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

Parity Resource Guide for Addiction & Mental Health Consumers, Providers and Advocates

WINTER 2015 • SECOND EDITION

Parity Implementation Coalition

THE KENNEDY FORUM

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Foreword

Often, the most difficult battles are fought after a law is passed. Never has that been truer than in the case of the Mental Health Parity and Addiction Equity Act.

Today, too many Americans are still being denied the care they need and the care they are guaranteed under this law. As a result, these individuals and families often need help filing appeals when their access to behavioral health services is denied, or when their health plans refuse to pay after they have received treatment.

If you find yourself, a family member, or friend in a similar situation, the guide you are holding is an essential tool to keep by your side as you navigate the insurance and regulatory systems. Perhaps you're a provider trying to help a patient get needed coverage; this guide will help you, too. The goal in developing this guide is to help ensure the best outcomes for you, your loved ones, friends, neighbors, or patients.

While this guide is primarily a consumer resource, advocates like The Kennedy Forum and the Parity Implementation Coalition will also use it to educate regulators, legal advocates, legislators, and others to ensure that the Mental Health Parity and Addiction Equity Act, and related federal and state laws, are fully implemented and enforced until mental health and addiction are treated equally.

It's true that we've been engaged in this cause for many years, but this is really just the beginning. Stay tuned as The Kennedy Forum and the Parity Implementation Coalition offer additional resources to ensure that you have the right information and tools at the right time to get the behavioral health coverage you deserve.

Patrick J. Kennedy

This resource guide 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.

The Parity Implementation Coalition, in conjunction with The Kennedy Forum, developed this resource guide to help you understand the law, file complaints and appeal denied claims. This resource guide was originally published as a toolkit in 2010, the second edition of which was updated in mid-2015. We will continue to update this publication as regulations are issued and clarified and as additional FAQs are made available.

The information included in this resource guide is meant to be helpful, but does not constitute legal advice or substitute for legal counsel. If you need help with the resource guide or have questions about parity, please send an email to **info@parityispersonal.org** or **info@thekennedyforum.org**.

Acknowledgements

We gratefully acknowledge the support from the following organizations *(along with their reference materials)***:**

The American Cancer Society
Community Catalyst
The Consumers Union
Kaiser Family Foundation
The Kennedy Forum
Mental Health America
Parity Implementation Coalition
The Patient Advocate Foundation
Watershed Addiction Treatment Programs

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PART I: Executive Summary

All too often, public policymakers, health plans, employers, medical establishments and others have failed to fully recognize the value of mental health and substance use disorder (MH/SUD) treatments. The primary purpose of this resource guide is to educate and inform patients, providers and other advocates of the action steps available to them to ensure that they receive the same type of insurance coverage for MH/SUD treatments as they receive for physical treatment services. For too long, reimbursement for MH/SUD treatments has not been a priority. With the enactment of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (the "parity law" or "MHPAEA"), and the regulations that instruct insurance plans on how to comply with the parity law, the groundwork for a level playing field to exist between insurance coverage for behavioral health and physical conditions is now in place.

The Parity Implementation Coalition (PIC), in conjunction with The Kennedy Forum, published this resource guide to serve as an aid for individuals seeking MH/SUD services. The guide should also be used by family members, providers, advocates and others to help them better understand the insured's rights and benefits under the parity law and how to file appeals from insurance coverage denials. The resource guide is designed to promote better communication with plans, assist consumers and providers in preparing and documenting information when disputes arise with a health plan over coverage and/or reimbursement and better understand basic appeals rights and procedures. Every plan has its own appeals policies and procedures that are typically provided to insureds and providers along with a coverage denial. It is important that insureds, providers and advocates examine the appeal instructions enclosed with denial of coverage letters and become familiar with the specific steps that they must take to file a successful appeal.

This Second Edition of the resource guide provides a more in-depth look at the types of appeals that may be taken and how and when to file them. It also includes tips on how to file parity appeals based on apparent violations of the federal parity law, medical necessity appeals, administrative or grievance appeals based on coverage limitations and/or exclusions included in the four corners of benefit plan documents. The guide also explains the external review appeals process available once all internal appeals have been exhausted.

The primary focus of the resource guide is the current federal parity law, also referred to as MHPAEA. The legislation was passed in 2008 to end discriminatory health care practices against those with a mental illness and/or addiction. The final regulations were published in 2013 and are now in full effect. Most notably, the law aims to remedy both the financial ("quantitative") and non-financial (or "non-quantitative") ways that plans have historically limited access to addiction

and mental health care in a more restrictive way than care for physical conditions. Individuals with mental illness and/or addiction, their families, professionals in the field, employers and health plans all worked together to pass the federal parity law.

To help individuals and providers better understand how to challenge benefit denials based on parity non-compliance and report parity violations, this resource guide includes sample appeal letters, tips on how to file regulatory complaints, guidance on how to report possible parity violations to accrediting bodies and options for judiciary action in the court system. To make this information user friendly, the resource guide provides frequently asked questions and answers (FAQs) for the specific steps to file an appeal.

As health care expenses have increased, both public and private health plans have experimented with various methods to control costs, including how medical claims are paid for. As a result, many plans have subjected MH/SUD benefits (also known as "behavioral health benefits") to more rigorous forms of cost containment than typically seen under medical benefits. These restrictions on coverage for care can take many forms, including higher co-pays and deductibles, shorter day and visit limits, pre-approval or "prior-authorization" for services and other forms of "medically managing" benefits.

When cost containment measures are used appropriately by plans to achieve quality and accountability, their impact can be beneficial to patients, providers and payers in the health care system. However, when they are used as a means to delay or deny medically appropriate care, they can have devastating consequences on individuals, families and the health system at large.

It is important to note that MHPAEA was not intended to eliminate cost containment or medical management. The legislative intent was to create equality in access to and coverage of MH/SUD benefits as compared with medical and surgical benefits.

We have seen a number of insurance methods that impact how behavioral health benefits are covered by health plans and accessed by plan participants. In many cases, health plans apply coverage criteria in a more stringent manner than under the medical/surgical benefits. Here are some examples of how plans restrict coverage of MH/SUD services:

- Excluding benefits based on whether a treatment is experimental or investigative
- Prior authorization required (e.g., pre-approval of a course of treatment)
- Denials or exclusions of coverage for particular treatments or levels of care

- Medical necessity criteria (i.e. denials or limitations of care because a service or treatment is not deemed "medically necessary" by the plan to treat an individual's behavioral health condition)
- Exclusions that prohibit coverage for any service provided by a certain facility or provider type

Many of these types of decisions are made through a plan's utilization review or utilization management (UM) program. Unfortunately, some plans implement overly restrictive UM guidelines as a way to ration or limit care. In addition, a denial of behavioral health benefits may be due to a scope of coverage issue. In these cases, the plan takes the position that the MH/SUD service or level of care is not covered under the insurance policy. This reference guide gives a fairly comprehensive overview of how these systems work and how an individual or provider can file an appeal when a denial of coverage, also known as an adverse benefit determination, is made by a health plan.

The Parity Implementation Coalition includes the American Academy of Child and Adolescent Psychiatry, American Psychiatric Association, American Society of Addiction Medicine, Bradford Health Services, Cumberland Heights, Hazelden Betty Ford Foundation, MedPro Billing, Mental Health America, National Alliance on Mental Illness, National Association of Psychiatric Health Systems, The Watershed Addiction Treatment Programs and Young Persons in Recovery. Many of these organizations advanced parity legislation for over twelve years in an effort to end discrimination against individuals and families who seek services for mental health conditions and substance use disorders and remain committed to its effective implementation.

The Kennedy Forum is supporting the Parity Implementation Coalition in the updating and distribution of this edition of the resource guide. Founded in 2013, The Kennedy Forum seeks to unite the health care system and rally the mental health community around a common set of principles: fully implement the 2008 parity law, bring business leaders and government agencies together to eliminate issues of stigma, work with providers to guarantee equal access to care, ensure that policymakers have the tools they need to craft better policy and give consumers a way to understand their rights.

Resource Guide Overview

This resource guide is drafted from the perspective of the patient or provider filing the appeal, but can be used by other stakeholders including caregivers, family members, policymakers and attorneys.

Frequently Asked Questions (FAQs)

The key sections on how to file various types of appeals are done through FAQs to provide a more direct way of outlining the steps that an individual or provider should take when filing an appeal.

Model Appeal Letters

The sample appeal letters highlighted in Appendix B MUST be customized. Individuals, families, their advocates and providers must carefully review each template and its introduction to make the best use of them given the insured's unique interactions with the plan.

Every place in the "templates" or sample appeal letters containing a [ ] must be filled in by an individual, advocate or provider filing the appeal. Attached to each template is a legal rationale that represents the consensus of the Parity Implementation Coalition and The Kennedy Forum. We encourage patients and providers to use this rationale to increase their chances for a successful appeal, along with any additional information, such as clinical details for the patient or clinical guidelines, tailored to the specific case

Common Abbreviations

MH/SUD:
Mental Health/Substance Use Disorders.

MHPAEA:
The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Act, "The Parity Law", The "Federal Parity Law" or "The Statute".

See Exhibit E for more common abbreviations used in this reference guide.

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@parityispersonal.org.**

PART II: Parity Background

Most Americans with health insurance face greater barriers in accessing services for mental illness and addiction than they do in accessing care for other medical conditions. This is because the majority of health plans have traditionally imposed, and in many instances, still 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. Unfortunately, reimbursement policy has not kept up with science.

Since 1992, advocates have fought for health care equality for those suffering from 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 end discriminatory health care practices against those with mental illness and/or addiction. The statute provides that plans cannot apply financial requirements or treatment limitations to mental health or substance use disorder (MH/SUD) benefits that are more restrictive than as applied to medical/surgical benefits. Plans also cannot not apply separate treatment limitations only to MH/SUD benefits. Most notably, the law aims to remedy both the financial ("quantitative") and non-financial ("non-quantitative") ways that plans limit access to addiction and mental health care, more so than plans do for other physical conditions. Individuals with mental illness and/or addiction, their families, professionals in the field and employers all worked together to pass the law.

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. Do they appear equal? If not, your plan may not be in compliance with the federal parity law.

Final implementing regulations went into full effect starting January 1, 2015 for all plans covered by MHPAEA (see next page for which plans parity applies to). These regulations provide greater clarity on how plans must apply the non-quantitative treatment limit requirements and what specific information and which documents must be given to patients, providers and their advocates. In the end, turning a law into real, lifesaving addiction and mental illness benefits means that we have to assert our new rights and use all available means, most especially the appeals process, to ensure that we receive the benefit coverage and reimbursements we are entitled to. This is our responsibility.

Parity Law Overview

The MHPAEA was signed into law on October 3, 2008. The first phase of the law went into effect for plan years beginning on or after October 3, 2009. The Final Regulations (final rules) went into effect for plan years beginning on or after July 1, 2014. For the majority of plans, the regulations' protections became effective on January 1, 2015.

Which plans does the federal parity law apply to?

PLAN	DOES MHPAEA APPLY?
Employer-funded plans with more than 50 insured employees	Yes
Medicaid managed-care plans	Yes
Children's Health Insurance Program plans	Yes
Medicaid Alternative Benefit plans (Medicaid expansion)	Yes
Non-grandfathered small employer plans (less than 51 employees)	Yes*
Non-grandfathered individual market plans	Yes**
Plans offered through the health insurance exchanges	Yes
Federal Employees Health Benefits Plans (FEHBP)	Yes***
TRICARE/DOD plans	No
Medicare plans	No
Veterans Administration	No

* Technically MHPAEA does not apply directly to small group health plans, although its requirements are applied indirectly to non-grandfathered small group plans in connection with the Affordable Care Act's essential health benefit (EHB) requirements.

** Non-grandfathered plans are plans that came into existence after the March 23, 2010 passage of the ACA.

*** While the MHPAEA statute does not apply to Federal Employees Health Benefits Program (FEHPB), the Office of Personnel Management has issued carrier letters directing such plans to comply with MHPAEA.

The parity statute originally applied to:

- Employer-funded plans with more than 50 insured employees
- Medicaid managed-care plans [1]
- CHIP (Children's Health Insurance Program)

The Affordable Care Act (ACA) expanded MHPAEA's protections to:

- Non-grandfathered employer plans with fewer than 51 employees (small group plans) [2]
- Non-grandfathered individual market plans
- Medicaid Alternative Benefit Plans (Medicaid expansion benefit)
- Plans offered through the health insurance exchanges

As enacted in 2008, MHPAEA did not require a plan to offer mental health and/or substance use disorder (MH/SUD) benefits; but if the plan chose to do so, it must offer the MH/SUD benefits on par with (equal to) the other medical/surgical benefits it covers. For example, if a plan allowed an individual to have as many appointments with an immunologist as he or she needs but only covers five appointments with a psychiatrist, this would violate the parity law.

