



Mental Health & Substance Use Disorder Treatment **Frequently Asked Questions**

As of February 10, 2021

The following are some of the questions we received at our “Understanding How to Access Insurance Coverage for Mental Health/Substance Use Disorder Treatment” Virtual Session that was held on January 12, 2021. A recording of this event is available at: <https://insurance.maryland.gov/Consumer/Pages/Webinar-Meetings.aspx>.

Question: Jessica[†] and Michael are worried about their daughter Abigail, who is 15 years old. They aren't sure what the problem is, but it seems to be beyond teenage general moodiness. Abigail's grades are falling, she's gotten into a physical fight with her younger brother, and her parents think she may be drinking. Her school social worker suggested an evaluation by a psychiatrist. Abigail's parents can't afford to go out of network to get this treatment. How should they start the process to have Abigail evaluated and make sure that it will be covered?

Answer: A good place to start is with Abigail's primary care provider for recommendations of behavioral health care providers. Typically, a referral is not needed anymore, but it can't hurt to start there. Jessica and Michael can also start looking for psychiatrists through the carrier's online directory. They should check that they are searching using the right plan shown on their insurance card, because different plans may have different networks and there will probably be multiple options on the carrier's website.

Question: They tried the online directory, but they found that there were mistakes and it was very frustrating. What should they do at that point?

[†] All names referenced in this FAQ are of fictitious people.

Answer: There are laws requiring carriers to keep their directories up to date, and so if there is incorrect information in the provider directory, it is helpful if you report the errors to the health plan. Maryland law requires health plans to list a way to report the incorrect information that is on their website and requires carriers to investigate and update the information. If they don't, then you can file a complaint with the MIA. Of course, in the short term, Jessica or Michael can also call the health plan for help and use the number on the back of their ID cards. There may be a separate number for behavioral health services, and some plans will provide additional help with finding a behavioral health provider if you ask.

Question: Jessica and Michael were able to get Abigail evaluated by a psychiatrist and she was able to start making progress with an in-network therapist. However, before her therapy sessions were over, the therapist indicated that they were no longer accepting the parents' insurance, and Jessica and Michael have been unable to find another in-network therapist with the same level of expertise to treat Abigail. What should they do at that point?

Answer: They can request a referral to keep seeing the same therapist. Maryland law requires health plans to have a process to request a referral to an out-of-network provider if you need one and they don't have an in-network provider with the expertise. To find those procedures, you can look in your policy or your certificate of coverage, or you can look in the health plan's online provider directory, because health plans are required to put that information with their provider directory. The health plan is also required to provide the procedures upon request, so you can call and request them. If a referral is given, the cost sharing will be the same as for an in-network provider. However, the provider may balance bill. Balance billing means the provider can bill for the difference between the health plan's allowed amount and the provider's usual charges. The health plan may enter into a single case agreement with the provider to prevent the balance billing. However, the agreement may be limited to certain services, and claims may have to be sent to a different address than the normal P.O. box than the carrier normally uses.

Question: What if the request was denied because the health plan says that there are providers in-network, but Jessica and Michael don't think that the particular in-network providers have the necessary level of expertise or that it's unreasonable for them to wait because there's going to be a delay before they actually get to an appointment. They really don't want to disrupt Abigail's treatment since she's been doing well and they don't want

to see any deterioration in the progress that she's been making. What would you recommend to the parents at this juncture?

Answer: Jessica and Michael have a right to challenge or appeal the health plan's decision that its in-network providers are adequate. The health plan's decision to not allow Abigail to receive treatment from an out-of-network provider is considered an adverse decision, a determination that a proposed or delivered health care service is not medically necessary, appropriate or efficient. Jessica and Michael have the right to protest this decision through the health plan's internal review process. When the health plan renders an adverse decision, they are required to provide the member with a detailed explanation in writing in the form of a letter, notice of adverse decision, or an explanation of benefits, EOB. Either document will instruct them on how to initiate the health plan's internal review process.

If the health plan again determines that it's in-network provider is adequate, Jessica and Michael may ask the Maryland Insurance Administration to review the health plan's grievance decision, the health plan's decision to uphold its adverse decision, by filing a complaint. The MIA has the authority to contract with independent review organizations to review medical necessity complaints. Based on the IRO's medical opinion, the MIA reaches a decision either to uphold, modify or reverse the health plan's decision.

