

Health Care Coverage for the Relentless

Insurance essentials from a mother's quest for mental health parity



INTRODUCTION

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This guide is intended to help families and individuals navigate the difficult terrain of health insurance in America. It provides information to individuals so that they are more informed about mental health care and substance use disorder insurance coverage. It also provides step-by-step guidance on what to do if your insurance company refuses to cover professionally recommended mental health or addiction care.

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ABOUT WELL BEING TRUST

Well Being Trust is a national foundation dedicated to advancing the mental, social, and spiritual health of the nation. Created to include participation from organizations across sectors and perspectives, Well Being Trust is committed to innovating and addressing the most critical mental health challenges facing America, and to transforming individual and community well-being. For more information, visit wellbeingtrust.org.

ACKNOWLEDGEMENTS

This guide was written by Carmen Bombeke, PE, BCPA, Maine-based mother, certified parent coach and structural engineer.

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FIND SUPPORT

If you or someone you know is struggling, you are not alone. There are many support services and treatment options that may help. Call The National Suicide Prevention Lifeline for Free, Confidential 24-hour Support:

1-800-273-TALK (8255)

Crisis Text Line 24/7 Support

Text HOME to 741741

TABLE OF CONTENTS

4	Foreword	58	Appeals
5	Fundamentals		Appeal Introduction
	The Plan		First Steps
	The Benefits		First Level Appeal – Administrative Denial
	Your Condition and Treatment Plan		First Level Appeal – Coverage Denial
	Your Diagnosis		First Level Appeal – Clinical Denial
	Providers		Filing Your First Level Appeal (All Types)
	Treatment Plan		Filing a Second (Or Third) Level Appeal (All Types)
27	Claims	76	External Review and Beyond
	Processes and Procedures		External Review
31	Explanation of Benefits		Arbitration, Litigation and Beyond
	Understanding an EOB	79	Concluding Remarks
	EOB Handling	80	Abbreviations
36	Reconsiderations	81	Glossary
	Applicability	88	References
	Filing a Reconsideration Request	89	Consumer Resources
41	Complaints		
	Applicability		
	Filing a Complaint		
	Taking it to the Next Level		
49	Denials		
	Denial Basics		
	Denial Assessment		

Foreword

It was a rainy day in Washington, D.C., when former U.S. Rep. Patrick Kennedy kicked off the Agenda for Change: Unite. Connect. Act.

The event was held in February 2020, and it was hosted by the Kennedy Forum, an organization founded to chart a course for mental health equity. The room was packed with attendees from policy makers to students; there was not an open seat.

I vividly remember this day for two reasons. First, it was one of the last trips I took before our country was hit by COVID-19 closing our opportunities for congregating for the foreseeable future. But it's the second part of my memory I want to tell you more about as it led to the product that you are now reading.

Carmen Bombeke, a mom, a structural engineer, and up until a year ago, not an expert in health insurance, shared her story about the challenges of getting help for her son and getting her health insurance to pay for that help. Rather than tell you the whole story, I encourage you to watch Carmen speak at the event. [You can watch the video here.](#)

Carmen had the room stunned. Her story of frustration, despair, and then hope inspired us all. When it was my time, I remember walking up to the dais and thinking "what could I possibly say that comes close to the power of what she just shared?" It truly was a moment to remember for those in attendance.

After the event, I made a beeline for the airport for the afternoon flight home. I had about an hour before my flight and decided to stop at Legal Sea Foods in Reagan National for some shrimp tacos before the four-hour flight home. I had just ordered when I notice someone sit next to me at the open seat at the bar. It was Carmen.

Our conversation began with me thanking her for her leadership in an area that most people would have given up, yet she persevered. I asked her about what

she thought families needed – what tools are needed to help them effectively navigate health insurance plans and coverage. Thankfully, the Kennedy Forum had done the lion's share of the work creating websites and products to help people navigate the ins and outs of mental health parity. But still, it felt like families still needed something – like as much help as they could get to be successful.

Carmen and I scarfed down our food and went to our respective planes. I emailed her a few weeks later asking about what it would look like for us to collaborate and develop tools and resources to help individuals and families better understand health insurance coverage and more specifically, mental health and substance use disorder coverage. A year later, that idea is in your hands.

We entitled this Health Care Coverage for the Relentless: Insurance essentials from a mother's quest for mental health parity because the soul of this work is Carmen's story. What she learned, what she wished she had known, and what she thinks would be helpful for others. Think of this less as a guide on mental health parity, though it does touch on that, and see this as more of a guide to navigate the treacherous terrain of health insurance in America. We often are without a roadmap, without the tools and resources, so Carmen stepped up and crafted a product that we think should be in every family's hands as they work to navigate the health care system.



Benjamin Miller, PsyD
Chief Strategy Officer
Well Being Trust

FUNDAMENTALS



CARMEN'S COMMENTARY

Health insurance is acknowledged as a key consumer issue. It ranks high in political polls. People say good health is one of the things they are most thankful for. But what do we really know about our health benefits? Especially mental health and substance use disorder (MH/SUD) coverage? I certainly didn't know much! My husband and I had similarly sized employers with similar plans. In August 2013, we decided to put our son on his plan based on the lower premium cost and slightly better HSA contributions by his employer. We didn't put much more thought into it than that.

In February 2017, my son lay unconscious on a stretcher in the emergency room as I handed his insurance ID card to the admission staff. I knew so little. Now, after years stumbling, begging and fighting my way through the health care maze (which is short compared to many of you!), I want to share what I learned the hard way in hopes of easing the journey and burden of other families.

The Plan

Who's Who in your health benefits plan?

It is essential that you understand the Who's Who of your specific health care plan: Who is covered; who is providing care; who is covering care; and who is overseeing the plan.



SUBSCRIBER

Person who enrolls in the plan (e.g., the employee in an employer-sponsored plan).



MEMBER

Person covered by the health plan, including the subscriber and any dependents.



DEPENDENT

A person covered by the plan other than the subscriber, such as a spouse, domestic partner and/or a child under 26 years old.



PROVIDER

Licensed professional or facility that delivers health care. Providers may be in-network or out-of-network according to your plan. In-network providers have contracted with the plan to provide services at a rate negotiated with the insurer. Out-of-network providers have no contract with the plan.



PLAN ADMINISTRATOR

Person designated to enroll people in a health care plan. Plan administrator roles and responsibilities vary depending on plan type.



INSURER

Company underwriting health care benefits.¹



BEHAVIORAL HEALTH INSURER (CARVE-OUT)

Insurer providing MH/SUD benefits as a subcontract to the insurance plan. This occurs when the primary insurer separates services from their plan, essentially "carving" them out, then contracts those carved-out services to another insurer.



REGULATOR

Legal or government authority charged with overseeing the plan and enforcing the health care provisions of state and federal laws.

What is your plan type?

There are a variety of types of health care plans and each plan has unique governing documents and provider networks. This guide will primarily focus on processes related to employer-sponsored health insurance plans, through which the majority of Americans receive health care coverage. To maximize your benefits and minimize out-of-pocket costs, you must follow the guidelines for seeking care according to your plan documents (e.g., getting a referral if required), and you must understand the benefit process for in-network and out-of-network services.

1

PREFERRED PROVIDER ORGANIZATIONS (PPOs)

PPOs give you the option of using in-network or out-of-network providers. You typically pay less for in-network providers and more for out-of-network providers. PPOs often have higher deductibles and out-of-pocket maximums for out-of-network services than in-network services. With a PPO plan you can visit a doctor without a referral.

2

POINT-OF-SERVICE (POS) PLANS

POS plans require you to select a primary care physician (PCP) from a list of participating providers. Your PCP can refer you to other providers when needed. POS plans give you the option to use in-network or out-of-network providers. You typically pay less for in-network providers and more for out-of-network providers. POS plans often have higher deductibles and out-of-pocket maximums for out-of-network services than in-network services. With a POS plan you need a referral from your PCP to see other providers.

3

HEALTH MAINTENANCE ORGANIZATIONS (HMOs)

HMOs usually require you to select a PCP from a list of participating providers who work for or contract with the HMO. Your PCP can refer you to other in-network providers when needed. With an HMO you need a referral from your PCP for your visit to other in-network providers to be eligible for coverage, except in an emergency. Only referrals to providers who work for or contract with the HMO will be eligible for coverage. If you visit a provider who is not in the HMO network, your visit will likely not be covered, and you should expect to pay out-of-pocket for the full amount plus any ancillary services.

Unfortunately, the MH/SUD benefits journey often begins with a crisis event. In the event of emergency care, you may not have the option to select an in-network provider. Health plans typically cannot deny coverage or require higher copayments or coinsurance when emergency services are provided by an out-of-network provider, although out-of-network providers may bill you for additional (non-medical) costs which may not be covered.



Who is funding your plan?

There are a variety of payers and payment arrangements in the health insurance system, including government-funded plans, government-subsidized plans and employer-sponsored plans.

MEDICARE

Medicare is a federally funded health insurance program for people who are 65 and older, certain younger people with disabilities and people with end-stage renal disease. You must meet certain conditions to get Medicare benefits. Medicare has four different parts, each covering specific services:

- **Medicare Part A** is often referred to as Medicare's hospital insurance. It covers inpatient hospital stays, care in a skilled nursing facility, hospice care and some home health care. Part A is free for people who paid Medicare taxes while they were working (or had a spouse who paid Medicare taxes). People who did not pay Medicare taxes may pay a premium for Part A. There is an inpatient deductible.
- **Medicare Part B** is often referred to as Medicare's medical insurance. It covers certain physician services, outpatient care, medical supplies and preventive services that Part A does not cover. Part B is optional. Most people must purchase Medicare Part B coverage. The Part B premium may be higher depending on your income and may vary from year to year depending on your income.²
- **Medicare Part C** is the Medicare Advantage Plan. Part C is offered by private companies that contract with Medicare. Medicare Advantage Plans (Part C) include Part A and Part B coverage and may also offer extra benefits such as hearing, vision, dental and/or health and wellness programs. Most Medicare Advantage Plans include prescription drug coverage as well (Part D). The cost for Medicare Advantage Plans varies. The private companies which administer the plans set the amounts they charge for premiums, deductibles and services.³
- **Medicare Part D** covers prescription drugs, including many recommended vaccines. Part D is offered by private companies that contract with Medicare. Part D requires a monthly premium (in addition to any Part B premium) and deductibles vary by plan. Some Medicare drug plans do not have a deductible. Actual drug costs will vary depending on the prescription drugs you use, your plan and your pharmacy (in-network or not).⁴



MEDICAID

Medicaid is a joint federal and state health insurance program that helps pay medical costs for low-income individuals and families who meet certain eligibility criteria recognized by federal and state law. Patients usually do not pay for covered medical services, although a small copayment is sometimes required. Medicaid is administered by state and local governments within federal guidelines. Medicaid may offer benefits not normally covered by Medicare, such as nursing home care and personal care services. It is possible to have both Medicare and Medicaid if you qualify. If you have both, Medicare pays first and Medicaid pays second.⁵

CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

CHIP provides free or low-cost insurance for children in working families who earn too much to qualify for Medicaid but may need assistance obtaining affordable insurance for their children. CHIP is a joint federal and state health insurance program. It is administered by state governments within federal guidelines. CHIP benefits vary by state, but all states provide comprehensive care including doctor visits, immunizations, prescriptions, preventive services, hospital care, emergency services, etc. Some services are free whereas others may require a copayment. Some states charge a premium for CHIP coverage, although typically no more than 5 percent of a family's income.⁶

HEALTH INSURANCE MARKETPLACE (MARKETPLACE OR EXCHANGE)

The [Patient Protection and Affordable Care Act](#) (ACA, also sometimes referred to as "Obamacare") was enacted in March 2010 to provide comprehensive healthcare reform and make affordable health insurance available to more people. As part of the ACA, the federal government established the Health Insurance Marketplace to help people shop for and enroll in health insurance plans; some states operate their own Marketplace. The cost for Marketplace plans varies depending on the plan and your income and household factors. Coverage and out-of-pocket costs vary significantly by plan. Premium and cost-sharing subsidies based on income are available through the Marketplace to make coverage affordable for individuals and families. To be eligible for Marketplace health coverage you must live in the United States, be a U.S. citizen or national (or be lawfully present) and not be incarcerated. Small businesses may use the Marketplace to buy coverage for their employees. If you have Medicare coverage you may not be eligible to use the Marketplace.⁷



EMPLOYER-SPONSORED HEALTH INSURANCE

Employer-sponsored health insurance is insurance offered by an employer. This is the most common form of health insurance in the United States. Typically, the employer offers one or more health plan options to eligible employees and covers all or part of the premium cost. Employees can usually add family members for an additional premium. Coverage and out-of-pocket costs vary significantly depending on the plan.

Some employer-sponsored plans are self-funded whereas others are fully-funded plans. Fully-funded plans operate like the traditional concept of insurance. The employer, group or individual engages an insurance company to administer and manage the plan and pay claims. The insurance company assumes the risk and pays claims out of monies received through premiums.

With a self-funded plan, the employer pays the cost of the health care services (claims) for its enrolled employees and their covered dependents. Historically, self-funded plans were only practical for very large companies with enormous assets because only they were able to assume the risk of a member incurring catastrophic health care costs. In these cases, companies could also customize their plans. However, self-funded plans are now common for smaller employers who may participate in multiemployer benefit plans or who purchase a self-funded plan combined with stop-loss insurance which puts a cap on the financial risk assumed by the employer. Employers with self-funded plans have fiduciary liability and responsibility. Small employers often engage a third-party administrator (TPA) to administer self-funded plans (process claims, etc.). Small employers purchasing self-funded plans often do not have the option to customize the plan. They may also be ill-equipped or unwilling to demand accountability from the TPA.

Who oversees your plan?

There is no single regulatory agency responsible for overseeing all insurance plans. Plans differ, as do rules, regulations and oversight organizations.

The U.S. Department of Health and Human Services (HHS), for example, oversees plans administered by the U.S. Centers for Medicare and Medicaid Services (CMS) on the Health Insurance Marketplace. Plans in this category include Medicare, Medicaid, the Federal Employees Health Benefits (FEHB) Program, Indian Health Services, and TRICARE – insurance for uniformed service members, retirees, and their families.

To an extent, HHS oversees private insurance plans that are self-funded, too. Most self-funded plans are subject to the Employee Retirement Income and Security Act of 1974 (ERISA) and overseen by the U.S. Department of Labor (DOL). In many cases the DOL only has jurisdiction over the employer, so infringements by the TPA may be difficult to resolve.

Fully-funded insurance plans, e.g. commercial insurance plans that employers often purchase and provide to their employee population, are overseen by the applicable state regulatory agency and may be subject to some federal laws, as well as state regulations.

Although there are regulations across all of these entities that are designed to protect consumers and ensure minimum standards, the lack of uniformity and consistency between each can make it difficult for the consumer to understand what rules apply to their plan and who, if anyone, has the clout to hold the insurer accountable. Accreditation organizations offer another form of accountability, but they do not tend to leverage their power frequently, as evidenced by the overwhelming percentage of insurers that hold and maintain their accreditation regardless of behavior.

