

Navigating mental health networks

4

Overview

If your child needs mental health services, you can probably get these services as long as you can pay for them. But mental health services are very expensive—which means the more important question is whether you can get help paying for them.

Having insurance is only the first step toward getting services and getting assistance paying for services. As discussed in Chapter 3, there are a variety of different private insurance plans and public programs that can help you pay for your child's mental health services. To get the best possible coverage for these services, you will need to be very familiar with your plan's benefits and procedures, and you may have to overcome some obstacles along the way.

Most insurance plans limit your choice of health care providers by covering more (or all) of the costs of care from certain providers while covering less (or none) of the costs of care from other providers. For example, if you and your child get your health care services through a Health Maintenance Organization (HMO), the HMO will only pay for services provided by the specific care providers who participate in the HMO's "provider network."

A plan's provider network is made up of the health care professionals who have agreed to participate in the network and who will accept payment from

that plan. In most cases, the plan's payment rates are low, which means that some providers may opt out of participating in that plan's network. You are not required to bring your child to a provider who is in the network. However, in the case of some HMO's, if you choose to have your child visit an out-of-network provider, your child's health care costs may not be covered at all and you may have to pay all of the costs out of your own funds.

The provider network arrangement varies from plan to plan and is not always as simple as it is with an HMO plan. For example, a Preferred Provider Organization (PPO) plan also has a network of providers. This network may not be as large as an HMO plan's network, but PPO plans are generally less strict about out-of-network coverage. If your child receives health care from an out-of-network provider, you will have to pay more personally (out of pocket) for this care, but the PPO plan will pay at least part of the costs.

When it comes to mental health care in particular, many insurance plans complicate the situation further by hiring a second company to manage the mental health and substance abuse services offered by the plan. Your plan's network of mental health providers will be listed in your plan's provider directory and/or in a mental health provider directory available from this second company.

This chapter will provide you with some fundamental information about how to navigate a mental health provider network, obtain services for your child from an appropriate provider, and obtain payment for services. You will also find information in this chapter about how to fight back against (or "appeal") an insurance plan's decision not to pay for your child's services.

**Getting
coverage for
mental health
services**

The summary of your plan's benefits

No matter which kind of plan you have, it is a good idea to contact the plan directly (or your employer's human resources office, if they have the information about your plan) to ask about the mental health benefits that are provided.

You are entitled to a written summary of all the benefits provided by your plan. This summary will also explain how to get services (including services from an out-of-network provider, if allowed by the plan) and how to file an appeal.

Be sure to carefully review the summary of benefits, also known as a "summary plan description" (SPD). Different plans offer different types of mental health benefits, and some plans pay for more services than others. Some plans may also pay more of the costs for services from out-of-network providers or may have smaller yearly deductibles. If you are familiar with the benefits your plan offers, you will be able to make better choices when you are trying to get services for your child.

Subcontracted mental health services

Some health insurance plans contract directly with mental health and substance abuse providers to furnish services directly. However, as mentioned earlier in this chapter, many private insurers in Massachusetts hire a second company to manage their mental health and substance abuse services. This process is often referred to as "carving out" services. The company handling the carved-out

Advocacy Tip

The summary plan description (SPD) of the insurance plan is a crucial source of information—so crucial, in fact, that you are entitled by law to receive it. An employer can be fined if it doesn't make its SPD available upon request.

mental health and substance abuse services usually provides these services through a separate network of licensed mental and behavioral health specialists.

In Massachusetts, some public insurance programs carve out mental health and substance abuse services, too. The management of these services is usually provided by an organization called the Massachusetts Behavioral Health Partnership (MBHP or “the Partnership”). The Partnership has its own network of mental health care and substance abuse care providers.

Advocacy Tip

Finding a provider who participates in the MassHealth network can be very difficult!

The mental health care carve-out company manages care and handles claims for the primary insurance company—for a price. You may run into several problems when dealing with a carve-out company. For example, if the carve-out company denies benefits, it can be difficult to get the primary company to address this problem and take responsibility for it. Also, many carve-out companies are large and operate in several different states. When you call the carve-out company, your call may be answered at a large call center that isn't in Massachusetts—and the medical specialist who is supposed to answer your question or help you determine coverage may not know very much about the availability of health care services in your area.

