of provider] is licensed by the state of [insert state] [and 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 the medical necessity criteria and specific reasons for denial that you rely on in reaching a different medical decision than my treating physician and refusing to cover my treatment services. **Please fax the medical necessity criteria and specific reasons for denial to my attention at fax # [insert #].** If you would like to speak with me, please contact [insert name of applicable care provider contact].

Sincerely,

[Patient's name]

Sample Facsimile Request for

Patient Request of Documentation of the Specific Criteria Applied "No More Restrictively Than"

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

Please disclose specific criteria (processes, strategies, evidentiary standards or other factors) showing that [insert plan name] used to deny coverage. Please document how this criteria was applied in a no more restrictive manner to behavioral health benefits than to the medical 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.

Sample Facsimile Request for

Provider Request of Documentation of the Specific Criteria Applied “No More Restrictively Than”

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

Please disclose specific criteria (processes, strategies, evidentiary standards or other factors) showing that [insert plan name] used to deny coverage. Please document how this criteria was applied in a no more restrictive manner to behavioral health benefits than to the medical 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.

STEPS TO TAKE DURING AN APPEAL

STEP #1--Ask your provider to help you:

If your provider recommends a course of treatment, s/he is ethically bound to appeal on your behalf. Providers may be held legally liable for negligence if they do not appeal and you or someone else is hurt as a result.

STEP #2--Make sure your provider requests a special, expedited appeal for emergencies:

Emergency care cannot be put off because of standard paperwork or decision making processes. Most insurance companies provide this special appeals process, so use it when necessary.

STEP #3--Confirm with the insurance company that your services will be covered during the appeal:

If this is not possible, ask what your financial obligations would be for these services if the appeal is unsuccessful so that you may discuss other options with your provider(s), as necessary.

STEP #4--Request, or have your provider request, written notification of the reasons for denial:

Your insurance company should send both you and your provider a written explanation of the reasons care is being denied. This notice should include a description of the information required for your treatment to be approved. By providing this information in writing, it reduces the chances that there will be a miscommunication between the insurance company and you and your provider. This is a new right under the parity law. If you do not receive this within 30 days, complain to the entity regulating your health plan.

STEP #5—Utilize the templates in this toolkit:

Section 5 of this toolkit contains sample letters for appealing the most commonly denied mental health/substance use disorder claims and accompanying legal justifications.

Be sure to carbon copy your state insurance commissioner, Member of Congress and the Parity Implementation Coalition on the appeal letter.

STEP #6--Make sure that you and your provider(s) meet all deadlines:

If your treatment is denied because either you or your provider missed a utilization review or appeals deadline, that denial is rarely overturned, even if the company agrees that treatment is necessary.

STEP #7--If you are on Medicaid, you may request a "state fair hearing" at the same time you file your appeal:

These processes vary by state. Contact your Medicaid office for details. See **Section 8** for links to state offices.

How can the government or your state government help?

Insured Plans

If you have an insured plan and you have tried unsuccessfully to resolve a denied claim with your company or agent, contact your state insurance department. Very often, companies will resolve disputes after the agency intervenes on a consumer's behalf. If it becomes necessary to file a written complaint with the state insurance department, be sure to include the following information to speed processing of your inquiry:

- Include your name, address, and daytime phone number.
- State your case briefly, giving full explanation of the problem and what type of insurance is involved. Include the name of your insurance company, policy number, and the name of the insurer or adjuster involved.
- Supply any documentation you have to support your case including phone notes.
- State what has been done to resolve your problem including whom you have talked to and what you were told.
- For future reference, keep a copy of your letter to the state insurance commissioner.

See Section 8 for links to each state's insurance commissioner.

If a decision is made that you have a legitimate complaint, your state insurance department will investigate your complaint and keep you advised of what has happened. If a company insists your complaint or claim is not valid, the state insurance department cannot require the company to make payment unless a state insurance law has been violated. In some cases, legal action is the only way to resolve health insurance disputes. You may want to consult a lawyer if your complaint cannot be resolved and it involves a significant amount of money.

STEPS TO TAKE IF YOUR APPEAL FAILS

STEP #1--Appeal again -- and again!:

Most insurance companies offer three to four levels of appeal, 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 the ombudsman program or your employer's Human Resources Department, if applicable:

Your state may have established an ombudsman to assist you with Medicaid 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 ask them to intervene with your insurer

5. MODEL APPEALS LETTERS

This section includes a template or sample letter of appeals to health plans for submission by the patient or treating clinician. The 6 samples were selected based on input from the real claims submitted by Coalition members around the country. These templates represent the most commonly denied claims of addiction and mental health services as of July 2010.

The 6 types of appeals letters are for:

- Exclusion or refusal to cover addiction or mental health services or levels of care
- Prior authorization requirement for outpatient mental health/addiction services in order to initiate in or out-of-network care
- Denial of case management services such as phone-based care management or disease monitoring technology
- If a plan will only reimburse for injectable medications if a patient fails first at oral medications
- If a plan refuses to allow a psychiatrist or addiction medicine physician bill for evaluation and management (E&M) services for mental health/addiction under established E&M CPT codes while permitting other physicians to use these codes for medical/surgical disorders
- If a plan has concurrent review requirements

Using the templates

Parity requires plans to equalize medical and addiction/mental health benefits. As a result, when preparing to file an appeal, you will need to look at your health insurance's plans Summary Plan Description and compare the medical/mental health/addiction benefits to see if the financial and non-financial treatment limitations on the addiction and mental health benefits appear to be generally the same as the medical benefits.

These templates provide you with real examples of why plans have denied claims. We include effective legal rationales to help appeal these denials. In some of the examples, you may have to substitute one of the benefits listed in the sample appeal for a benefit that you have been denied. We could not include every addiction and mental health benefit in these sample appeals letters. Look for the sample letter that most closely resembles your specific

HELPFUL TIP

Expect to provide the following information in your written appeal:

- ✓ Your name, address & 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 want to have 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
- ✓ Additional research on your medical condition or treatment, such as treatment guidelines, information from medical journal articles, or research 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 justification

denied claim. Every place you see [] you must substitute your own text to personalize the templates.

