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WHEN PROBLEMS OCCUR

- ## HOW CAN I TELL IF MY PLAN OFFERS THESE SERVICES?

If you live in Massachusetts and your health insurance comes from a state-regulated plan, your insurance carrier must offer access to the new Behavioral Health benefits for Children and Adolescents (BHCA). This includes coverage through an individual plan or an employer-sponsored plan. If you live in a neighboring state, but work in Massachusetts and your plan is regulated by the state of Massachusetts, your insurance plan must offer you these services within the plan's service area.

Information about your eligibility for these services probably doesn't appear on your insurance card. You will most likely need to call the membership services number on the back of the card and ask whether you are covered for BHCA services.

- ## IS MY PLAN FULLY-INSURED OR SELF-FUNDED?

If your plan is fully-insured (also sometimes called fully-funded) and is based in Massachusetts, it is subject to the law and must cover the new Behavioral Health services for Children and Adolescents.

Providing the benefit is a requirement for fully-insured plans. A fully-insured plan is a plan purchased by an individual or an employer from an insurance carrier. You and/or your employer pay the premiums and the insurance carrier is responsible for paying the claims for covered services. A plan purchased by you through the Health Connector or directly from a Massachusetts health insurance carrier is always fully-insured/fully funded.

Self-insured or self-funded health plans are not participating plans. Self-funded health plans often look the same as fully-insured plans, because employers usually hire an insurance carrier to manage or administer the self-funded health plans. Your health plan card/materials may have an insurance carrier name or logo on them, even if the plan is self-funded. Please do not assume that an insurance carrier name or logo on your card/materials means that your health plan provides the BHCA Services.

If you are not certain which type of plan you have, ask your employer's Human Resources Department or contact your health plan directly to ask if these services are covered.

• WHO SHOULD I CONTACT WITH QUESTIONS ABOUT MY SERVICES?

If you have questions about your insurance benefits, such as finding out what services are offered or finding a provider, you can contact membership services at your insurance carrier. The phone number can be found on the back of your insurance card. If you have an existing provider, you can refer them to a contact listed on the list for providers with questions about contracting with your insurer to provide Behavioral Health Services for Children and Adolescents.

- Contact list for providers here
- Contact list for families here

• WHAT SHOULD I DO IF MY INSURANCE CARRIER LIMITS COVERAGE FOR THE NEW SERVICES?

Your insurer may not refuse outright access to the new services but might limit coverage. Examples of limiting coverage may include:

- You have requested in-home therapy and your insurance carrier informs you there are no providers in your area.
- You are told there is a waiting list for services.
- Your insurance carrier tells you that they don't cover the service you requested (see a list of service descriptions here).
- Your insurance carrier offers you partial services. For example, your plan says it covers in-home therapy but strictly limits the duration or number of sessions.

Your insurance plan is required to have an adequate list of providers across the state and must cover all of the new services. If you are told they will limit your services, you can contact the Division of Insurance directly for help. Please contact:

- Kevin Beagan at kevin.beagan@state.ma.us
- Niels Puetthoff at niels.puetthoff@state.ma.us

You can also call 617-521-7794, or go online here to file a written complaint.

- ## WHAT SHOULD I DO IF MY INSURANCE CARRIER REFUSES TO COVER THE NEW SERVICES?

Denial

A denial is when your insurance carrier refuses to pay or denies responsibility to pay for medical services or treatment that have been provided to you or a family member. The denial can apply to a service that has already been received or to one that has not been delivered yet. If the denial letter says that the services were not "medically necessary" or that they are "not covered because they are not medically necessary" you have a strong basis to appeal the denial. Denials occur most often because the insurer has decided that the service is not medically necessary, or that the provider is out of network and your insurance carrier believes that they have enough providers in their network to deliver the services.

Partial denial

A partial authorization is the same as a partial denial. You can also file an appeal when your insurance carrier only authorizes your services partially. If you appeal a partial denial, the provider can continue to provide services for your child for the number of hours authorized from the previous treatment plan.

- ## WHAT SHOULD I DO IF I RECEIVE A DENIAL?

Insurers are required to provide a denial in writing outlining the reason for denial. However, if the services are limited, you may not receive a written notice. Be sure to keep notes on your conversation and the reason for limiting services.