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

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1 While the statute applies to Medicaid Managed Care Plans, the Final Rule does not. More CMS guidance will be forthcoming.

2 "Non-grandfathered plans" are plans that were established after March 23, 2010 in accordance with the Affordable Care Act.

Exemptions

- Local and state self-funded government plans may apply for an exemption from the Centers for Medicare and Medicaid Services (CMS).
- MHPAEA does not apply to Medicare plans
- MHPAEA does not apply to TriCare/Department of Defense (DOD) plans

Cost Exemptions

- Plans that experience cost increases of 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

At the time of the publication of this resource guide, no plans have qualified for a cost exemption under MHPAEA.

Combined 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.

Common Parity Compliance Issues

Here are examples of parity compliance issues:

- Plans that provide out-of-network coverage under the medical/surgical benefit must provide on par out-of-network coverage under the MH/SUD benefit
- Financial requirements (e.g., deductibles, co-payments, coinsurance or out-of-pocket expenses) imposed on MH/SUD benefits may NOT be more restrictive than those imposed on medical/surgical benefits
- Treatment limitations (e.g., frequency of treatment, number of visits, number of days or similar limits on scope or duration of treatment) imposed on MH/SUD benefits may NOT be more restrictive than those imposed on medical/surgical benefits
- Plans cannot require a patient to go to a MH/SUD facility in their own local or state area if the plan allows plan members to go outside of local or state areas for other medical services
- Plans are prohibited from using “separate but equal deductibles.” In other words, MH/SUD and medical/surgical benefits must add up together towards the same, combined deductible
- Plans cannot exclude certain types of MH/SUD facilities or provider types while covering a full range of medical/surgical facilities and provider types

- Criteria for medical necessity determinations must be made available to any current or potential plan participant, beneficiary or contracted provider (in-network) upon request
- The reason for any denial of reimbursement or payment must be made available to the participant or beneficiary
- Where there is a similar state parity law or regulation, the federal parity law serves as the floor. State regulators must enforce at a minimum the federal requirements, along with any additional state requirements
- State laws that offer more consumer protections than the federal law are NOT preempted

Parity Rule Summary

A brief summary of the final rules is below. Click here for a technical, detailed summary of the final rules.

The final regulations explaining how the law must be complied with were published by the U.S. Department of Labor (DOL), U.S. Department of Health and Human Services (HHS) and the U.S. Department of Treasury (Treasury) on November 13, 2013.

Final Regulations Overview

The parity law regulations were published in two stages: as interim final rules and final rules. The final rules were published in November 2013, and all health plans that are subject to the law now must comply with the final rules.

Scope of Service

The final rules clarified the scope of service issue by stating:

1. The six classification of benefits scheme (i.e. inpatient in- and out-of-network, outpatient in- and out-of-network, emergency care and prescription drugs) was never intended to exclude intermediate levels of care (intensive outpatient, partial hospitalization or residential)
2. The language in the final rules on scope makes it clear that each classification and sub-classification has to meet all parity tests within that classification and further states that "the classifications and sub-classifications are intended to be comprehensive and cover the complete range of medical/surgical benefits and mental health or substance use disorder benefits offered by health plans and issuers." This language, coupled with the new, specific examples around intermediate levels of care, demonstrates that the range and types of treatment services offered by the plan for MH/SUDs must be comparable to the range and types of treatment services offered for medical/surgical conditions within each class

3. The final rules clarify that plans must assign intermediate MH/SUD benefits to the same classification of benefits as plans or issuers assign comparable intermediate medical/surgical benefits

The preamble to the final rules explains:

> For example, if a plan or issuer classifies care in skilled nursing facilities or rehabilitation hospitals as inpatient benefits, then the plan or issuer must likewise treat any covered care in residential treatment facilities for mental health or substance user disorders as an inpatient benefit. In addition, if a plan or issuer treats home health care as an outpatient benefit, then any covered intensive outpatient mental health or substance use disorder services and partial hospitalization must be considered outpatient benefits as well. [78 F.R. 68247]

The net effect of this provision is that parity requirements (as clarified by the Frequently Asked Questions (FAQs) issued by the Department of Labor) extend to intermediate levels of MH/SUD care and that such services must be treated comparably with medical/surgical care under the plan.

Parity Testing Criteria

Under the final rules, there are two methods to test for parity compliance when comparing MH/SUD benefits with medical/surgical benefits:

Quantitative Treatment Limitations (QTLs)

As described in the final rules, these include day and visit limits, deductibles, co-pays and coinsurance.

Non-Quantitative Treatment Limitations (NQTLs)

The final rules provide examples of NQTLs that include, but are not limited to:

- Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness or based on whether the treatment is experimental or investigative
- Formulary design for prescription drugs
- For plans with multiple network tiers (such as preferred provider networks and participating provisions), network tier design

Standards for provider admission to participate in a network, including reimbursement rates:

- Plan methods for determining usual, customary and reasonable charges
- Refusal to pay for higher-cost therapies until it can be shown that a lower cost therapy is not effective (also known as fail-first policies or step therapy protocols)
- Exclusions based on failure to complete a course of treatment

- Restrictions based on geographic location, facility type, provider specialty and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage

The preamble to the final rules also provides additional NQTL examples, such as:

- Limitations on inpatient services for situations where the participant is a threat to self or others
- Exclusions for court-ordered and involuntary holds
- Service coding
- Exclusions for services provided by clinical social workers
- Network adequacy

Disclosure and Transparency

The final rules offer additional regulatory guidance and examples that clarify the application of pre-existing federal law disclosure requirements under the Employee Retirement Income Security Act (ERISA) and claims procedure, internal appeals and external review regulations to MHPAEA and its implementation and enforcement.

MHPAEA requires that the criteria for medical necessity determinations be made available to any potential or current enrollee or contracting provider upon request. MHPAEA also requires that the reason for the denial of coverage or reimbursement must be made available to the plan participant or beneficiary.

Additionally, ERISA requires employer group plans to disclose the medical necessity criteria for both MH/SUD and medical/surgical benefits within 30 days of the request, as well as the processes, strategies, evidentiary standards and other factors used to apply an NQTL to both behavioral and medical benefits. Moreover, ERISA plans are required to comply with the Department of Labor's (DOL) claims procedure regulations; non-grandfathered group plans and health insurance providers in both group and individuals markets are required to comply with the DOL's rules under the ACA regarding claims and appeals.

The preamble to the final rules also offers a reminder that regulations under the ACA and guidance under FAQs issued by the DOL require certain plans and issuers to provide the claimant, free of charge, during the appeals process with any new additional evidence considered relied upon or generated by the plan or issuers in connection with a claim.

Enforcement

The final rules clarify, as codified in federal and state law, that states have primary enforcement authority over health plans that offer insurance coverage in the state-licensed group and individual markets. As such, states are intended to be the primary means of enforcing implementation of MHPAEA.

The HHS, through CMS, has enforcement authority over issuers in states that do not comply. The DOL has primary enforcement authority over self-insured ERISA plans.

Medicaid Managed Care, CHIP and Alternative Benefit Plans

As set forth in CMS's April 6, 2015 "Medicaid Fact Sheet: Mental Health Parity Proposed Rule for Medicaid and CHIP":

- The proposed Medicaid/CHIP/Alternative Benefit Plans rule for MHPAEA ensures that all beneficiaries who receive services through managed care organizations, alternative benefit plans or CHIP will have access to mental health and substance use disorder benefits regardless of whether services are provided through the managed care organization or another service delivery system
- The proposed rule also prevents inequity between beneficiaries who have mental health or substance use disorder conditions in the commercial market (including the state and federal marketplace), Medicaid and CHIP and helps promote greater consistency for these beneficiaries
- The proposed rule requires states to include contract provisions calling for compliance with parity standards in all applicable contracts for these Medicaid managed care arrangements, including prepaid inpatient health plans or prepaid ambulatory health plans
- Under the proposed rule, states that have contracts with managed care organizations and states with Medicaid alternative benefit plans will be required to meet the parity requirements regarding financial and treatment limitations consistent with the regulation applicable to private insurers. Under the proposed rule, all types of CHIP programs, regardless of delivery system (including fee-for-service and managed care), will be subject to parity standards

In addition, the proposed rule requires plans (or in some instances the state) to make available upon request to beneficiaries and contracting providers the criteria for medical necessity determinations with respect to mental health and substance use disorder benefits. The proposed rule directs the state to make available to the enrollee the reason for any denial of reimbursement or payment for services with respect to mental health and substance use disorder benefits.

NOTE: The proposed Medicaid parity rule is not final. This resource guide is intended to be updated periodically to include new developments regarding parity law implementation.

Other Issues

Cost Exemption for Plans and Issuers

The final rules provide a formula for how plans and issuers can file a cost exemption if the changes necessary to comply with the parity law raise costs by at least 2% in the first year. No plan has received such a cost exemption to date.

Tiered Networks

The final rules allow plans and issuers to sub-classify benefits to reflect multiple provider network tiers, but only if tiering is based on reasonable factors in accordance with the NQTL rule and without regard to whether the provider is a medical/surgical or MH/SUD provider. After sub-classifications are established, the plan or issuer may not impose financial requirements or treatment limitations more stringently on MH/SUD benefits in any sub-classification than the plan imposes on medical/surgical benefits in accordance with the NQTL rule.

Helpful Consumer 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

Application to the Individual and Group Markets

The final rules apply to large group plans and all individual plans for the plan year beginning on or after July 1, 2014. As referenced above, MHPAEA indirectly applies to non-grandfathered, small group health plans through the Affordable Care Act's essential health benefit (EHB) requirements.

Non-Federal Governmental Plans

Local and state self-funded governmental plans may continue to apply to CMS for an exemption from MHPAEA's requirements. Such plans must, however, comply with specific disclosure requirements to maintain exemption eligibility.

Multi-Tiered Prescription Drugs

A plan may have multi-tiered prescription drug programs that apply different levels of financial requirements to different tiers of prescription drugs if such tiers are based on reasonable factors in

accordance with the NQTL rule and without regard to whether the drug is prescribed under the medical/surgical or MH/SUD benefits.

Final Rule Enhancements

The final rules contain important additional guidance and clarifications to the 2010 interim final rules:

Scope of Service. Parity requirements are extended to intermediate levels of care (e.g., intensive outpatient, partial hospitalization and residential). (See examples 9 and 10 in the final rules for additional details on how this rule impacts residential SUD facilities.)

Removal of NQTL Exception. The "recognized clinically appropriate standard of care" exception to the NQTL rule was removed, so that plans are no longer permitted to apply more stringent limitations on MH/SUD services by simply stating that "recognized clinically appropriate standards of care permit a difference." (See NQTL section on the following page for more detail.)

Disclosure and Transparency under ERISA. Instruments under which the plan is established or operated must be furnished to a participant or authorized representative within 30 days of request. Plan documents/instruments include any document or instrument that specifies procedure, formulas, methodologies or schedules to be applied in determining or calculating a participant's entitlement under the plan regardless of whether such information is contained in a document designated as a "plan document." Plans subject to these ERISA requirements include both self-insured and fully funded large and small group plans.

NQTLs. Plans may not impose geographic location, facility type, provider specialty or other limitations or exclusions that limit the scope or duration of benefits, including intermediate levels of care, unless they are imposed comparably under the medical benefit. These are examples of medical management techniques for which the NQTL rule applies. Thus, for instance, plans will no longer be able to require a patient to go to an MH/SUD facility in their own state if the plan allows plan members to go out-of-state for other medical/surgical services.

The final rules maintain the "comparable and no more stringently" standard on NQTLs and continue to require plans to disclose the "processes, strategies, evidentiary standards and other factors used by the plan or issuer to determine whether and to what extent a benefit is subject to an NQTL and be comparable and applied no more stringently for MH/SUD than for medical/surgical" benefits.

A significant improvement in the final rules is that plan participants or those acting on their behalf will now be able to request a copy of all relevant documents used by the health plan to determine whether a claim is paid. (See disclosure section for more detail on what documents may be requested. Current or potential enrollees may request this information and plans are required to provide it within 30 days.)

Reimbursement Rates

The final rules re-affirm that provider reimbursement rates are a form of NQTL. The preamble clarifies that plans and issuers can look at an array of factors in determining provider payment rates such as service type, geographic market, demand for services, supply of providers, provider practice size, Medicare rates, training, experience and licensure of providers. The final rules re-affirm that these factors must be comparable and applied no more stringently to MH/SUD providers than as applied to medical/surgical providers.