Additional information about plans overseen by the HHS and DOL can be found at the following links:

Medicare: <https://www.medicare.gov/claims-appeals> or the Ombudsman: [cms.gov/Center/Special-Topic/Ombudsman/Medicare-Beneficiary-Ombudsman-Home](https://www.cms.gov/Center/Special-Topic/Ombudsman/Medicare-Beneficiary-Ombudsman-Home)

Medicaid (appeals handled at state level, as benefits and services can vary by state): [medicaid.gov/about-us/contact-us/contact-your-state-questions/index.html](https://www.medicicaid.gov/about-us/contact-us/contact-your-state-questions/index.html)

The Federal Employees Health Benefits (FEHB) Program: [opm.gov/healthcare-insurance/healthcare/consumer-protections/#url=Disputed-Claims](https://www.opm.gov/healthcare-insurance/healthcare/consumer-protections/#url=Disputed-Claims)

Indian Health Services: [ihs.gov/forpatients](https://www.ihs.gov/forpatients)

TRICARE: [tricare.mil/FormsClaims/Claims/MedicalClaims/DeniedClaims](https://www.tricare.mil/FormsClaims/Claims/MedicalClaims/DeniedClaims)

The Benefits

You get what you pay for (hopefully)!

At the time of enrollment, you are presented with a Summary of Benefits and Coverage (SBC). The SBC describes the benefits and coverage under the plan in supposedly easily understandable terms.

It summarizes key aspects of the plan including the health plan's costs such as deductible, copayments, coinsurance, out-of-pocket limits, out-of-network payments, pharmacy deductible (if different) and prescription drug benefits. It identifies key features such as whether you need to select a PCP, whether referrals or precertification are required and certain key exclusions and limitations.



CARMEN'S COMMENTARY

Amazingly, we (or our employers) are paying significant amounts of our salaries for health benefits, yet few have any real understanding of exactly what we are buying. I cannot think of another time where we (or our employers) routinely make such significant financial investments, with so little understanding of the "product specifications." Most plans will not even provide you with the complete plan documents until 30-90 days after you enroll.

SBC KEY TERMS AT A GLANCE

Deductible: Amount you pay for covered services before the plan begins to pay.

Copayment: A fixed dollar amount you pay when you visit a health care provider, until your out-of-pocket maximum is met.

Coinsurance: Percentage of the cost you pay for a service when costs are shared with the insurer.

Out-of-pocket maximum: Maximum amount you will pay for covered services in a calendar year, including the deductible, copayments and coinsurance.

In-network: Pertaining to providers or facilities contracted with the plan.

Out-of-network: Pertaining to providers or facilities not contracted with the plan.

Your health benefits policy is a contract between you and the insurer. The terms and conditions of the contract are detailed in the Summary Plan Description (SPD) or Certificate of Coverage (COC).⁸ The SPD explains the health benefits you and your dependents have under the plan. It tells you about your covered benefits – what they are and how to get them – and what is excluded by the plan. It describes eligible health services and identifies how you and the insurer will share costs for covered benefits. It also provides details on the Complaint and Appeals processes, and who to contact in the event you have questions about your plan.

Note that current regulations do not require most plans to disclose the SPD until 30 to 90 days after enrollment. This could mean that for one quarter of the period you are enrolled in a plan, you may not be given access to the contract you have entered! Until this is fixed, the best you can do is request a copy of the SPD from the plan administrator immediately upon enrollment.

Once you have a copy of your SPD you may wonder what to do with it. It will be a long and detailed document which can seem overwhelming or irrelevant, however it establishes the benefits you are owed. It also defines the steps you must follow for those benefits to be actuated, such as how long you have to file a claim, when you must get precertification, etc. In the event you need treatment or need to negotiate with your plan, the SPD will become invaluable, so it is best to get a copy early.

Everything has limits

Health care insurance plans revolve around the payment of medical or mental health services. Plans assist members in paying for their health care needs. Some services may be covered in full without the need to meet a deductible, such as select preventative services.

Other services may be excluded or could be very expensive depending on the details of your plan, the service, your selected provider, etc. Key financial benefits and limitations are summarized in the SBC and described in more detail in the SPD. At a minimum, you should understand effective dates of coverage, the deductible and out-of-pocket maximum. These three things establish the most basic parameters of your plan.

You will also want to understand what preventive services are covered in full by your plan (e.g., many plans include an annual physical, an eye exam, etc.), what services are excluded and what services may have limits.

Preventive services covered in full are benefits you receive without any additional cost to you. Yes, something free! Well, not really free. All cost is borne by the insurer, which means you (or your employer) paid for them already, so you should use them. The purpose of covering preventive services in full is to improve health outcomes and reduce higher long-term costs associated with lack of care, lack of a provider relationship, delayed diagnosis, etc. To maximize your benefits, it is best to take advantage of all available preventive services that are covered in full, as they do not add to your out-of-pocket costs and may be beneficial to your health.

Excluded services are not covered by your plan. If you require (or desire) services that are not covered by your plan, you will have to pay for those services out-of-pocket, in addition to any health care costs associated with your plan. In addition, if your plan limits services (e.g., to a certain number of treatments), you would have to pay for any treatment beyond those limits.

Your SPD likely includes an exclusions section which lists specific health service exclusions that your plan does not cover. Examples of services that may have value to your well-being but may be excluded by your plan include marriage counseling; custodial care (e.g., help with daily functioning that can be provided by a person without medical training); educational services including therapeutic programs within a school setting; experimental or investigational drugs or treatments; wilderness therapy programs; etc.

While exclusions are common, do not assume that they are appropriate or compliant with the [Mental Health Parity and Addiction Equity Act](#) (MHPAEA), federal legislation passed in 2008 to create equal coverage for treatment of mental health and substance use disorders, simply because they are listed.

Through MHPAEA, a plan cannot apply criteria that limits scope or duration of benefits more stringently to MH/SUD services than to medical/surgical services. If there is concern that the criteria to determine benefits, also called non-quantitative treatment limits (NQTLs), are being applied more stringently to MH/SUD services, this may be a parity violation as well.

The Consolidated Appropriations Act of 2021 (CAA) amended the 2008 MHPAEA to provide new protections related to parity. As of February 10, 2021, group health plans and issuers that cover mental health and substance use disorders and medical/surgical benefits must prepare and provide to applicable regulators upon request a comparative analysis of any non-quantitative treatment limits (NQTLs) that apply. The list of specific information that health plans must disclose upon request overlaps with information in the Department of Labor's (DOL) [self compliance tool](#) for evaluating whether NQTLs comply with the parity law. The CAA defines a corrective action process and requires annual reporting to Congress and the public that includes a summary of the comparative analyses reviewed during the year and the identity of each plan or issuer receiving a final determination of noncompliance.

Your plan may also not cover services performed by an out-of-network provider or may cover them at a lower rate than an in-network provider.



Your Condition and Treatment Plan

Insurance is a payment system. Insurers only pay for services covered by the plan. Whether or not a service is covered also relates to your condition, the service itself and the provider.

As a simple example, chemotherapy at a licensed cancer facility may be covered if you are diagnosed with cancer, however if you are not diagnosed with cancer, such care would not be covered. Similarly, if you are diagnosed with cancer, but you go to a chiropractor for a spinal adjustment as treatment for your cancer, such care would not be covered because the service is not an accepted cancer treatment.

Most insurers have criteria by which they determine the level of care necessary and associated coverage for services. Many require that requested treatment be consistent with Generally Accepted Standards of Care (GASC) for your diagnosis (typically reflecting evidence-based medicine) and must be performed by a provider qualified to perform that treatment.

However, there is generally no requirement that plans follow GASC. Therefore, familiarizing oneself with the [Wit v. United Behavioral Health](#) (UBH) case in 2018 could prove helpful. Wit v. United Behavioral Health provided credible sources for establishing standards of care and assessing if standards being applied for behavioral health are more restrictive than medical services. The Wit v. United Behavioral Health decision established the following eight core principles of GASC:

- 1 Effective treatment requires treatment of the individual's underlying condition and is not limited to alleviation of the person's current symptoms. MH/SUD conditions are often long-term and chronic and should be treated as such.
- 2 Effective treatment requires treatment of co-occurring MH/SUD disorders and medical conditions in a coordinated manner that considers the interactions of the disorders and conditions, and their implications for determining the appropriate level of care.
- 3 Patients should receive treatment for MH/SUD at an appropriate level of care. Placement in a less restrictive environment is appropriate only if it is likely to be safe and just as effective as treatment at a higher level of care in addressing a patient's overall condition, including the underlying and co-occurring conditions.
- 4 When there is ambiguity as to the appropriate level of care, the provider should err on the side of caution by placing the patient in a higher level of care, which health plans should cover. Research has demonstrated that patients who receive treatment at a lower level of care than is clinically appropriate face worse outcomes than those who are treated at the appropriate level of care.
- 5 Effective treatment of MH/SUD includes covering services aimed at preventing relapses or deterioration of the patient's condition and level of functioning.
- 6 The appropriate duration of treatment for MH/SUD conditions should be based on the individual needs of the patient, and there should not be specific limits placed on the duration of such treatment.
- 7 The unique needs of children and adolescents must be considered when making decisions regarding level of care involving their treatment. This may include the need to relax the threshold requirements for admission and continued services at a given level of care.
- 8 The determination of the appropriate level of care for patients with MH/SUD care should be made based on a multidimensional assessment that considers a wide variety of information about the patient.

These standards of care come from peer-reviewed studies, academic journals, consensus guidelines from professional organizations, and materials distributed by government agencies, including the:

- [American Society of Addiction Medicine \(ASAM\) Criteria](#)
- [Child and Adolescent Service Intensity Instrument \(CASII\)](#)
- [Level of Care Utilization System \(LOCUS\)/Child and Adolescent LOCUS \(CALOCUS\)](#)
- [Medicare Benefit Policy Manual](#)
- [Practice Guidelines for the Treatment of Patients with Major Depressive Disorder](#)
- [Practice Guidelines for the Treatment of Patients with Substance Use Disorders](#)
- [Principles of Care for Treatment of Children and Adolescents with Mental Illness in Residential Treatment Centers](#)

Your Diagnosis

Your diagnosis is the starting point for assessing benefits coverage.

To the consumer, and possibly even to practitioners, MH/SUD diagnoses can seem daunting because there are so few absolutes. Unlike diabetes, there is no blood test for depression. MH/SUD diagnoses are based on symptom descriptions, many of which overlap and most of which are self-reported.

DSM CODES

MH/SUD diagnoses eligible for coverage must typically be listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). DSM defines and classifies mental disorders to improve diagnosis, treatment and research. DSM includes diagnostic criteria sets and descriptive text for each disorder. The diagnostic criteria indicate symptoms that must be present (and for what duration) and a list of symptoms, disorders and conditions that must first be ruled out to qualify for a particular diagnosis. The descriptive text provides additional information about each disorder such as diagnostic features, subtypes, prevalence, development and course description, risk factors, diagnostic measures, functional consequences, and more. Providers use the DSM diagnostic criteria and descriptive text, along with clinical judgment, to diagnose and classify mental disorders in their patients. Each diagnosis includes a unique diagnosis code based on the International Classification of Diseases (ICD).⁹ Your DSM diagnosis and diagnosis code will be used by the insurer when evaluating claims.

Getting the right diagnosis may be a journey unto itself

The search for the right diagnosis can be challenging, frustrating, humbling and exhausting, but it is part of the process. The good news is that it can evolve.

Hopefully, you are getting closer and closer to the right diagnosis and associated treatment; or perhaps you are healing and overcoming a condition, thereby distancing yourself from a former diagnosis. Wherever you are on the journey, try to understand your condition and diagnosis to the greatest extent you can – and accept that it may change. The best way to understand your diagnosis is to discuss your condition with your provider, including what specific diagnosis they believe most accurately reflects your condition. You may have multiple diagnoses. Your provider may also use other diagnostic labels, such as developmental trauma disorder, that are gaining credence but are not yet recognized in the DSM. This can be valuable for understanding your condition, but a DSM code will still be required for insurance purposes.

Request copies of your medical records (preferable electronic and hardcopy) and verify the diagnosis in your records matches your understanding from your discussions with your provider. The diagnosis in your records will be sent to the insurer and will be used in their decision about your coverage benefits. Your diagnosis also informs your treatment plan, making it doubly important that it is accurate.



Providers

Where to begin?

Your PCP is often the best place to start unless you already have a provider assisting you with your condition. Historically PCPs may have been thought of primarily for physical health, however they can be a valuable resource for MH/SUD. PCPs tend to have a general and broad approach to individual health care since they do not specialize in only one aspect of your health. A PCP can be a good resource to help you connect with the right specialty care provider(s). MH/SUD conditions often require a multi-disciplined approach with more than one specialist, so a PCP may be able to help you build the team you need. Depending on your plan, you may also need a referral from your PCP for specialist treatments to be covered.

If you do not have a PCP, you can obtain a list of in-network PCP providers from your insurer. If you do not need a referral from a PCP, you may be able to go directly to a mental health provider for MH/SUD treatment. Your insurer can provide you with a list of in-network mental health providers in your area as well.

In-network versus out-of-network providers – What is the difference?

You should research and select your providers with care. Most plans differentiate between in-network and out-of-network providers. Some plans will not cover out-of-network providers at all; others will cover out-of-network providers but at lower rates or with other limitations on coverage.

Seeking care from an in-network provider will typically be advantageous for a variety of reasons, including lower cost for treatment, lower deductible and out-of-pocket limits, in-house claims filing, etc. Unfortunately, there is a shortage of MH/SUD providers to meet the demand for services, and access to an in-network provider is sometimes more limited because many do not contract with insurers.

You can obtain a directory of in-network providers from the insurer. This information is also often online (and subject to change). If you have a specific provider in mind, you can also call the provider or insurer and ask if they are in-network for your plan. If a provider is in-network, they have a contract with the plan, so their claims are more likely to be processed smoothly. In addition, if you encounter problems, the in-network provider already has a relationship with the plan, and therefore may be more adept – and willing – to navigate whatever obstacles may present themselves on the path to securing coverage for treatment.

Out-of-network providers are also an option, although insurance benefits for out-of-network providers may be limited. Some plans may not cover out-of-network providers at all; other plans may cover out-of-network providers at reduced rates or present other limitations on coverage. Covered out-of-network services also accrue against separate, and often markedly higher, deductibles and out-of-pocket maximums, which is disadvantageous.

Balance billing is also common with out-of-network providers. Since out-of-network providers do not have a contract with the plan to perform services at a negotiated rate, the insurer may not cover or reimburse you for the full billed amount. In turn, the provider may bill you for the difference between the insurer's allowed amount and the provider's billed amount, which can be a substantial difference. In addition, any difference you pay will not be counted toward your deductible or out-of-pocket maximum; only the insurer's allowed amount will apply.

So, you may be asking: Why would anyone consider an out-of-network provider? Reasons vary significantly, ranging from network scarcity to personal preference to quality of care. However, even if pursuing out-of-network services may be necessary in some situations, the cost of out-of-network care is not often financially viable for most people. If you opt for an out-of-network provider, be prepared to do a lot of paperwork and to become extremely familiar with the claims benefit, complaint and appeals processes. You will have to verify provider qualifications and they may have limited experience – or willingness – to jump through hoops to help you secure coverage. Out-of-network providers also usually require payment in full at the time of service, so even if some of the cost is covered eventually, you may have to bear the full financial burden until you receive reimbursement for any covered claims.

Special circumstances

There are some circumstances where out of-network providers may be accepted by the insurer to be covered as in-network.

This is often referred to as a Single Case Agreement (SCA) whereby the out-of-network provider and the insurer agree to provide/accept services at benefit and cost-sharing levels and rates associated with in-network providers for a specific treatment or series of treatments for a specific patient over a certain period. Since the SCA is an agreement between the insurer and the provider, you will need the support and cooperation of the out-of-network provider. Two commonly accepted justifications for an SCA for an out-of-network provider include:



CONTINUITY OF CARE

Continuity of care gives members the option to continue working with their current provider if that provider is no longer in-network with the plan. This most frequently occurs when an in-network provider stops working with the plan and becomes out-of-network. It can also happen if you are receiving treatment from an in-network provider then change health plans and that same provider is not in-network with your new plan. There must be a medical reason to request continuity of care, such as a negative effect on the well-being of a patient from changing providers. In mental health, where a strong and trusting provider-patient relationship results in improved outcomes, and loss of relationship can jeopardize a patient's progress, continuity of care is important.