Guidance for individuals/providers/advocates using these templates

1. Customize the wording of the letter to address the exact phrase in the coverage/claims process where you are seeking the service i.e. the pre-authorization request (see "**Terms to Know**"), claim, coverage denial or other point in the claims process
2. Include specific details on you or your patient's medical condition but keep it brief and try not to exceed 3 pages plus attachments
3. Make sure that you or your provider are not duplicating efforts. You usually have only two or three opportunities to appeal and do not want to waste one of these opportunities by not coordinating individual and provider appeals
4. You must customize the appeal letter. There are placeholders in the letters where information specific to the appeal should be inserted
5. If you see a "note" on the template, the note must be deleted before customizing and sending the appeal letter

Exclusion or Refusal to Cover Addiction or Mental Health Services or Levels of Care

Overview

There are generally two common reasons why a plan refuses to cover a specific addiction/mental health service or level of care and this template covers both of these reasons:

1. The plan excludes coverage for that treatment, service or level of care altogether, hence the word "exclusion;" or
2. The plan will refuse to pay for a specific mental health/addiction treatment, service or level of care because the plan will claim there is no similar treatment, service or level of care in their medical benefit.

HELPFUL TIP

When a plan excludes coverage of a treatment, service or level of care, it is very helpful if you can include guidelines or a research study showing why that particular treatment, service or level of care is recommended or effective in treating someone with your condition with your appeals letter.

Ask your provider or advocate to help you find guidelines or a study if you have difficulty or go to www.google.com and enter the treatment or service for which you seek coverage in the search bar. www.guideline.gov is another good resource.

Note: This sample letter could serve as a template appeals letter for any of the following denied claims:

1. Residential treatment for psychiatric or substance use disorders
2. Intermediate levels of care such as intensive outpatient treatment, psychological rehabilitation, partial hospitalization and assertive community treatment
3. Office based diagnostic and treatment interventions for mental health and substance use disorders such as psychological testing for diagnostics assessments, other standardized tests like the PHQ.9 or other treatment services like psychotherapy

Sample model appeal letter for exclusion or refusal to cover addiction or mental health services or level of care

[Insert Date]

[Insert Name]

[Insert Company Name/Plan]

[Insert Address]

Re: [Insert Patient's Name, Patient's Insurer, Patient's ID Number and Patient's Group Number]

Dear [Name of contact at health insurance plan]:

I am writing to appeal to [insurance plan name]'s decision to deny coverage for [state the name of the specific treatment service denied]. It is my understanding based on your letter of denial 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 been a member of your plan since [date]. My [insert name of clinician] believes that the best care for me at this time would be [state treatment or service here].

I have enclosed a letter from [name of clinician] explaining why [he/she] recommends [treatment or service], [his/her] qualifications and the legal justification for why I am entitled to this service under the *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity law* (P.L. 110-343).

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: Patton Boggs Legal Analysis
[Clinical guidelines where appropriate]

Legal Opinion from Patton Boggs on Denial of Services Based on No Legal Requirement Under Parity for Coverage For a Specific Service or Treatment

A plan refuses to reimburse for a type or level of care for a MH/SUD condition because they state that there is no parity legal requirement to cover any treatment service (i.e. no requirement for scope of service parity within a benefit classification or across benefit classifications). Examples include:

- 1. Residential treatment for psychiatric disorders or substance use disorders;***
- 2. Intermediate levels of care such as intensive outpatient treatment, psychosocial rehabilitation, and assertive community treatment; and***
- 3. Office-based diagnostic and treatment interventions for MH/SUD such as psychological testing for diagnostic assessments, standardized tests like the PHQ 9, or other treatment services like psychotherapy.***

“The regulations and underlying Act require parity across classifications of benefits and within classifications. This imposes a two-fold requirement on plans: MH/SUD benefits must be provided in all classifications in which medical/surgical benefits are provided, and plans must provide a similar range of benefits to those provided for medical/surgical benefits within each classification.

In regard to the issue of parity across classifications the Act is clear that limits on the scope and duration of treatment must be applied no more restrictively in the MH/SUD benefit than in the medical/surgical benefit. The statute defines treatment limitations as “limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the *scope or duration of treatment.*” [Emphasis added] The statute then prohibits limitations on the scope or duration of treatment under the MH/SUD benefit that are more restrictive than those imposed under the medical/surgical benefit. Thus, the plain language of the statute explicitly discusses scope of services and requires parity in scope.

The regulations create six classifications for purposes of applying the parity requirements: (1) inpatient, in-network; (2) inpatient, out-of-network; (3) outpatient, in-network; (4) outpatient, out-of-network; (5) emergency care; and (6) prescription drugs. The regulations require that when a plan “provides [MH/SUD] benefits in any classification of benefits” described in the rule, MH/SUD benefits “must be provided in every classification in which medical/surgical benefits are provided.” This language demonstrates that if a plan is going to offer one MH/SUD service in any classification, it must offer MH/SUD services for each of the relevant classifications.

Similarly, the preamble and the text of the regulations state that “if a plan provides benefits for a mental health condition or substance use disorder in one or more classifications but excludes benefits for that condition or disorder in a classification in which it provides medical/surgical benefits, the exclusion of benefits in that classification for a [MH/SUD] otherwise covered under the plan is a treatment limitation.” This statement requires parity across classifications in the scope of services that are offered for a particular condition. For example, a plan provides benefits for schizophrenia in the outpatient in-network classification but excludes benefits for schizophrenia for the inpatient in-network classification, even though it offers medical/surgical benefits in that classification. The regulations prohibit such a plan design. The language of the regulations is a scope of services parity requirement because it precludes

the ability of a plan to limit MH/SUD treatment services to less than all of the six classifications, provided medical/surgical benefits are offered for each classification.

The regulations' standard governing non-quantitative treatment limitations (NQTLs) also demonstrates that a range of services must be offered in the MH/SUD benefit if offered in the medical/surgical benefit both across and within the six classifications. The regulations clearly state that NQTLs cannot be applied more stringently or in a non-comparable manner to MH/SUD benefits than to medical/surgical benefits. This limitation implicitly confers a scope of services in the MH/SUD benefit that is at least similar to the scope of services offered in the medical/surgical benefit for each classification. If a treatment limitation cannot be applied more stringently or in a non-comparable manner in one benefit than in another, the scope of services offered in each benefit classification should be largely analogous. Additionally, to remain consistent with the clear language of the Act, the regulations should also be read to prohibit NQTLs that are more restrictive in MH/SUD than in medical/surgical. This requirement again requires a similar scope of services by prohibiting more restrictive limitations on MH/SUD benefits.¹

The regulations' requirements for scope of services parity within classifications is well demonstrated by an example. Imagine a plan that offers only one or two types of MH/SUD treatment services or levels of care in each of the six required classes, while at the same time offering many types of treatment services for medical/surgical within each classification. Although the regulations do not require a plan to cover identical MH/SUD and medical surgical services within a classification, they do require that the limitations in each MH/SUD classification be no more restrictive than the limits in the corresponding medical/surgical classification. If limitations were being applied in a no more restrictive manner in the situation above, it is unlikely that only one or two MH/SUD services would be covered while many medical/surgical services are covered. Presumably, the plan has developed some reasoning for excluding coverage of other MH/SUD services. If the reason the plan is offering such limited MH/SUD services in a classification is that the plan is applying a treatment (coverage) limitation to MH/SUD benefits that is more restrictive or not comparable than the treatment limitation applied in the medical/surgical benefit, the plan has violated the requirements of the parity regulations.