Health Plan Coverage Checklist

My health plan coverage is through:

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

My health plan:

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

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

My primary care physician is: _____

My physician's phone number: _____

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

I need prior authorization for: _____

- ❑ I do not need a referral from my primary care physician

OR

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

Benefit Coverage Checklist: Exclusions and Limitations

Depending on your type of health insurance plan, you may have a Summary of Benefits and Coverage, a Summary Plan Description, Evidence or Certificate of Coverage and a Benefits Booklet.

I have reviewed the Exclusions, Limitations and Non-Covered sections of my benefit coverage. My health plan will not pay for or limits the following mental health/substance use disorder services:

- _____
- _____
- _____

If I have in-network benefits only, 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 my plan's service area?

For non-urgent care:

Provider: _____

Phone: _____

For urgent care:

Provider: _____

Phone: _____

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 and canceled checks
- Keep a daily log of events and expenses
- Maintain a list of addiction/mental health care team members and all other contact persons with their phone and fax numbers. Keep filed in a notebook or file for easy access

KEEP RECORDS OF THE FOLLOWING:

- Medical bills from all health care providers
- Claims filed
- Reimbursements (payments from insurance companies) received and explanations of benefits
- Dates, names and 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 and treatments
- Drugs given and prescriptions filled

PART III: Appeals Overview

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

Patients and their providers can leverage a number of different resources and regulations to support their adverse determination (denial of coverage) challenge as described in this resource guide. Regulations governing the types of appeals that an insured or authorized representative provider can file, the process and timeframes are also addressed though this guide. In addition to a direct parity challenge through MHPAEA, appeal options include, but are not limited to, federal and state laws supporting utilization management appeals or medical necessity, administrative grievance filings and external review.

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
3. Plans are required to disclose their parity compliance review and testing if a parity law challenge is made

How to Get Answers to Insurance-Related Questions

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

- Speak with your insurer or managed care provider's customer service department.
- Ask for the person's name each and every time you call.
- Make a note of the person's name 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 Appendix C in this toolkit for helpful links.
- Learn about the laws regarding insurance that protect the public.

Understanding Appeals

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 several levels of appeals available to plan members depending on the type of plan. Typically, an initial appeal for requested services or treatment must be denied before a second level appeal can be sought.

The initial (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 attending provider or a health plan medical director a delay in treatment poses a threat to the patient's life, an expedited review should be requested. Health plans must have expedited processes to deal with requests for medical services that a patient's physician feels are urgent. If a patient's appeal involves an urgent need for care, the individual filing the appeal must make that clear to the health plan so the appeal will be expedited. For example, 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 or treatment center. Some health plans report that they handle the first level of reviews within one business day for services not yet provided, but others may take longer. Timeframes will vary depending on what type of health insurance an individual may have (e.g., employer-based versus individual market) and who regulates or oversees the individual's policy. Timeframe requirements can be established by federal and state laws and/or by accreditation standards. If more than one source of timeframes apply, then the shortest timeframe will govern.

If the insured individual or the attending provider does not agree with the result of the plan's initial review, most plans allow either party to appeal the decision to another plan physician who was not involved in the initial decision. Each health plan has its own rules about who will be members of the review panel, but the plan must follow any applicable federal and state laws. It may include physicians, consumers or 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. Many state laws and accreditation standards also require a true "peer to peer" consultation.

In addition, most health plan offerings are subject to federal or state "external review" requirements. In such cases, plan officials must notify the insured individual and their doctor that the original adverse determination (denial) has been upheld and then tell the patient how to file an external appeal.

What types of appeals are there?

There are a number of types and levels of appeals that an insured individual, attending provider or advocate can utilize, some of which overlap. The resource guide describes the following type of appeal:

- Internal Health Plan Appeals
  - Parity Appeal (i.e. MH/SUD vs. other physical coverage comparability analysis)
  - Clinical/Utilization Management (UM) Appeal (e.g., "medical necessity" appeal)
    - Expedited (for urgent circumstances)
    - Standard
  - Administrative/Grievance Procedure Appeal (e.g., payment or scope of coverage related to the plan documents dispute)
- External Appeals
  - External Review Appeal
  - Regulator Complaints
  - Accreditation Audits
  - Arbitration Hearing
  - Judicial Hearing

How do the internal appeal options differ?

Each internal health plan appeal has a particular focus, but it is important to understand that some issues subject to the grievance or appeal may overlap. The good news is that if the insured, attending provider or their representative goes down one track, they can always switch gears and file another type of internal appeal.

In fact, the insured has access to a number of internal appeal options to get the ball rolling. Typically, there are two entry points to initiate an appeal based upon a parity violation:

- **Clinical/Utilization Management Appeal.** An insured individual, family member or attending provider will typically file a UM appeal when the health plan has denied or reduced the level of care based on what the plan deems is "medically necessary". A UM decision

is based upon evidence-based medical necessity criteria or guidelines. The basis of the appeal may or may not be parity-related. There are many
other reasons why a health plan should cover an insured's MH/SUD services.

If the adverse determination was related to a clinical issue, then a medical necessity or UM appeal probably should be filed. Here are some questions to ask:

- Is the treatment, service or medically necessary item indicated for this patient at this point in time?
- Are essential treatments excluded or does the plan refuse to pay for entire levels of care?
- Is the treatment considered experimental or a non-standardized treatment?
- Is the plan using internally developed medical necessity criteria that diverge from nationally recognized standards of care?

- **Administrative/Grievance Procedure Appeal**
  An administrative appeal typically addresses a nonclinical issue and is filed when there is a dispute about the level of benefits being covered by the insurance coverage itself, such as a non-covered benefit or exclusion. Insured individuals may need to consult with their attending healthcare providers or their state's consumer assistance program or regulator to make sure they are taking the correct follow-up action. The patient or their advocate should review the summary plan description (SPD) or certificate of coverage to become familiar with the scope of coverage and any exclusions. Familiarity with federal and state mandated benefit laws can also be important (e.g., the ACA, which is the 2010 health reform law, mandates MH/SUD coverage as one of ten essential health benefits; many states have statutes mandating behavioral health benefit coverage as well).

  If the adverse determination was related to a coverage issue, then an administrative appeal probably should be filed. Here are some sample questions to ask:

Appeal Tracking Checklist

Who to call 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)

Level 1: _____

Level 2: _____

Expedited Review (For Urgent Care): _____

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

- Has the plan denied care for a behavioral health treatment because it is not a covered benefit?
- Has the plan refused to pay its full share of an out-of-network claim based upon the benefit coverage description?
- Is the plan excluding entire levels of care while providing similar levels of care for medical conditions?
- Is the plan excluding non-hospital facility types while providing coverage for non-hospital facilities for medical conditions?

Managed Care Appeals Checklist

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

What type of appeal is more common regarding a parity violation?

According to advocates, many appeals involving a dispute related to a parity issue are initiated and handled through the UM appeals process. This is due to several factors. For example, the UM appeals system has been in place for decades and many parity violations involve medical necessity coverage determinations (i.e. a "nonquantitative treatment limitation" as discussed throughout this resource guide). In addition, several court decisions have issued rulings based upon a medical necessity test of the requested service rather than delving into a parity test. In other cases, a parity appeal could be handled through the administrative process or through another avenue. Patients or their advocates should check in with the applicable regulator, plan administrator, attorney or other expert to confirm which appeals process to use.

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

When filing an appeal, the insured, their attending provider or advocate should take advantage of the additional disclosure, transparency and analysis requirements afforded by MHPAEA. In many respects, this gives the patient more due process to ensure that the health plan is not taking any shortcuts regarding the obligations of the insurer to cover MH/SUD services to the same extent as medical/surgical services. For example, an appeal that includes a challenge based on MHPAEA compliance should entitle the insured or their attending provider to plan documents the individual would not be eligible to receive in other appeal types. In some cases, the insurer and group health plan

sponsor may be two different entities with different information available under MHPAEA, so the insured or their authorized representative may need to reach out to one or both entities depending on the specific circumstances of how the coverage is offered.

How is the initial UM determination made?

The UM or medical necessity decision-making process is usually comprised of several important steps:

- **Initial Clinical Review.** In order to make an adverse determination (denial) for a recommended treatment, the health plan must have a "first-level review" or an "initial clinical review" completed by an appropriately licensed or qualified professional. This is not considered an appeal, but is a normal part of the peer review process within utilization review before a formal adverse determination or denial is made.
- **Peer Clinical Review.** During the initial clinical review process or upon reconsideration after the initial adverse determination, the insured or their representative can request a "peer clinical review." Health plans must conduct this additional layer of peer review for all cases where care is denied in part or in full through initial clinical review or pre-review screening. The peer clinical reviewer used by the insured's health plan (or another qualified professional who is board certified in the same or similar practice as the treating provider) must be available to have a "peer to peer" conversation with the insured's attending provider as part of the process.

State of New Jersey Department of Banking and Insurance

For one example of a state's UM appeals process, see New Jersey. Click here.

What are the different levels of appeal?

When an adverse determination, such as a denial to pay for care, is made through the UM process, the insured has several levels of appeals that they can pursue:

- **Expedited or Standard Appeal.** The insured or the attending provider must be informed by the health plan about their rights to file an expedited appeal for urgent cases (where the patient is in imminent danger) and a standard appeal for non-urgent cases. The health plan must explain the entire process of how to file an appeal within the applicable timelines. The insured, attending provider or treating facility must have the opportunity to submit all of the appropriate documentation supporting their case.

  In most cases, a health plan will offer a second level UM appeal process. The insured, their provider or representative must check the plan documents and be sure to carefully read the appeal instructions enclosed with the upheld denial on the first level appeal. Second level

appeals are oftentimes required to be exhausted, but for some plans, they are optional. Once the internal UM appeals process is exhausted and if the adverse determination or denial has been upheld, further appeal options are outlined below. Again, plan documents, instructions enclosed with the second level denial being upheld and federal and state regulations will direct the insured or their provider to the next step.

- **External Review.** Most states and the federal government, through the ACA, have established an additional layer of consumer protections called external review, which is supposed to be handled by independent third parties. For background information on how to file an external or independent review appeal, click here. Instructions for submitting an external review, including contact information of the external review organization, timeframe for submission, types of documents to include, etc. are enclosed with the plan's decision to uphold a denial on the second level internal appeal. Please read and follow the instructions carefully. If insureds or their representatives have further questions, they should contact their state regulator (for fully-insured plans) or federal regulators (for self-insured plans) to find out what the insured or their attending providers' specific rights are.

  Please note that this option may not necessarily be available for insureds covered by self-funded, grandfathered ERISA plans. In such cases, recourse may be limited to a civil lawsuit in federal court.

- **Other Options.** After exhausting one or more of the internal or external review appeals mechanisms, insureds or their representatives may consider filing formal grievance with the applicable regulators or accreditation agencies. In addition, insureds might want to consider filing a legal action against their health plans or third party claims administrators. See Appendix C for links to the relevant regulators or the section below on accreditation agencies.

How are administrative appeals handled?

In terms of a grievance associated with the amount of payment or "scope of coverage" issue (benefit exclusions or limitations) under the insurance benefit plan, the health insurance plan and applicable regulatory agency may have a different process to file a complaint or appeal than what is used to file a UM appeal. Instructions for filing administrative appeals from administratively denied care are typically enclosed with the denial letter. The insured or their representative could also contact the applicable health plan or regulator to learn more. It is important to review the plan documents such as the SPD, appeal instructions and/or applicable regulations to determine how many levels of appeals are available through an administrative appeal.

What are the timeframes to make a decision?

Different timeframes must be followed depending whether the care is being requested prior to care (e.g., "prospective UM"), during care (e.g., "concurrent UM") or after care has been delivered (e.g., "retrospective UM").

- All appeals that concern future or ongoing medical care must be handled in a timely manner. Timeframes have been standardized for all non-grandfathered plans by the ACA and applicable state laws
- In cases involving life-threatening or urgent care, appeals must be handled on an expedited basis
- Appeals involving care that has already been delivered (e.g., retrospective review of claims) typically take longer

Please check with state, federal and/or accreditation guidelines to find what the specific timelines are in a particular case. In most cases, if the patient is actively seeking care, health plans must respond within 24 to 72 hours. Retrospective reviews of payment decisions can take 30 days or more.

Do appeals cost money?