To have services by an out-of-network provider treated as in-network for continuity of care reasons, you or the provider (preferably) will need to submit a request to the insurer. The request should summarize your past and current treatments with the provider and demonstrate a credible medical reason why continuity of care matters. Note that there is often a time limit to continuity of care approvals.

2

NETWORK SCARCITY

Network scarcity, also known as network deficiency, occurs when your plan has a deficiency in the availability of in-network providers. This is unfortunately common for MH/SUD provider networks in particular and appears to be largely due to insurers under-valuing MH/SUD services and thus being unable to recruit and maintain enough qualified MH/SUD providers in their network to meet the needs of communities. Network scarcity may present in a few different ways, including not having in-network providers within a reasonable distance of your home; having in-network providers in your community, but they are not accepting new patients; or having in-network providers in your community, but not within the specialty area your condition merits.

Most health plans are required to meet “network adequacy standards,” which dictate the parameters related to availability of in-network providers for covered services. Though these standards vary by state, knowing these requirements can help support justification for approval for coverage of out-of-network care, or may compel the insurer to work on your behalf to identify in-network providers and services that comply with the network adequacy standards.

A state-by-state analysis of network adequacy standards can be found in the Legal Action Center’s, [Spotlight on Network Adequacy Standards for Substance Use Disorder and Mental Health Services](#). Confirming network adequacy rules for your health plan may help justify a need for out-of-network services that must be covered to the same degree as in-network services by your plan – but establishing that with your plan in writing in advance is important to ensure you are not left with unanticipated expenses.

To have services by an out-of-network provider treated as in-network due to network scarcity, you or the provider (preferably) will need to submit a request to the insurer. The request will need to address why in-network providers are not appropriate or available. For example, you might print the search results from the insurer’s in-network directory for your area and show that there are no in-network providers within a reasonable driving distance.

Unfortunately, neither personal preference nor perceived quality of care are accepted by insurers as grounds for an SCA to treat an out-of-network provider as in-network.



CARMEN'S COMMENTARY

Unfortunately, although the entire health benefits industry centers around payment for health care services, the consumer often experiences great difficulty finding out the out-of-pocket cost of services prior to treatment. This may be particularly true for out-of-network services where the insurer and provider do not have a negotiated rate. In these cases, your out-of-pocket cost will be the provider's billed amount minus the insurer's allowed amount. Usually, you can find out what the provider will charge in advance; however, confirming the insurer's allowed amount may be more difficult – although it is your right to be able to obtain this information. My recommendation is to ask for allowed amount cost information from the plan and keep asking until you get it. Seek assistance from the plan administrator if they will help. If you do not receive useful and accurate information, file a complaint.

Treatment Plan

You will also want to verify the treatment recommended by your provider is covered by your plan. You may have several treatment options, in which case whether any or all are covered by your plan may affect your decision. This is especially true of prescription drugs, some of which can incur significant expense, even when covered by your plan. Keep in mind that your MH/SUD treatment plan may evolve over time and your MH/SUD benefits may change from year to year, so it is important to revisit your treatment plan and prescriptions with your provider periodically.

Is a certain treatment covered – and at what rate?

If you are working with an in-network provider, they should be familiar with the terms and conditions of your plan.

Ask the provider to confirm with your insurer that any recommended treatment is covered by your plan. Request a quote from the provider detailing the negotiated rate that will be billed and any anticipated copays or coinsurance that you may be responsible for. If you have not yet met your deductible, it is likely that you will be responsible for at least a portion, if not all, of the billed amount. You are responsible for out-of-pocket costs up to your deductible, then any coinsurance or copays up to your out-of-pocket maximum, if you have one.

If your provider is out-of-network, it may be difficult to assess whether treatment will be covered and at what rate until after you submit a claim for reimbursement. Many out-of-network providers will not deal with insurers; others are not familiar with the plan or processes. In theory, you should be able to see if a particular treatment is covered by your plan in the SPD. You can also find information about how out-of-network services are covered, if at all. However, you may still not know the allowed amounts. You can request this from your insurer, however you will need to submit diagnosis codes and billing codes, which you will have to get from your provider. If you are having difficulty, your plan administrator may be able to assist you to obtain relevant information from the insurer.

Remember that out-of-network providers can set their own rates. You may be responsible for the difference between an out-of-network provider's billed amount and the allowed amount according to your plan, which may be significant.

Are my prescriptions covered – and at what rate?

The first place to look for information on your prescription drug coverage is the formulary that applies to your plan. A formulary is a list of generic and brand name prescription drugs covered by your health plan. Formularies can be open, closed or tiered, with tiered being the most common. The insurer develops its formulary based on factors such as drug cost, availability and clinical effectiveness as compared to other drugs for the same treatment. An open formulary will cover most prescription drugs at varying copays whereas a closed formulary only covers certain drugs and provides no coverage for drugs not listed (unless you apply for and are granted an exception). A tiered formulary groups drugs into "tiers" with specific copays that apply to each tier.

You can obtain a copy of your plan formulary from the insurer. Check the formulary to see if the drug you are taking (or plan to take) is listed, and then verify how any cost sharing is handled. Given the high cost of prescription drugs and the variability among plans, understanding the costs associated with your specific prescription drug is essential to understanding and managing your out-of-pocket expenses. Remember that you will be responsible for out-of-pocket costs up to your deductible, then any coinsurance or copays up to your out-of-pocket maximum, if you have one.

Your pharmacist may be your best source for determining your out-of-pocket cost for a particular drug. You can sometimes get this information before you even have a prescription by asking your pharmacist directly (they will need a copy of your insurance ID card). If your prescription has already been sent to the pharmacy, they can give you an exact quote.

If you find yourself faced with high out-of-pocket costs for a prescription drug under your plan, your pharmacist or provider may be able to review your plan formulary and recommend alternatives.

Also worth noting is that while you are under your deductible and out-of-pocket maximum (if you have one), your out-of-pocket costs for prescription drugs may vary from one pharmacy to another. Shopping around may save you money, although some insurers have partnered with certain pharmacies (or bought them out altogether), in which case your plan may only cover prescriptions filled at certain pharmacies. This is especially true for maintenance medications which are a common part of a comprehensive MH/SUD treatment plan. Also be aware that if you purchase prescriptions through a discount program (e.g., GoodRx), those costs may not accrue toward your deductible and out-of-pocket limits.

Additional Insurer-Imposed Criteria

In some cases, particularly for out-of-network services, there may be additional criteria that a provider or program needs to achieve to be eligible for coverage. For out-of-network providers this may be to ensure a certain quality of care or credentials. However, it can sometimes feel like yet another way the insurer is intentionally inhibiting access. If these additional requirements are unreasonably restrictive or the application of the criteria results in a violation of network adequacy rules, these may not comply with parity laws and can be grounds for a complaint or legal challenge.

A common example of this is encountered with residential treatment centers (RTCs). Many plans impose additional requirements on RTCs, thereby creating a more restrictive definition of RTC for the purposes of benefits coverage (or denial). As a result, a facility licensed as an RTC by applicable state or federal laws and accredited by relevant agencies, may be denied as an RTC because they do not also meet the additional requirements that the insurer imposes. Examples of additional criteria that plans may impose on mental health RTCs include having a medical director that is a psychiatrist; having a behavioral health provider on active duty 24 hours per day 7 days per week; and having the patient treated by a psychiatrist at least once per week. Examples of additional criteria that plans may impose on substance use disorder RTCs include having a medical director that is a physician who is an addiction specialist; having a behavioral health provider on active duty during both day and evening therapeutic programming; and having a registered nurse on-site 24 hours per day 7 days per week.

Experimental (or Investigational) Treatments

Health plans only cover eligible services proven to be medically effective and safe based on thorough research and testing. Newer or alternative treatments without sufficient evidence to prove they are medically effective and safe are often considered experimental.

Whether a treatment is experimental may change as research and testing of the treatment evolves. Experimental treatments are excluded by most plans because the insurer only covers services medically proven to work. In rare cases the insurer may cover experimental treatments, but only if numerous stringent criteria are met. Common criteria for coverage of an experimental treatment include: a diagnosis with probable death in less than one year; standard therapies have failed or are not medically appropriate; there is peer-reviewed medical and scientific evidence that the proposed treatment may be beneficial; treatment is part of a Food and Drug Administration (FDA) clinical trial approved by an Institutional Review Board that will oversee the investigation, etc.¹⁰

CLAIMS



Processes and Procedures

Following protocol

For your benefits to unfold appropriately, you and your provider must follow the proper steps and procedures as outlined in your SPD.

This includes obtaining a referral or precertification if required, filing the benefits claim within the allotted timeframe and in accordance with the insurer's requirements (e.g., proper forms, codes, etc.), filling your prescription per the plan requirements, etc. The claims process can be very daunting, and some insurers do not make it easy; until that is rectified with a more uniform and transparent process, we need to work hard to understand and follow the rules of our plans so that we receive the benefits we (or our employers) pay for. If you have an in-network provider, they will typically take the lead on claims processing, which is a big advantage. If you have an out-of-network provider, you will likely have to take on much more responsibility during the claims process.

Once you have enrolled in a plan you are largely stuck with its limitations, however you can optimize your coverage by accessing the full extent of your benefits and not making costly errors that could be avoided. Applying for coverage in accordance with your plan is critical to accessing and maximizing your benefits. Choosing providers who will guide you through this process has value.

Precertification and Predetermination

PRECERTIFICATION

Your plan may require you to submit a precertification request before receiving treatment, except in emergency cases. (Precertification may also be referred to as preauthorization, prior authorization or prior approval). Precertification requirements will be covered in your plan documents.

Precertification is frequently required for inpatient stays, complex treatments and for prescription drugs. Some insurers will only cover certain services or drugs if the patient meets certain criteria. A precertification request may be only approved for a specific provider, in which case if you decide to seek the same treatment from a different provider you may need to submit a new precertification request. If you use an in-network provider, the provider is responsible to obtain precertification. If you choose an out-of-network provider, you may be responsible for obtaining precertification approval.

Contrary to logical interpretation, precertification approval is not a promise by the insurer to cover the claim. When required, precertification is a step you must go through to be eligible for coverage but does not necessarily guarantee coverage by the insurer.

PREDETERMINATION

Predetermination is a review process by the insurer to determine if services are medically necessary and covered by the plan. A predetermination approval typically guarantees the insurer will cover the service, as long as the treatment is provided in a timely manner and the patient's condition does not materially change during the interim.

Predetermination is optional and may not be commonly sought. Although predeterminations may take time, they provide an added layer of confidence that a service will be covered and at what rate. Obtaining a predetermination can help avoid unexpected denials or large out-of-pocket expenses. If you use an in-network provider, the provider may apply for a predetermination review for you. If you choose an out-of-network provider, you will likely have to request a predetermination review on your own.

Claim submission – In-network

The claims process varies dramatically depending on whether you have an in-network or out-of-network provider. In-network providers will interact directly with the insurer whereas many out-of-network providers may not.

In-network providers will submit the claim form directly to the insurer. The insurer will reimburse the provider directly if your plan allows. The insurer will issue an Explanation of Benefits (EOB) to you which explains its determination with regard to the claim submitted. If you owe money to the provider beyond anything paid by the plan, you will receive a bill directly from the provider. This may occur if you have not yet met your deductible or if your plan has a copay or coinsurance for the service you received. The amount invoiced to you by the provider should match the amount the insurer says you may owe on the EOB.

Claim submission – Out-of-network

Choosing an out-of-network provider may result in additional administrative effort and cost for you unless your insurer and provider agree to an out-of-network single case agreement. Out-of-network providers may not submit claims directly to the insurer and may require payment in full at the time of service. This means you must pay the full amount the provider wishes to bill, which has not been discounted or negotiated with your plan, and then you can try to secure reimbursement from the insurer after the fact.

This will usually entail submitting a completed and signed claims benefit reimbursement form along with a copy of the bill from the out-of-network provider. It is also highly probable that you will only be reimbursed a portion of the total amount you paid, sometimes a very meager amount. In some cases, insurers will not cover out-of-network services at all.

If you are submitting claims yourself, make sure you send them to the proper address and keep a copy for your records. If you can submit claims online, this may be an easy way to document your submissions.

Note that some out-of-network providers do help clients with their insurance claims. This is becoming more common, especially with larger and more expensive programs such as RTCs, partial hospital programs (PHPs), intensive outpatient programs (IOPs), etc. Families considering out-of-network treatment may wish to consider whether the provider offers utilization management (UM) services, such as applying for precertification, submitting claims, filing appeals, etc. If you intend to seek reimbursement for out-of-network services, having the provider submit claims, medical records and handle insurance inquiries directly is a huge advantage. In the event you are denied (which is unfortunately likely), having a UM team to support you will be an asset. You may still have your work cut out for you, but whatever they do will hopefully decrease the burden on you.

EXPLANATION OF BENEFITS

Understanding an EOB

The anatomy of the Explanation of Benefits

The Explanation of Benefits (EOB) can seem overwhelming at first. However, it is extremely important to become comfortable reading and understanding EOBs because these are the primary way the insurer communicates with you about your claims. EOBs can be used by the insurer to deny services. On other occasions, the insurer may request additional information deemed necessary for processing the claim. If you do not understand this and/or do not respond with the information requested in a timely manner, your claim may be denied for failure to provide necessary information.

You must read, understand and act upon (if required) every EOB you receive to maximize the receipt of benefits to which you are entitled.

The basic components of an EOB are as follows:

Date	Establishes timeframe for any required response
Member	Person covered by the health plan
Member ID	Unique insurance identification number
Patient	Person who received the service
Provider	Licensed professional or facility that provided the service
Billing Code (CPT)	Procedural code the provider used to bill the service
Date of service	Date service was performed
Claim ID	Code assigned to the claim by the insurer during claim processing
Billed Amount	Amount your provider charged for services
Member rate	Amount covered by your plan. This would be the negotiated rate for an in-network provider or the allowed amount for an out-of-network provider
Pending or Not Payable	Charges that are either not covered or need more review by the insurer
Deductible	Amount you pay for covered services before the plan begins to pay
Coinsurance	Amount you pay for a service when costs are shared with the insurer (this is typically a percentage of the cost)
Copayment	Fixed amount you pay when you visit a health care provider
Payment Summary	Summarizes amount your plan paid (and to whom) and amount you owe or may have already paid
Claim Remarks	Remarks that clarify important points about your claim. These are often keyed with Claim Remark numbers that apply to certain claims if multiple claims are included on a single EOB
Benefit Balance	Summary of individual and family benefits used and remaining



CARMEN'S COMMENTARY

I dread receiving EOBs! Mostly because it means I must find time to review them, and because I often find errors – which means more problems to fix, which takes more time... But avoidance plays into the hand of the insurer. Disciplining ourselves to overcome the frustration of improper claims processing and take the deep dive into understanding every detail on our EOBs is one of the best ways to maximize benefits.

Were your claims covered?

Claims identified as “Pending or not payable” (or similar) have not been covered or may have only been partially covered. You must identify these claims and associated Claim Remarks so that you can determine why the claim was not covered and what action can be taken to have the insurer reprocess the claim.

“Pending or not payable” does not necessarily mean not covered by your plan or not medically necessary. The insurer is often requesting additional information to make a determination. The insurer may legitimately need the additional information, or they may just be creating another step to complicate accessing your benefits. Regardless, you must learn to read the EOB and follow up on all claims marked as “pending or not payable.” Failure to do so may result in denial of benefits you are rightly owed.

