



Consumer Tips Webinar: Filing Mental Health Insurance Appeals

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Presenters



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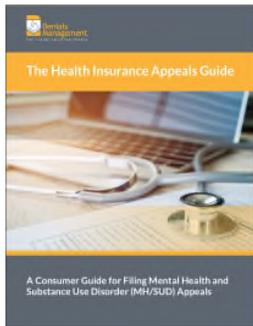
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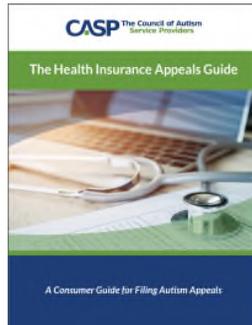
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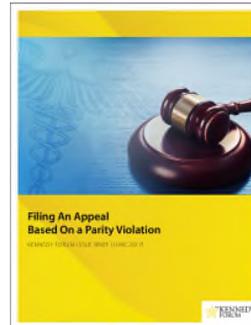
Resources: MH/SUD Appeal Guides



www.fixmyclaim.org



www.casproviders.org

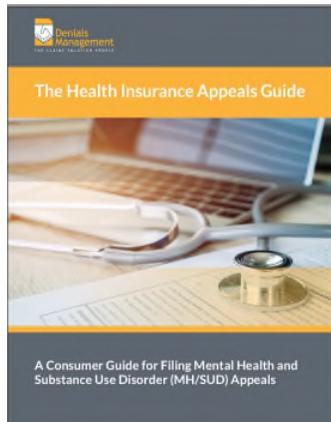


www.thekennedyforum.org



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Health Insurance Appeals Guide Overview



The Health Insurance Appeals Guide

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Resources: Parity Registry.org




We want to help you fight back.

This site is here to provide you with the information and resources you need to exercise your right to equitable insurance coverage. If you choose to share your story and submit a complaint, we can use the information you provide to advocate for better enforcement of the law for your family and other families like yours. We are working to ensure that mental health and addiction treatment is covered in the same manner as other health conditions.



What is Parity?

Parity is the Law: The Mental Health Parity and Addiction Equity Act (the Federal Parity Law) requires that health plans cover mental health, eating disorder, and addiction care health benefits the same way they cover physical health benefits.

The Mental Health Parity and Addiction Equity Act (Federal Parity Law) requires insurers to cover treatment for mental health and substance use disorders no more restrictively than treatment for illnesses of the body, such as diabetes and cancer. Visit our website, DonDenyME.org, for helpful fact sheets and other materials, as well as brochures and posters just for providers who want to help educate patients about parity.

DON'T DENY ME

www.parityregistry.org

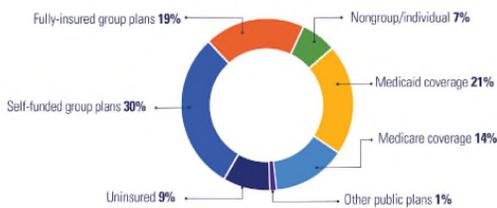


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U.S. Health Insurance Coverage



U.S. Population Percentage by Health Insurance Market Type



Source: The Kennedy Forum

Insurance Plan Types:



Source: Kaiser Family Foundation



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Regulatory Oversight



- The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)
- Federal and state oversight
 - Utilization management
 - Grievance procedure
 - External review
- Accreditation agencies (e.g., NCQA, URAC)
- Unfortunately, current regulations are often:
 - Limited
 - Out-of-date
 - Not enforced



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Navigating The Health Insurance Appeals System



Source: The Kennedy Forum



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Denials: Adverse Benefit Determinations



- Types of denial of care
 - Medical necessity
 - Benefit coverage
 - Administrative
- Types of appeals
 - Appeals vs grievances
 - Standard written versus expedited/phone
 - Internal appeals versus external appeals
- Challenges
 - Consumer knowledge of policy provisions
 - Clinical criteria application
 - What evidence to gather



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Appeal Rights: Consumer Knowledge