The answer is usually not, but it depends on the type of appeal:

- **Internal Appeal.** A health plan cannot charge an insured individual or the attending provider to file or process an appeal.
- **External Appeal.** Most external reviews do not cost money, but there are one or two rare exceptions. Check with your local regulator to be sure.
- **Regulator/Accreditor Complaint.** No charges should be incurred by the insured individual or their attending provider to file a complaint with the applicable regulator or accreditation agency.
- **Arbitration/Litigation.** After the health plan appeals process has been exhausted, an insured individual or their attending provider may incur charges by using outside experts such as an arbitration panel or lawyer.

PART IV: Parity Appeals

Background

What is the source of parity regulations?

A parity appeal can be based upon the federal parity law or a similar state law. In addition, if an insured's health plan is accredited by URAC pursuant to its Mental Health Parity Accreditation Standards or by the National Committee for Quality Assurance (NCQA) pursuant to its Managed Behavioral Healthcare Organization Standards, those requirements would apply.

What information should a person know about their insurance policy?

As a patient, provider or advocate, there are certain steps that must be taken to ensure the greatest likelihood of successfully appealing a claim.

BEFORE DOING ANYTHING ELSE, THE INSURED OR THEIR REPRESENTATIVE SHOULD:

Understand the insurance policy and benefits

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

Know when the patient needs to obtain pre-authorization

The attending provider or facility will typically contact the plan to verify which types of services under the plan require pre-notification, pre-authorization and/or referral. Individuals can also find this information in the benefit plan documentation or by calling the insurance company's customer service.

What does a parity violation look like?

The term parity means "equal to"[1]. The parity law is fundamentally grounded in ensuring equal access to treatment services under both the behavioral health and medical benefits offered by a health plan. Thus, the parity law requires that a health plan's policies and practices to cover behavioral health services cannot be more restrictive than policies and practices for medical or surgical services. The comparisons between behavioral and medical/surgical benefits are made according to the same classes of benefits, namely:

- Inpatient to inpatient
- Outpatient to outpatient
- In-network to in-network
- Out-of-network to out-of-network
- Emergency care to emergency care
- Prescription drugs to prescription drugs

A parity violation can take many forms. Some policies and practices covered under the parity law are easily measured by a dollar amount or a number; for example, "financial requirements" such as co-payments or deductibles and "quantitative limits" such as the number of outpatient visits allowed each year. Under the parity law, financial requirements and quantitative limits cannot be more restrictive for behavioral health services than for medical services in the same class of benefits.

Other health plan practices or policies are called "nonquantitative treatment limitations" because these limitations cannot be measured by a dollar amount or number (NQTL). The basic rule is that a health plan cannot impose an NQTL that is not comparable or that is applied more stringently to MH/SUD benefits than to medical/ surgical benefits.

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

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

1 Guidance in this section provided courtesy of Community Catalyst Guidance for Advocates: Identifying Parity Violations & Taking Action. Guidance for Advocates: Identifying Parity Violations & Taking Action.

- **More restrictive prior authorization policies for behavioral health.** Many health plans require prior authorization for non-emergency inpatient facility or hospital services, both medical and behavioral health. However, if in practice a health plan's prior authorization routinely approves up to seven inpatient days for medical services but just three inpatient days for behavioral health inpatient services, the plan is likely in violation of the federal parity law. The parity violation is the result of the health plan applying the prior authorization process more stringently to behavioral health services.
- **Excessive concurrent review policies.** When a patient is admitted to an inpatient or residential treatment facility or to day treatment, or is in need of long-term outpatient counseling, health plans may periodically review the medical necessity of the treatment in a process known as concurrent review. If health plans require concurrent review too frequently or impose overly burdensome requests on behavioral health care providers as compared with medical care providers to justify continued treatment, the plan may be in violation of the federal parity law.

In addition, under federal and state laws, health plans must make meaningful disclosures of plan documents and clinical guidelines to enable a parity appeal, as well as other types of medical necessity or administrative appeals.

What is the testing methodology to assess whether a parity violation has occurred?

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

Quantitative Treatment Limitation (QTL)

A parity violation may have occurred pursuant to a QTL analysis under one of these types of scenarios for each class of benefits:

- Are the patient's behavioral health benefits subject to higher out-of-pocket spending than at least 2/3 of the medical benefits in the same class?
- Are the patient's behavioral health co-insurance amounts higher than the co-pay or co-insurance amounts applied to at least 2/3 of the medical benefits in the same class?
- Are the patient's behavioral health day and visit limits applied more restrictively than the day and visit limits applied to at least 2/3 of the medical benefits in the same class?

Does the net effect of the plan's treatment limitation result in zero (0) days of coverage for MH/SUD care? For example:

- Does the plan exclude levels of care for behavioral health services, while covering a full continuum of care for medical/surgical services?
- Does the plan offer out-of-network coverage for behavioral care that is more limited than out-of-network coverage for other medical conditions?
- Is the plan requiring the patient to receive in-state treatment for MH/SUD treatment while permitting medical/surgical patients to receive care out-of-state?

Non-Quantitative Treatment Limitation (NQTL)

A parity violation may have occurred pursuant to an NQTL analysis under one of these types of scenarios. For example:

- Is a comparable treatment, service or medically necessary item provided by the plan to covered individuals with other medical conditions?
- Is the plan requiring the patient to "fail first" at MH/SUD lower cost treatments?
- Are there differences between behavioral health and medical/surgical coverage regarding:
  - Formulary design for prescription drugs?
  - Standards for provider admission to participate in a network, including reimbursement rates?
  - Plan methods for determining usual, customary and reasonable charges?
  - Exclusions based on failure to complete a course of treatment?
  - Restrictions based on geographic location, facility type, provider specialty or other criteria that limit the scope or duration of benefits?

Helpful Tip

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

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

Filing a Parity Appeal

What is a MH/SUD parity appeal?

The focus of this resource guide is to help the insured, a provider or an authorized representative to challenge an adverse determination or denial of coverage related to mental health and substance use disorders (MH/SUD). MHPAEA and some state laws allow insured individuals or their providers to challenge a coverage determination if the plan does not cover the same level or scope of services for MH/SUDs as the plan covers for medical/surgical conditions. A parity appeal of denied or limited services may be based upon the insurer's determination that the behavioral services requested are not medically necessary or are not a covered service under the benefit plan.

How should an individual initiate a parity appeal?

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

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

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

Critical Information

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

For example, the health plan may require that it receive your appeal within one year of the date of treatment or within 60 days of the date the plan tells 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 one to three days if you have an urgent need. Know your rights!

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

- Resubmit the request for care or claim a third time and request a doctor to doctor (peer to peer) review
- Ask to speak with a supervisor who may have the authority to reverse a decision
- Request a written response outlining the reason for the denial
- Keep the originals of all letters
- Keep a record of dates, names and conversations about the denial
- Get help from a consumer service representative from a state or federal agency (see Appendix C for helpful links)
- Do not back down when trying to resolve the matter
- Formally appeal the denial in writing, explaining why the request for care or claim should be paid

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, take notes about the conversation and **request a Reference Number for your call.** Keep copies of every document you send the plan.

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!

What information does someone need to file an appeal?

MHPAEA requires that plans use the same cost containment techniques, both "quantitative" and "nonquantitative treatment limitations" (see "Terms to Know") on behavioral health conditions as imposed on other medical conditions. As a result, to better prepare the appeal, the patient should request the following from the plan:

1. A copy of the plan's summary plan description (SPD), complete benefit booklet and any other evidence/ certificate of coverage documents
2. A complete list of the medical/surgical conditions covered by the plan and the terms under which they are covered
3. A copy of the plan's medical necessity criteria for MH/SUD services and for other medical services
4. Any clinical guidelines used by the plan to make benefit determinations for both medical and MH/SUD conditions

5. If the plan is subject to ERISA (large and small employer group plans), request all plan documents or instruments related to how the plan is established or operated

What timeframes apply?

The federal ERISA regulations applicable to employer-sponsored health plans establish maximum response times for different types of appeals: 72 hours for urgent care appeals; 15 days for standard appeals; 30 days for post-service decisions for plans with two levels of appeal; 60 days for post-service decisions for plan with one level of appeal.

State law and accreditation standards also establish response times for appeals for health plans. If a health plan is subject to more than one source of standards, the most rigorous standards should apply (i.e. the shortest timeframe to consider an appeal that benefits the patient).

What are some tips for a successful appeal?

Appeals are only successful when they are:

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

Helpful Hint

Start by calling your state insurance regulator to learn more about your rights to file a grievance. See contact information in Appendix C.

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

Because individuals are entitled to behavioral health benefits under MHPAEA at the same levels as medical/surgical benefits, we also recommend that patients include the legal rationale to support why the service or treatment should be covered under the law. The sample letters and legal rationales in this resource guide help provide examples.

Plan Compliance with the NQTL Rule

In order for plans to comply with the parity law, they are required to do their own parity compliance testing. In terms of NQTLs, plans must demonstrate that "any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to MH/SUD benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical surgical/benefits in the classification." On the next page, please find a helpful checklist for providers to obtain documents from the plan to ensure that the limits on MH/SUD benefits are comparable and not more stringently applied.

Provider Request for Documentation

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

To: _____ From: _____

Mgd Care Co: _____ Provider: _____

Fax: _____ Fax: _____

Phone: _____ Phone: _____

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

Patient/Insured's Name: _____

Insurance Company: _____

Insurance Policy ID#: _____

Level(s) of care requested: _____

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

PART V: Other Appeal Types

Medical Necessity/Utilization Management Appeals

What is a utilization management (UM) or "medical necessity" appeal?

A UM appeal allows patients, attending providers and family members to challenge an adverse determination based upon a finding by the health plan that the care is not medically necessary or clinically appropriate. This type of appeal is often closely associated with a parity appeal. It is not uncommon for the parity and UM appeals to be combined when an individual or their provider is trying to get requested behavioral health services covered by the health plan.

What are the sources of regulations?

To date, the vast majority of state insurance departments regulate UM appeals. In addition, the U.S. Department of Labor (DOL) regulates self-funded ERISA plans. Further, URAC and NCQA have adopted specific UM accreditation standards that might be applicable to the individual's health plan. It is important to assess which regulations and standards apply to the patient's given circumstance.

What is the difference between prospective, concurrent and retrospective UM decisions?

It is important to understand that UM decision-making and appeal timelines may vary depending when the patient is receiving care. As a result, different regulations, standards and health plan policies might apply. Regarding a particular episode of care, here is a general guide:

- Prospective UM takes place before the patient is going to receive care or is admitted for treatment

Helpful Tip

Expect to provide the following information in your written appeal:

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

- Concurrent UM takes place while the patient is receiving care or in the facility or hospital
- Retrospective UM takes place after the patient has received care or has been discharged from the facility or hospital

Timeframes can differ dramatically for each type of UM review. It is important to check with the patient's health plan, government agency overseeing the insurance policy, patient advocate or other person who is familiar with the regulatory requirements or plan/timelines.

Administrative/Grievance Appeal

What is an administrative appeal?

If an adverse determination or denial for MH/SUD services does not involve a clinical determination of necessity for the services and instead involves an administrative basis for denying care, the insured, their attending provider or representative can file a grievance with the health plan. In most states, administrative appeals cover a range of issues including an adverse determination or denial of coverage related to services or provider types (settings) not covered by the plan or payment issues.

What are the sources of the regulations?

To date, the vast majority of states regulate how an individual or provider can file an administrative appeal or grievance against a health plan. In addition, the DOL adopted grievance and appeal requirements that cover all ERISA plans. As highlighted below, the ACA also provides a framework for filing a grievance. Further, URAC and NCQA have adopted specific grievance procedure requirements that might be applicable to the health plan in question. It is important to assess which regulations and standards apply to the patient's given circumstance.

What are the new federal appeals procedure protections?

NEW FEDERAL RULES AS A RESULT OF HEALTH CARE REFORM LAW

> **PLEASE NOTE:** If the health 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. 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.

Internal Review

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 became effective as a result of the ACA, which standardizes the internal appeals process used by new plans that patients can use to appeal coverage or reimbursement decisions made by their health plans.

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
- Provide consumers with an expedited appeals process in urgent cases

Helpful Form: Patient Request for Medical Necessity Criteria for Behavioral Health Coverage

Sample Facsimile/Email Request

[Date]

Via Facsimile – [Fax No#] (or Email)

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

Dear [Member Services or other applicable dept.]:

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

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

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

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

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

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

External Review

What is an external review appeal?

If the insured, their attending provider or authorized representative is not satisfied with the health plan's decision after completing the plan's internal review process, they may be able to appeal the plan's adverse determination or denial of coverage to the state's external review program and/or under the new ACA requirements.