EOB Handling

Avoid EOB avoidance

Create a routine to follow upon receipt of an EOB to help minimize avoidance of this critical correspondence. Downloading EOBs electronically can greatly reduce the stress of reviewing the EOB under a deadline.

Sometimes our EOBs would take up to 21 days to land in our mailbox! If a response to something was required in 30 or 45 days from the date of the EOB, half my time was used up already. I download our EOBs and set aside time within one week to review the EOB in detail and decide if I need to take action. Your approach may vary but developing a routine to help you stay on top of the EOBs is crucial, particularly if you have multiple claims to keep track of.

Keep track of your claim status

If you have numerous claims, a key task throughout this process will be to keep track of your claims. Unpaid, partially paid or incorrectly processed claims can easily get lost or be overlooked if you are not keeping a detailed accounting of your claims.

The insurer may, and occasionally does, make errors in their accounting. You cannot find these if you are not doing your own accounting and verification. If you have multiple claims, things can get confusing very quickly, so it is best to start keeping track as soon as you receive your first EOB and keep updating your information as you receive subsequent EOBs.

A good way to keep track of your claims is to create a spreadsheet in a software program such as Microsoft Excel. If that is not possible, you can keep track by hand, similar to balancing your checkbook. At a minimum, your record needs to include the following (presented in spreadsheet header format):

Claim ID	Date of service	Provider	Billing code	Amount billed	Amount plan paid	Amount you paid

As you keep track of your claims you should also be able to keep track of your deductible and out-of-pocket amounts used. Once you reach your deductible the plan should begin to pay for at least a portion of any covered services. Once you have reached your out-of-pocket maximum (if you have one), your plan should start to pay 100% of all covered services. Note that many plans have separate deductibles and out-of-pocket limits for in-network and out-of-network providers. The amounts you pay for covered out-of-network services do not count toward your in-network deductible or out-of-pocket maximum, and vice versa. If this applies to you, you may want to have two spreadsheets, one for in-network services and one for out-of-network services. Some plans also handle pharmacy and medical claims separately, which may suggest separate spreadsheets as well.

Note that services which are denied as not covered by your plan do not count toward your deductible or out-of-pocket maximum. Only services at amounts covered by your plan accrue against these limits. If your provider performs and bills for services not covered by your plan and/or does not meet the qualifications to perform the services billed for, those expenses will be your sole responsibility and are not counted toward any benefit limits.

Keeping track of your claims should help you understand your benefits and stay on top of actions needed. It will also serve as an early warning if certain claims are not covered so that you can assess your alternatives before accruing many months of bills, only to later realize your plan is not covering the services as you hoped.



CARMEN'S COMMENTARY

Although federal law requires a health insurer to generate an adverse benefit determination letter if it determines that a benefit is not covered for any reason, this was not our experience. With over a quarter million dollars of initially unpaid claims, we only received a formal denial notice for one provider. Tens of thousands of dollars worth of claims were "denied" via claim remarks on our EOBs. Claims were noted as "Pending" with a claim remark such as "If we do not receive the information we need, this charge will be denied. The effective date of the denial will be 46th day after the date you receive this statement. The basis for the denial will be that we do not have the information we need to consider this charge. ... You will not receive any other notice of denial."

In many cases, the information the insurer said they needed had already been provided. In one case, although 10 months worth of claims had been processed for our son while we were under the deductible, as soon as the claims exceeded our deductible, the insurer denied our claims as "pending," requesting to know if there was a court order establishing which parent is financially responsible for health care expenses; who has custody; who does he reside with; how many months of the year; whether any family members have Medicare, etc. That these questions were not asked until we exceeded the deductible is telling.



Unpaid claims

Claims marked as "Pending or not payable" (or similar) require your immediate attention. First you must determine why the claim was not paid and decide on the appropriate course of action, whether that be a reconsideration or appeal.

Reconsiderations are appropriate for correcting errors and responding to requests for additional information. Examples where a reconsiderations process may be appropriate include if you or your provider made an error submitting the claim (e.g., typo); the insurer made an error processing your claim (e.g., account error); or the insurer wants more information to make its determination.

Appeals are appropriate for more content-based denials, such as whether you followed the processes and procedures set forth in your SPD, whether a particular service is covered by your plan or whether treatment is medically necessary. Appeals are often in response to formal denial notices but can also be appropriate responses to denials communicated through EOBs.

RECONSIDERATIONS



CARMEN'S COMMENTARY

Our insurer made dozens, if not hundreds, of errors processing our claims. At the time I did not understand the difference between reconsiderations and appeals, so I filed complaints. This was a strategic attempt to make the insurer correct its errors and reprocess our claims, without initiating the appeal process before I was fully prepared to launch my appeal. This was effective for me because it allowed me to gather additional documentation that I later used in my appeal, however it also meant we had to pay out-of-pocket longer. In retrospect I think the ideal approach would be to file reconsideration requests for simple errors (whether by the insurer, provider or you), file a written complaint if the insurer is repeatedly mishandling your claims, and file an appeal whenever the insurer had all the correct information and unfairly denied coverage.

Applicability

Are reconsiderations a thing?

There is a lot of discussion and information about appeals, but less so about “reconsiderations.” Plans may or may not refer to reconsideration as a thing unto itself. Some plans do, and some plans do not.

Regardless of whether your plan refers to reconsiderations specifically, I want to treat them separately from appeals because reconsiderations are typically simpler and faster than appeals. Reconsiderations usually apply to errors or requests for additional information, often not communicated with a formal denial notice.

Errors

Mistakes happen. Everyone makes them. When we are talking about errors here, we are talking about simple, unintentional mistakes, like typos, that are not typically up for interpretation. Errors by any party may be resolved through a reconsideration process. When you or your provider make an error, you will likely be denied coverage; when the insurer makes an error, it could result in a denial, underpayment, overpayment, or something else.

The best way to find errors is to review your EOB in detail and keep an accounting of your benefit payments and balances. The claim remark on the EOB will often alert you to the source of the error. For example, if the claim remark says “coverage was not effective at the time of service” and you know your coverage was effective, this may be an error by the insurer (e.g., not updating the system correctly at renewal). If the claim remark says, “the billing code is not appropriate to the patient’s gender,” your provider may have submitted the claim with an incorrect billing code (e.g., typo). Or, while tracking your expenses you may find that a certain service was covered at a different rate from one EOB to another. This suggests the insurer may have made an error in one of its payment calculations (assuming the claims are for the exact same service, provider, etc.).

An effective reconsideration request will identify the error, supply documentation to correct the error, and request reprocessing of the claim.



Requests for additional information

Sometimes the insurer will not pay a claim because it wants more information. This is the “pending” part of “pending or not payable” on the EOB. This suggests a claim may have been submitted with incomplete information or the insurer is unsure about some aspect of your treatment or coverage.

If you have an in-network provider, the insurer may request the additional information directly. In other cases, particularly if you have an out-of-network provider, the insurer may request the additional information in a claim remark on the EOB. This may be the only notice you receive! It will also likely include a statement that if the additional information is not provided within a certain timeframe, the claim will be denied due to insufficient information.

Additional information requests may include questions about other coverage, diagnosis or billing codes, medical records or other details. An effective reconsideration request responding to an insurer’s request for more information will provide the additional information and request reprocessing of the claim.

If the additional information requested is not available to you or seems irrelevant or over-reaching, contact the insurer to discuss.

Filing a Reconsideration Request

What to include in a reconsideration request?

If the error was made by your provider, ask them to correct the error and resubmit the claim.

If the error was a coding or billing error (or another typo), they must complete the entire submission form, correcting for the error, and noting the correction in the remarks section of the form (if it has one). They should include a brief letter with the corrected form. The letter should:

- Reference the patient and include identifying information (DOB, ID number, etc.).
- Reference the relevant EOB (by date), claim ID or other correspondence from the insurer citing the error.
- Explain the anticipated cause of the error (e.g., the wrong code was input).
- Reference the corrected submission.
- Request reprocessing of the claim.

Both the original EOB and the corrected submission form should be attached to the reconsideration request letter.

If the error was made by you, you must similarly resubmit the entire submission form, correcting for the error, and noting the correction in the remarks section of the form (if it has one). Include a brief letter including the key components noted above.

If you think the error was made by the insurer, secure documents that will demonstrate your point. For example, if the insurer denied a claim citing coverage was not effective at the time of service, you should submit a copy of your insurance card and SBC showing the effective dates of coverage for your plan. Submit the information with a brief letter including the key components noted above.



Submitting a reconsideration request

Ask your insurer if there is a specific reconsideration form you need to use and where to submit a request for reconsideration. If your plan does not specifically identify “reconsiderations” in its processes, you may be directed to file an appeal or a complaint. (Given the choice between appeal or complaint I would submit reconsideration requests associated with errors by me or my provider as appeals, and errors by the insurer as complaints; but you must defer to the process your plan prescribes).

Do as much as possible in writing. If you call the insurer for any reason, request the name of the agent and a call reference number as soon as you are connected. (If you ask later, they may hang up on you – or at least that was common with our TPA!). Record the agent name, call reference number, date and time of the call and take notes about the content of the call. You will need this information to accurately refer to information verbally conveyed to you by an insurer representative in a phone call (e.g., in a complaint or appeal). If you do not have this information, future references to the call may seem more like a he said/she said situation rather than a firm statement which can be verified.

COMPLAINTS



CARMEN'S COMMENTARY

At the height of my battle over our insurer's denial of medically necessary care for our son, I filed 12 written complaints in 9 months (plus several appeals). I leveraged those complaints by sending copies to the plan administrator, Department of Labor (DOL), the accreditation organization, and others, requesting that they follow-up with the insurer on my behalf and report back to me. In this way I was able to multiply my impact with little to no additional work. I also built a paper trail so that outsiders (e.g., plan administrator, DOL, advocacy groups, etc.) could not doubt my credibility or misjudge my verbal recounting of the egregious insurer behavior we were subjected to.

Applicability

When should you file a complaint?

There are infinite scenarios that may warrant a complaint, however complaints in response to violations are the most impactful. You should exercise your right to file a complaint anytime you are dissatisfied.

However, if a violation has occurred, a complaint is an especially valuable tool when seeking accountability from the insurer. It is also an effective method to formally document the violation in a way that can be easily shared with your plan administrator, regulatory agency, accreditation agency, advocacy group, etc. Regulatory agencies are typically tasked with enforcing insurance laws to ensure members are treated fairly, so making them aware of unfair or inconsistent treatment by an insurer has value.

Common types of violations

Your insurance benefits are a legal contract between you and the entity providing your benefits.

The contract is governed by the terms of your specific plan and applicable legal regulations. A violation occurs when a term of the contract or a provision on an applicable regulation is breached. The type of violation depends on where the rule is defined, typically either in the plan documents or a state or federal statute. Three common types of violations are described below.

PLAN VIOLATION

The specific terms of your insurance benefits are outlined in the plan documents, often the SPD or Benefits Booklet.

The contract includes terms by which both you and the insurer must abide. If the insurer does not abide by a certain provision of the plan documents, the insurer has violated the plan (Plan violation).

As you become familiar with your plan documents you will be able to identify some plan violations yourself. Your plan administrator, State Bureau of Insurance or the DOL may also be able to help you determine if a plan violation has occurred.

REGULATORY VIOLATION

An assortment of state and/or federal regulations apply to your plan. Which regulations apply will depend on the specific plan you have, what state you live in, etc. Regulations establish legally binding rules the insurer must follow in its administration of your health insurance benefits. If the insurer does not adhere to the regulations that apply to your plan, the insurer has violated a state or federal law (Regulatory violation).

Regulatory violations may be difficult to identify. If you are not sure, you should contact your State Bureau of Insurance or the DOL to help you determine if a regulatory violation has occurred.

PARITY VIOLATION

A parity violation is a form of regulatory violation, however it is specific to MH/SUD. The Mental Health Parity and Addiction Equity Act (MHPAEA, also referred to as the Federal Parity Law) was legislated to create equality in access to and coverage of MH/SUD benefits compared to medical and surgical benefits.

There are two methods to test for parity compliance: Quantitative Treatment Limitations (QTLs) and Non-Quantitative Treatment Limitations (NQTLs). Most, but not all plans, must abide by some form of parity law. In these cases, if the insurer is not providing equal access and coverage for mental health and substance use disorders, the insurer has violated parity laws (Parity violation).

Parity violations may be especially difficult to identify, even if the insurer provides you with the medical necessity criteria, processes, strategies, evidentiary standards and other factors used to apply NQTL to behavioral and medical benefits. An advocacy group such as The Kennedy Forum or your State Bureau of Insurance or the DOL may be able to help you determine if a parity violation has occurred.

When in doubt, assert a violation, seek answers, and demand accountability.

Generally Accepted Standards of Care (GASC)

Unfortunately, insurers seem to regularly mishandle benefits, often to their own benefit and to the detriment of the member. Many have denied health benefits and restricted coverage through lack of transparency, plus the use of flawed clinical review criteria as part of the utilization management process. Too often “medical necessity” guidelines that have been developed internally and used by insurers are not consistent with generally accepted standards of care (GASC) for mental health and substance use disorder (MH/SUD) services as shared in the *Wit vs. United Behavioral Health*.

We have come to expect errors and unfairness in the processing of our insurance plans, but we do not need to accept it. Insurers must be held to a professional standard of conduct, ethics and performance.

If the insurer is not administering the plan professionally and ethically, filing a complaint based on the insurer failing to meet GASC may have merit.

Complaint process limitations

I highly encourage you to use the complaints process, however it must be noted that the complaints process has limitations.

- **Complaints are not appeals.** Used properly, complaints can help correct claim mismanagement issues, document violations, secure relevant documents, and more. Filing complaints may be useful as you prepare your appeal; however, an actual appeal must be submitted to request reversal of an adverse determination (denial).
- Complaints will not change your plan documents or the state or federal regulations (or lack thereof) intended to protect consumers. Complaints afford you an opportunity to express discontent, but if your plan and/or applicable regulations do not provide for what you want, a complaint is unlikely to deliver the outcome you desire.



Filing a Complaint

How to write an effective complaint

Complaints are an excellent tool you can use to your advantage. Well-written complaints accomplish several things simultaneously, including:

- Establish written documentation of the problem you are facing and/or violations by the insurer.
- Integrate applicable reference materials as they pertain to administration of your plan.
- Require a response from the insurer, hopefully correction of the problem.
- Present another task the insurer must handle in accordance with the plan documents (typically issue a written response within 30 days).
- Create a document which can be easily shared with other parties, including the regulatory agency, accreditation agency, plan administrator, provider, etc.

A well-written complaint must be clear, accurate and assertive (if not demanding). The complaint must include all pertinent information (member information, plan information, date, etc.) and must include three primary sections:

- 1 Identify the problem or violation.
- 2 Refer to specific documents (SPD, regulation, etc.) that support your complaint and demonstrate why the insurer's action (or inaction) is a problem or violation.
- 3 Request immediate resolution – and a written response to the complaint.

The table below provides example problems or violations members may face which deserve a formal complaint, along with common reference materials that may apply to the issue and examples of the resolution a member might request. These are only hypothetical examples; each circumstance is unique.