To allow otherwise would mean that a plan could, for example, offer visits to a primary care physician for a prescription of an anti-depressant medication as the only outpatient, in-network benefit for the treatment of depression. In this example, no psychotherapy treatments are covered by mental health specialists and no diagnostic tests like psychological testing are reimbursed, even though a full range of treatments and diagnostic tests are reimbursed for substantially all medical illnesses. The NQTL and other parity requirements would prohibit this benefit limitation.

Finally, the definitions of "mental health benefits" and "substance use disorder benefits" under the Act also demonstrate a scope of service parity requirement within and across classifications. The statute defines MH/SUD benefits as "benefits with respect to services for mental health conditions, as defined under the terms of the plan and in accordance with applicable Federal and State law."² Proponents of limiting services may point to the statutory definition of MH/SUD benefits to argue that there is no scope of service parity because a plan has the ability to define the services under the terms of the plan. The statute defines MH/SUD benefits as "benefits with respect to services for mental health conditions, as defined under the terms of the plan and in accordance with applicable Federal and State law." Proponents of limiting services might argue that plans maintain the flexibility to determine which services

¹ More information on this argument can be found in the memo from Patton Boggs to the Parity Implementation Coalition, dated March 26, 2010.

² § 1185a(c)(4), (5).

to provide because the Act specifically allows them to be “defined under the terms of the plan.” However, the statute is clear that this process of defining the terms of the plan must be “in accordance with Federal and State law.” This means that the terms of the plan must be in harmony with the Act. This gives rise to two implications for plans. First, a plan has the flexibility to offer or not offer a MH/SUD benefit. The Act clearly states that its parity requirements apply only to a plan “that provides *both* medical and surgical benefits and mental health or substance use disorder benefits.” [Emphasis added]. However, any plan that offers both medical/surgical and MH/SUD benefits, must offer them “in accordance with Federal and State law,” including the Act. Under this reading, a plan has flexibility as to what mental health conditions and substance use disorders it covers. However, once it decides to cover the condition or disorder, it is subject to the parity requirements governing services described in the statute and regulations (predominant and substantially all, comparable and no more stringently, etc).”

Prior Authorization Requirement for Outpatient Mental Health/Addiction Services in Order to Initiate In or Out-of-Network Care

Overview

Plans often use “prior authorization” or pre-approval techniques. Used improperly, prior authorization techniques simply delay or limit your access to care. When used properly, prior authorization techniques can be an effective quality control measure. Currently, most plans are imposing prior authorization requirements prior to approving coverage for an outpatient in or out-of-network mental health/addiction treatment or after a set number of addiction/mental health outpatient visits. While there may be certain medical benefits where prior authorization requirements are also imposed before or after a certain number of visits (i.e. physical therapy) the new parity law requires that cost containment techniques or “NQTLs” must be applied “no more stringently” on mental health and addiction benefits than they are applied to medical benefits. If prior authorization requirements are applied to only a few medical benefits and virtually all addiction/mental health benefits, then the plan has failed the “no more stringently” standard of the NQTL provision in the law and would be non-compliant.

Sample model letter for prior authorization requirement for outpatient mental health/addiction services in order to initiate in or out-of-network care

[Insert Date]

[Insert Name]

[Insert Company Name/Plan]

[Insert Address]

Re: [Insert Patient’s Name, Patient’s Insurer, Patient’s ID Number and Patient’s Group Number]

Dear [Name of contact at health insurance plan]:

I am writing to appeal to [insurance plan name]’s decision to deny coverage for [state the name of the specific treatment service denied]. It is my understanding based on your letter of denial 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 been a member of your plan since [date]. My [insert name of clinician] believes that the best care for me at this time would be [state treatment or service here].

I have enclosed a letter from [name of clinician] explaining why [he/she] recommends [treatment or service], [his/her] qualifications and the legal justification for why I am entitled to this service under the *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity law* (P.L. 110-343).

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: Patton Boggs Legal Analysis
[Clinical guidelines where appropriate]

Legal Opinion from Patton Boggs on Prior Authorization Requirement for Outpatient MH/SUD Services in Order to Initiate In or Out-of-Network Care

Plan has a prior authorization (PA) requirement for outpatient MH/SUD services provided by MH/SUD practitioners in order to initiate treatment for in or out-of-network care. This PA requirement may include a refusal to reimburse if the patient isn't "registered" with the plan or may also require the submission of a brief treatment plan (either telephonically, electronically or submitted by mail) at the beginning of treatment or after a defined number of visits. There is no similar PA requirement for primary care doctors or specialty physicians for any medical conditions. Would this be a MHPAEA violation?

"A plan that implements a prior authorization (PA) requirement for outpatient MH/SUD services provided by MH/SUD practitioners but does not implement a similar requirement for medical/surgical treatment by primary care or specialty practitioners is in violation of the regulations' comparable and no more stringently standards and the underlying statute.

The treatment limitations section of the Act prohibits treatment limitations that are "more restrictive" in the MH/SUD benefit than in the medical/surgical benefit. Additionally, the Act states that health plans must ensure that "there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits." Where a plan has a PA requirement for outpatient MH/SUD services provided by MH/SUD practitioners but does not have any such requirement for medical/surgical care, it has implemented a "more restrictive" treatment limitation and has created a "separate" treatment limitation that applies "only with respect" to MH/SUD. Accordingly, it has acted contrary to the treatment limitations requirements of the statute.

The regulations state clearly that any "processes, strategies, evidentiary standards, or other factors" used in applying a NQTL to MHSUD benefits in a classification must be "comparable to" and be applied "no more stringently" than the processes, evidentiary standards, or other factors used in applying the limitation to medical/surgical benefits in a classification. This standard prohibits plans from instituting a NQTL in MH/SUD while refusing to institute a "comparable" NQTL in the medical/surgical benefit.³ Here the plan has no similar PA requirement in the medical/surgical benefit as in the MH/SUD benefit. Thus, an NQTL is being applied in MH/SUD that does not exist in medical/surgical. This is inconsistent with the regulations' prohibition on NQTLs that are not "comparable."