Most state and federal laws require the insured, their attending provider or representative to complete all the steps in the plan's internal appeals procedure before requesting external review. Most jurisdictions specify time limits for the internal review, and some allow the individual to file for external review if they have not received a response from the plan within the required time. In emergency circumstances, patients may be permitted to file concurrent external appeals at the same time as internal appeals.

If the patient or their attending doctor/facility has completed all the steps in the internal appeals process and the plan has upheld the initial denial, they should receive a follow-up written communication from the health plan explaining the rational for upholding the "adverse determination" along with instructions on how to file an external review appeal. Usually the individual must file within a specified period, often within 4 months after receiving the adverse determination, in order to be eligible for external review.

If a delay in receiving services will cause the patient serious harm, most states have what is called an "expedited review", which requires a decision in a much shorter period, usually within 72 hours of the external review organization's receipt of the appeal. (Note: the entire expedited external appeals process can take up to 10 days due to current bureaucratic delays in many states.)

What are the sources of regulations?

External review requirements can come from several sources, including federal law, state law and accreditation standards. As highlighted below, most states regulate external appeals, and the new federal health care reform law includes external review requirements. Further, URAC has adopted external review accreditation standards that might be applicable to the insured's health plan.

It is important to assess which regulations and standards apply to the patient's given circumstance. Here are some examples:

Commercial Coverage

- If a health plan is "non-grandfathered" and offers coverage through the commercial marketplace or the Exchanges, federal or state law will apply depending on whether the state has adopted regulations similar to the NAIC (see discussion below)
- If the health plan is "grandfathered" (was in existence before March 23, 2010 and has not made significant changes to the plan's costs or benefits) and offered through the commercial marketplace or the Exchanges, state law will apply

Self-Insured Coverage

- If the health plan is "non-grandfathered" and is offering self-insured, employer-based coverage, the new federal requirements will apply
- If the health plan is a "grandfathered" offering and is self-insured, employer-based coverage, neither the existing federal nor state requirements will apply. Therefore, the patient may have to turn to filing a legal suit in civil court

Accredited Coverage

- If a health plan is accredited by URAC for external review, URAC's External Review Standards will apply in addition to the applicable federal or state law(s)

A good starting point is to contact your plan administrator, local consumer advocate or state regulator (as highlighted in Appendix C) to sort out which regulations and standards apply.

What are the new federal external review requirements?

AGAIN, PLEASE NOTE: If the health 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.

The federal regulations issued as part of the health care reform law creates a national standard for how the external review process works for adverse determinations (denied claims). Under the federal external review protections, the new requirements apply to any issues involving "medical judgment." The ACA external review rules include "whether a plan is complying with the nonquantitative treatment limitation provisions of the Mental Health Parity and Addiction Equity Act and its implementing regulations, which generally require, among other things, parity in the application of medical management techniques" as a type of claim eligible for external review. The term "medical judgment" is also intended to encompass benefit plan exclusions of provider–types or levels of care. With respect to eligibility disputes under the benefit contract, state external review laws may govern the appeal.

Generally speaking, the source of external review regulations will vary depending on the type of health plan coverage, the issue in dispute and how rigorous the state standards are. Therefore, consumers should check with their state insurance regulator, referenced in Appendix C, or other advocate/expert to determine which laws apply.

Under the new federal standards, plans will have to:

- **Allow insured individuals to file a request for external review within four months** after the date they received a notice of an adverse benefit determination or final internal adverse benefit determination
- **Complete, within five business** days of receiving the request for external review, a preliminary review of the request, to determine if the insured individual:
  - Is or was covered under the plan;
  - Was denied care based on the claimant's ineligibility under the terms of the plan, thus making the claim ineligible for federal external review;
  - Exhausted the internal process, if required; and
  - Provided all necessary information to process the review
- **Then, within one 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 DOL'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.

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 that the IRO must consider during its review. The plan must provide to the IRO within five 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 one business day of its decision to reverse; then the plan has to carry out the IRO's decision.

The IRO provides a new review of the claim 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, 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.

What is the new expedited federal external review process?

Effective July 2011, the Affordable Care Act's regulations set out procedures for expedited review in the following situations:

1. Following an adverse benefit determination involving a medical condition for which the timeframe 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 independence.
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 receives one of these appeals, it must "immediately" conduct the preliminary review previously described above and then "immediately" provide a written notice to the insured 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" customarily 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 that has to, in turn, decide the external review request as expeditiously as the claimant's medical condition requires, but no more than 72 hours after the IRO receives the request for expedited review.

When do state external review laws apply?

The new federal external regulations defer to state law in some circumstances. Specifically, 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 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 urgent situations or cases where their health plan did not follow the rules in the internal appeal.
- **Health plans to pay the cost of the external appeal** under state law; 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 are binding** so, if the consumer wins, the health plan is expected to pay for the services that were previously denied.

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

Who can initiate a state-based external review appeal?

Most states have external review programs they oversee and/or regulate, 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. 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). Click here for state by state processes.

An individual can typically rely on their state's external review program if the health plan is an insured, employer-sponsored plan or an individual insurance plan that the patient has purchased on their own or through an Exchange. In some instances, commercially-insured plans (that are not grandfathered) also may be subject to the new federal external review law if the state where the patient lives has not met the ACA or NAIC standards for external review.

Remember, state external review laws do not apply to employer-sponsored health plans that are self-insured. These plans will typically be subject to the federal protections described in this resources guide (unless they are grandfathered). In addition, state external review programs also do not apply to Medicare and Medicaid beneficiaries. If the patient is a Medicare beneficiary, he or she must follow the Medicare review process described in the Medicare handbook. If the patient is a Medicaid beneficiary, state or local Medicaid offices must be contacted about their appeals procedure.

In most states, the patient can give someone else written authorization to appeal for them, or the provider may appeal on the patient's behalf with their written authorization. A sample authorized representative form can be found in Appendix B.

What types of issues can a state-based external review appeal be initiated for?

Most states require that the issue on appeal involve "medical necessity." That means that the patient's doctor must believe a particular procedure, treatment or prescription drug is essential for the patient's health and recovery. The health plan, for a variety of reasons, may disagree. For example, the plan may believe a particular treatment is ineffective for the patient's condition, so it will not pay for it or reduce the level of coverage.

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

External reviews are available for "determinations involving medical judgment," which is a reasonably broad category, including medical necessity, appropriateness, health care setting, level of care and effectiveness determinations, but it does not include certain coverage or eligibility decisions. Importantly, any external appeal that challenges parity law compliance, regardless of whether the appeal relates to clinical medical necessity or other types of treatment limitations, falls within the definition of "determinations involving medical judgment." The insured individual should check to see what process is in place in the state where their insurance plan is issued (as further discussed in this reference guide).

Several states require that the dispute involve a minimum amount of money, usually from $100 to $500. In other states, the right to appeal a denied claim is not limited by the amount of money involved.

Helpful Hints

Steps to take if your appeal fails

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

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

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

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

How is a state-based external review appeal started?

Every state has a different procedure for handling external reviews. The patient will usually receive instructions for filing an external appeal when the internal appeal is denied by the health plan. In some states, the patient begins the external appeal by contacting the health plan again. Others require that the individual contact the state's department of insurance or other state agency to initiate the appeal.

The actual review may be performed by the state agency itself or through an independent review organization (IRO) hired by the state or selected by the plan. Usually patients 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 the patient demonstrates that the filing fee would cause financial hardship.

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

Filing a Regulatory Complaint

How can government officials help?

A number of different government agencies might be able to help a patient depending on where they live and who oversees the person's health plan coverage.

Types of Insurance

Commercial Insurance. State Insurance Commissioners are the primary enforcement authority when it comes to parity for most insurance plans. Contact the patient's state insurance department to learn about available complaint processes for consumers. The state regulators in charge of most appeals programs are listed in Appendix C. If they do not oversee the external review program directly, they can tell you who does in their respective states.

If the state insurance commissioner cannot or does not assist the patient, they can contact the regional office of the federal Department of Labor's Employee Benefit Security Administration (EBSA). Be sure to contact the regional EBSA Office that governs the plan, which is determined by the principle place of business of the employer in the case of employer group plans. Also be sure to obtain the tracking number for your case.

Employer Self-Insured. If the plan is a self-insured group employer plan (sometimes called an ERISA or self-funded plan), the individual can submit a complaint directly to the federal government. EBSA can be contacted online to initiate a consumer complaint: www.askebsa.dol.gov.

Medicaid. If the plan is a Medicaid managed care plan, the state Office of Medicaid is responsible for helping the patient with the appeal and enforcing the parity laws.

Medicare. MHPAEA does not apply to Medicare; the U.S. Center for Medicare and Medicaid Services (CMS) is responsible for assisting Medicare beneficiaries with their appeal.

Department of Defense/Veteran's Affairs. MHPAEA does not apply to DOD/VA plans. If the patient is in a military plan, the U.S. Department of Defense and/or the Veteran's Affairs is responsible for helping the individual facilitate their appeal.

Useful Information

The following agencies specialize in health plan accreditation:

- URAC: www.urac.org
- NCQA: www.ncqa.org
- AAAHC: www.aaahc.org

State Attorneys General. Though the state's Attorney General (AG) is not the primary enforcement authority for filing an appeal or complaint raising a parity law violation, an AG's office has significant investigative and enforcement tools at its disposal. For example, the New York Attorney General's Office has demonstrated significant enforcement power by reviewing consumer complaints of parity violations, investigating health plans against which complaints were filed, and assessing penalties and issuing assurances of discontinuance when violations were found.

Members of Congress Constituent caseworkers for the patient's Members of Congress may also be able to assist.

Use your zip code to find your Member of Congress.

- U.S. House: www.house.gov
- U.S. Senate: www.senate.gov

Accreditation Audits

How can an individual initiate a complaint about a health plan with an accreditation agency?

Accreditation agencies are public or private agencies that give authorization or approval of health plans. Most accreditation agencies allow the insured, their attending providers or representative to file a complaint against an accredited health plan. The first step is to look up the health plan on the online directory to see if they are accredited. The insured or their advocate then can file a complaint by calling the accreditation agency to find out the process. Many states and federal agencies "recognize" accreditation standards are part of the licensing and regulatory oversight process. If the complaint is serious enough, the health plan may lose its accreditation or be put on probation, which can have serious consequences for the health plan.

What is an accreditation audit?

Typically, accreditation agencies will complete desktop and onsite audits of the health plan both upon renewal of their accreditation and on a random basis during the accreditation period. When a serious complaint is filed, including a patient safety issue, most accreditation agencies must complete an unannounced onsite audit. This ensures that the health plan is addressing any deficiencies.

Arbitration

What is an arbitration appeal?

Arbitration is a process in which two parties present their views of a dispute to a neutral third party, an arbitrator, who will then decide how to resolve the dispute. The health plan may offer or, in some cases, require that the patient resolve the dispute through a process called arbitration. Arbitration may be binding, in which case 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.

What rules govern arbitration?

A number of different rules could impact how the insured or the ordering provider pursues an arbitration claim. Typically, the rights to arbitration would be outlined in the insurance policy or in the participating provider's network contract. Many health plans offer an arbitration process that follows the American Arbitration Association or similar type group. Other sources of regulations could come from state or federal requirements depending on how the insurance coverage is regulated.

Commercial Insurance

Specifically, the insured's state may have rules that regulate how health plans can use arbitration. If a plan requires that the insured agree to arbitration to settle disputes over claims for benefits, the insured or their representative may want to contact the state insurance commissioner to determine what their rights might be.

Self-Insured

In addition, 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 the patient cannot be charged a fee for the arbitration. In such cases, if an employer-sponsored health plan requires that the insured enter into mandatory arbitration, it must be one of the two allowed levels of internal appeal and the insured may challenge the arbitrator's decision in court (in other words, the arbitrator's decision cannot be binding).

When should an individual or provider initiate an arbitration appeal?

It depends. In most cases, the patient or their advocate will probably want to exhaust all of the state and federal remedies for internal and external review as highlighted above. After those appeal remedies are exhausted, a patient might want to consider filing for an arbitration appeal rather than going to court. It is advisable that the patient consult with an attorney before making this decision to make sure that they are fully aware of their rights, responsibilities and obligations associated with any arbitration proceeding.

Judicial Action

Is filing a judicial or court action an option?

Yes. When an insured patient has exhausted the internal appeal remedies with the health plan, they may be entitled to file a lawsuit against the health plan and/or the plan's s third party claims administrator. Although this option can be expensive and time-consuming, there may be times where this might be the final recourse for the patient to get the coverage that they need.

It is recommended that individuals consult a number of different attorneys before securing legal counsel. Make sure that the patient understands the terms of engagement with the lawyer, including how the attorney will be compensated.

When does someone have legal standing to initiate a court action?

