Getting more information

- For more about the Mental Health Parity and Addiction Equity Act, go to the U.S. Department of Labor (DOL) Mental Health Parity website: www.dol.gov/ebsa/mentalhealthparity/ or call toll-free at 1-866-444-3272 to speak to a DOL benefits adviser.
- For health insurance issues in Minnesota, or if you think a patient's or client's benefits are being administered in violation of state or federal laws, contact the Minnesota Department of Commerce at 651-539-1600 (800-657-3602, Greater MN-only) or KnowYourHealthInsuranceRights@state.mn.us
- For additional resources, go to the Substance Abuse and Mental Health Services Administration (SAMHSA) website at www.samhsa.gov/health-financing/implementation-mental-health-parity-addiction-equity-act or the Centers for Medicare & Medicaid Services (CMS) website at www.medicaid.gov/medicaid/benefits/bhs/index.html

Understanding what federal and state laws mean for your patients

The Mental Health Parity and Addiction Equity Act of 2008 is a federal law that protects patients' mental health and substance use disorder insurance benefits. Both federal and Minnesota laws require certain health plans to provide similar coverage for mental health and substance use disorder treatment as they do for physical health services.

Here are examples of benefits that must be comparable to those of physical health services (such as medical and surgical benefits).

- Co-payments
- Deductibles
- Yearly visits
- Prior authorizations
- Proof of medical necessity
- Pharmacy benefits
- Adequate provider network

COMMERCE DEPARTMENT

85 7th Place East, Suite 280
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KnowYourHealthInsuranceRights@state.mn.us

Know Your Patients' Insurance Rights

For Providers

Mental Health and Substance Use Disorder Treatment

Understanding your patients' or clients' rights

Most health plans cannot impose costs for mental health and substance use disorder care that are not comparable to physical health care costs.

Most health plans cannot impose limits on the number of visits for outpatient mental health and substance use disorder care, if there are no limits for physical health care.

Prior authorization requirements for mental health and substance use disorder services must be equal to or less restrictive than the requirements for physical health services.

Nonquantitative Treatment Limitations (NQTLs)

Processes, strategies, evidentiary standards or other factors used in applying nonquantitative treatment limitations to mental health/substance use disorder benefits must be comparable to, and applied no more stringently than those used with respect to medical/surgical benefits.

Here are examples:

- Medical management standards limiting or excluding benefits based on medical necessity or appropriateness
- Pharmacy formulary design
- Network tier design
- Standards for provider participation in a network, including reimbursement rates
- Plan methods for determining Usual, Customary and Reasonable fee standards
- Fail-first policies or step therapy protocols
- Exclusions based on failure to complete a course of treatment
- Restrictions based on geographic location, facility type or provider specialty

Rights to information

- Health plans must provide information on the mental health and substance use disorder benefits offered. Patients and providers can receive the criteria that health plans use to determine if a service is medically necessary. The plan or issuer must make the reason for any denial of reimbursement or payment available to participants.
- If a health plan denies payment or authorization for mental health or substance use disorder services, it must give participants a written explanation for the denial, information on how to appeal the decision, and provide more information upon request.

Appealing a claim

If a health plan denies a claim, your patient can appeal.

- Your patient should contact the health plan and ask for more information on why the claim was denied. Your patient can ask the health plan to review its decision and reconsider.
- Most health plans must provide a process that allows a patient to request an independent, external review of the denial of a claim.