Question: The situation has gotten worse. Abigail has threatened to kill her brother and herself and it's clear that she needs emergency treatment. What can be done to make sure that she's able to obtain the treatment that she needs at this point?

Answer: In the case of mental health, emotional health disorder or substance use disorder emergencies, if a patient is in imminent danger to self or others and the determination is made by the patient's physician or psychologist and a member of the medical staff of the facility who has admitting privileges, then an insurance company cannot deny the first 24 hours of the admission based on medical necessity. It's important that Abigail or her parents notify the insurance company as soon as possible. For an emergency inpatient admission for treatment of mental illness, emotional health disorder or substance use disorder, the insurance company must make a decision on whether to preauthorize the treatment within two hours of receiving the requested documents. If the insurance company denies the request for an admission, call the Maryland Insurance Administration at 1-800-492-6116. The MIA is available 24 hours a day for complaints and emergencies when care has not yet been rendered. In

an emergency, the MIA will make a decision within 24 hours. If the MIA does not regulate your health plan, your complaint will be sent to the agency that does regulate the plan.

Question: The parents have found and it's been recommended that Abigail go to this mental health facility that's located in Arizona that has a history of success dealing with these particular issues. What should the parents do if they would like to send her to that particular facility?

Answer: It's important to note inpatient care usually requires prior authorization. To start the process of obtaining preauthorization for an out-of-network provider, call the number on the back of the patient's health insurance ID card first. The insurance company will ask what health care services you would like to receive, and when appropriate, what facility you would like to use. The insurance company will tell you what documents it needs in order to decide if it will preauthorize the health care service.

Maryland requires that insurance companies accept a provider's uniform treatment plan form if the health plan is subject to Maryland law. A uniform treatment plan form is a document used by the provider to record the information needed by the insurance company to decide whether it will preauthorize the requested service and/or facility. If the services are authorized under out-of-network benefits, there may be higher cost sharing and balance billing. Jessica and Michael can appeal the amount paid if it seems unreasonably low, and can file a complaint with the MIA if the carrier upholds its appeal. Lastly, the MIA can review whether the payment is based on their policy or certificate of coverage or violates Maryland law.

Question: Abigail has been authorized to receive treatment and she goes to the facility and her treating psychologist, Dr. Gomez, says that she needs two visits every week for the next 12 weeks and the plan says she can have two for only four weeks. Is there anything that the family can do at this point?

Answer: Yes. First, if Dr. Gomez agreed to accept the authorization for four weeks, it may not be a denial. However, if Dr. Gomez did not agree, then we're talking about an adverse decision. Dr. Gomez can file a grievance on behalf of Abigail and her parents. Many providers get a written consent form as part of the paperwork for a new patient.

Providers often try to call for a peer-to-peer discussion and become frustrated at the time it takes. Dr. Gomez can mail, email or fax a written grievance, and the health plan will have to respond in writing. This may save time in the long run, and will satisfy the legal requirements to exhaust the internal appeals process. If the health plan still says that two visits a week for twelve weeks is not medically necessary, then Dr. Gomez or Abigail's parents may file a complaint with the MIA. The MIA can send the complaint to an independent review organization to get an opinion on whether the care is medically necessary.

Question: Can you speak about nontraditional or nonlicensed mental health providers sometimes referred to as peer counselors, life coaches, etc. Given the scale of need, how are these types of services brought on board to offer service in a surge capacity?

Answer: A health care policy will have an exclusion for providers who are not licensed or certified, and a member has the benefits that are spelled out in the policy, because that's the contract, subject to any exclusions. So if the policy does have text that says that only licensed health care providers or certified health care providers acting within the scope of their license or certification are covered, unfortunately, that's going to be what is covered. Unless there is some kind of statutory requirement to provide additional coverage, that exclusion will apply.

Question: The next question is: will you cover billing codes during this meeting? So maybe, Mary, if you want to speak just generally a little bit about billing codes, but this may be one that this person needs a little bit of one on one.