An insured party will have standing to file a court complaint after they have exhausted their internal administrative remedies with the health plan. This means that insured parties must

complete all levels of internal health plan appeals. Insured parties are not required to submit external appeals, which are voluntary. After exhaustion of administrative remedies, insured parties wishing to file lawsuits must do so within time periods specified by applicable state or federal laws.

It is important to hire a reputable attorney who has expertise in health or insurance law. Depending on the circumstances, the insured may sue in state or federal court.

What is a class action lawsuit and can it help?

A class action lawsuit is a type of lawsuit where a number of plaintiffs join in a group to sue a common defendant on a similar set of facts and on similar legal claims. A number of class action lawsuits have been filed against several large insurers for mental health and substance use disorder coverage disputes. The advantage of these lawsuits is that the law firms handling these legal actions typically take a fee only if they are successful, so the insured does not need to fund the attorneys directly for their time. The disadvantage is class actions often take years to reach a conclusion, so aggrieved patients need to be patient.

St. Luke Hos

PART VI: Final Thoughts

It is our hope that the information, resources and other tips provided herein are helpful to consumers, provider, and all readers of this resource guide. Please note that this guide will be updated as final Medicaid managed care parity regulations are issued. The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act is a landmark law, and it may take some time before its full impact is realized. Be patient. We understand that filing appeals is complicated. It requires patients to make contacts with plans, seek help from providers, document these contacts, gather information and write letters. Get a notebook or create an electronic file, gather the documentation, remain courteous, write everything down and take it one step at a time.

We want to hear from you and help you if we can! Copy us at **info@parityispersonal.org** and/or **info@thekennedyforum.org** on your appeals.

Helpful Tip

When a plan excludes coverage of a treatment, service or level of care, it is very helpful to 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. **www.guideline.gov** is another good resource.

Appendix A: Terms to Know

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CAUTIONARY NOTE: Patients and providers should be cautioned that not all external appeals are reviewed by truly "independent" organizations. In self-funded ERISA cases, IROs are hired by the health plans or their agents that issued the denials the IROs are reviewing. Many IROs are also assigned by states to review denials made by the same organizations in fully-insured cases. Since external appeals are generally voluntary, consumers and their advocates should weigh the prospect that a health plan may attempt to rely on an external review denial to justify its internal denials when future care is sought or during any court case that may arise.

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

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

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

Fully Insured Plan: Employer-sponsored insurance plan where the employer contracts with another organization to assume financial responsibility for the enrollees' medical claims and for all

incurred administrative costs. These plans are regulated by state insurance commissions. The term is synonymous with "fully-funded plan."

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

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

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

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

Inpatient: A term used to describe care rendered in a hospital or non-hospital based facility (e.g., inpatient detoxification, residential detoxification, inpatient rehabilitation, residential treatment, skilled nursing care, inpatient physical rehabilitation), as defined by the plan.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Appendix B: Model Appeal Letters

Introduction

This section includes templates or sample letters of appeal with accompanying legal rationale to support entitlement to coverage for submission to health plans by the insured patient or treating provider (which is often the patient's authorized representative). The samples set forth herein will be helpful for the four types of appeals described in this resource guide:

- Parity Appeal
- UM Appeal
- Grievance Appeal
- External Review Appeal

The appeal documentation will also be critical for other legal proceedings such as arbitration or a civil lawsuit.

The seven samples were selected based on input from real-life claims submitted by Coalition members around the country. These templates represent the most commonly denied claims of mental health and substance use disorder services as of January 2015.

The types of appeals letters are for:

1. If a plan excludes or refuses to cover mental health or substance use services based on facility type
2. If a plan excludes or refuses to cover mental health or substance use services based on levels of care
3. If a plan excludes or refuses to cover office-based diagnostic and treatment interventions
4. If a plan has prior authorization or concurrent review requirements for inpatient levels of care
5. If a plan has prior authorization or concurrent review requirements for outpatient psychotherapy
6. If a plan has prior authorization or concurrent review requirements for other outpatient levels of care (PHP, IOP)

7. If a plan refuses to allow a psychiatrist or addiction medicine physician to bill for evaluation and management (E&M) services for mental health or substance use under established E&M CPT codes while permitting other physicians to use these codes for medical/surgical conditions

Using the Templates

Parity requires plans to provide equal medical/surgical and mental health/substance use benefits. As a result, when preparing to file an appeal, the patient or provider will need to look at the health plan's SPD and compare the medical/surgical benefits with the mental health/substance use benefits to see whether the financial requirements and the numerical and non-numerical treatment limitations imposed on the mental health and substance use benefits appear to be generally the same as or different than those imposed on the medical/surgical benefits.

These templates provide real examples of the reasons why plans have denied claims. We include effective legal rationales to help appeal these denials. In some of the examples, an individual may have to substitute one of the benefits listed in the sample appeal for a benefit that they have been denied. We could not include every type of mental health and substance use benefit in these sample appeals letters. Look for the sample letter that most closely resembles the patient's specific denied claim. Every place where [ ] is, the patient or provider must substitute their own text to personalize the templates.

Guidance for individuals/providers/advocates using these templates

1. Customize the wording of the letter to state at what point in the process your treatment services were denied (e.g., the pre-authorization request, concurrent review request, etc.)
2. Include specific details on the patient's medical and clinical condition, but keep it brief; try not to exceed three pages plus attachments
3. Make sure that the patient or the provider is not duplicating efforts. Individuals 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. The insured must customize the appeal letter. There are placeholders [ ] in the letters where information specific to the appeal should be inserted
5. If the patient sees a "note" on the template, the note must be deleted before customizing and sending the appeal letter

Sample Appeal Letters

Disclaimer: The following documents are intended as general educational materials. The Parity Implementation Coalition and The Kennedy Forum are not law firms and do not provide legal advice. The opinions expressed herein are the consensus of the Parity Implementation Coalition and The Kennedy Forum regarding the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 and are not a comprehensive analysis of all applicable rules governing access to care. Patients and providers challenging health plan denials of mental health or substance use disorder benefits are encouraged to seek knowledgeable counsel to discuss their particular circumstances.

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

Note: Highlights facility-related adverse determinations or denials.

[Insert Date]

[If URGENT, then indicate URGENT APPEAL]

[Insert Name]
[Insert Company Name/Plan]
[Insert Address]

Re: [Insert Patient's Name]
[Insert Patient's Date of Birth]
[Insert Patient's Insurance ID Number]
[Insert Patient's Group ID Number]
[Insert Disputed Service, provider of service, and dates of disputed coverage]

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

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

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

Sincerely,

[Insert your name]

Cc: [insert patient's name]
[insert State Insurance Commissioner's Name]
[insert your Member of Congress' name]

Enclosure: Parity Implementation Coalition Analysis
[Clinical guidelines where appropriate]

The Parity Implementation Coalition has adopted the following position statement with respect to any covered mental health and substance use disorders with **blanket exclusions** of certain provider or facility types (e.g., freestanding or residential treatment facilities).

* * *

Foundationally, the Affordable Care Act, Section 2706 provides that non-grandfathered group health plans may not discriminate against "any health care provider who is acting within the scope of that provider's license or certification under applicable State law." This includes duly licensed freestanding and/or residential treatment facilities.

In addition, and far more specifically, with respect to both grandfathered and non-grandfathered plans, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("Federal Parity Act")[2] requires, without exception:

> In the case of a group health plan or a health insurance issuer offering group or individual health insurance coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that . . .
>
> (ii) the treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage) and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.

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." The regulations implementing the Federal Parity Act reinforce that treatment limitations can be either quantitative (i.e. numeric) or non-quantitative (i.e. non-numeric). The regulations permit only six benefits 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 Interim Final Regulations provide 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

2 The Federal Parity Act was enacted as a set of parallel amendments to the Employee Retirement Income Security Act ("ERISA"), the Public Health Service Act, and the Internal Revenue Code. 75 Fed. Reg. 5411. Accordingly, the federal agencies charged with implementing the Parity Act are the Department of Labor, Department of Health and Human Services, and the Department of the Treasury (collectively, the "Departments"). After the Parity Act was passed, the Departments jointly issued a Request for Information soliciting comments on what regulations would be required. 74 Fed. Reg. 19155 (Apr. 28, 2009). The Departments later jointly issued Interim Final Regulations ("IFRs") on February 2, 2010, see 75 Fed. Reg. 5410 et seq., and Final Regulations on November 13, 2013. See 78 Fed. Reg. 68240 et seq.

disorder in a classification in which it provides medical/surgical benefits, the exclusion of benefits in that classification for a mental health condition or substance use disorder otherwise covered under the plan is a treatment limitation." The Final Regulations underscore that the Federal Parity Act "specifically prohibits separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits." The Final Regulations expressly illustrate that coverage limits based on "facility type" are non-quantitative.

When a plan excludes medically necessary services (i.e. facility type) for covered mental health or substance use disorders based on provider or facility-type, but offers medically necessary treatment services for comparable provider or facility-types for medical/surgical conditions within the same classification, it improperly imposes treatment limitations (i.e. exclusions of facility type) that are not comparable to and applied more stringently than the treatment limitations imposed under the medical and surgical benefits within a classification, and moreover, is applying separate treatment limitations "only" with respect to mental health or substance use disorder benefits. The following example of the impermissible nature of these types of exclusions is set forth in the Final Regulations:

> Facts. A plan generally covers medically appropriate treatments. The plan automatically excludes coverage for inpatient substance use disorder treatment in any setting outside of a hospital (such as a freestanding or residential treatment center). For inpatient treatment outside of a hospital for other conditions (including freestanding or residential treatment centers prescribed for mental health conditions, as well as for medical/surgical conditions), the plan will provide coverage if the prescribing physician obtains authorization from the plan that the inpatient treatment is medically appropriate for the individual, based on clinically appropriate standards of care.
>
> Conclusion. Although the same nonquantitative treatment limitation—medical appropriateness—is applied to both mental health and substance use disorder benefits and medical/surgical benefits, the plan's unconditional exclusion of substance use disorder treatment in any setting outside of a hospital is not comparable to the conditional exclusion of inpatient treatment outside of a hospital for other conditions.

Since the net result of facility-type exclusions is zero (0) days of coverage for medically appropriate treatment, the limitation also violates the prohibition on disparate quantitative limits. This is because the limitation is "more restrictive" than the "predominant limitations on "substantially all" the medical/surgical benefits in the classification. Thus, a plan that covers skilled nursing facilities, physical rehabilitation facilities, home health services or other non-hospital medical/surgical levels of care, while categorically excluding coverage for non-hospital facilities, such as freestanding or residential treatment centers for mental health or substance use disorders, violates both the quantitative and non-quantitative treatment limitations rules of the Federal Parity Act.

Appeal Letter Sample 2: Denial Based on Level of Care Exclusions

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

[Insert Date]

[If URGENT, then indicate URGENT APPEAL]

[Insert Name]
[Insert Company Name/Plan]
[Insert Address]

Re: [Insert Patient's Name]
[Insert Patient's Date of Birth]
[Insert Patient's Insurance ID Number]
[Insert Patient's Group ID Number]
[Insert Disputed Service, provider of service, and dates of disputed coverage]

Dear [Name of contact at health insurance plan]:

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

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

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

Sincerely,

[Insert your name]

Cc: [insert patient's name]
[insert State Insurance Commissioner's Name]
[insert your Member of Congress' name]

Enclosure: Parity Implementation Coalition Analysis
[Clinical guidelines where appropriate]

The Parity Implementation Coalition has adopted the following position statement with respect to any covered mental health and substance use disorders for which **levels of care are categorically excluded.**

* * *

Foundationally, the Affordable Care Act, Section 2706 provides that non-grandfathered group health plans may not discriminate against "any health care provider who is acting within the scope of that provider's license or certification under applicable State law."

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("Federal Parity Act")[3] requires, without exception:

> In the case of a group health plan or a health insurance issuer offering group or individual health insurance coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that . . .
>
> (ii) the treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage) and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.

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." The regulations implementing the Federal Parity Act reinforce that treatment limitations can be either quantitative (i.e. numeric) or non-quantitative (i.e. facility type). The regulations permit only six benefits 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 Interim Final Regulations provide 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 mental health condition or substance use disorder otherwise covered under the plan is a treatment limitation," and the Final Regulations underscore that the Federal Parity Act "specifically

3 The Federal Parity Act was enacted as a set of parallel amendments to the Employee Retirement Income Security Act ("ERISA"), the Public Health Service Act, and the Internal Revenue Code. 75 Fed. Reg. 5411. Accordingly, the federal agencies charged with implementing the Parity Act are the Department of Labor, Department of Health and Human Services, and the Department of the Treasury (collectively, the "Departments"). After the Parity Act was passed, the Departments jointly issued a Request for Information soliciting comments on what regulations would be required. 74 Fed. Reg. 19155 (Apr. 28, 2009). The Departments later jointly issued Interim Final Regulations ("IFRs") on February 2, 2010, see 75 Fed. Reg. 5410 et seq., and Final Regulations on November 13, 2013. See 78 Fed. Reg. 68240 et seq.

prohibits separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits."