The regulations give an example of a similar situation. In the regulations' example 1, a plan requires concurrent review for inpatient, in-network MH/SUD benefits but does not require it for any inpatient, in-network medical/surgical benefits. The plan conducts retrospective review for inpatient, in-

³ 75 Fed. Reg. 5416

network medical/surgical benefits. The plan violates the regulations because the concurrent review process is not comparable to the retrospective review process. In similar fashion, the plan in the scenario above applies a PA restriction to MH/SUD benefits that is not “comparable” to any restriction on medical/surgical benefits. Accordingly, the plan in such a situation violates the clear language of the regulations.”

Denial of a Claim for Management Interventions Such as Phone-Based Case Management and Disease Monitoring Technology

Overview

Under the Mental Health Parity and Addiction Equity Act (MHPAEA), plans may not deny claims for phone based case management, disease monitoring technology or other management interventions used in behavioral health if the plan reimburses for these services for medical conditions. It is important for you to familiarize yourself with what management interventions are covered under the plan's medical benefits and the guidelines or criteria used to justify their use.

Sample model letter for a denial of a claim for management interventions such as phone-based case management and disease monitoring technology

[Insert Date]

[Insert Name]

[Insert Company Name/Plan]

[Insert Address]

Re: [Insert Patient's Name, Patient's Insurer, Patient's ID Number and Patient's Group Number]

Dear [Name of contact at health insurance plan]:

I am writing to appeal to [insurance plan name]'s decision to deny coverage for [state the name of the specific management intervention denied]. It is my understanding based on your letter of denial dated [insert date of denial] that this [management intervention] has been denied because:

[Quote the specific reason given in the denial letter].

I have been a member of your plan since [date]. My [insert name of clinician] believes that the best care for me at this time would be [state treatment or service here].

I have enclosed a letter from [name of clinician] explaining why [he/she] recommends [treatment or service], [his/her] qualifications and the legal justification for why I am entitled to this service under the *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity law* (P.L. 110-343).

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: Patton Boggs Legal Analysis
[Clinical guidelines where appropriate]

If a plan offers to reimburse a range of disease management interventions such as phone-based case management, disease monitoring technology and tests for medical conditions but refuses to reimburse for these same services for any or most chronic MH/SUD would this be a violation of MHPAEA?

A plan that provides coverage for a range of medical/surgical disease management interventions, while refusing to reimburse for such interventions for MH/SUD violates the statute and regulations if the reason for the differing coverage is a MH/SUD treatment limitation that is more restrictive, not comparable, or more stringent than that applied to medical/surgical benefits.

The parity statute prohibits a plan from applying treatment limitations to MH/SUD benefits that are more restrictive than those applied to medical/surgical benefits. Treatment limitations are defined as various items that limit the scope and duration of treatment under a plan. In the scenario above, the plan has presumably developed some reasoning or policy for excluding coverage of MH/SUD disease management interventions. If the reason the plan is offering such limited MH/SUD services is that the plan is applying a treatment limitation to MH/SUD benefits that is more restrictive than the treatment limitation applied in the medical/surgical benefit, the plan has violated the requirements of the parity statute.

Such an exclusion may also violate the parity standards in the regulations. The regulations define NQTLs as limitations that are not numeric but that “otherwise limit the scope or duration of benefits for treatment under a plan.” Here, it appears that there is some non-numeric policy or standard that is prohibiting coverage of MH/SUD disease management interventions. As such, these policies would fall into the category of NQTLs and be governed by the NQTL parity standard.

The regulations subject all NQTLs to the comparable and no more stringently standard. The comparable and no more stringently standard states that a plan may not impose a NQTL for MH/SUD benefits unless the processes, strategies, evidentiary standards, or other factors used in applying the NQTL are “comparable to, and are applied no more stringently than” those used in applying the NQTL to medical/surgical benefits.⁴ Here, the plan may be in violation of both standards.

The regulations prohibit plans from instituting a NQTL in MH/SUD while refusing to institute a “comparable” NQTL in the medical/surgical benefit. Here, if medical/surgical and MH/SUD NQTLs were comparable, it seems unlikely that a wide range of medical/surgical disease management interventions would be covered while no or very few MH/SUD are covered. If the NQTLs are not comparable in MH/SUD and medical surgical, the plan has violated the regulations’ comparable standard.

The “no more stringently” standard focuses on the manner in which NQTLs are *applied*. The regulations state that a plan may not impose a NQTL unless the processes, strategies, evidentiary standards, or other factors are “applied” no more stringently in medical/surgical than in MH/SUD.⁵ Under this rule, plans can have the same NQTL in both MH/SUD and medical/surgical and still violate the parity

⁴ 75 Fed. Reg. 5436.

⁵ 75 Fed. Reg. 5412.

requirements by applying these NQTLs differently.⁶ Here, for example, the plan may have the same medical necessity standards but could be applying them more stringently to MH/SUD benefits to exclude MH/SUD disease management interventions. If so, the plan has violated the no more stringently standard.

⁶ The regulation states explicitly that the no more stringently standard was “included to ensure that any processes, strategies, evidentiary standards, or other factors that are comparable on their face are applied in the same manner to medical/surgical and to MH/SUD benefits.” *Id.*

If a Plan Will Only Reimburse for Injectable Medications if a Patient Fails First at Oral Medications

Overview

Plans frequently deny claims for injectable medications until a patient “fails first” at oral medications, even if the injectable is the only one in its class, if the patient has failed at an oral medication or if the injectable medication provides a substantial improvement in a patient’s ability to adhere to a medication regimen. “Fail first” requirements were specifically named in the Mental Health Parity and Addiction Equity Act’s (MHPAEA) regulations as a “non-quantitative treatment limitation” that would have to be applied equally to medical and behavioral health benefits in order to be legal.

Carefully review your health plan to see if fail first requirements are imposed on behavioral health pharmacotherapies in a heavy handed manner as compared with drugs used to treat other medical conditions. If so, an appeal of a denied claim may be in order.