Answer: I'd like to know more exactly about what you mean by that, so that might be something to follow up with in a breakout room or off line if you follow up with us. Billing codes -- I think what I keep telling my staff is the codes represent services and the services are described in the member's policy, and so the carrier can look to see if the billing codes accurately describe the services and then whether a service is covered or not is based on the member's policy.

Question: The next question is coverage for dialectic behavioral therapy.

Answer: Maryland's law requires coverage of treatment that is medically necessary and appropriate for the condition, so I don't think that there is anything specifically about dialectical behavioral therapy unless you have a question to go into in the breakout room. Typically, I would expect it to be

covered, but it may be subject to concerns about whether it's medically necessary or appropriate.

Question: Why would a health plan be approved with no out-of-network coverage.

Answer: There are various types of products that companies are allowed to offer in Maryland, and certain products to save costs and lower premiums limit the providers to in-network coverage only. That would be, for example, an HMO plan or an exclusive provider organization plan which is often called an EPO, so those are permitted under the law. Even in that situation, however, they are required to have an adequate network of providers, and if there is not a provider in the network that can provide the services needed, the companies are required to cover certain services out of network. Emergency services and certain urgent care services are always covered out of network. But typically it should be a consumer choice when they're selecting a product if they'd like to pay a higher premium for a product that provides in-network and out-of-network coverage, or if they want to save some money. Lower premium products would be those types of products that limit you to in-network providers in those situations.

Question: What are the consequences for multiple violations for noncompliance of updating the directory? There is no incentive for insurance companies to comply if they can limit access to maximize profit.

Answer: We have a couple of units at the MIA that can address violations of the law. The first is my unit, the Complaint Unit. We act on individual complaints, and if we find that there is a violation of law, we can issue an order, and the order may include monetary penalties. Now, if we think there's more going on, we also have a Market Conduct Unit and the Market Conduct Unit can go out to the carrier's offices, well, in non-COVID times, but they can do a more in-depth look and see how extensive the violation is, how often it occurs, and what kind of procedures the company has in place to comply with the law. They can do a more in-depth exam and then issue penalties, and require a compliance plan. Now, of course it helps if we have complaints and can identify a problem. It lets us know that we also need to devote market conduct resources to it, though they may also look at it at other times as well.

Question: Is there a separate system or queue to get an initial triage appointment promptly even if wait times are generally long?

Answer: That would depend on the health plan and the providers. We have been told that some health plans do have that kind of system. I did refer to the possibility of asking for extra help finding a mental health provider and I don't want to single out any carriers because I don't know what all of them have, but we have had some of the health plans tell us that they will help you get an immediate or urgent appointment if you ask for that help when you call.

Question: How long do all of these processes take in terms of authorizations, appeals.

Answer: If we're dealing with a medical emergency, the administration has 24 hours to resolve such a complaint. Otherwise, the law provides us with 45 days from start to finish to investigate a complaint where the denial is based on medical necessity. That means 45 days from the time that we receive the complaint until we actually conclude our investigation, so the time frame will be determinative based on the medical necessity or the urgency associated with the complaint that we actually receive, so you would be looking at anywhere from 24 hours to 45 days.

For the carrier's internal processes for authorizations, Maryland law allows them two working days from the time they receive all necessary information, and so they have two working days normally. It is two hours if it's a mental health emergency admission. If the care has not been provided yet, there are processes to get an expedited appeal within the carrier's process and there are also processes to come straight to the MIA or usually to Louis' section because it cannot wait while you go through that process. So again, it's going to depend on whether the services have been provided yet or not, and you can request an expedited appeal. You can call the MIA -- we're available 24 hours -- and say that you need something, and you think it cannot wait to go through the carrier's appeals process.

Now, if it is not medical necessity, you first should file an appeal and the carrier has 60 working days to resolve it, unless it's a case where there is an urgent situation involving care that has not been provided, but typically they will have 60 working days to resolve it. This happens most often for claims complaints where it's a CPT code or something else that is not medical necessity, and then you can file a complaint with us, and most of our complaints are resolved within 90 days.

Question: Is there a Maryland standard uniform treatment plan that is used by all carriers in Maryland?

Answer: Yes, it is established by regulation.

Question: In case of a transfer from an out-of-network to an in-network provider, will a provider-to-provider consult be covered in support of a smooth transition?