The Final Regulations also provide that "[t]he Departments did not intend that plans and issuers could exclude intermediate levels of care covered under the plan from MHPAEA's parity requirements." "Plans and issuers must assign covered intermediate mental health and substance use disorder benefits to the existing six benefit classifications in the same way that they assign comparable intermediated medical/surgical benefits to these classifications." For example, if the plan treats skilled nursing treatment services as inpatient benefits, then the plan must treat residential treatment services as inpatient benefits, if the plan treats home health care as an outpatient benefit, it must treat PHP and IOP as outpatient benefits. When a plan excludes medically necessary services (e.g., residential level of care, PHP, IOP) for covered mental health or substance use disorders but offers multiple levels of care for medical/surgical conditions within the same classification, it improperly imposes treatment limitations that are not comparable to and applied more stringently than the treatment limitations imposed under the medical and surgical benefits within a classification, and moreover, is applying such separate treatment limitations "only" with respect to mental health or substance abuse benefits. The following impermissible example is highlighted by the Final Regulations:

> A plan generally covers medically appropriate treatments. The plan automatically excludes coverage for inpatient substance use disorder treatment in any setting outside of a hospital (such as a freestanding or residential treatment center). For inpatient treatment outside of a hospital for other conditions (including freestanding or residential treatment centers prescribed for mental health conditions, as well as for medical/surgical conditions), the plan will provide coverage if the prescribing physician obtains authorization from the plan that the inpatient treatment is medically appropriate for the individual, based on clinically appropriate standards of care.
>
> Conclusion. Although the same nonquantitative treatment limitation—medical appropriateness—is applied to both mental health and substance use disorder benefits and medical/surgical benefits, the plan's unconditional exclusion of substance use disorder treatment in any setting outside of a hospital is not comparable to the conditional exclusion of inpatient treatment outside of a hospital for other conditions.

Since the net result of level of care exclusions is zero (0) days of coverage for medically appropriate treatment, the limitation also violates the prohibition on disparate quantitative limits. This is because the limitation is "more restrictive" than the "predominant limitations on "substantially all" the medical/surgical benefits in the classification. Thus, a plan that covers skilled nursing facilities, physical rehabilitation facilities, home health services or other non-hospital medical/surgical levels of care, while categorically excluding coverage for levels of care such as residential, PHP or IOP for mental health or substance use disorders, violates both the quantitative and non-quantitative treatment limitation rules of the Federal Parity Act.

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

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

[Insert Date]

[If URGENT, then indicate URGENT APPEAL]

[Insert Name]
[Insert Company Name/Plan]
[Insert Address]

Re: [Insert Patient's Name]
[Insert Patient's Date of Birth]
[Insert Patient's Insurance ID Number]
[Insert Patient's Group ID Number]
[Insert Disputed Service, provider of service, and dates of disputed coverage]

Dear [Name of contact at health insurance plan]:

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

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

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

Sincerely,

[Insert your name]

Cc: [insert patient's name]
[insert State Insurance Commissioner's Name]
[insert your Member of Congress' name]

Enclosure: Parity Implementation Coalition Analysis
[Clinical guidelines where appropriate]

The Parity Implementation Coalition has adopted the following position statement with respect to any covered mental health and substance use disorders with **blanket exclusions** of **office-based diagnostic and treatment interventions** (such as psychological testing for diagnostic assessments or other treatment services like individual psychotherapy and family counseling).

* * *

Foundationally, the Affordable Care Act, Section 2706 provides that non-grandfathered group health plans may not discriminate against "any health care provider who is acting within the scope of that provider's license or certification under applicable State law."

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("Federal Parity Act")[4] requires, without exception:

> In the case of a group health plan or a health insurance issuer offering group or individual health insurance coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that . . .
>
> (ii) the treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage) and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.

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." The regulations implementing the Federal Parity Act reinforce that treatment limitations can be either quantitative (i.e. numeric) or non-quantitative (i.e. non-numeric). The regulations create six benefits 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 Interim Final Regulations provide 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

4 The Federal Parity Act was enacted as a set of parallel amendments to the Employee Retirement Income Security Act ("ERISA"), the Public Health Service Act, and the Internal Revenue Code. 75 Fed. Reg. 5411. Accordingly, the federal agencies charged with implementing the Parity Act are the Department of Labor, Department of Health and Human Services, and the Department of the Treasury (collectively, the "Departments"). After the Parity Act was passed, the Departments jointly issued a Request for Information soliciting comments on what regulations would be required. 74 Fed. Reg. 19155 (Apr. 28, 2009). The Departments later jointly issued Interim Final Regulations ("IFRs") on February 2, 2010, see 75 Fed. Reg. 5410 et seq., and Final Regulations on November 13, 2013. See 78 Fed. Reg. 68240 et seq.

classification for a mental health condition or substance use disorder otherwise covered under the plan is a treatment limitation," 75 Fed. Reg. 5410, 5413 (Feb. 2, 2010), and the Final Regulations underscore that the Federal Parity Act "specifically prohibits separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits." 78 Fed. Reg. 68240, 68245 (Nov. 13, 2013).

When a plan excludes medically necessary services for covered mental health or substance use disorders but offers multiple services for medical/surgical conditions within the same classification, it improperly imposes treatment limitations (i.e. exclusions of medically necessary services) that are not comparable to and applied more stringently than the treatment limitations imposed under the medical and surgical benefits within a classification, and moreover, applies such separate treatment limitations "only" with respect to mental health or substance abuse benefits.

Since the net result of excluding office-based diagnostic and treatment interventions is zero (0) days of coverage for medically appropriate treatment, the limitation also violates the prohibition on disparate quantitative limits. This is because the limitation is "more restrictive" than the "predominant limitations on "substantially all" the medical/surgical benefits in the classification.

Appeal Letter Sample 4: Medical Necessity Denial for Inpatient Services

Note: Highlights prior authorization or concurrent review requirements or inpatient services.

[Insert Date]

[If URGENT, then indicate URGENT APPEAL]

[Insert Name]
[Insert Company Name/Plan]
[Insert Address]

Re: [Insert Patient's Name]
[Insert Patient's Date of Birth]
[Insert Patient's Insurance ID Number]
[Insert Patient's Group ID Number]
[Insert Disputed Service, provider of service, and dates of disputed coverage]

Dear [Name of contact at health insurance plan]:

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

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

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

Sincerely,

[Insert your name]

Cc: [insert patient's name]
[insert State Insurance Commissioner's Name]
[insert your Member of Congress' name]

Enclosure: Parity Implementation Coalition Analysis
[Clinical guidelines where appropriate]

The Parity Implementation Coalition has adopted the following position statement with respect to any covered mental health and substance use disorders requiring **prior authorization or concurrent reviews for inpatient levels of care.**

* * *

Foundationally, the Affordable Care Act, Section 2706 provides that non-grandfathered group health plans may not discriminate against "any health care provider who is acting within the scope of that provider's license or certification under applicable State law."

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("Federal Parity Act")[5] requires, without exception:

> In the case of a group health plan or a health insurance issuer offering group or individual health insurance coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that . . .
>
> (ii) the treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage) and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.

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." The regulations implementing the Federal Parity Act reinforce that treatment limitations can be either quantitative (i.e. numeric) or non-quantitative (i.e. non-numeric). The regulations create six benefits 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.

Both the Interim Final Regulations and the Final Regulations expressly identify "preauthorization," "concurrent review," "case management," and "utilization review" as "medical management techniques" used by plans to assess medical necessity. Although health plans may condition both mental health/substance use disorder and medical/surgical benefits on medical necessity, the regulations nonetheless

5 The Federal Parity Act was enacted as a set of parallel amendments to the Employee Retirement Income Security Act ("ERISA"), the Public Health Service Act, and the Internal Revenue Code. 75 Fed. Reg. 5411. Accordingly, the federal agencies charged with implementing the Parity Act are the Department of Labor, Department of Health and Human Services, and the Department of the Treasury (collectively, the "Departments"). After the Parity Act was passed, the Departments jointly issued a Request for Information soliciting comments on what regulations would be required. 74 Fed. Reg. 19155 (Apr. 28, 2009). The Departments later jointly issued Interim Final Regulations ("IFRs") on February 2, 2010, see 75 Fed. Reg. 5410 et seq., and Final Regulations on November 13, 2013. See 78 Fed. Reg. 68240 et seq.

require that any processes and strategies used to assess medical necessity for mental health/substance use disorder care be comparable to and applied no more stringently than those used to assess the medical necessity of medical/surgical care. Thus, health plans may not require preauthorization only for inpatient admissions for mental health or substance use disorders without requiring the same for medical/surgical care within the corresponding classifications.

Additionally, as highlighted by the Final Regulations, health plans may not apply concurrent reviews more stringently for inpatient mental health or substance use care than for medical/surgical care within the corresponding classifications:

> Facts. A plan requires prior authorization from the plan's utilization reviewer that a treatment is medically necessary for all inpatient medical/surgical benefits and for all inpatient mental health and substance use disorder benefits. In practice, inpatient benefits for medical/surgical conditions are routinely approved for seven days, after which a treatment plan must be submitted by the patient's attending provider and approved by the plan. On the other hand, for inpatient mental health and substance use disorder benefits, routine approval is given only for one day, after which a treatment plan must be submitted by the patient's attending provider and approved by the plan.
>
> Conclusion. In this [e]xample, the plan violates the rules . . . because it is applying a stricter nonquantitative treatment limitation in practice to mental health and substance use disorder benefits than is applied to medical/ surgical benefits.

Appeal Letter Sample 5: Medical Necessity Denial for Outpatient Psychotherapy

Note: Applies to prior authorization or concurrent review requirements.

[Insert Date]

[If URGENT, then indicate URGENT APPEAL]

[Insert Name]
[Insert Company Name/Plan]
[Insert Address]

Re: [Insert Patient's Name]
[Insert Patient's Date of Birth]
[Insert Patient's Insurance ID Number]
[Insert Patient's Group ID Number]
[Insert Disputed Service, provider of service, and dates of disputed coverage]

Dear [Name of contact at health insurance plan]:

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

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

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

Sincerely,

[Insert your name]

Cc: [insert patient's name]
[insert State Insurance Commissioner's Name]
[insert your Member of Congress' name]

Enclosure: Parity Implementation Coalition Analysis
[Clinical guidelines where appropriate]

The Parity Implementation Coalition has adopted the following position statement with respect to any covered mental health and substance use disorders requiring **prior authorization** or **concurrent reviews** for **outpatient psychotherapy.**

* * *

Foundationally, the Affordable Care Act, Section 2706 provides that non-grandfathered group health plans may not discriminate against "any health care provider who is acting within the scope of that provider's license or certification under applicable State law."

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("Federal Parity Act")[6] requires, without exception:

> In the case of a group health plan or a health insurance issuer offering group or individual health insurance coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that . . .
>
> (ii) the treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage) and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.

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." The regulations implementing the Federal Parity Act reinforce that treatment limitations can be either quantitative (i.e. numeric) or non-quantitative (i.e. non-numeric). The regulations create six benefits 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.

Both the Interim Final Regulations and the Final Regulations expressly identify "preauthorization," "concurrent review," "case management," and "utilization review" as "medical management techniques" used by plans to assess medical necessity. Although health plans may condition both mental health/

6 The Federal Parity Act was enacted as a set of parallel amendments to the Employee Retirement Income Security Act ("ERISA"), the Public Health Service Act, and the Internal Revenue Code. 75 Fed. Reg. 5411. Accordingly, the federal agencies charged with implementing the Parity Act are the Department of Labor, Department of Health and Human Services, and the Department of the Treasury (collectively, the "Departments"). After the Parity Act was passed, the Departments jointly issued a Request for Information soliciting comments on what regulations would be required. 74 Fed. Reg. 19155 (Apr. 28, 2009). The Departments later jointly issued Interim Final Regulations ("IFRs") on February 2, 2010, see 75 Fed. Reg. 5410 et seq., and Final Regulations on November 13, 2013. See 78 Fed. Reg. 68240 et seq.

substance use disorder and medical/surgical benefits on medical necessity, the regulations nonetheless require that any processes, strategies, evidentiary standards or other factors used to assess medical necessity for mental health/substance use disorder care be comparable to and applied no more stringently than those used to assess the medical necessity of medical/surgical care. For purposes of parity compliance, health plans may not apply medical management techniques such as preauthorization or concurrent reviews to all outpatient mental health/substance abuse benefits while doing so for only a de minimis portion of benefits within the corresponding medical/surgical classifications. In fact, this specific scenario was highlighted in the Interim Final Regulations:

> A group health plan limits benefits to treatment that is medically necessary. The plan requires concurrent review for inpatient, in-network mental health and substance use disorder 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 . . . Although the same nonquantitative treatment limitation—medical necessity—applies to both mental health and substance use disorder benefits and to medical/surgical benefits for inpatient, in-network services, the concurrent review process does not apply to medical/surgical benefits. The concurrent review process is not comparable to the retrospective review process . . . such a difference… is not permissible for distinguishing between all medical/surgical benefits and all mental health or substance use disorder benefits.