Sample model letter if a plan will only reimburse for injectable medications if a patient fails first at oral medications

[Insert Date]

[Insert Name]

[Insert Company Name/Plan]

[Insert Address]

Re: [Insert Patient’s Name, Patient’s Insurer, Patient’s ID Number and Patient’s Group Number]

Dear [Name of contact at health insurance plan]:

I am writing to appeal to [insurance plan name]’s decision to deny coverage for [state the name of the specific pharmacotherapy denied]. It is my understanding based on your letter of denial dated [insert date of denial] that this [pharmacotherapy] has been denied because:

[Quote the specific reason given in the denial letter].

I have been a member of your plan since [date]. My [insert name of prescribing clinician] believes that the best care for me at this time would be [state pharmacotherapy here].

I have enclosed a letter from [name of clinician] explaining why [he/she] recommends [treatment or service], [his/her] qualifications and the legal justification for why I am entitled to this service under the *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity law* (P.L. 110-343).

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: Patton Boggs Legal Analysis
[Clinical guidelines where appropriate]

Legal Opinion from Patton Boggs on Denials of Claims Because the Patient Did not “Fail First” At an Oral Medication

Plans develop medical necessity criteria that require a patient to fail first on oral medications for MH/SUD before reimbursing for MH/SUD injectables. However the plan frequently pays for injectables on the medical side without requiring a failed trial of oral medications first. Would this be a MHPAEA violation?

“A plan that requires fail first on oral medications prior to covering injectables for MH/SUD, but does not require fail first on oral medications prior to covering injectables for medical/surgical conditions has violated both the regulations and the statute.

MHPAEA is clear that MH/SUD treatment limitations must be “no more restrictive than the predominant treatment limitations applied to substantially all” medical/surgical benefits covered by the plan.⁷ This phrase contains three discrete tests: (1) is the limitation applied to substantially all medical/surgical benefits; (2) is it the predominant treatment limitation; and (3) is it more restrictive in the MH/SUD benefit than in the medical/surgical benefit? Importantly, the statute applies this standard to *all* treatment limitations.⁸ Accordingly, the standard can be used here to judge the appropriateness of the plan’s action. Here, the treatment limitation does not apply at all in the medical/surgical benefit and therefore clearly fails to meet the “substantially all” and “predominant” tests above.

The regulations define two types of treatment limitations: QTLs and NQTLs. NQTLs are limitations that are not numeric but that “otherwise limit the scope or duration of benefits for treatment under a plan.” Because NQTLs are not expressed numerically, it is often challenging to identify when an NQTL is “more restrictive.” Accordingly, the regulations create the comparable and no more stringently standard to put the no more restrictive standard into practice.

The comparable and no more stringently standard states that a plan may not impose a NQTL for MH/SUD benefits unless the processes, strategies, evidentiary standards, or other factors used in applying the NQTL are “comparable to, and are applied no more stringently than” those used in applying the NQTL to medical/surgical benefits.⁹ The regulations explicitly state that fail-first policies are a form of NQTL. As such, these standards are subject to the regulations’ comparable and no more stringently standards. The “comparable to” requirement is the decisive factor in determining plan compliance under the scenario above.

⁷ *Id.*

⁸ 29 U.S.C. 1185a(a)(3)(A)(ii).

⁹ 75 Fed. Reg. 5436.

The regulations prohibit plans from instituting a NQTL in MH/SUD while refusing to institute a “comparable” NQTL in the medical/surgical benefit. Here the plan has a specific coverage limitation in the MH/SUD benefit, but no such limitation in the medical/surgical benefit. Thus, an NQTL is being applied in MH/SUD that does not exist in medical/surgical. This is inconsistent with the regulations’ prohibition on NQTLs that are not “comparable.”

The regulations give an example of a situation similar to the scenario above. In the regulations’ example 5, plan participants are able to access MH/SUD benefits only after exhausting counseling sessions offered under an employee assistance program (EAP). The plan violates the regulations because no similar exhaustion requirement applies with respect to medical/surgical benefits. In similar fashion, the plan in the scenario above applies a restriction to MH/SUD benefits that does not apply to any restriction on medical/surgical benefits. Accordingly, the plan in such a situation violates the clear language of the regulations.

Applying a NQTL in MH/SUD while not applying a comparable NQTL in medical/surgical is likewise consistent with the other parts of the underlying Act. The treatment limitations section of the Act states that health plans must ensure that “there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.” Where a plan imposes fail first policies to MH/SUD injectables but does not apply similar criteria to medical/surgical injectables, it has created a “separate” treatment limitation that applies “only with respect” to MH/SUD. Accordingly, it has acted contrary to the treatment limitations requirements of the statute.

In addition, allowing a NQTL in MH/SUD while not imposing any similar limitation in medical/surgical would be inconsistent with the purpose of the Act. The purpose of the Act, as stated by each of the five Committees that considered the bill, was to ensure “parity” between MH/SUD benefits and medical/surgical benefits. Parity is “the quality or state of being equal or equivalent.” It seems clear that a plan with a NQTL for MH/SUD but not for medical/surgical is not “equal or equivalent.” In addition, the legislation was enacted to remedy a specific problem, namely, “the discrimination that exists under many group health plans with respect to mental health and substance-related disorder benefits.” Interpreting the Act to allow the application of a NQTL in MH/SUD while not applying a more restrictive NQTL in medical/surgical perpetuates the discrimination that Congress intended to eliminate.”

If a Plan Refuses to Allow A Psychiatrist or Addiction Medicine Physician Bill for Evaluation and Management (E&M) Services for Mental Health/Substance Use Disorders Under Established E&M CPT codes while Permitting Other Physicians to Use these Codes for Medical/Surgical Disorders

Overview

Currently, plans often refuse to allow psychiatrists or addiction physicians to bill for evaluation and management (E&M) codes for mental health and substance use disorders under established CPT codes while permitting other physicians to use these codes for medical/surgical disorders. This is a non-quantitative treatment limitation under the parity law in the form of a discriminatory provider reimbursement practice.

Sample model letter if a plan refuses to allow a psychiatrist or addiction medicine physician to bill for evaluation and management services for mental health/substance use disorders under established E&M CPT codes

[Insert Date]

[Insert Name]

[Insert Company Name/Plan]

[Insert Address]

Re: [Insert Patient's Name, Patient's Insurer, Patient's ID Number and Patient's Group Number]

Dear [Name of contact at health insurance plan]:

I am writing to appeal to [insurance plan name]'s decision to deny coverage for [state the name of the specific treatment service denied]. It is my understanding based on your letter of denial 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 been a member of your plan since [date]. My [insert name of clinician] believes that the best care for me at this time would be [state treatment or service here].