Answer: It's going to depend on the terms of the member's policy. That's something where I'd really need to see the specific situation. It's not something we can address in a general way.

Question: Does the MIA's review process ever involve speaking with the providers above and beyond the uniform treatment plan form?

Answer: When we receive a complaint, there will be times when we may need additional medical information or clarification, and that typically will come from the patient's health care provider, so long as we have that information there are times when we will send a letter to the patient's treating physician to get additional information, information that would assist us in rendering a determination, so the answer to that question would be yes.

Question: What if the insurance company does not require an authorization for outpatient visits for the patient's diabetes, but on the behavioral health side outpatient services do require authorization, is that a parity concern?

Answer: It's definitely a parity concern. We couldn't say for sure whether it's a parity violation without investigating it more and looking at the entire contract, but generally if they're requiring prior authorization for a certain type of service on the medical side, but not on the mental health or substance abuse side, that would be a parity violation. There are policies and procedures that go into that. There's just -- the one example here is diabetes. It would be possible that prior authorization is not required for diabetes but was required for other medical surgical outpatient visits, and it could technically still comply with parity, so we would have to look at that and investigate it on a case-by-case basis, but those are the type of issues we would certainly like to be made aware of because that's definitely a big red flag there.

Question: Does any of this information apply to national accounts, for example, the employer group is not based in Maryland?

Answer: In general, probably not. The general information will apply, but Maryland law-specific information will not, because we are limited to contracts or policies issued in the state of Maryland for insured plans.

Question: Can DBT be covered by Maryland health insurance for DBT offered by cash only practices? Is the covered person allowed to request reimbursement?

Answer: In general yes, but it can get a bit complicated because Maryland has a law about HMOs, health maintenance organizations, that is designed to protect consumers by holding them harmless for any charges except for their regular cost-sharing.

And what this means is that, if your treating doctor gives you a referral to or directs you to go to a specific provider, that may be covered even if that provider is out of network, or in an emergency situation, as examples, that means Maryland law sets a payment rate that the HMO has to pay and that the doctor has to accept.

Now, the issue with when you say a cash-only practice is you can also enter into an agreement with a provider and say that you will not file a claim so that the provider will not be bound by the HMO's payment and the protections in Maryland law, and so that's where it can get a bit complicated. If you're in a PPO and you go to an out-of-network provider and pay cash, then you can file a claim to get reimbursed.

If you're going to a provider who is cash-only and is unwilling to give you the information to file a claim, you may have problems because the health plan is going to want to know what services were provided, what the diagnosis was, and those specifics are usually expressed using CPT codes and diagnosis codes, and so if the provider is unwilling to give you CPT codes or diagnosis codes, it may be practically very difficult for the patient to file a claim.

Question: Who decides what is medically necessary? Some insurance companies are auditing after a certain number of minutes to disincentivize the use of higher rate treatment sessions.

Answer: The carriers are required to have an internal appeals process in place and that process is monitored by a board certified physician within the carrier, so the carriers, when they're conducting utilization review in order to determine whether to establish medical necessity, that has to be done by a board certified physician. With regards to the second portion, I would encourage that the individual to actually reach out to us to actually file a formal complaint with us so that we can look and receive more details to provide more specifics to that particular request.

But in general, the carriers are required to meet certain requirements whenever they conduct utilization review to establish medical necessity. That has to be done by a board certified physician who has skill or understanding in the condition that's under review. So it's very important that whenever the carrier renders a medical necessity decision or a decision based on medical necessity, that decision has to be rendered by an individual who is a board certified physician.

When it comes to audits and CPT codes what we see, and this is not just in mental health, we see it a lot for emergency room physicians and other types of providers, is that the carriers are also looking to see if the medical records document that the services described by the CPT code were in fact rendered. So for many visits there are five levels of codes, and so if a provider typically bills a level five code far more often than peers do, the carrier may audit and look at the medical records, not for medical necessity, but to see if the code is appropriate to describe the services.

Question: How does one know if the carriers contract with providers, whether in or out-of-network, who provide quality care and are co-occurring capable in order to treat individuals who have both substance use and mental disorders?