Problem/Violation	Reference Materials	Resolution Request
Insurer did not process a claim within the allotted timeframe (Plan violation)	Plan documents	Insurer immediately process the claim and provide a written explanation
Insurer did not provide requested Personal Health Information (PHI) (Plan and Regulatory violation)	Plan documents HIPAA	Insurer immediately provide requested PHI and provide a written explanation for prior failure to disclose PHI upon request
Insurer representatives gave wrong, conflicting, or incomplete answers to benefits inquiry (GASC violation)	Phone notes with call reference number, date and time Online messages printouts	Insurer immediately provide a complete and accurate answer to the benefits inquiry
Insurer processed in-network provider as out-of-network (GASC violation)	Documentation of provider's in-network status Insurer network list printout	Insurer immediately reprocess claim as in-network
Insurer did not describe the reason for a medical necessity denial in terms specific to the member's condition (Regulatory violation; Accreditation violation)	State or federal statute Accreditation standards	Insurer describe the reason for the medical necessity denial in terms specific to the member's condition

Making your complaint powerful with supporting documentation

Everyone likes to complain – especially about insurance companies! Unfortunately, unfounded or poorly supported complaints have little impact. A powerful complaint must include documentation that supports your assertion.

Supporting documentation is best included as an attachment to a well-written, concise complaint letter. Do not attempt to reiterate everything that is included in the supporting documentation in the complaint letter. Instead refer to it clearly in your complaint letter, then attach documentation that supports the key points you are making in your complaint.

Each circumstance will be different, however examples of documentation to attach include copies of insurer correspondence (EOB, denial letter, precertification letter, etc.), specific pages from the SPD, relevant documents from the provider or other correspondence (e.g., printouts from insurer's online message system).

Sending your complaint

Once you have written your complaint, you must ensure it is submitted correctly. Address your complaint to the insurer's Complaint Department. Insurance companies are large and complex.

The contact information for a complaint may be different than for other correspondence. Contact the insurer to confirm the proper mailing address for the Complaint Department. Send your complaint certified mail (signature required) and keep a copy of the receipt for your records.

You may be able to submit your complaint online. This can be fast and effective; and it builds your electronic paper trail. However, electronic complaint filing may not be available for all plans. It is also only recommended if you feel comfortable with the technology required to securely create and submit a combined complaint in PDF format, with all attachments.

Regardless of how you submit your complaint, keep a copy of the complete complaint for your records.

Taking it to the Next Level

Leveraging your complaint for maximum effect

Once you have written your complaint, it takes relatively minimal extra effort to share the complaint with agencies and individuals who may be able to apply pressure to your insurer.

This is also an effective way to inform your provider and plan administrator of the problems you are having. Unfortunately, the journey to access MH/SUD benefits is often fraught with challenges. It may be necessary to lean on outside resources to get the treatment and consideration you deserve.

Sharing your complaint with any or all of the following may be beneficial:

- Regulatory agency that oversees your plan
- Provider that performed services your complaint relates to
- Accreditation agency that accredits your insurer for your specific plan *
- Plan administrator (often part of your employer's Human Resources department) *
- Reputable advocacy group *

* Special Privacy Note: It is extremely important to protect your personal health information (PHI). Licensed medical providers and government regulatory agencies (State Bureau of Insurance or DOL) must comply with HIPAA, including not sharing or distributing your personal health information without your consent. However, many other agencies and individuals (even those who could potentially be helpful) are not subject to HIPAA regulations. Be careful when disclosing personal health information to any organization not covered by HIPAA.

Filing an executive complaint

If you have filed multiple complaints and you are not getting satisfactory or understandable answers, an executive complaint may be helpful.

Contact the insurer's corporate office to find out how to file an executive complaint. Executive complaints will likely only be effective after you have exhausted the regular complaints process without a resolution.

DENIALS



Denial Basics

The dreaded denial

Insurance denials for MH/SUD claims are all too common. They are also often heartbreaking. However, like EOBs, denials must be dealt with head on, with the first task being to understand why you were denied.

Denials may come in the form of a denial notice – federal law requires a health insurance issuer to notify you if a benefit is not covered for any reason – or may simply be communicated to you on the EOB. A denial can be discretely conveyed to you as a claim noted as “pending or not payable” (or similar) on the EOB with an associated claim remark. Although a denial on an EOB may not provide you with a lot of information to work with – a denial notice for medical necessity, for example, must include the grounds for the denial in understandable terms specific to the patient and plan – it must identify any criteria used to uphold the denial, alert you to your right to request a copy of that criteria, and both the EOB and denial notice must disclose your right to appeal and information about how to do that. If applicable, the notice must also advise you that you have the right to request relevant documents that were reviewed when the adverse determination was made.

Types of denials

There are three common types of denials: administrative denials, coverage denials and medical necessity denials/clinical denials.

1

ADMINISTRATIVE DENIALS

Administrative denials pertain to the rules and requirements for how the plan will be executed. These include things such as complying with the timeframe to submit the claim, getting a referral if the plan requires one, obtaining precertification if required, using the proper claim submission form, etc. If you have an in-network provider, they should submit claims correctly and accurately. Diligence and attention to detail by your provider will help avoid most administrative denials. If you have an out-of-network provider who does not offer utilization management (UM) services, you may have to submit claims yourself, which puts the onus on you to comply with the administrative procedures and processes outlined in your plan.

2

COVERAGE DENIALS

Coverage denials pertain to interpretation of the insurance policy itself, typically in terms of what is and is not covered. For example, if you submit a claim for an excluded treatment, such as an experimental drug, you may be denied because the treatment is beyond the scope of what the plan covers.

3

CLINICAL DENIALS

Medical necessity or clinical denials pertain to the medical needs of the patient and the clinical appropriateness of the treatment. Medical necessity or clinical denials are based on clinical judgement and are therefore more subjective – and perhaps more difficult to prove. The most stated reason for a clinical denial is lack of medical necessity, also referred to as a medical necessity denial. A medical necessity denial may reference internal criteria established by the insurer that serves as the guiding document to which its clinicians must refer when evaluating medical necessity.

Denial Assessment



CARMEN'S COMMENTARY

Our provider's denial notice was received 21 days after the date on the letter, at which point the 14-day timeframe to request the peer-to-peer review had already passed (yes, strategic I think). In addition, although my denial notice explicitly stated "a copy" was being sent to the provider (and vice versa); only the provider's notice included disclosure of the peer-to-peer review opportunity and 14-day timeframe. My copy omitted that information. Our insurer repeatedly denied our requests for a peer-to-peer review, even after I submitted multiple complaints requesting they take accountability for delaying the provider's letter and for distributing different denial notices, yet saying they were "copies." Although I never obtained the peer-to-peer review as requested, I cited the insurer's repeated refusals to speak with our clinician as evidence the insurer had no interest in understanding our son's condition.

Peer-to-peer review

In the case of a medical necessity denial, most plans must give your clinician the opportunity for a peer-to-peer review. This is sometimes only disclosed in the denial letter to the provider and may not be included in the denial letter you receive. The window of opportunity for the provider to request the peer-to-peer review is abhorrently short, typically only 14 days from the date on the denial notice. Correspondence from insurers often takes 10-14 days (minimum) to arrive, thus the provider may only have a day or two to request the peer-to-peer review.

Peer-to-peer review is the process whereby the insurer gives the provider the opportunity to discuss clinical denial decisions with a physician or other appropriate reviewer within the insurer organization. It provides an opportunity for a one-on-one discussion between your clinician and the insurer's clinician about the terms of the denial, condition of the patient and more. Your provider can optimize the productivity of the peer-to-peer review opportunity by doing the following:

- **Establish themselves as the foremost expert on your condition.** This includes presenting appropriate credentials but is largely predicated on having direct engagement with you and direct observation of your condition (as opposed to the insurer's clinician who has never met, observed or interacted with you). Your provider must establish that they know you and your needs best and are the most reliable source to determine medical necessity.
- **Demand a detailed explanation of the insurer's primary grounds for the denial.** Your provider should request more specific information than just the criteria used. The provider must determine the exact parts of the criteria which the insurer says you do not comply with. This will inform your appeal.
- **Assert clearly that he or she believes this care is medically necessary.** This is extremely important! The provider must state clearly that they strongly believe this care is medically necessary. Ideally the provider will be familiar with the criteria used by the insurer and will be able to directly refute the insurer's denial grounds. If not, they must at least state medical necessity and provide examples about your specific condition that support their position.

- **Be familiar with local, state and federal legislation (e.g., MHPAEA) and generally accepted standards of care (GASC).** The provider should articulate the way(s) the determination violates applicable regulations and/or GASC.
- **Request the insurer reverse its adverse determination and cover treatment.** Also extremely important! A peer-to-peer review is not an appeal, however the provider can request a reversal on your behalf.
- **Take copious notes and provide you a copy.** Notes should include the date and time of the call, the name, position and credentials of the insurer's clinician, the insurer's clinician's explanation of the grounds for the denial and key points the provider presented as evidence of medical necessity as well as any relevant response from the insurer's clinician. Ask your provider to give you a copy of their notes.

Do not leave the peer-to-peer review solely to your provider. Since the peer-to-peer review must be requested nearly immediately after the denial notice is received, you will have limited time to discuss strategies with your provider. Be proactive! Tell your provider in advance that if you are denied by your insurer for medical necessity, you want to immediately request a peer-to-peer review. Give the provider an outline of the key points you hope they will cover.

What are the stated grounds for the denial?

Try to understand the insurer's stated grounds for the denial – right or wrong. If it is an administrative or coverage denial, your plan documents will be the primary resource. If it is a clinical denial, the peer-to-peer review will shed some light on this, along with a review of other documents you must request from the insurer.

For an administrative or coverage denial, you will want to review your plan documents. The denial notice may include a copy of the relevant pages of the plan documents that the insurer used to deny the claim or it may just refer to a procedure stated in the plan documents. Understanding the insurer's position on an administrative or coverage denial should be straight forward, as there should be specific language regarding the procedure or coverage in the plan documents. If not included in the denial notice, request the insurer identify the specific clauses and definitions in the plan documents which apply to the denial. This will enable you to quickly and confidently find the parts of the plan document the insurer is using for its denial.

Administrative denials in particular may involve actions performed by the provider, such as submitting the claim on time, requesting precertification, or identify the treatment as emergency care. Ask your provider to review your denial notice and advise you on what corrective action should be taken. If your provider is in-network, they have a relationship with the plan which typically includes taking some responsibility for proper claims handling. If they made a mistake which led to your denial, ask them to file an appeal to correct it for you.



Understanding the insurer's grounds for a clinical denial may take more time and effort. Although in most cases the denial notice must identify the grounds for the denial in terms specific to the patient's condition, the level of detail given in many denial notices is insufficient. The insurer is often issuing a form letter with one brief sentence that applies to your condition. This may not be sufficient for you to understand the grounds of the denial and is almost certainly not adequate for you to mount an informed appeal.

You have the right to obtain the clinical criteria used by the insurer when it made its adverse determination. You may also have the right to request relevant documents. Relevant documents include anything the reviewer used to make its determination, including, but not limited to:

- Claim submission forms.
- Medical records.
- Supporting documentation submitted by you or your provider.
- Relevant clinical criteria (which may be an internal document).
- Insurer's clinician's notes and opinions (if applicable).

You should request all of these documents as soon as possible after receiving a clinical denial notice. Document your request and keep a copy for your records.

Once you receive the clinical criteria and relevant documents that were used in the denial, review them in detail. Share them with your provider if they are willing to help you. Ask the provider to explain the grounds for the denial based on their review of the materials provided.

Keep in mind that the clinical criteria used by the insurer may have been developed in-house and may not represent GASC. Several recent court judgments have ruled that the clinical criteria insurers applied to MH/SUD benefits were overly stringent. As described previously, GASC is not a written list of acceptable or legal practices, but is based on evidence or expert testimony regarding whether certain practices in a specific situation adhere to what one can fairly expect of a reasonably competent health care provider, or insurer in this case. Court judgments like *Wit. vs. United Behavioral Health* may be a good source to reference if you believe the insurer policies or procedures may not comply with GASC.

Evaluate the validity of the denial

Some denials are wrongful; others are valid. Although you will undoubtedly be discouraged by any denial, it is best to understand if it is valid (or how valid) before launching into an appeal process. An honest evaluation of the validity of a denial will also inform you about how to proceed, and what to do differently next time.

Administrative denials should be the easiest to verify. These are about the processes and procedures stipulated by the plan, and whether you and/or the provider followed them correctly. Examples of valid administrative denials may include:

- You did not submit a claim for reimbursement within the allotted timeframe.
- You did not obtain a referral to see a specialist as required by your plan.
- You did not seek precertification for a service that requires precertification to be eligible for coverage.

Understanding the grounds for a coverage denial is similar to understanding the grounds for an administrative denial, as the denial should be based on specific language included in the plan documents.

Clinical denials, by definition, require clinical judgment, which means they may be more difficult to evaluate on your own. However, your starting point is to review the clinical criteria and relevant documents supplied by the insurer and compare that to what you know about your condition and medical needs. You are almost certainly going to disagree with the insurer, but the task at hand is to understand the other party's perspective and evaluate the validity of it, considering the information they have.

If your provider is willing, ask them to review the information available, including the clinical criteria used in the denial. Discuss the denial with your provider. Ask them to explain the clinical grounds of the denial to you. Take notes. Decide with your provider whether the denial appears valid from a clinical perspective.



Assess whether the denial may include a parity violation

All three types of denials may be subject to a parity challenge. The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (also known as MHPAEA or the Federal Parity Law) makes it illegal for insurers to discriminate against those with mental illness and/or addiction. The statute aims to ensure equal access to addiction and mental health care as to health care for physical conditions. The law addresses bias in financial requirements, quantitative treatment limitations (QTLs) and non-quantitative treatment limitations (NQTLs).

MHPAEA applies to most, but not all, insurance plans. It directly applies to employer-funded plans with more than 50 insured employees, Medicaid managed-care plans, Children's Health Insurance Program (CHIP) plans, Medicare alternative benefits plans (Medicaid expansion), non-grandfathered individual market plans and plans offered through health insurance marketplaces. The MHPAEA is indirectly applied to non-grandfathered small employer plans (less than 51 employees) via the Affordable Care Act's essential benefits requirements and to Federal Employees Health Benefits Plans (FEHBP) via carrier letters issued by the Office of Personnel Management. MHPAEA does not apply to TRICARE/DOD plans, Medicare plans, Veterans Administration and grandfathered individual market plans.¹¹ Other plans may also be subject to MHPAEA or similar regulations.

If the status of your plan relative to MHPAEA is unclear, you can contact your regulatory agency to ask if the plan is subject to MHPAEA regulations and if not, whether any similar non-discriminatory requirements apply.



CARMEN'S COMMENTARY

It is my opinion that a parity violation is difficult for the consumer to detect. In my own battle, I was unable to even extract the parity compliance documents from the insurer that I was legally due, let alone attempt to understand everything outlined herein and make a comparison between MH/SUD and medical/surgical benefits. If you feel over your head regarding "parity," that's not surprising. I certainly did!

If MHPAEA applies to your plan, additional consumer protections are in place. Upon request the plan must provide details to prove parity compliance. In addition to the clinical criteria request you already made to understand the grounds for your denial, you also have the right to request a copy of the plan's clinical criteria for comparable medical/surgical benefits. Per MHPAEA, plans are required 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. In other words, the plan must provide you with a copy of its internal procedures document that discusses how they assess parity between MH/SUD and medical/surgical benefits.

MHPAEA final rules designate six classifications of benefits: inpatient in-network; inpatient out-of-network; outpatient in-network; outpatient out-of-network; emergency care; and prescription drugs. Parity is evaluated within a classification. For example, inpatient out-of-network MH/SUD treatments must achieve parity with inpatient out-of-network medical/surgical treatments. This is important because you must identify the classification of your treatment and its associated benefits, then compare that to the medical/surgical benefits for a similar treatment in the same classification.

Note that intermediate classifications do not exist; all treatments are classified into one of the six classifications above. Plans must assign intermediate care to one of the six classifications. For parity to be achieved, the plan must assign similar types of intermediate care for MH/SUD and medical/surgical to the same classification. For example, treatment at a MH/SUD RTC should be grouped into the same classification as treatment at a rehabilitation hospital or skilled nursing facility.