- Studies have found that most Americans don't know where to file an appeal
 - 2/3 of privately insured Americans are uncertain about which state entity is responsible for resolving issues
 - Most (87%) don't know the state agency/department tasked with handling health insurance complaints
 - Many (72%) are unsure if they have the right to appeal to the state/an independent medical expert or to their employer
- External review protections were developed by states to provide an additional check and balance on the appeals process for medical necessity denials
- Need more education and streamlined appeals processes

Source: 2015 Consumer Reports Survey



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Understanding the Appeals Process



Internal Appeals

- UM Appeal
 - Timing: Expedited vs. Standard
 - Type: Prospective, Concurrent, Retrospective
- Administrative/Grievance Procedure Appeal



External Appeals

- External Review Appeal
- Regulator/DOI Complaints



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Filing an Appeal

- Identify the right denial type
- Document all communications with everybody you talk to
- Understand the filing requirements and timelines
- Make sure you have the appropriate documentation/evidence
 - Attending provider clinical recommendations
 - Policy language
 - Other
- When to use a consumer advocate
- Health plan tricks and ambiguity
- Getting a denial overturned



APPEAL ADVICE

At a minimum, the written appeal should include:

- The individual's name, address, and telephone number
- The individual's insurance identification information, including ID number, group number, and any relevant claim or document numbers
- The provider's name and the date(s) the service was received
- A description of the service or supply the individual is appealing
- A copy of the health plan's adverse benefit determination
- Evidence supporting why the service should be covered, as explained in this Guide



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Landmark Court Decision: Wit vs United



- United Behavioral Health (UBH) breached its fiduciary duties under ERISA by developing and employing flawed medical necessity criteria for mental health and addiction services
- UBH internal Guidelines (i.e. Level of Care Guidelines -- LOCGs and Coverage Determination Guidelines – CDGs) were “unreasonable and an abuse of discretion” and “infected” by financial incentives meant to restrict access to care.
- At the heart of the case was UBH’s reliance on and manipulation of the LOCG and CDG Guidelines, and its failure to use national evidence-based guidelines developed by nonprofit, clinical specialty organizations such as the American Society of Addiction Medicine (ASAM).



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Generally Accepted Standards of Care Principles



- *More than Symptom-Based.* Covers individual’s underlying conditions and is not just limited to alleviation of the individual’s current symptoms.
- *Co-Occurring Conditions.* Integrates co-occurring behavioral health disorders and/or medical conditions in a coordinated manner.
- *Safe and Effective Threshold Requirements* Mandates patients to receive treatment for at the least intensive and restrictive level of care that is safe and effective.
- *Erring on the Side of Caution.* If there is ambiguity as to the appropriate level of care, requires the practitioner to err on the side of caution by placing the patient in a higher level of care.
- *Maintaining Function or Preventing Deterioration.* Mandates effective treatment protocols to include services needed to maintain functioning or prevent deterioration.
- *No Default Time Limits.* Identifies appropriate duration of treatment based on the individual needs of the patient; there is no specific limit on the duration of such treatment.
- *Factoring the Needs of Young Patients.* Incorporates the unique needs of children and adolescents to be considered when making level of care decisions involving their treatment.
- *The Need for a Multidimensional Assessment.* Requires the appropriate level of care for patients should be made based on a multidimensional assessment that considers a wide variety of information about the patient.



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Filing a Legal Action: Key Steps



- Find the right attorney
- Exhausting internal appeals
- Federal vs state action
- Filing a complaint
- Elements of a legal action
- Litigation vs settlement
- Judgement
- Attorney fees

risk property proof
 term protect ee
Insurance legal
 condition claim policy
 premium loss compensation
 coverage licence fine



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Public Policy Opportunity



- The health insurance appeals system is outdated and broken
- We have an opportunity to work with the following stakeholders to promote a better system
 - Congress
 - Federal regulators
 - State legislators
 - State regulator
 - Accreditation agencies
 - Consumer advocacy groups
 - Provider societies and related organizations
 - The insurance industry itself
- Many care management models exist that demonstrate that traditional UM system is not as effective
- Move to population health



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