Filing an Appeal or Grievance

Background

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires health insurance carriers to achieve coverage parity between MH/SUD and medical/surgical benefits, especially in regard to financial requirements and treatment limitations. The MHPAEA, originally applied to group health plans and group health insurance coverage, was amended by the Affordable Care Act (ACA) to also apply to individual health insurance coverage. The U.S. Department of Health and Human Services (HHS) has jurisdiction over public sector group health plans (referred to as “non-federal governmental plans”), while the Departments of Labor and the Treasury have jurisdiction over private group health plans.

Key MHPAEA provisions include:

- If a group health plan or health insurance coverage includes both medical/surgical and MH/SUD benefits, the financial requirements (e.g., deductibles and co-payments) and treatment limitations (e.g., number of visits or days of coverage) that apply to MH/SUD benefits must be no more restrictive than the predominant financial requirements or treatment limitations that apply to substantially all medical/surgical benefits.
- MH/SUD benefits may not be subject to any separate cost-sharing requirements or treatment limitations that only apply to such benefits.
- If a group health plan or health insurance coverage includes medical/surgical and MH/SUD benefits, and the plan or coverage provides for out-of-network medical/surgical benefits, it must provide the same access for out-of-network MH/SUD benefits.
- Standards for medical necessity determinations and reasons for any denial of benefits relating to MH/SUD benefits must be disclosed upon request.

Filing an Appeal or Grievance

If the patient (or the insured individual), family member or attending provider believes care has been unfairly denied or has restricted MH/SUD coverage, the patient is protected under state and federal law. The patient or attending provider rights include the ability to file a grievance or an appeal with the patient's health plan, external review organization and the applicable government agency. After exhausting these resources, the patient also may choose to pursue arbitration or file a court action.

Here are seven important steps that a patient or their representative can take to get started to appeal a decision not to cover a MH/SUD benefit or service:

1. ***Contact the Treating Provider.*** The patient or their representative should check in with the patient's physician, psychologist, counselor or attending provider to document why the MH/SUD coverage is needed (e.g., why is the treatment medically necessary?).
2. ***Pursue Disclosure.*** Health plans must give the patient constructive notice throughout the process regarding how they are responding to the patient's appeal. For a non-certification decision, the health plan must give the patient the "clinical rationale" or other principle reasons for denying the requested care or reducing the treatment level. The explanation must be clear to allow the patient or attending provider to respond to the information in a meaningful way.
3. ***Collect Documentation.*** The patient or their representative should collect key documents, including plan documents, the denial or non-certification letter, and other evidence, to support the position that the MH/SUD should be a covered benefit.
4. ***Contact the Health Plan.*** The patient or their representative should contact their health plan to find out how to file an appeal or grievance. State and federal law mandates that health plans must offer patients an internal dispute resolution process to address the patient or attending provider's concerns. All calls and communication should be documented, including tracking letters and emails through certified mail/return receipt.
5. ***Contact the Regulator.*** The patient or their representative should contact the state insurance department (or other applicable agency) to learn about the patient's rights to file a formal grievance, utilization management (UM) appeal and/or an external appeal. In some cases, such as self-funded health plans, the U.S. Department of Labor may be the agency in charge.
6. ***File the Appeal.*** Click here to learn more about the Parity Implementation Coalition Toolkit, which shows the patient, their attending provider and/or another representative how to file and track an appeal. Please note that The Kennedy Forum is currently working with the Coalition to update this document.
7. ***Don't Give Up.*** Trying to secure coverage for the patient can be a time-consuming and challenging process. Patients and their representatives

should not give up. Health plans must follow state, federal and accreditation rules of conduct. Experts are available to lend a helping hand to patients or providers to answer questions about the appeals process.

Process Overview

Several key concepts that is important to understand when filing a grievance or an appeal:

What is the difference between a grievance and a UM appeal?

A patient, family member or attending provider will typically file a UM appeal when the health plan has denied or reduced the level of care based on what is "medically necessary"." A grievance is typically filed when there is a dispute about the level of benefits being offered via the insurance coverage itself, such as a non-covered benefit. Consumers may need to consult with an insurance expert, like an ombudsman or regulator, to make sure they are taking the right follow-up action.

How does the appeals process work in a nutshell?

The UM decision-making and appeals process usually is comprised of several important steps:

- ***First Level*** – Initial Clinical Review. After an initial non-certification of services is recommended, the health plan must have a "first-level review" or an "initial clinical review" by an appropriately licensed or qualified professional to double-check the health plan's determination.
- ***Second Level*** – Peer Clinical Review. If the first-level review is completed and the coverage is still denied or the level of care is reduced, the patient or their representative can request a "second level review" or "peer clinical review." Please note that the peer clinical reviewer used by the patient's health plan (or another qualified professional who is familiar with the case) must be available to have a "peer-to-peer" conversation with the patient's attending provider as part of the process.
- ***Third Level*** – Expedited or Standard Appeal. The patient and attending provider shall be informed by the health plan about their rights to file an expedited appeal for urgent cases and a standard appeal for non-urgent cases. The health plan must explain the entire process of how to file an appeal within the applicable timelines. The patient, attending provider or treating facility must have the opportunity to submit all of the appropriate documentation supporting their case.
- ***Fourth Level*** – External or Independent Review Appeal. Most states and the federal government, through the Affordable Care Act, have established an additional layer of appeal that must be processed by third parties other than the health plan itself. For background information on how to file an external or independent review appeal, click here. However, it is important to stress that

patients or their family members should contact their state regulator (or if applicable, federal regulator) to find out what the patient's or attending provider's specific rights are.

- ***Other Options.*** After exhausting one or more of the internal or external review appeals mechanisms, the patient may want to consider filing a formal grievance with the applicable regulator or accreditation agency. In addition, the patient might want to consider filing a legal action against the health plan.

In terms of a grievance associated with the "scope of coverage" provided under the insurance arrangement, the patient's health plan and applicable regulatory agency will likely have a different process to file a complaint or appeal. The patient or their representative should contact the applicable health plan or regulator to learn more. The grievance procedure is typically more straight-forward and does not include as many levels of appeal as created for UM and external appeals.

What are the timeframes to make a decision?

All UM appeals must be handled in a timely manner. In cases involving life-threatening or emergency care, appeals must be handled on an expedited process. In addition, there are different timeframes that must be followed depending where the care is being requested ahead-of-time (e.g., "prospective UM"), during care (e.g., "concurrent UM"), or after the care has been delivered (e.g., "retrospective UM"). Please check with state, federal and/or accreditation guidelines to find out the specific timelines are in a particular case. In most cases, if the patient is actively seeking care, health plans must respond within 24 to 72 hours.

Do appeals cost money?

A health plan cannot charge a patient or attending provider to file or process an internal UM review appeal. However, if a patient files an external appeal, there may be a small fee associated with the filing. In addition, if the patient or attending provider uses an outside expert such as a lawyer anywhere along the appeals process, charges may be incurred.