APPEALS



CARMEN'S COMMENTARY

An appalling number of mental health denials are never appealed. Exhausting the appeals process will inevitably lead to more members getting the coverage they deserve, and more cases going to external review which will in turn bring more attention to the systemic problems families are facing. It will also send the message to insurers that we are no longer going to give up and just accept "No" for an answer. It is not ideal, but as long as the system remains broken, we must take advantage of what due process we have available.

Appeal Introduction

An appeal is a request to your insurer to review and reconsider an adverse determination or denial.

It is the process by which you can exercise your right to request the insurer reverse their decision and cover treatment. The EOB or denial notice must disclose your right to appeal and provide direction as to how the appeal process works (e.g., where to send the appeal, minimum information, timeframe, etc.). Unfortunately, the appeals process description on the EOB or denial notice may lack important details specific to your plan, such as how many levels of appeal your plan has. Your SPD is your primary source for understanding the appeals process for your plan.

First Steps

Identify your timeframe

Identify the deadline by which the insurer must receive your appeal. This requires two pieces of information: the date on the EOB or denial notice and the number of calendar days allowed by your plan to submit an appeal. The number of days allowed by your plan to submit an appeal may vary depending on the type of claim.

Most appeals are for post-service claims which typically have a minimum timeframe of 180 days to appeal. Knowing the timeframe for your appeal process is essential. Look it up in the SPD and consider requesting confirmation from your insurer (in writing) if you have any doubts.

Note that the insurer must receive your appeal within the given timeframe. There is inherent bias in the insurance timeframe system: the insurer's timeframe starts with the date on their correspondence, whereas your timeframe is always based on when the insurer receives your information (not even the postmarked date). Plan to complete your appeal at least 2 weeks before it is due.

Also be aware that the timeframe may differ depending on the level of appeal you are on. Although you will usually have at least 180 days to file a first level appeal for most post-service claims, your timeframe to submit second (or third, if necessary) appeals may be shorter (e.g., 60 days). Your appeal timeframe for pre-service or urgent care claims may differ as well.

Single or multi-level appeals process considerations

You must refer to your SPD to determine the number of internal appeal levels your plan has.

The appeals process provides consumer protections but can also be a deterrent to consumers. Since the member often cannot seek external review or take legal action until the internal appeals process is exhausted, creating multiple levels of appeals creates multiple obstacles for the member. (Yes, this is probably strategic!)

Engage your allies

You may feel alone, underqualified, over-your-head and out-gunned. This is normal, and partially unavoidable given the nature of the situation, but you have resources. People care and there are rules in place to help you.

I will not lie and say it is easy, but you do not need to do it alone. Engage your resources early and lean into them for support and assistance. Let them know you have been denied coverage, that you intend to appeal, and you would like their help.

The resources you rely on will depend on the type of denial you are appealing. If you are filing an administrative appeal, your primary resources will include your provider (particularly if in-network), plan administrator and overseeing regulatory agency. If you are filing a medical necessity appeal, you may need to engage additional resources, including other current or past providers that may also have relevance to your appeal. External advocacy groups may also be a good resource. If you have a case manager through the insurer, they may be helpful in assisting you to understand the process but will not help you develop your appeal itself.



Assess the scope and complexity of your appeal

It is hard to give general advice on filing an appeal without oversimplifying or overwhelming, neither of which benefit you. The truth is that some denials are simpler to appeal whereas others are going to take every resource you can muster.

For errors or claims marked as pending additional information, see reconsiderations. I recommend submitting reconsiderations for errors by the insurer as complaints as well as reconsiderations. Documenting errors and misconduct by the insurer whenever the plan is administered unjustly, incompetently, or illegally is relevant to the appeals process because accumulated violations may impact reversal of denials.

An appeal is the appropriate response to denials which are not associated with simple errors or insurer requests for additional information. For denials with large monetary value or impact, mount all your resources to the best of your ability. Submit the most comprehensive and compelling appeal you can.

First Level Appeal – Administrative Denial

Use the SPD to your benefit

An administrative denial is about compliance with the processes and procedures of your plan, which are stipulated in the SPD. As such, an appeal to an administrative denial should refer to the SPD as the primary source for refuting the denial.

The SPD will contain a definitions section which may include key terms that apply to your appeal. It will also include descriptions of the processes and how they apply to different situations. Your task is to identify the key terms and sections of the SPD that apply to your claim then to demonstrate in your appeal that you followed the processes and procedures correctly.

Your plan administrator should be knowledgeable about the processes and procedures described in your SPD and may be able to help you identify relevant sections.

Consult with your provider

If you have an in-network provider or an out-of-network provider that offers UM services, they can likely assist you.

In-network providers and trained UM personnel should be knowledgeable about the processes and procedures described in your SPD, or at least familiar with the SPD terminology, to quickly help you identify relevant sections. If the administrative denial seems related to a misunderstanding in your condition, a letter from the provider (or additional medical records) may help justify the processes and procedures you or your provider followed. In-network providers, and some out-of-network UM teams, may be willing to file the appeal for you, although I suggest reviewing and approving any appeal that will be submitted on your behalf.

Seek regulatory assistance/review

Your plan is subject to myriad state or federal regulations which could affect the processes and procedures.

If you have received an administrative denial, your regulatory agency may be able to assist you in deciphering applicable sections of the SPD. They can also advise you if there are state or federal regulations that apply to your plan which may be relevant to your appeal.

Gather your documents

A strong appeal will include documentation to support your point and copies of relevant correspondence. Supporting documentation will vary depending on the specifics of the denial, however examples of supporting documentation may include:

- Insurance ID card and SBC (with effective dates of coverage).
- Copies of relevant sections and definitions from your SPD.
- A letter from the overseeing regulatory agency regarding the apparent validity of your appeal and any state or federal regulations that may apply.
- Copies of applicable sections of state or federal regulation that have relevance to your appeal and differ from or extend upon the details outlined in your SPD.
- A letter from your provider identifying any specific terms of your treatment or claim that affect the processes and procedures that may apply (e.g., emergency care).
- Copies of relevant documentation from the insurer directing you on processes or procedures relevant to the denial (e.g., for example if you called your plan about a treatment and were told precertification was not required, then you were denied for lack of precertification, you would include your phone notes along with the call reference number, agent name, date and time of the call).

Consider a parity challenge

As mentioned previously, parity may be challenging to assess, and it does not apply to all plans.

Whether you are sure there is a parity violation or not, asserting a parity challenge does not harm an appeal. Indeed, it offers several advantages, including additional disclosure, transparency and analysis requirements. A substantiated parity challenge may also make an administrative appeal eligible for external review, where it would not be otherwise. If you already requested a copy of the insurer's internal procedures document that discusses how they assess parity between MH/SUD and medical/surgical benefits, you can use those documents to assert a parity challenge if the plan appears to have bias in financial requirements, quantitative treatment limitations (QTLs) and non-quantitative treatment limitations (NQTLs). In the case your insurer has not provided you sufficient documentation to assess parity, you can assert a parity challenge directly in your appeal. Your overseeing regulatory agency or a qualified advocacy group may be able to help you assess the parity compliance of your plan and guide you as to what aspects of your denial (if any) may be subject to a parity challenge.



How to write an effective appeal letter for an administrative denial

Your appeal letter should be accurate, specific and to the point. Administrative appeals are about the terms and conditions of your plan. The appeal must include all pertinent information (member information, plan information, date, etc.) and should achieve the following:

- Identify the denial you are appealing and clearly state you are appealing the denial.
- Identify relevant details about your claim or treatment that impact which procedures and processes must be followed (e.g., post-service claim, emergency care, out-of-network provider, etc.).
- Identify the specific sections of the SPD or other relevant documents that apply to your claim and associated appeal.
- Assert that your claim should be covered according to your SPD and/or any other relevant documents.
- Request the insurer reverse its denial and cover the claim.
- Include a list of attachments at the end of your appeal letter to formalize their inclusion in your appeal.

First Level Appeal – Coverage Denial

General

A coverage denial is about the scope of what your plan does and does not cover. Many treatments and prescriptions are covered. These will typically be clearly and specifically enumerated in the SPD.

Other treatments are excluded. A list of exclusions is included in the SPD. A coverage denial may deal with a treatment that is neither specifically covered, nor specifically excluded, in which case coverage may be up to interpretation. It is also possible the insurer mistakenly denies treatment saying it is not a covered benefit when it is.

Legal or contractual interpretation coverage denials

If you are denied coverage for a treatment or service which is not clearly covered or excluded by your plan, you will likely need to perform research and seek legal counsel to determine if an appeal is worthwhile and what avenues have worked in similar cases in the past.

Legal and contractual interpretation of coverage denials is beyond the scope of this guide. Possible resources to get you started include the plan administrator, overseeing regulatory agency, or an attorney with experience in health care coverage denials.

Error by the insurer coverage denials

In my experience there is no limit to the type, depth, and egregiousness of errors the insurer may make.

Thus, although perhaps less common, it is possible you could be denied coverage for a treatment that is indeed covered by your plan. For this type of denial (coverage error by the insurer) your approach can be very similar to that described above for an administrative appeal. Your plan administrator, provider and overseeing regulatory agency should be familiar with typically covered treatments and may be able to help you identify relevant sections of the SPD or other relevant documents.

Consider a parity challenge

A coverage appeal may also be a candidate for a parity challenge, particularly if it pertains to a gray area in the plan that is up for interpretation.

Adding a parity challenge to a coverage appeal is worth discussion with your overseeing regulatory agency and/or legal counsel.

How to write an effective appeal letter for a coverage denial

A coverage appeal must include all pertinent information (member information, plan information, date, etc.) and should achieve the following:

- Identify the denial you are appealing and clearly state you are appealing the denial.
- Identify the treatment you received.
- Identify the specific sections of the SPD that identify your treatment as a covered benefit.
- If your treatment is not specifically listed as a covered treatment, you may at least be able to show that it is not excluded.
- Assert that your treatment is covered by your plan according to your SPD and/or any other relevant documents.
- Request the insurer reverse its denial and cover the claim.
- Include a list of attachments at the end of your appeal letter to formalize their inclusion in your appeal.



CARMEN'S COMMENTARY

Clinical denials are often about medical necessity. Clinical denials, by definition, require clinical judgment and are thus inherently more difficult to challenge on your own. However, we must not undersell ourselves. We know ourselves; we know our families; we know our situation and history. Although I may not have known the clinical terminology for our son's condition, I knew that when I was too scared to go to work because he might not be alive when I got home, intensive care was medically necessary. That knowledge – and the associated fear of what might happen without the medically necessary care – only intensifies the frustration, anger and disappointment we feel when an insurer denies care as not medically necessary, or, as in our case, says there is no credible risk of harm. Although it is wounding and burdensome, do not walk away from what you know. Find support, find answers, seek help and keep going. You are not alone!

First Level Appeal – Clinical Denial

Review the medical records submitted to the insurer

The insurer makes its determination based on the information provided during the claim submission and claim processing periods.

This may include medical records and notes if these were submitted with the claim initially or subsequently during a reconsiderations process. Typically, the insurer will only have medical records from the provider who offered the treatment; medical records from other providers may not have been submitted. Medical records submitted in association with your claim are considered relevant documents, so you should have received a copy of these if you requested relevant documents upon receiving your denial notice.

Reviewing the insurer's relevant documents will inform you of any missing records that you may want to submit with your appeal; allow you to verify the accuracy and completeness of the records submitted; and find specific records that you may want to quote in your appeal.

Review the clinical criteria used in the denial

The insurer's task in making a medical necessity determination is to identify the lowest level of care that is appropriate for the current condition reported in the claim submission and associated records.

The insurer will not pay for treatment at a higher level of care than is deemed medically necessary. It will also not pay for treatment at a certain level of care for any longer than is deemed medically necessary. The clinical criteria act as a tool for the insurer's clinician to use as a roadmap to match the patient's apparent current condition, based on the information provided, with the lowest level of care that is medically appropriate.

There are two key tasks to consider when reviewing the clinical criteria used to deny your claim:

- 1 Do you meet the clinical criteria outlined for the level of care or treatment you are requesting coverage for?
- 2 Are the clinical criteria excessively narrow and/or limiting?

If you believe you meet the clinical criteria outlined for the level of care or treatment you are requesting coverage for, one of your key tasks in the appeal will be to rewrite the roadmap using the insurer's own criteria to show your condition matches your level of care and treatment.

If you believe the clinical criteria may be excessively narrow and limiting (which is common), another task may be to demonstrate the criteria the insurer is using is overly stringent and does not comply with the GASC; or that its application of the criteria is overly restrictive. Mental health GASC are evolving, with recent court judgments paving the way for more reasonable and less restrictive access to higher levels of care, for longer durations (especially for adolescents). It is very possible that your insurer is using criteria that is not up to date with current GASC.

Consult with your provider

Clinical denials require clinical judgment, therefore the affirmative judgment of your provider is essential.

Hopefully, you or your provider requested a peer-to-peer review upon receipt of the denial notice and your provider has taken advantage of your right to have your clinician discuss your condition with a clinician employed by the insurer. The provider's key tasks during the peer-to-peer review included:

- Establish themselves as the foremost expert on your condition. This includes appropriate credentials but is largely predicated on having direct engagement with you and direct observation of your condition.
- Demand a detailed explanation of the insurer's grounds for the denial.
- Assert clearly that they believe this care is medically necessary.
- Request the insurer reverse its adverse determination and cover treatment.
- Take copious notes and provide you a copy.

Consult with your provider to understand the insurer's grounds for the denial. This will become the target of your appeal. Your objective is to persuade the reader of the appeal that the insurer's grounds for the denial are invalid and that care is medically necessary and thus should be covered by your plan.

Obtain a clinical statement from your provider appealing the denial

Request a letter from your provider. The letter should aim to accomplish many of the same things as the peer-to-peer review, including establishing themselves as the foremost expert on your condition and asserting clearly that this care is medically necessary.

However, the provider's letter should go beyond the basics to include as much detail specific to your condition as possible. A provider letter should ideally do the following, and more as appropriate:

- State that they are submitting the letter in support of your appeal.
- Reference the denial notice, the insurer's stated grounds for the denial and the clinical criteria used to deny treatment.
- List the provider's position, credentials and qualifications.
- Describe the provider-patient relationship, including how long they have known you, how often you have had treatments (if ongoing or recurrent), etc.
- Identify your primary diagnosis. Include a list of other past and current diagnoses if applicable.
- Describe specific events or conditions that precipitated this specific treatment.
- List any previous treatments that have failed.
- Cite specific examples from the medical records of relevant behavior or symptoms that demonstrate this care is needed.
- Discuss underlying conditions if applicable.
- Cite evidence-based medicine best practices that support the current treatment plan.
- Identify relevant GASC, including the need for treatment to be both effective and safe (not one without the other).
- Characterize any improvements that have been achieved (or are in progress) and show how those are directly attributable to the current treatment.
- Reference the insurer's criteria to map out why the current treatment is the appropriate level of care and is medically necessary.
- State the provider's clinical conclusion and professional judgment.
- Reiterate the need for treatment to be covered and request reversal of the adverse determination (denial).

This is a lot to ask of the provider, however their testimonial may be the most important document in your appeal. The same statements made by you or any other non-clinician do not carry the same weight.

Provide context to your clinical appeal

Many MH/SUD claims represent only a snapshot in time along a much more involved journey. Although insurers try to limit their review to only current treatment at the current moment, a patient's MH/SUD history can be a key component when assessing medical necessity.

Presenting the larger picture provides context to the current medical records and treatment plan. It also provides you an opportunity to fill in the blanks around the clinical judgment offered by your provider and to reiterate why this treatment is needed and why lesser levels of care are not appropriate.