Further reinforced in the Final Regulations, "Cross-walking or pairing specific mental health or substance use disorder benefits with specific medical/surgical benefits is a static approach that the Departments do not believe is feasible, given the difficulty in determining 'equivalency' between specific medical/surgical benefits and specific mental health and substance use disorder benefits and because of the differences in the types of benefits that may be offered by any particular plan." 78 Fed. Reg. at 68243. Accordingly, health plans cannot require preauthorization for outpatient psychotherapy without requiring the same for all outpatient, office-based medical/surgical visits.

Likewise, health plans cannot impose concurrent reviews (that effectively impose preauthorization) to ration outpatient psychotherapy already in effect if the same is not imposed for outpatient medical/surgical office visits within the corresponding classifications.

Moreover, not only must the processes and strategies assessing medical necessity (such as preauthorization and concurrent reviews) be comparable between mental health/substance use benefits and medical/surgical benefits within the same classifications, but the processes and strategies assessing medical necessity for mental health or substance use disorder benefits must also be applied "no more stringently than" those applied to medical/surgical benefits within the corresponding classifications. Thus, requiring treatment plans or submission of continued service requests for mental health or substance use care when the same is not required at all or at the same frequencies for medical/surgical care within the same classifications would violate the "comparability" and "no more stringent than" tests of the nonquantitative treatment limitation parity rule.

Appeal Letter Sample 6: Medical Necessity Denial for Non-Psychotherapy, Outpatient Levels of Care

Note: Applies to prior authorization or concurrent review requirements (i.e. PHP, IOP).

[Insert Date]

[If URGENT, then indicate URGENT APPEAL]

[Insert Name]
[Insert Company Name/Plan]
[Insert Address]

Re: [Insert Patient's Name]
[Insert Patient's Date of Birth]
[Insert Patient's Insurance ID Number]
[Insert Patient's Group ID Number]
[Insert Disputed Service, provider of service, and dates of disputed coverage]

Dear [Name of contact at health insurance plan]:

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

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

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

Sincerely,

[Insert your name]

Cc: [insert patient's name]
[insert State Insurance Commissioner's Name]
[insert your Member of Congress' name]

Enclosure: Parity Implementation Coalition Analysis
[Clinical guidelines where appropriate]

The Parity Implementation Coalition has adopted the following position with respect to any covered mental health and substance use disorders requiring **prior authorization** or **concurrent reviews** for **outpatient levels of care.**

* * *

Foundationally, the Affordable Care Act, Section 2706 provides that non-grandfathered group health plans may not discriminate against "any health care provider who is acting within the scope of that provider's license or certification under applicable State law."

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("Federal Parity Act")[7] requires, without exception:

> In the case of a group health plan or a health insurance issuer offering group or individual health insurance coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that . . .
>
> (ii) the treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage) and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.

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." The regulations implementing the Federal Parity Act reinforce that treatment limitations can be either quantitative (i.e. numeric) or non-quantitative (i.e. non-numeric). The regulations create six benefits 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.

Both the Interim Final Regulations and the Final Regulations expressly identify "preauthorization," "concurrent review," "case management," and "utilization review" as "medical management techniques" used by plans to assess medical necessity. Although health plans may condition both mental health/substance use disorder and medical/surgical benefits on medical necessity, the regulations nonetheless

7 The Federal Parity Act was enacted as a set of parallel amendments to the Employee Retirement Income Security Act ("ERISA"), the Public Health Service Act, and the Internal Revenue Code. 75 Fed. Reg. 5411. Accordingly, the federal agencies charged with implementing the Parity Act are the Department of Labor, Department of Health and Human Services, and the Department of the Treasury (collectively, the "Departments"). After the Parity Act was passed, the Departments jointly issued a Request for Information soliciting comments on what regulations would be required. 74 Fed. Reg. 19155 (Apr. 28, 2009). The Departments later jointly issued Interim Final Regulations ("IFRs") on February 2, 2010, see 75 Fed. Reg. 5410 et seq., and Final Regulations on November 13, 2013. See 78 Fed. Reg. 68240 et seq.

require that any processes, strategies, evidentiary standards or other factors developed and applied to assess medical necessity for mental health/substance use disorder care must be comparable to and applied no more stringently than how they are developed and applied to assess the medical necessity of medical/surgical care. Thus, health plans may not require preauthorization or concurrent review for outpatient level of care admissions for mental health or substance use disorders without requiring the same for outpatient medical/surgical care within the corresponding classifications.

Appeal Letter Sample 7: Service Coding

Note: Applies to billing issues related to behavioral health coverage.

[Insert Date]

[If URGENT, then indicate URGENT APPEAL]

[Insert Name]
[Insert Company Name/Plan]
[Insert Address]

Re: [Insert Patient's Name]
[Insert Patient's Date of Birth]
[Insert Patient's Insurance ID Number]
[Insert Patient's Group ID Number]
[Insert Disputed Service, provider of service, and dates of disputed coverage]

Dear [Name of contact at health insurance plan]:

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

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

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

Sincerely,

[Insert your name]

Cc: [insert patient's name]
[insert State Insurance Commissioner's Name]
[insert your Member of Congress' name]

Enclosure: Parity Implementation Coalition Analysis
[Clinical guidelines where appropriate]

The Parity Implementation Coalition has adopted the following position statement with respect to **service coding** for any covered mental health and substance use disorders.

* * *

Foundationally, the Affordable Care Act, Section 2706 provides that non-grandfathered group health plans may not discriminate against "any health care provider who is acting within the scope of that provider's license or certification under applicable State law."

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("Federal Parity Act")[8] requires, without exception:

> In the case of a group health plan or a health insurance issuer offering group or individual health insurance coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that . . .
>
> (ii) the treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage) and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.

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." The regulations implementing the Federal Parity Act reinforce that treatment limitations can be either quantitative (i.e. numeric) or non-quantitative (i.e. non-numeric). The regulations create six benefits 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.

Whereas the Interim Final Regulations held 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 mental health condition or substance use disorder otherwise covered under the

8 The Federal Parity Act was enacted as a set of parallel amendments to the Employee Retirement Income Security Act ("ERISA"), the Public Health Service Act, and the Internal Revenue Code. 75 Fed. Reg. 5411. Accordingly, the federal agencies charged with implementing the Parity Act are the Department of Labor, Department of Health and Human Services, and the Department of the Treasury (collectively, the "Departments"). After the Parity Act was passed, the Departments jointly issued a Request for Information soliciting comments on what regulations would be required. 74 Fed. Reg. 19155 (Apr. 28, 2009). The Departments later jointly issued Interim Final Regulations ("IFRs") on February 2, 2010, see 75 Fed. Reg. 5410 et seq., and Final Regulations on November 13, 2013. See 78 Fed. Reg. 68240 et seq.

plan is a treatment limitation," the Final Regulations underscore that the Federal Parity Act "specifically prohibits separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits." The Final Regulations specifically establish that any limitations on "service coding" are non-quantitative.

Thus, a plan that categorically refuses to allow a psychiatrist or addiction specialist physician to bill for evaluation and management services for mental health or substance use disorders under established evaluation and management ("E&M CPT") physician codes while permitting all other non-psychiatric physicians to use these codes for medical/surgical disorders plainly violates the parity requirements by applying a treatment limitation ("service coding") exclusively to benefits for mental health or substance use disorders.

Appendix C: Helpful Resources

State Resources

External Review Process by State from the Kaiser Family Foundation:
http://kff.org/other/state-indicator/external-appeals-review-processes/

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.

State Insurance Regulators

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Missouri
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Nebraska
Jason McCartney
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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 Service's website on the Affordable Care Act health reform law: www.healthcare.gov

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/CCIIO/Resources/Fact-Sheets-and-FAQs/non_federal_governmental_plans_04072011.html

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.

http://www.samhsa.gov/health-financing/implementation-mental-health-parity-addiction-equity-act
For information about parity.

National Association of Insurance Commissioners:
http://naic.org/state_web_map.htm

U.S. Centers for Medicare and Medicaid Services (CMS): http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html

U.S. 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 and 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.

Appendix D: 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.

- The American Academy of Child and Adolescent Psychiatry: www.aacap.org
- The American Psychiatric Association: www.psych.org
- The American Society of Addiction Medicine: www.asam.org
- Cumberland Heights: www.cumberlandheights.org
- The Hazelden Betty Ford Foundation: www.hazeldenbettyford.org
- MedPro Billing: www.medprobill.com
- Mental Health America: www.mentalhealthamerica.net
- National Alliance on Mental Illness: www.nami.org
- National Association of Addiction Treatment Providers: www.naatp.org
- National Association of Psychiatric Health Systems: www.naphs.org
- The Watershed Addiction Treatment Programs: www.thewatershed.com
- Young People in Recovery: www.youngpeopleinrecovery.org

Appendix E: Abbreviations

AAAHC:
Accreditation Association for Ambulatory Health Care, Inc.

ACA:
Affordable Care Act

BHO:
Behavioral Health Organization

CMS:
Centers for Medicare and Medicaid Services

DOI:
Department of Insurance (state level)

DOD/VA:
U.S. Department of Defense/Veteran's Affairs

DOL:
U.S. Department of Labor

ERISA:
Employee Retirement Income Security Act

FAQ:
Frequently Asked Questions

HHS:
U.S. Department of Health and Human Services

IRO:
Independent Review Organization

MCO:
Managed Care Organization

MH/SUD:
Mental Health/Substance Use Disorder

NAIC:
National Association of Insurance Commissioners

NCQA:
National Committee for Quality Assurance

NQTL:
Non-Quantitative Treatment Limitations

QTL:
Quantitative Treatment Limitations

SPD:
Summary Plan Description

Treasury:
U.S. Department of Treasury

UM:
Utilization Management

UR:
Utilization Review

URAC:
Formerly the Utilization Review Accreditation Commission, which now just goes by URAC

Appendix F: About The Kennedy Forum

The Kennedy Forum was founded in 2013 as a way to convene cutting-edge thinkers who are united by the potential for reform in mental health service delivery made possible by new laws, new technologies and an enhanced understanding of effective services and treatments. Our inaugural event in October 2013 brought a call for the Forum to develop a platform to advance the best thinking across a host of issues in our field. To meet this demand, The Kennedy Forum is organized as a think tank, poised to drive real, lasting and meaningful policy change, bringing the nation closer to fulfilling President Kennedy's vision as outlined in the 1963 Community Mental Health Act.

Today, The Kennedy Forum's work is not singular in its focus; we are promoting mental health coverage through a series of initiatives by:

- Ensuring health plan accountability and compliance with the letter and spirit of the parity law, in large part by educating consumers, providers and regulators, so that each group holds themselves and others accountable for enforcing it.
- Establishing ways to promote provider accountability through evidence-based outcomes measures that are validated and quantifiable.
- Implementing proven collaborative practice models that promote the integration of MH/SU disorder services into mainstream health care.
- Using technology to optimize electronic/digital communications and enhance assessment/treatment tools.
- Promoting brain fitness and wellness, which includes identifying opportunities to translate neuroscience research findings into preventative and treatment interventions.

Please monitor our website, www.thekennedyforum.org, to track our ongoing activities in support of these five initiatives and other activities central to The Kennedy Forum's mission.

The Parity Implementation Coalition includes the American Psychiatric Association, American Society of Addiction Medicine, Cumberland Heights, Hazelden Betty Ford Foundation, MedPro Billing, Mental Health America, National Alliance on Mental Illness, National Association of Psychiatric Health Systems, National Association of Addiction Treatment Providers, The Watershed Addiction Treatment Programs and Young People in Recovery. The organizations advanced parity legislation and implementing regulations for over fourteen 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. More information about the Coalition is available at www.parityispersonal.org.