I have enclosed a letter from [name of clinician] explaining why [he/she] recommends [treatment or service], [his/her] qualifications and the legal justification for why I am entitled to this service under the *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity law* (P.L. 110-343).

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: Patton Boggs Legal Analysis
[Clinical guidelines where appropriate]

Legal Opinion from Patton Boggs on If a Plan Refuses to Allow A Psychiatrist or Addiction Medicine Physician Bill for Evaluation and Management (E&M) Services for MH/SUD Conditions Under Established E&M CPT codes while Permitting Other Physicians to Use these Codes for Medical/Surgical Disorders

A plan refuses to allow a psychiatrist or addiction specialist physician to bill for evaluation and management services for MH/SUD conditions under established E&M CPT physician codes while permitting all other non psychiatric physicians to use these codes for medical/surgical disorders.

“A plan that prohibits the use of E&M codes for MH/SUD practitioners, while allowing the use of these codes for medical/surgical professionals has implemented a non-comparable treatment limitation that violates the regulations.

Under the parity regulations, the processes, strategies, evidentiary standards, or other factors used in applying a NQTL to a MH/SUD benefit must be comparable and no more stringent than those applied to a medical/surgical benefit. NQTLs are non-numeric plan policies that “limit the scope or duration of benefits for treatment under a plan.”¹⁰ While the illustrative list of NQTL examples does not specifically list coding limitations as an NQTL, it does list several other payment-related policies that qualify as NQTLs. For example, one of these NQTLs is “standards for provider admission to participate in a network, including reimbursement rates.”¹¹ Another listed NQTL is “plan methods for determining usual, customary, and reasonable charges.” Like these examples, coding is closely related to reimbursement. As with these other payment-related examples, coding restrictions can be considered a NQTL.

E&M codes generally pay more than psychiatry CPT codes and many plans preclude psychiatrists from using these codes to bill for services. Both of these factors may ultimately affect a psychiatrist's willingness or ability to participate in a provider network, which will, in turn, affect the scope of services available to a beneficiary. Additionally, a plan's decision to prohibit a psychiatrist or addiction specialist physician from using E&M codes will restrict who can provide basic medical management services to persons with MH/SUD. As discussed above, because of the potential effect on the “scope” of services caused by limitations on the use of E&M codes by psychiatrists and addiction specialist physicians, such restrictions likely qualify as an NQTL.

As an NQTL, coding policies are subject to the regulations' “comparable” standard. The comparable standard clearly prohibits plans from instituting a NQTL in MH/SUD while refusing to institute a “comparable” NQTL in the medical/surgical benefit.¹² Here, the plan prohibits the use of E&M codes for MH/SUD practitioners, while allowing the use of these codes for medical/surgical professionals. On its

¹⁰ 75 Fed. Reg. 5445.

¹¹ 75 Fed. Reg. 5443.

¹² 75 Fed. Reg. 5416

face, such a policy is not comparable. An NQTL is being applied in MH/SUD that does not exist in medical/surgical. This is inconsistent with the regulations' prohibition on NQTLs that are not comparable.”

Concurrent Review Requirements

Overview

Plans often impose concurrent review requirements, especially when a patient seeks residential or inpatient addiction/mental health care. When implemented properly, concurrent review can be an important quality control tool; improperly implemented it can harm quality patient care, drain clinical resources and bring facility budgeting planning to a standstill. If and how concurrent review programs are imposed on both medical and mental health/addiction benefits are important in establishing whether or not an appeal should be filed.

Sample model letter for concurrent review requirements

[Insert Date]

[Insert Name]

[Insert Company Name/Plan]

[Insert Address]

Re: [Insert Patient's Name, Patient's Insurer, Patient's ID Number and Patient's Group Number]

Dear [Name of contact at health insurance plan]:

I am writing to appeal to [insurance plan name]'s decision to deny coverage for [state the name of the specific treatment service denied]. It is my understanding based on your letter of denial 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 been a member of your plan since [date]. My [insert name of clinician] believes that the best care for me at this time would be [state treatment or service here].

I have enclosed a letter from [name of clinician] explaining why [he/she] recommends [treatment or service], [his/her] qualifications and the legal justification for why I am entitled to this service under the *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity law* (P.L. 110-343).

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: Patton Boggs Legal Analysis
[Clinical guidelines where appropriate]

Legal Opinion from Patton Boggs Concurrent Review Requirements

A plan has concurrent review requirements for MH/SUD inpatient (in or out-of-network) care but no such review is required for any medical/surgical inpatient. Is this a MHPAEA violation?

“A plan that has concurrent review requirements for MH/SUD care but no similar requirement for medical/surgical care violates both the statute and the regulations.

MHPAEA is clear that MH/SUD treatment limitations must be “no more restrictive than the predominant treatment limitations applied to substantially all” medical/surgical benefits covered by the plan.¹³ This phrase contains three discrete tests: (1) is the limitation applied to substantially all medical/surgical benefits; (2) is it the predominant treatment limitation; and (3) is it more restrictive in the MH/SUD benefit than in the medical/surgical benefit?¹⁴ Importantly, the statute applies this standard to all treatment limitations.¹⁵ Accordingly, the standard can be used here to judge the appropriateness of the plan’s action. Here, the treatment limitation does not apply at all in the medical/surgical benefit and therefore clearly fails to meet the “substantially all” and “predominant” tests above. Even if the predominant and substantially all standards were met, the treatment limitation here is “more restrictive” because it applies to MH/SUD benefits but not to medical surgical benefits.

The regulations define two types of treatment limitations: QTLs and NQTLs. NQTLs are limitations that are not numeric but that “otherwise limit the scope or duration of benefits for treatment under a plan.” Because NQTLs are not expressed numerically, it is often challenging to identify when an NQTL is “more restrictive.” Accordingly, the regulations create the comparable and no more stringently standard to put the no more restrictive standard into practice.

The comparable and no more stringently standard states that a plan may not impose a NQTL for MH/SUD benefits unless the processes, strategies, evidentiary standards, or other factors used in applying the NQTL are “comparable to, and are applied no more stringently than” those used in applying the NQTL to medical/surgical benefits.¹⁶ The “comparable to” requirement is the decisive factor in determining plan compliance under the scenario above.

The regulations prohibit plans from instituting a NQTL in MH/SUD while refusing to institute a “comparable” NQTL in the medical/surgical benefit. Here, the plan implements a concurrent review process in the MH/SUD benefit, but does not utilize this process in the medical/surgical benefit. Thus, an NQTL is being applied in MH/SUD that does not exist in medical/surgical. This is inconsistent with the regulations’ prohibition on NQTLs that are not “comparable.”