Answer: You should refer to the carrier's network of providers. The carriers are required to provide that information to their members. The member can reach out to those particular providers that have been identified to determine whether or not they meet the satisfaction of the particular member insofar as do they have the training, do they have the skill, is this an area of expertise that they regularly engage in, do they see patients on a regular basis.

The starting point would be to reach out to the carrier to receive the network of providers in that particular area and then do some additional research as the member is able to do.

Question: What happens if a client in a similar scenario, and obviously they're referring to the scenario that we went through in the presentation, has private insurance and Medicaid, and residential treatment options provided are not approved by private insurance for prior authorization. Can they then bill Medicaid if accepted or look for RTCs, and that would be residential treatment centers, that would take Medicaid?

Answer: It can get a bit complicated when you have two different health plans, whether it's Medicaid and private insurance or even if you have coverage under two different health plans because a child might be covered under each parents' employer plan and there are rules about determining which plan is primary. Typically, you do have to follow the rules of your health plan to have the health plan cover it.

Now, Medicaid is a little bit different because it's a government program and it will typically seek to recoup its costs from private health plan. I'm not sure about the description of the details of the example, but I will say from what I have seen, the scenario typically comes about in cases of child birth because pregnant women qualify for Medicaid more often than people who are not pregnant. And so that's the scenario I'm most familiar with, and you still need to follow your regular health plan's rules even though then Medicaid may try to recoup the money, but to have it covered typically you need to follow the health plan's rules.

Question: If the provider does their due diligence in using the DSM-5 to determine diagnosis and determines that a particular type of therapy aligns with the treatment plan, then it sounds like the insurance carrier has last word on treatment choice based on their policies. Is that correct? If so, that is unfortunate and may not allow the therapist to adequately advance the change process.

Answer: A big part of whenever a treating physician or provider recommends a particular course of care there will be -- we've seen complaints where the carrier's medical staff, the physician, they've denied it. Typically, those are the sort of complaints where that's not the end of the inquiry. We have the ability to investigate those complaints, so the carrier doesn't necessarily have the final word. If what is being proposed has been determined to be medically necessary after we've had the opportunity to gather all the necessary information, this is assuming a complaint has been filed with the Maryland Insurance Administration, and the case has been sent to an independent review organization and that determination comes back as what's been requested by the

patient's health care provider is medically necessary, then at that point the administration can require the carrier to authorize what has been requested, so there is a process in place.

The carriers are required to have their internal appeals process, but simply because the carrier upholds their determination does not mean that that's the end of the inquiry. The Maryland Insurance Administration is available to investigate those types of complaints.

And as one point of clarification to the way the question was worded: the insurance company never makes treatment choices, period. Their determinations are based on reimbursement and whether they will pay for it. And of course I understand that in most cases if it's expensive treatment and the insurance company is not going to pay for it, then the consumer is not going to be able to get that treatment, because they're not going to be able to afford it. But I just wanted to clarify that the treatment choices are always up to the provider. The insurance company's determinations are based on whether or not they will reimburse for that treatment.

Question: How does the MIA look at the carrier's way of defining medical necessity for treatment of a problem? For example, a patient has been abusing opioids and has had near fatal overdoses. That patient presents for treatment. However, they used a few hours before coming for treatment so they are not experiencing a medically life threatening emergency at the time. The carrier may state the patient does not meet medical necessity. However, the patient is a danger for relapse and possible overdose if not authorized.

Answer: Typically, that sort of complaint we're going to be relying on the patient's medical records because the medical records speak for the patient when the patient cannot speak for themselves, so in a particular case where the medical records document the patient's history, the fact that there may be some ebbs and flows in terms of their use, that would not necessarily negate or not establish medical necessity. Again, we would be reviewing the patient's medical records to establish medical necessity, not necessarily looking at where the patient is at a particular point in time. So again, the medical records are critical to a complaint investigation that the Administration would undertake. And then again, we do have the opportunity to forward those medical records and have them reviewed independently, so we would be looking at the totality of the circumstances associated with a patient, not necessarily a little window.

In that case, in determining if it qualifies for an expedited review, our regulations say that it can be an emergency case if, without immediate medical attention, it could cause the member to continue using intoxicating substances in an imminently dangerous manner. It may also be a reason to come directly to the MIA if a member is in danger to himself or others, but that includes if the member is unable to function in activities of daily living or care for self without imminent dangerous consequences, so the danger to self is more broadly defined there in cases of substance use disorder.