One way to provide context is to create an abbreviated chronological summary of your MH/SUD treatment journey. Starting at the earliest relevant event and/or treatment, list all providers you have worked with (in chronological order) and highlight any key events (e.g., suicide attempt, psychotic episode, etc.). Also include a brief description of your presentation during the relevant time period while working with each provider (e.g., gained or lost excessive amounts of weight, school refusal, lost your job due to absenteeism, medication non-adherence, etc.). Identify the dates of key events and periods of treatment with relevant providers.

Gather medical records from current and past providers. Ideally you would obtain and submit the complete medical file for each provider, however if that becomes overwhelming, at least include the discharge summaries. If it is a current provider, a copy of your master treatment plan may suffice if complete records are not available or are too much to handle. Reference attached medical records in your abbreviated chronological summary to provide a framework for the reviewer.

If the current treatment you are appealing comes after previous failures at lower levels of care, identify those failures as evidence that lower levels of care were ineffective and/or unsafe.

How to write an effective appeal letter for a clinical denial

Use effective communication skills to write a clear and compelling letter based on accurate information. The appeal must include all pertinent information (member information, plan information, date, etc.). A possible outline for an effective clinical appeal is below:

OUTLINE

Executive Summary

- Identify the denial you are appealing and relevant service dates (if more than one).
- Identify the monetary amount of the denied MH/SUD services you are appealing.
- Clearly state you are appealing the denial.
- Request immediate reversal of the adverse determination (denial).

Denial Understanding & Background

- Identify the insurer's stated grounds for the denial.
- Reference the clinical criteria the insurer used for the denial.
- Quote and correct any sections of the denial notice that are erroneous to negate perpetuation of false information.
- Identify any requests for relevant documents, including parity compliance documents, that have not been properly responded to by the insurer and discuss how that is inhibiting your ability to file an informed appeal (if applicable).

Grounds for Clinical Appeal

- Refer to provider letters and medical records that support your appeal.
- Identify any key MH/SUD events relevant to the claim (e.g., past episodes of self-harm, hospitalization, etc.).
- Identify failures at lower levels of care (if applicable).
- Describe how the current care is both effective and safe.
- Walk through the insurer's clinical criteria to demonstrate how your condition matches the treatment for which you are appealing coverage.

Parity Challenge

- Assert any identified grounds for a parity violation. This may include discussion of the clinical criteria if you have determined the clinical criteria (or the insurer's application of it) may be overly restrictive.
- Request parity compliance documents (if not received already).

OUTLINE CONT.

Conclusion

- Clearly state again that you are appealing the denial.
- Reiterate your request for immediate reversal of the adverse determination (denial).

Signature

Schedule of Attachments

- Number and list all attachments, including the following, as applicable:
 - 1 Denial notice or relevant EOB.
 - 2 Insurer's clinical criteria used to deny treatment.
 - 3 Provider's letter(s).
 - 4 Abbreviated chronological summary.
 - 5 Past and current medical records with relevance to the claim.

Each appeal is unique, so the outline above does not apply to all cases. It is intended only to provide a framework to understand some of the key components of an effective clinical appeal. For simpler appeals, you may only need to include some sections. For more involved appeals, you may have an even more extensive package. If your provider is helping, they may already cover some sections in the letter supporting your appeal.

Remember that a clinical denial is about clinical judgment. Your abbreviated chronological summary may include some amount of description of the emotional burdens of your journey, but a direct plea, however heartfelt and compelling, is unlikely to win an overturn if it is not supported by clinical evidence and judgments by licensed providers.

Filing Your First Level Appeal (All Types)

Collate your appeal documents into a combined package

Once you have finalized your appeal letter, you will want to combine that with your supporting documents to generate one comprehensive appeal package. Your insurer may require you (or your provider) to submit your appeal with an appeal form.

Contact your insurer to see if there is a specific appeal form you must use. Note that sometimes insurers have different requirements for appeal forms depending on whether you or the provider are submitting and signing the appeal. Your appeal should include the appropriate appeal form (if required by the insurer), your appeal letter and copies of all relevant attachments, including the denial notice or applicable EOB and all supporting documentation.

Send your appeal

Address your appeal to the address given on the denial notice or EOB you received. Send your appeal certified mail (signature required) and keep a copy of the receipt for your records.

You may be able to submit your appeal online if the file is not too large. This can be fast and effective; and it builds your electronic paper trail. However, electronic appeal-filing may not be available for all plans and is only recommended if you feel comfortable with the technology required to securely create and submit a combined appeal in PDF format, including all attachments.

Regardless of how you submit your appeal, keep a copy of the complete appeal for your records, preferably in electronic and hardcopy formats.

Activate your allies

Send a copy of the appeal to your provider – and thank them for any support they provided, including any letters they wrote to support your appeal.

Filing a Second (Or Third) Level Appeal (All Types)

If your first level appeal is unsuccessful and you have a multi-level appeals process, take it one step at a time. Ideally you presented a strong appeal on the first level which will greatly reduce the effort required to file a second (or third) level appeal. Most importantly, **DON'T GIVE UP!**

Understanding the insurer's response to your first level appeal

If the insurer upholds its denial, it will inform you of this in a new denial notice.

If that notice contains new information regarding the insurer's stated grounds for the denial, you will want to revisit the same process you went through upon receiving the original denial, including consulting your provider to understand and evaluate any newly stated grounds for upholding the denial. If the insurer simply states it is upholding its denial and refers to the same rationale it presented in the original denial, you do not need to revisit the whole process again.

Writing an effective second (or third) level appeal (all types)

If you feel you already submitted your best effort in your first level appeal and the insurer's notice upholding the denial did not include anything new for you to respond to, your second level appeal can be very simple:

- Create a concise appeal letter stating you are submitting a second (or third) level appeal.
- Identify the denial you are appealing and relevant service dates (if more than one).
- Refer to your first level appeal and request the insurer review the appeal and all associated attachments in full again.
- Request immediate reversal of the adverse determination (denial).
- Sign and include a Schedule of Attachments.
 - Include your first level appeal (and its attachments) as Attachment 1
 - Include the insurer's letter upholding its denial as Attachment 2

If the insurer's notice upholding the denial included new information for you to respond to, or you have additional documents to share, your second level appeal should discuss those in the appeal letter and include additional attachments as needed. If the insurer's letter upholding the denial includes erroneous information, take this opportunity to point out the error and correct the misinformation. This both highlights the insurer's lack of attention to detail and accuracy and corrects the record for the next reviewer. Follow the procedures above, including referencing the first level appeal and submit it and the new denial notice as attachments.

Collate and send your second (or third) level appeal (all types)

The most important thing to do in a second (or third) level appeal is just to submit the appeal!

Collate and send your second (or third) level appeal in the same manner you followed for the first level appeal. Use the appropriate appeal form (if required by the insurer) and include all attachments. Address your appeal to the address given on the notice you received upholding the denial. Send your appeal certified mail (signature required) and keep a copy of the receipt for your records. Send a copy of the appeal to your provider.

If this is your final appeal, send a copy of your appeal to the overseeing regulatory agency and your plan administrator. Request detailed information on how to pursue external review if your second (or third) level appeal is denied. Ensure you know the timeframe to exercise your right to external review in advance, as the timeframe may be shorter than other appeal periods. In the event you are trying to get external review of an administrative or coverage denial based on a parity challenge, you may also need to do extra legwork to get approved for that in advance, as most administrative or coverage denials are not eligible for external review. A parity advocacy group may be able to assist you with evaluating options for external review based on a parity challenge.

EXTERNAL REVIEW AND BEYOND



CARMEN'S COMMENTARY

If you have made it this far you have demonstrated a determination and resourcefulness which many can only aspire to; yet your appeals have failed to result in the overturn you desired (and likely need!). I can empathize with the enormous discouragement you may feel. You have jumped through every hoop and obstacle presented, and still there has been no change in the insurer's response. It is hard to see anything positive in this situation, but it is a major accomplishment to simply navigate the complex appeal system and exhaust the appeals process. In doing so, you advocated for yourself, fought for those you loved and never gave up. The silver lining is that you can now exit from the insurer's internal appeals process and obtain potentially less biased review through external review or litigation.

Once you have exhausted the internal appeals process you have the right to bring a civil action lawsuit against your insurer. You also may have the right to external review depending on the details of your denial.

External Review

Up to this point your appeals will have been reviewed by internal reviewers who work for the insurer and therefore may not be entirely unbiased.

External review is an opportunity to have your appeal reviewed by an external review organization (ERO). The ERO is an independent third party not employed by your insurer. Typically states (and other overseeing agencies) maintain a list of approved EROs, one of which will be assigned to your case if you request and qualify for external review. The ERO will have a clinical reviewer examine information submitted by you and the insurer and will make a final decision. If you proceed to external review, the ERO's decision is binding on the insurer, meaning if the ERO decides care is medically necessary and/or not experimental, then the insurer must reverse its denial and cover treatment according to your plan. The external review will be performed by a clinician familiar with the diagnoses and treatments specific to your condition.

Note that though an external review may be more objective than the internal review conducted by the insurer, it is still based on individual judgement that may not be totally unbiased – underscoring the need to provide evidence and documentation that supports the case for appeal, as well as possible compliance violations.

Is your appeal eligible for external review?

Most clinical appeals are eligible for external review. If your appeal is eligible for external review, the insurer's final adverse determination letter must inform you of your right to seek external review.

The letter should also describe the external review process and may include necessary forms. Common conditions for external review include denials where the claim decision involved medical judgment; the insurer decided treatment was not medically necessary or that the treatment is experimental. External review is usually free, except for any incidental costs to submit your materials.

In some cases, if an administrative or coverage denial involves a parity challenge it may be eligible for external review. In this case the insurer may not advise you of such. You will need to seek assistance from your overseeing regulatory agency to see if external review is available to you if you are appealing an administrative or coverage denial based on a parity violation. Otherwise, administrative and coverage denials are not usually eligible for external review.

What to submit

External review is about whether the insurer made a correct and fair decision based on the information provided.

Therefore, the information that will be reviewed by the ERO usually comes directly from your appeal documents. You may not have the opportunity to submit new documentation for review. Follow the instructions on your final denial notice. At a minimum you should submit any required external review form, a copy of the final denial notice from your insurer, and complete copies of all previously submitted appeals.

Are there possible disadvantages to pursuing external review?

If you think you might pursue litigation if you are denied during external review, you may wish to consult with a qualified attorney prior to requesting external review.

Although there is undoubtedly question about how independent EROs actually are, an adverse decision by an ERO adds some amount of credibility to the insurer's denial, in that the insurer is not the only one to disagree with you. For this reason, sometimes people forego external review and proceed directly to litigation.

Arbitration, Litigation and Beyond

The process to undertake litigation against your insurer is beyond the scope of this guide.

If you intend to take legal action, seek legal counsel from a qualified attorney versed in MH/SUD appeals and litigation, ideally with experience specifically related to your circumstance. The best time to retain an attorney will vary depending on your specific situation, however starting the conversation before you exhaust the appeals process may have benefits, including giving you more time to find the right attorney, strategizing ways to handle the final appeal stage(s) to put you in the best position for future litigation, allowing the attorney to become familiar with your case in advance, letting the insurer know you intend to pursue your case further if you continue to be denied, etc. Options to discuss include having the attorney request your medical file from the insurer, issuing a demand on the plan, filing an individual civil action lawsuit, or joining a class action lawsuit. It may be possible to pursue litigation based on a contingency, so you only pay attorney fees if you win. Class action lawsuits are usually pursued that way.

Concluding Remarks

The American healthcare system is complex and challenging, especially for families and individuals seeking MH/SUD care and benefits coverage.

At times, the system seems intentionally designed to discourage us from accessing the care and benefits it is supposed to deliver. Understandably, families can sometimes feel the journey is too exhausting, the road too uphill and a successful outcome too improbable to continue. However, the quest for MH/SUD care and benefits can also bring a sense of purpose and renewed passion to achieve meaningful change.

Families will do everything in their power to get the care their loved ones need. For this reason, families have the potential to be a powerful and influential voice for change. We are many and we can make a difference – for ourselves, for those we love, and for our communities. Your journey matters.

I hope this guide empowers you to pursue your health care benefits on a higher level. Whatever you learn from this guide and whatever forward progress you make toward accessing your own MH/SUD health care benefits contributes to the universal effort needed to transform health care benefits from a fragmented maze into an indispensable asset, accessible and available to all in need.

And most importantly, I hope this guide reminds you that you are not alone.



Carmen Bombeke, PE, BCPA
Mother/Advocate

ABOUT THE AUTHOR

Carmen is passionate about improving mental health care and equipping parents and families with tools and resources to navigate the difficult terrain of health insurance coverage. As a Board-Certified Patient Advocate and Certified Parent Coach, Carmen is committed to helping families become more informed about mental health care parity and coverage so they can focus on the well-being of their loved ones rather than fighting their insurers for coverage of the care they need.

She has lived-experience navigating the mental health care maze whilst maintaining her full-time career as a structural engineer, showing up 100% for her son, fighting an exhaustive battle for reimbursement of over a hundred thousand dollars of wrongfully denied claims, and striving to stay present and well day to day. She lives in Maine with her husband and is thankful every day that her son is alive. FMI: Visit bombekeconsulting.com

Abbreviations

ACA	Affordable Care Act (“Obamacare”)
CHIP	Children’s Health Insurance Program
CMS	Centers for Medicare and Medicaid Services
CPT	Current procedural terminology
DOB	Date of birth
DOL	U.S. Department of Labor
DSM	Diagnostic and Statistical Manual of Mental Disorders
EOB	Explanation of benefits
ERISA	Employee Retirement Income Security Act of 1974
ERO	External review organization
FDA	U.S. Food and Drug Administration
GASC	Generally accepted standard(s) of care
HHS	U.S. Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act of 1996
HMO	Health management organization
ICD	International classification of diseases
IOP	Intensive outpatient program
IRO	Independent review organization
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
MH/SUD	Mental health and substance use disorder
MHPAEA	Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008
NCQA	National Committee for Quality Assurance
NQTL	Non-quantitative treatment limitations
OOP	Out-of-pocket
PCP	Primary care physician
PHI	Personal health information
PHP	Partial hospital program
POS	Point-of-service
PPO	Preferred provider organization
QTL	Quantitative treatment limitations
RTC	Residential treatment center
SBC	Summary of Benefits and Coverage
SCA	Single case agreement
SPD	Summary Plan Description
TJC	The Joint Commission
TPA	Third party administrator
UM	Utilization management
UR	Utilization review
URAC	Utilization Review Accreditation Commission

Glossary¹²

Accreditation – Validation that a health plan or provider has demonstrated their ability to meet certain standards.

Accreditation organization – An independent organization that reviews a company's operations to ensure that the company is meeting generally accepted standards of care established by the accreditation organization.

Administrative denial – Refusal to approve coverage for a health care service based on administrative procedures and processes.

Adverse determination – Decision that a service is not medical necessity. See also Denial.

Allowed amount – The amount the plan will pay for a given service. Allowed amounts typically apply to out-of-network services where a rate has not already been negotiated between the insurer and the provider. Also referred to as Recognized rate. See also Balance billing.

Appeal – A formal request to the insurer for review (and overturn) of a denied claim.

Balance billing – Charging a patient the difference between the provider's billed amount and the insurer's allowed amount. This typically only occurs with out-of-network providers.

Behavioral health – See Mental health.

Billing code – A procedural code used to identify a specific health care service (e.g., CPT code)

Call reference number – A unique number assigned by the insurer to reference a phone call that took place with a member or provider. This must be requested from the insurer during the call.

Certificate of coverage (COC) – A document issued by the insurer that details the benefits afforded by the plan. Members have a right to obtain a copy of this document. See also Summary plan description.