The regulations give an example of a similar situation. In the regulations’ example 1, a plan requires concurrent review for inpatient, in-network MH/SUD benefits but does not require it for any inpatient, in-network medical/surgical benefits. The plan conducts retrospective review for inpatient, in-network medical/surgical benefits. The plan violates the regulations because the concurrent review process is not comparable to the retrospective review process. In similar fashion, the plan in the scenario

¹³ *Id.*

¹⁴ More information on this argument can be found in the memo from Patton Boggs to the Parity Implementation Coalition, dated March 26, 2010.

¹⁵ 29 U.S.C. 1185a(a)(3)(A)(ii).

¹⁶ 75 Fed. Reg. 5436.

above applies a concurrent review process to MH/SUD benefits that is not “comparable” to any review process on medical/surgical benefits. Accordingly, the plan in such a situation violates the clear language of the regulations.

Applying a NQTL in MH/SUD while not applying a comparable NQTL in medical/surgical is likewise consistent with the other parts of the underlying Act. The treatment limitations section of the Act states that health plans must ensure that “there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.” Here, the limitation is clearly only applicable to the MH/SUD benefit and, accordingly, is inconsistent with the statute.”

6. CONCLUSION

It is our hope that these tips and checklists are helpful. The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act is a new law and it may take some time before its full impact is realized in the marketplace. Be patient. Filing appeals is complicated. It requires you to make contacts with plans, document these contacts, gather information and write letters. Get a notebook, gather your documentation, remain courteous and polite, write everything down and take it one step at a time; one day at a time.

We want to hear from you and help you if we can. Copy us at info@mentalhealthparitywatch.org on your appeals.

7. TERMS TO KNOW

Appealing a Claim: The process to fight a denied medical claim. Most insurance carriers have their own process and timeline.

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 and the fee for a particular service exceeds the allowable charge for that service.

Carrier: The insurance company that issues your insurance policy.

Carve-Out: - An independent managed behavioral health organization who manages mental health and addiction benefits separately from the plan's medical benefits.

Claim: An overview of care provided and a request for payment, typically submitted by the provider to the patient's insurance company. Claims are reviewed by the insurance company. This review process determines coverage of services and ultimate payment to the provider.

Classification: One of the 6 categories of benefits required under MHPAEA (i.e in-network inpatient or out-of-network outpatient)

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

Co-payment: The 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 make any benefit payments.

Denied Medical Claim: Reject of a request for reimbursement of healthcare services delivered to the insured patient. The insurance company often informs the patient of the rejected claim and explains why the services are believed to be outside of the scope of those covered in the insurance policy.

Effective Date: The date your insurance is to actually begin. You are not covered until the policies' effective date.

Employee Assistance Programs (EAPs): Mental health counseling services that are sometimes offered by insurance companies or employers. Typically, individuals or employers do not have to directly pay for services provided through an employee assistance program.

Employee Retirement Income Security Act (ERISA): A broad-reaching 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 or treatments 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 healthcare provider, how those charges were processed, and the total amount of patient responsibility for the claim

External Review: External review is part of the health insurance claims denial process. It typically occurs when an independent third party reviews your claim to determine whether the insurer is obligated to pay. External review is one of several steps that comprise the appeal and review process. It is performed *after* the appellant has exhausted the insurance company's internal review process without success.

Financial Requirements: e.g., deductibles, copayments, coinsurance, out-of-pocket maximums

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

Fully Insured plan: Employer-sponsored insurance purchased through an insurance company. These plans are regulated by state insurance commissions.

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 healthcare markets.

Independent External Review: An appeals review that is conducted by a third party that is not affiliated with the health plan or a providers' association and has no conflict of interest or stake in the outcome of the review. This is usually the third level of review. This is often defined by state law. Also note, the new federal health care reform regulations address external review:

<http://www.healthcare.gov/law/provisions/appealing/appealinghealthplandecisions.html>

Inpatient: A term used to describe a person admitted to a hospital for at least 24 hours. It may also be used to describe the care rendered in a hospital when the duration of the stay is at least 24 hours.

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 expense and medical expense coverage to the low-income population and certain aged and disabled individuals.

Medically Necessary: Medical services that are essential or required for the diagnosis and/or treatment of a medical condition.

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.

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

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

Out-of-Plan/Out-of-Network: Physicians, hospitals, 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 who is able to return home after care without an overnight stay in a hospital or other inpatient facility.

Partial Hospitalization Services: Also referred to as "partial hospital days," this is a healthcare term used to refer to outpatient services performed in a hospital setting as an alternative or follow-up to inpatient mental health or addiction 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. (Also known as prior authorization)

Provider Payment: Amount of money paid to the healthcare provider by the insurance company.

Quantitative Treatment Limitation: Financial requirements such as co-payments, co-insurance, deductibles that must be paid by plan participants.

Reasonable and Customary Fees/Usual and Customary Fees: The average fee charged by a particular type of health care practitioner within a geographic area. These fees are often used by insurers to determine the amount of coverage for health care provided by out-of-network providers. The individual 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 Reasonable and Customary 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. These codes are very important in understanding 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.

Summary plan description or document: A description of the benefits included in your health plan.

Treatment Limitations: Limits based on frequency of treatment, number of visits, days of coverage, days in a waiting period.

Note: This list of terms is not intended to be exhaustive. These terms are useful in understanding the parity law and navigating the appeals process.

8. HELPFUL LINKS

STATE RESOURCES

External Review Process by State from the Kaiser Family Foundation:

<http://statehealthfacts.org/comparetable.jsp?ind=361&cat=7>

State Laws Mandating or Regulating Mental Health/Addiction Benefits:

<http://www.ncsl.org/IssuesResearch/Health/StateLawsMandatingorRegulatingMentalHealthB/tabid/14352/Default.aspx>

State insurance commissioners oversee insured plans. For assistance or to file a complaint, please click on the link for your state's office. (See federal resources below for assistance for self-funded (ERISA) plans)

Alabama: <http://www.aldoi.gov/Consumers/default.aspx>

Alaska: <http://www.commerce.state.ak.us/insurance/consumerinfo.htm>

Arizona: <http://www.id.state.az.us/>

Arkansas: <http://www.insurance.arkansas.gov/Consumers/divpage.htm>

California: <http://www.insurance.ca.gov/0100-consumers/0020-health-related/>

Colorado: <http://www.dora.state.co.us/insurance/consumer/HealthMainPage.htm>

Connecticut: <http://www.ct.gov/cid/cwp/view.asp?Q=390126&cidNav=|>

Delaware: <http://delawareinsurance.gov/departments/consumer/consumerhp.shtml>

District of Columbia:

<http://disr.dc.gov/disr/cwp/view,a,1299,Q,634581,disrNav,|32810|.asp>

Georgia: <http://www.gainsurance.org/ConsumerService/HealthInsurance.aspx>

Florida: <http://www.floir.com/>

Hawaii: http://hawaii.gov/dcca/ins/consumer/consumer_information/health

Idaho: <http://www.doi.idaho.gov/>

Illinois: <http://insurance.illinois.gov/>

Indiana: <http://www.in.gov/idoi/>

Iowa: <http://www.iid.state.ia.us/>

Kansas: <http://www.ksinsurance.org/>

Kentucky: http://insurance.ky.gov/Home.aspx?Div_ID=4

Louisiana: <http://www.lidi.la.gov/>

Maine: <http://www.maine.gov/pfr/insurance/consumer/index.htm>

Massachusetts:

http://www.mass.gov/?pageID=ocaterminal&L=4&L0=Home&L1=Government&L2=Our+Agencies+and+Divisions&L3=Division+of+Insurance&sid=Eoca&b=terminalcontent&f=doi_DivisionOfInsurance&csid=Eoca

Maryland:

<http://www.mdinsurance.state.md.us/sa/jsp/consumer/Consumer.jsp?divisionName=Consumer+Information&pageName=/sa/jsp/consumer/Consumer.jsp>

Michigan: http://www.michigan.gov/dleg/0,1607,7-154-10555_12902_35510---,00.html

Minnesota: <http://www.state.mn.us/portal/mn/jsp/content.do?id=-536893703&agency=Insurance>

Missouri: <http://insurance.mo.gov/>

Mississippi: <http://www.mid.state.ms.us/>

Montana: <http://www.sao.state.mt.us/>

Nebraska: <http://www.doi.ne.gov/index.htm>

Nevada: <http://www.doi.nv.gov/consumer.aspx>

New Hampshire: <http://www.nh.gov/insurance/>

New Jersey: http://www.state.nj.us/dobi/division_consumers/insurance/health.htm

New Mexico: <http://www.nmprc.state.nm.us/consumer.htm>

New York: <http://www.ins.state.ny.us/consindx.htm>

North Carolina: <http://www.ncdoi.com/>

North Dakota: <http://www.nd.gov/ndins/consumer/health-insurance/>

Ohio: <http://www.insurance.ohio.gov/Pages/default.aspx>

Oklahoma: <http://www.ok.gov/oid/>

Oregon: <http://www.cbs.state.or.us/external/ins/index.html>

Pennsylvania:

http://www.insurance.pa.gov/portal/server.pt/community/services_for_consumers/5232

Puerto Rico: <http://www.ocs.gobierno.pr/ocspr/>

Rhode Island: <http://www.ohic.ri.gov/>

South Carolina: <http://www.doi.sc.gov/consumer/health.htm>

South Dakota: <http://www.state.sd.us/drr2/reg/insurance/index.html>

Tennessee: <http://www.state.tn.us/commerce/insurance/index.shtml>

Texas: <http://www.tdi.state.tx.us/health/index.html>

Utah: <http://www.insurance.utah.gov/health/index.html>

Vermont: <http://www.bishca.state.vt.us/health-care/health-care-administration>

Virginia: <http://www.scc.virginia.gov/division/boi/webpages/boiconsumer.htm>

Washington: <http://www.insurance.wa.gov/>

Wisconsin: <http://oci.wi.gov/consinfo.htm>

West Virginia: <http://www.wvinsurance.gov/Default.aspx?tabid=373>

Wyoming: <http://insurance.state.wy.us/>

FEDERAL RESOURCES

Agency for Healthcare Research and Quality section on "Questions and Answers About Health Insurance": www.ahrq.gov/consumer/insuranceqa/

U.S. Department of Health and Human Services' website on the 2010 health reform law: healthcare.gov

For information on your new health insurance rights and benefits go to:
<http://www.healthcare.gov/foryou/conditions/insurance/index.html>

For information on

U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services list of exempt state and local plans:

<http://www.cms.gov/selffundednonfedgovplans/>

U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA): www.samhsa.gov

For information about addiction and mental health generally

National Association of Insurance Commissioners:

http://naic.org/state_web_map.htm

US Centers for Medicare and Medicaid Services (CMS):

https://www.cms.gov/HealthInsReformforConsume/04_TheMentalHealthParityAct.asp

US Department of Labor, Employee Benefits, Security Administration (EBSA):

www.dol.gov/ebsa or Toll-free hotline: 1.866.444.EBSA (3272)

Information on requirements of employer-based insurance coverage and self-insured health plans. EBSA has benefit advisors who are available to answer questions, provide assistance in obtaining your benefits.

U.S. House: www.house.gov

Use your zip code to find your Member of Congress. Your Member of Congress can help answer questions and resolve problems with government programs such as Medicaid.

U.S. Senate: www.senate.gov

Your Senator can help answer questions and resolve problems with government programs such as Medicaid.

PARITY IMPLEMENTATION COALITION MEMBERS

The Parity Implementation Coalition members advanced parity legislation for over twelve years in an effort to end discrimination against individuals and families who seek services for mental health and substance use disorders and remain committed to its effective implementation.

American Academy of Child and Adolescent Psychiatry: www.aacap.org

American Psychiatric Association: www.psych.org

American Society of Addiction Medicine: <http://www.asam.org>

Betty Ford Center: <http://www.bettyfordcenter.org>

Hazelden Foundation: <http://www.hazelden.org/web/public/publicpolicy.page>.

Faces and Voices of Recovery:

http://www.facesandvoicesofrecovery.org/about/campaigns/equity_main_page.php

Mental Health America:

http://takeaction.mentalhealthamerica.net/site/PageServer?pagename=Equity_Campaign_parity_legislation

National Alliance on Mental Illness:

http://www.nami.org/Template.cfm?Section=Issue_Spotlights&Template=/TaggedPage/TaggedPageDisplay.cfm&TPLID=5&ContentID=15944

National Association of Psychiatric Health Systems: <http://www.naphs.org/>

National Council for Community Behavioral Healthcare:

http://www.thenationalcouncil.org/cs/public_policy/resources_and_issues/parity

Watershed Addiction Treatment Centers: www.thewatershed.com