Question: Can consumers receive a refund for poor or unsatisfactory service such as being diagnosed with bipolar when the actual issue is borderline personality disorder.

Answer: That would be a provider issue and we do not regulate providers. We can only regulate the health plans and enforce the insurance laws of the state.

Question: Does the MIA have any jurisdiction or relationship regarding employee assistance programs funded by employers, can we discuss MIA outreach, how EAP -- that's employee assistance program -- is often underutilized?

Answer: In all likelihood we would not have authority over EAP services. As mentioned here, when they're funded by employers if it's part of a self-funded plan, it's not something we have authority over. If it was actually offered through an insurance company, maybe we would. Most of the EAP services we are aware of are directly funded by the employers, which means we don't have jurisdiction.

Question: Is there a guideline for how many in-network providers a consumer should contact with no success before they file a complaint? What about the distance access? Also, how does one prove that they have been attempting. In this market there are no answers from providers or insurance representatives who provide the consumer with an inaccurate list.

Answer: You should review the carrier's offering. Obviously, if you make your request to the carrier that you want to see a particular physician or that you have a particular need in response to that, the carrier will provide you with their network of in-network providers. When you go through that network, if it's established that they don't have a provider that meets the

patient's particular need what you in essence have concluded is that the carrier's network is inadequate. We do investigate those sort of complaints. Insofar as giving you a specific number of providers that you need to reach out to before you can establish whether their network is inadequate, I don't necessarily have a number to give you. But when we receive those sort of complaints we actually, not necessarily stand in the shoes of the consumer or the complainant, but based on the information that we would receive from the carrier in response to such a complaint, we would reach out to some of those providers that they provided us with their contact information to determine whether or not they're seeing patients, is there a waiting list, things of that sort. And then to your earlier point with regards to time and delay they are also factors in considering whether or not a carrier's network is adequate or inadequate. So it is a process that one would have to go through, but what I would encourage you to do is if you have any questions, if you have a specific, you know, complaint in this area feel free to give us a call, reach out to us and we'll be more than happy to investigate that complaint.

Question: In regards to the example given about the insurance carrier auditing certain services per certain codes in terms of medical necessity, did I understand that the review is being done by a board certified provider who works for the same provider that is auditing the service?

Answer: For the internal appeals process that carriers are required to have in place, there is the initial adverse decision that is rendered by one individual board certified physician. The appeal is reviewed by a different board certified physician so the same person is not rendering the initial denial and then reviewing their own denial and approving or continuing to uphold their decision. So there is a process in place where you don't have the same individual who rendered the denial also reviewing the appeal or the grievance.

Question: I am still having difficulty finding a pediatric counselor as most of the providers listed in the insurer's network are -- as many have closed or moved 45 minutes or more away from our home. Others listed are not taking new patients, so I guess the question is what can they do.

Answer: This may be a situation where they could request a referral to an out-of-network provider. They should contact us to discuss their particular issue.

Question: Is there a Maryland medical agency responsible for alternative treatments and differences of professional opinion or perspective about the overall philosophy of mental health care, is there a Maryland agency facilitating culturally aligned mental health care in addressing complaints of micro aggression?

Answer: If there is a board or a group that looks at that, that would probably be within the Department of Health, and so it may be useful to reach out there. I don't know if the Behavioral Health Administration looks at that kind of thing, but they may be a place to start.

Question: Can you provide a summary of how someone can receive out-of-network service if the appropriate in-network service is not available?

Answer: The first thing that you would do is reach out to the health plan, and they may have different terms for this. I think one health plan calls it a gap exception, but say that you want to get a referral to see an out-of-network provider as if they were in network and they should be able to describe how to do that, and they also ought to have their procedures with their online provider directory, as well as send you those if you ask for them.

Question: Our facility has been having difficulty obtaining authorization under Optum Health under Medicaid congruent with DDA funding. We were advised to drop those individuals that we have been providing services under the psychiatric program, so I guess they're just looking for guidance as to what they should do.

Answer: We cannot regulate that because it is part of Medicaid and we have very limited authority over entities that administer Medicaid payments.