Claim – Request for payment by the plan for a health service.

Clinical criteria – Written procedures and guidelines used by the insurer to determine the necessity and appropriateness of health care services.

Clinical denial – Refusal to approve coverage for a health care service based on clinical criteria and/or clinical judgment.

Clinical judgment – Process by which a provider or clinician makes a health-related decision about a patient based on clinical experience, practice and knowledge.

Clinician – Licensed health care provider.

Coinsurance – A percentage of the cost of a service the member pays after the deductible. The plan pays the remaining percentage up to any benefit maximum.

Complaint – A statement of dissatisfaction or formal allegation. For this document, a Complaint is considered a written statement.

Concurrent review – Utilization review conducted during a patient's course of treatment.

Consolidated Appropriations Act – A February 2021 amendment to the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) that requires group health plans and issuers that cover mental health and substance use disorders and medical/surgical benefits to prepare and provide upon request to applicable regulators a comparative analysis of any non-quantitative treatment limits (NQTs) that apply.

Copay – See Copayment.

Copayment – A fixed fee amount the plan requires the member to pay out-of-pocket for a covered service. Copayments are usually paid when the service is rendered.

Cost sharing – When the patient and the insurer share the cost of a covered service, typically by copayment or coinsurance.

Covered benefit – See Covered service.

Covered service – Service or treatment eligible to be paid for by the plan.

Customary and reasonable – A limit on the amount the plan will pay, typically established by the insurer based on what providers usually charge. Also referred to as Reasonable charge, Prevailing rate or Usual, customary and reasonable.

Deductible – The amount the member must pay for covered services before the plan begins to pay.

Denial – Refusal by the insurer to approve coverage for a health care service.

Denial notice – Written notification of a denial determination.

Dependent – A person covered by the plan other than the subscriber (e.g., child, spouse).

Diagnosis – Assigned or identified condition based on evaluation of patient history, examination, laboratory data, testing, etc.

Diagnosis code – Medical classification code used to identify groups of diseases, disorders, symptoms, etc. (e.g., DSM code)

Effective dates of coverage – The dates a member is enrolled in a plan. This is the time period that coverage is active.

Eligible health service – Service or treatment that is covered by the plan.

Emergency – Serious illness or injury that requires immediate medical care to prevent death or serious health problems.

Evidence-based medicine (EBM) – Conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research.

Exchange – See Health insurance marketplace.

Exclusions – Conditions or services the plan does not cover.

Explanation of benefits (EOB) – Statement issued by the plan to the member that shows charges, payments and balances owed for submitted health claims.

External review – Independent review of an adverse determination or denial. This review is not conducted by the insurer.

External review organization (ERO) – Organization that provides external review services.

Federal parity law – Paul Wellstone and Pete Domenici Mental Health Parity and Additional Equity Act of 2008 (MHPAEA).

Formulary – A list of prescription drugs the health plan covers.

Fully-funded plan – An employee-sponsored health plan where the employer engages an insurance company to administer and manage the plan and pay claims. The insurance company assumes the risk in these plans. Also referred to as a fully-insured plan.

Generally accepted standard(s) of care (GASC) – Practices judged to be comparable to the practices of a reasonably competent health care professional providing services in a similar setting under similar circumstances. GASCs are based on expert judgment and are not readily available as a written list of performance standards.

Health insurance marketplace – A resource administered by federal and state governments where individuals, families and small businesses can learn about health coverage options and compare, choose and enroll in a health care plan. Also referred to as Exchange or Health insurance exchange.

Health care plan – Any health benefits plan that helps pay for health care services.

Independent review organization (IRO) – See External review organization.

In-network provider – A provider that has contracted with the plan to provide services at rates negotiated with the insurer. Also referred to as a participating provider.

Insurer – Company providing health care benefits. For this document, insurer is used as an umbrella term to include third party administrators that administer self-funded plans.

Internal procedures document – A document developed by the insurer outlining insurer procedures and protocols. Some internal procedures documents may be obtainable by the member, particularly in the case of parity compliance.

Internal review process – Review conducted by the insurer.

Level of care – The amount of assistance or treatment a patient requires or receives. A level of care determination is an evaluation of the intensity of a patient’s health service needs.

Maintenance medication – Prescription medications taken on a regular basis to help treat chronic conditions. Some maintenance medications are only covered if purchased through a mail-order company.

Marketplace – See Health insurance marketplace.

Medical necessity – See Medically necessary.

Medically necessary – Care that is deemed necessary according to medical standards and/or research that shows care is safe and effective.

Member – A person covered by the health plan, including the subscriber and any dependents.

Member rate – See Negotiated rate.

Mental health – Pertaining to a person’s cognitive, psychological, behavioral, emotional and social well-being. Mental health includes addiction and substance use disorders. Also referred to as Behavioral health.

Negotiated rate – The amount an insurer contracts to pay a provider for a given service.

Network – See In-network provider and Out-of-network provider.

Network adequacy standards – Requirements, which vary by state, that can help support justification for approval for coverage of out-of-network care, or that may compel an insurer to work on a beneficiary’s behalf to identify in-network providers and services that comply with the network adequacy standards.

Network scarcity – Lack of in-network providers. Also referred to as network deficiency.

Non-Quantitative Treatment Limits (NQTLs) – Non-numerical limits on the scope or duration of benefits for treatment, such as preauthorization requirements.

Out-of-network provider – A provider that has not contracted with the plan. Out-of-network providers may charge more than the Allowed amount. Also referred to as a nonparticipating provider.

Out-of-pocket cost – Medical costs the member must pay, including copayments, coinsurance and deductibles.

Out-of-pocket maximum – Maximum amount the member must pay for covered services. Not all plans have an out-of-pocket maximum.

Overturn – Reversal, typically of a denial.

Parity – Equity. For the purposes of this document, parity references equality among medical and mental health benefits.

Parity challenge – Formal inquiry or demand on the plan requiring the insurer to demonstrate parity compliance.

Parity compliance – Adherence to MH/SUD parity requirements.

Parity violation – Breach of MH/SUD parity requirements. Any act or procedure that does not provide mental health benefits on an equal basis to medical health benefits.

Patient – Person receiving care.

Peer-to-peer review – Discussion between a patient’s provider and a qualified clinician employed by the insurer regarding a patient’s condition and treatment, as it relates to an adverse determination. This is typically done as a phone call.

Personal health information (PHI) – Documentation relevant to a person’s health, including diagnoses, claims, treatment plans, health history, etc.

Plan – Health care plan as outlined in the plan documents and administered by the insurer.

Plan administrator – The person designated to enroll people in a health care plan. Plan administrator roles and responsibilities vary depending on the plan type. Plan administrators may have fiduciary responsibility in self-funded plans.

Plan document(s) – Written document(s) that establish the rights of the plan participants and beneficiaries, describe the details of coverage and guide the plan sponsor and plan administrator in execution of the plan. Plan documents often include the group agreement (contract), group policy, Certificate of coverage (COC), Summary plan description (SPD) and Summary of benefits and coverage (SBC).

Plan sponsor – The group that sets up and manages a health plan, such as an employer, labor union or government agency.

Plan violation – Breach of plan rules and requirements, as established in the plan documents.

Policy holder – See Subscriber.

Post-service – After a service has been provided (e.g., post-service claim).

Preauthorization – See Precertification.

Precertification – Determination made by the insurer before the patient receives care that the proposed treatment is medically necessary and eligible for coverage based on the information submitted by the provider and the plan documents. Some treatments require precertification to obtain coverage. Also referred to as preauthorization, prior authorization or prior approval

Predetermination – A guarantee made by the insurer before the patient receives care that the proposed treatment will be covered by the plan. Predetermination is a voluntary process initiated by the patient or provider.

Preferred care provider – See In-network provider.

Premium – The amount paid to the insurer for health insurance benefits.

Prescription drug – Type of medicine only available with a doctor's prescription.

Pre-service – Before a service has been provided (e.g., pre-service claim).

Prevailing rate – See Customary and reasonable.

Primary care physician (PCP) – An in-network physician specializing in family medicine, community internal medicine, general medicine, pediatrics, etc. who is the patient's primary contact for health care needs. The PCP may make referrals for other care and coordinate care their patients get from specialists and other care facilities. Some plans require members to choose a PCP and/or obtain referrals for specialty services to be eligible for coverage.

Provider – Licensed professional or facility that delivers health care.

Quantitative treatment limitations – Numerical limits on the scope or duration of benefits for treatment, such as visit limits and day limits.

Reasonable charge – See Customary and reasonable.

Recognized rate – See Allowed amount.

Reconsideration – A request to the insurer for correction of an error or to supply additional information so that an unpaid, pending or denied claim may be reprocessed.

Referral – Process by which a PCP sends a patient for treatment by another care provider. Referral is also the term for the document the PCP submits to the insurer and/or other provider so the patient can get the care. Referrals may be required by some plans for certain services to be eligible for coverage.

Regulator – Legal or governmental authority charged with overseeing and enforcing health care provisions of state and federal laws.

Regulatory agency – See Regulator.

Regulatory violation – Breach of regulatory rules and requirements, as established by applicable laws and statutes.

Reimbursement – Payment by the insurer to the member for out-of-pocket costs the member already paid.

Relevant documents – Documents used by the insurer when reviewing a claim. Relevant documents will vary depending on the situation. Relevant documents include documents submitted by the provider and/or member (e.g., claim submission form, medical records, diagnosis, etc.) and applicable internal documents of the insurer. Internal relevant documents need not be specific to the claim, but are those documents used by the plan when it reviewed the claim, or uses when reviewing similar claims, such as the specific plan rules or guidelines governing the application of specific protocols, criteria, rate tables, fee schedules, etc. Relevant documents are available upon request and free of charge for most plans.¹³

Reprocess (a claim) – To review again, typically with corrected or additional information.

Reversal – A change in determination, typically sought after a denial.

Self-funded plan – An employee-sponsored health plan where the employer may engage a third party administrator to administer and manage the plan. The employer pays the health care claims. The employer assumes much of the risk in these plans. Many employers with self-funded plans obtain stop-loss insurance to minimize their risk. Also referred to as a self-insured plan.

Stop-loss insurance – A product employers with self-funded plans can purchase that provides risk protection to the employer by putting caps on the amount the employer will pay. If health care costs exceed the cap, the third party administrator or insurer will pay the overage.

Subscriber – Person who enrolls in the plan (e.g., the employee in an employer-sponsored plan). Also referred to as the enrollee.

Summary of benefits and coverage (SBC) – Abbreviated document that highlights primary elements of the plan, including deductible, copay and out-of-pocket limits. SBCs must use a certain format to ease direct comparison between plan options. Members have a right to obtain a copy of this document prior to enrollment.

Summary plan description (SPD) – Detailed document that outlines the plan benefits, processes and procedures. Members have a right to obtain a copy of this document.

Third party administrator (TPA) – Organization or institution that provides administrative services in execution of a self-funded plan. The TPA may share fiduciary liability with the employer.

Urgent care – Illness or injury that requires prompt medical care but for which a brief time lapse before receiving treatment will not cause death or serious health problems.

Usual, customary and reasonable – See Customary and reasonable.

Utilization management – Prospective, concurrent or retrospective assessment of medical necessity and the appropriateness of health care services. For this document, Utilization management for out-of-network providers has been used as a general term for prospective, concurrent or retrospective assessment as well as claims and/or appeal processing.

Utilization review – See Utilization management.

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U.S. Centers for Medicare and Medicaid, Baltimore, MD, www.cms.gov

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Legal Action Center: [Spotlight on Network Adequacy Standards for Substance Use Disorder and Mental Health Services](#)

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[Faq's About Mental Health And Substance Use Disorder Parity Implementation And The Consolidated Appropriations Act, 2021 Part 45](#)

National Council for Behavioral Health: [A Compelling Argument for Facilitating the Equitable Standards of Care – Strategies for Mental Health and Substance Abuse](#)

- 1 In the case of self-funded plans, the insurer may be the employer. In these cases, the employer often hires a third party administrator (TPA) to manage the plan. For simplicity, this document refers to "insurer" as the agency which the member interacts with when accessing benefits.
- 2 U.S. Department of Health & Human Services, www.hhs.gov/answers/medicare-and-medicaid/index.html (Accessed 1/1/2021)
- 3 U.S. Centers for Medicare & Medicaid Services, www.medicare.gov/your-medicare-costs (Accessed 1/1/2021)
- 4 U.S. Department of Health & Human Services, www.hhs.gov/answers/medicare-and-medicaid/index.html (Accessed 1/1/2021)
- 5 U.S. Centers for Medicare & Medicaid Services, www.medicare.gov/what-medicare-covers (Accessed 1/1/2021)
- 6 U.S. Centers for Medicare & Medicaid Services, www.healthcare.gov/medicaid-chip/childrens-health-insurance-program (Accessed 1/1/2021)
- 7 Kaiser Family Foundation, www.kff.org/faqs/faqs-health-insurance-marketplace-and-the-aca/what-is-the-health-insurance-marketplace (Accessed 1/1/2021)
- 8 The Summary Plan Description (SPD) and Certificate of Coverage (COC) are similar documents referred to differently based on the type of plan. For the purposes of this document, we refer to SPD. COC may apply interchangeably in many instances.
- 9 American Psychiatric Association, www.psychiatry.org/psychiatrists/practice/dsm (Accessed 1/1/2021)
- 10 Fair Health, Inc., www.fairhealthconsumer.org/insurance-basics/your-health-plan/experimental-treatments (Accessed 1/1/2021)
- 11 Denials Management/Schooner Strategies, The Health Insurance Appeals Guide, A Consumer Guide for Filing Mental Health and Substance Use Disorder (MH/SUD) Appeals, 2020
- 12 Unless noted otherwise, terms in this Glossary are derived from common knowledge, personal experience and/or the following references: Merriam-Webster, www.merriam-webster.com (Accessed 1/1/2021), Law Insider, Inc., www.lawinsider.com/dictionary (Accessed 1/1/2021)
- 13 Employee Benefits Security Administration, U.S. Department of Labor, www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/benefit-claims-procedure-regulation (Accessed 1/1/2021)

Consumer Resources

The Kennedy Forum, www.thekennedyforum.org

Parity resources for consumers, mental health advocates, business leaders, government agencies and legislators.

The Kennedy Forum, Don't Deny Me, www.parityregistry.org/dont-deny-me

A website that educates consumers and providers about patient rights under the Federal Parity Law and connects them with appeal resources and guidance.

National Alliance on Mental Illness (NAMI), www.nami.org

Advocacy, education, support and public awareness resource for individuals and families affected by mental illness.

National Association of Insurance Commissioners (NAIC),

content.naic.org/state_web_map.htm

Consumer reference links and insurance department contact information for each state.

Department of Labor Resources

Ask EBSA: dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa

Information about programs and services, provide answers to questions, and assistance if you believe you have been inappropriately denied a retirement, health, disability, or other ERISA employee benefit.

Form to request documentation from an employer-sponsored health plan or an insurer concerning treatment limitations: dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/mhpaea-disclosure-template-draft.pdf

Parity Track, paritytrack.org

Collaborative forum that works to aggregate and elevate the parity implementation work taking place across the country. Parity Track seeks to help consumers understand their rights under the Federal Parity Law and state parity laws and to empower consumers to exercise those rights.

Well Being Trust, wellbeingtrust.org

Resource for prevention, treatment, and recovery for mental health and substance misuse issues prioritizing upstream focus on resilience and well-being in communities.

Well Being Trust, Healing the Nation: Advancing Mental Health and Addiction Policy,

healingthenation.wellbeingtrust.org

Policy guide outlining the current state of the mental health crisis in the United States and policy steps to address it.