You must review the denial letter carefully so that you understand what is being denied and why. If you do not understand the reason for the denial, request a copy of your claim file and any records relating to the denial. Your insurer is required to provide this information to you free of charge. After you understand the reason for the denial, you can either pay the out-of-pocket cost directly to the provider or file an appeal.

You should make this request in writing, rather than by phone. Your claim file includes a copy of the criteria or standards that the insurer used to evaluate the claim and all documents related to the claim. You should receive a response to your request in 30 days, sooner if medically necessary. While documenting your appeal in writing is ideal, if you are unable to do so, you can call your insurer to make your appeal over the phone. Request a copy of the phone appeal to be sent to you (typically this is documented in a phone log with the insurance carrier). Make a regular habit of documenting all phone calls.

If your insurance carrier denies you the requested services or is limiting them, you can file an appeal. You can also file a complaint with the Division of Insurance by clicking here and filling out a complaint form.

- ## WHAT INFORMATION SHOULD I INCLUDE WITH MY APPEAL?

You should include all member and insurance plan information, including a copy of the denial letter, the date of the service denied, and the provider name and treatment. Quote directly from the denial document and add information from the notes you have, restating the criteria that the health plan applied in denying your claim (for example, that the service or treatment was not "medically necessary"). List the reasons why you believe the services or treatments do, in fact, meet the criteria. Make sure to address each requirement separately. Try to be as clear as you can and provide references to your medical records. Include a doctor's letter of support, copies of all medical records, and a personal statement about what this treatment or service means to you or your loved one (impact on your day-to-day living, for example). Send a copy of the insurance criteria and denial letter to the servicing provider to review.

• WHERE CAN I GET EXAMPLES OF A CLAIM FILE REQUEST AND AN APPEAL LETTER?

Health Law Advocates (HLA) has a Guide to Appeals that is available for free. This guide includes sample letters for you and your provider to use to help with your appeal. Download the Guide to Appeals or call 1-617-338-5241.

• WHEN SHOULD I FILE THE APPEAL?

Take action as quickly as possible and be sure not to miss the appeal deadline. For private insurance, the deadline is **180 days** after you receive any notice from the health insurer that says the plan will not pay for the requested service. This includes receiving the "Explanation of Benefits" or "EOB" document that usually says, "This is not a bill."

• WHAT IF MY APPEAL GETS REJECTED OR PROLONGED?

If your appeal is not being processed in a timely manner or gets denied, you can send another appeal or reach out for further help. Your health insurance carrier must resolve your appeal in writing within **30 calendar days** of receiving your request for an internal appeal.

If you are appealing coverage of **immediate and urgently needed services** and you request an expedited internal appeal, your health insurance carrier must resolve your case in writing within **72 hours** of receiving it.

Most insurers allow two internal appeals before you can request an external review of your denial. This is a review of your denial by an Independent Review Organization (IRO) not associated with the insurer. An external review is typically only available when the reason for denial is that the requested service or treatment has been deemed not medically necessary. Where to get help if your appeal gets denied:

- Request for an external review with Massachusetts Office of Patient Protection (OPP) website or call 800-436-7757 for more information. They can also walk you through the process of appealing a denial.
- File a complaint with Massachusetts Division of Insurance online or call them at 617-521-7794. Phone line is open Monday – Friday from 8.45am-5pm.

- File a complaint with [Office of the Child Advocate] online or call them at 617-979-8360. Phone line is open Monday – Friday from 9am-5pm.

GOT PROBLEMS ACCESSING THE SERVICES? PLEASE SHARE YOUR EXPERIENCE WITH US!

If you are running into problems accessing the services or reaching your designated provider or insurance carrier representative, please let us know! PPAL will gather information on the possible obstacles with accessing the required services and will use this info to advocate for a better accessibility of behavioral health care in Massachusetts.

- ★ Contact Project Coordinator Milla Paumo at mpaumo@ppal.net

Sources:

Children's Mental Health Campaign, Appeals

MA Office of Patient Protection, FAQ's about Internal Appeals

The Autism Insurance Resource Center, Insurance Denials and Appeals