



**Department of
Financial Services**

Insurance Coverage for Substance Use Disorder Treatment

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Topics

- Federal Mental Health Parity
- Utilization Review
 - Initial denial
 - Internal appeal
 - External appeal
- Claims processing
 - Prompt Pay
 - Timely filing of claims



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Mental Health Parity and Addiction Equity Act (MHPAEA)

- The ACA, MHPAEA and 45 CFR 146 have changed the landscape for coverage of treatment for mental health (MH) conditions and substance use disorders (SUD).
- Collectively, these laws require policies sold on the individual and group markets to provide coverage for MH and SUD treatment at the same level as medical conditions.



Mental Health Parity and Addiction Equity Act (MHPAEA) and 45 CFR Part 146

- Benefit classifications
 - Inpatient in-network
 - Inpatient out-of-network
 - Outpatient in-network (office visits and other)
 - Outpatient out-of-network (office visits and other)
 - Emergency
 - Prescription drugs



Mental Health Parity and Addiction Equity Act (MHPAEA) and 45 CFR Part 146

- Compliance with MHPAEA requires a comparison of MH/SUD benefits within a specific classification with medical/surgical benefits in the same classification.
- Insurers must ensure that the financial requirements for MH/SUD benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered under the policy.



Mental Health Parity and Addiction Equity Act (MHPAEA) and 45 CFR Part 146

- Insurers must also ensure that the quantitative treatment limitation (QTL) applied to MH/SUD meets the same test as the financial requirements.
- The “substantially all” standard would be met if the limitation applies to at least two-thirds of all medical/surgical benefits in that classification.



Mental Health Parity and Addiction Equity Act (MHPAEA) and 45 CFR Part 146

- Once the two-thirds test is met, the insurer must determine the predominant level of the financial requirement or QTL. The predominant level is the one that applies to more than one-half of the medical/surgical benefits in that classification.



Mental Health Parity and Addiction Equity Act (MHPAEA) and 45 CFR Part 146

- Insurers may not impose non-quantitative treatment limitations (NQTL) with respect to MH/SUD coverage unless the standards applied are comparable to those applied to medical/surgical benefits.
- Insurers may consider a wide array of factors in determining provider reimbursement rates, however the factors must be applied comparably to both benefits.



Utilization Review

- Article 49 of the NY Insurance Law and NY Public Health Law establish the requirements for health plans when performing medical review to determine if a service covered under the policy is medically necessary to treat the patient's condition. The law also establishes the right for an internal and external appeal of denials.
- Chapter 41 of the Laws of 2014 amended the law as it relates to coverage for SUD treatment.



Utilization Review

- Title 1 of Article 49 describes the process for the initial review of services as well as the internal appeal.
- Denials must be reviewed by a physician or other healthcare professional who specializes in behavioral health and has experience in the delivery of SUD courses of treatment.



Utilization Review

- Health Plans are required to use recognized evidence-based and peer-reviewed clinical review criteria that are appropriate to the age of the patient and are deemed appropriate and approved by OASAS.
- Health Plans are strongly encouraged to use LOCADTR but may submit alternate criteria to OASAS for approval.



Utilization Review

- If the initial request for inpatient SUD treatment was received within 24 hours before discharge from an inpatient admission, the determination must be rendered within 24 hours.
- Any request that is denied can be appealed with the health plan on an expedited basis. Health plans must render a determination on an expedited appeal within 24 hours of receipt.



Utilization Review

- If an expedited internal and external appeal are requested within 24 hours from receipt of the initial denial, a UR agent may not deny on the basis of medical necessity or lack of prior authorization while the determination is pending.
- For outpatient services that require pre-authorization, health plans must make a determination within 72 hours of receipt of all necessary information.
- Standard appeals must be decided within 60 days.



Utilization Review

- Title 2 of Article 49 establishes the right to request an External Appeal of a utilization review denial.
- An External Appeal provides for a medical review by a neutral clinical peer reviewer, who must be a physician, with a valid license, who is board certified or board eligible to provide SUD treatment; or a healthcare professional that possesses a valid license, has been practicing for at least 5 years in the treatment of SUD and is knowledgeable about the service under appeal.



Utilization Review

- Requests for External Appeal are submitted to NYS Department of Financial Services who will screen the application for eligibility.
- If eligible, the application will be assigned randomly to one of three external appeal agents who will determine if the services are medically necessary and if the health plan acted reasonably, with sound medical judgment and in the best interest of the patient.
- External Appeal decisions are binding.



Utilization Review

- External Appeal agents must render a decision on an expedited appeal within 72 hours of receipt.
- Providers should be available to provide medical records and respond to questions. Decisions will not be delayed pending receipt of documents.



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Utilization Review

- Information on the External Appeal process, including a copy of the application, can be found at:
<http://www.dfs.ny.gov/insurance/extapp/extappqa.htm>



Claims Processing (Prompt Pay)

Section 3224-a NY Insurance Law

- Claims must be processed within specific time frames after receipt by the health plan.
 - If the claim is submitted via paper, the claim must be paid within 45 days of receipt. If the claim is submitted electronically the claim must be paid within 30 days of receipt, or
 - All claims must be denied within 30 days of receipt, or



Claims Processing (Prompt Pay)

- The health plan must request all additional information within 30 days of receipt.
 - The request must include all missing information and must be in writing.
 - Once the information is received the clock starts over and the health plan must pay the claim in 30 or 45 days or deny within 30 days.



Claims Processing (Prompt Pay)

- Any claim not paid within the required timeframe accrues interest beginning on the day the payment is due.
 - 12% simple interest.
 - Earned interest less than \$2 per claim does not have to be paid.
 - Is applicable to adjusted claims, if health plan made an error. Interest is applied only to the additional amount due.



Claims Processing (Prompt Pay)

- Processing a claim late does not create a liability that does not otherwise exist.
 - Unlike No-fault where an insurer is prohibited from denying the claim if they don't do so within the specified timeframe.
- A late request for information does not mean that interest is due if the claim is ultimately paid.



Claims Processing (Prompt Pay)

- Time period for submission of claims
 - Claims must be initially submitted within 120 after the date of service, unless both parties agree to a longer time period.
 - 90 days for Medicaid managed care.
 - This does not apply to the additional time allowed when an insured is covered by two policies (COB).



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Claims Processing (Prompt Pay)

- Use the link below to file a complaint with the Department of Financial Services regarding delays in payment of claims. Scroll down to “Provider Prompt Pay Complaints” and follow the directions.

<http://www.dfs.ny.gov/consumer/fileacomplaint.htm>



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- For questions regarding utilization review or the external appeal process call 800-400-8882 or email externalappealquestions@dfs.ny.gov.
- For questions regarding claim payment call 518-549-8586 or email consumers@dfs.ny.gov.