In general, some carve-out companies have a reputation for denying claims and may be more difficult to deal with than the primary insurance company. Recent legislative changes clarify that your primary insurance company is directly responsible for the performance of its mental health care carve-out company. So, if you run into problems with a carve-out company, you should first seek

Advocacy Tip

If you have a complaint or concern regarding your insurance plan, be sure to put it in writing—and keep a record of all correspondence.

assistance from your primary insurer. The insurer should be responsive to your concerns. If it is not, you should consider consulting with a mental health advocate or attorney.

The mental health network

If your insurance plan and/or carve-out company offers mental health and substance abuse benefits through a network of health care providers, this network determines how and where you will get the most coverage for your child's services. Generally, you can expect full coverage for mental health services that are included in the insurance plan and provided by a health care professional who is in the plan's mental health provider network. This is usually the easiest and least expensive way to obtain mental health services for your child.

If you are interested in getting services from a particular health care professional who is not a member of the plan's network, you will want to consider the following two questions:

- Does your plan provide any coverage for the particular service you want if the provider is not in the plan's network?
- If the plan does provide coverage for the service even with an out-of-network provider, how much coverage is provided and how much will you have to pay out of your own pocket?

Note that—regardless of whether you are seeking help for your child from an in-network provider or an out-of-network one—you will need to follow the plan's instructions about contacting a mental health provider, as discussed in the next section.

Advocacy Tip

The providers participating in your plan's network will all be listed in your plan's provider directory. However, some providers in the directory will be unavailable because they aren't taking any new patients.

Prior approval and referrals

In addition to its rules about which mental health services are covered and whether services from an out-of-network provider are covered, an insurance plan also has procedures you should follow when trying to get mental health services for your child.

For example, when you want your child to receive a particular service in a non-emergency situation, you may need to get prior approval of that service from a primary care physician or from the carve-out company itself. Otherwise, your plan might not cover the cost of that service. In some cases, the plan requires you to get a referral to a particular provider from your child's pediatrician or primary care physician. In other cases, the plan may allow a certain number of mental health services visits with an in-network provider without prior approval, but the plan may require prior approval for any additional visits beyond that number.

Note that the primary care physician's prior approval or referral must be formal and in writing. Usually, the doctor signs a form and then faxes or emails it to the insurance plan. If your primary care physician only gives you verbal approval of a service, this is not an official approval or referral, and your insurance plan will be free to disregard it. Be sure to ask your doctor to send the referral or prior approval in writing to the insurance company.

**Problems
you might
encounter**

It is important to remember that some plans require prior approval or a referral even if you are bringing your child to a mental health care provider who is a member of the plan's provider network.

The “adequate access” problem

There are several types of problems that can occur when you are trying to get (or are getting) mental health services for your child under your particular insurance plan. First, you may have difficulty finding a provider for the particular service your child needs, even though your insurance plan covers the service. For example, there may be no providers of this service in your community or there may be too few of them, in which case you will be told that there is a long wait for services.

This is an “adequate access” problem. Most private insurance plans are required by law to make sure that you and your child have adequate access to mental health services (whether or not the services are managed by a carve-out company). This adequate access requirement is only satisfied if the insurance plan meets these conditions:

- Its network of health care providers has all of the different provider types required by Massachusetts law
- The network providers offer the full range of mental health services required by the law (including specific treatments that are appropriate for children of different ages and with different kinds of conditions)

Advocacy Tip

Some insurance plans have very different procedures for dealing with in-network providers versus out-of-network providers, especially in terms of prior approval. Learn about these procedures and follow them with care!

- The network has enough providers so that no patient has to wait an unreasonably long amount of time to get treatment for a severe condition
- Mental health care is delivered promptly and appropriately
- The insurer provides you with referral assistance upon request to help identify an appropriate provider
- The insurer, upon request, investigates and confirms whether a provider in its network is available to provide needed services
- If no in-network mental health provider is available, the insurer pays for services from an out-of-network provider who is available

If you believe your insurance company is not meeting its legal obligation to provide adequate access to services, you can try to resolve the problem in one of the following ways:

- Ask the insurance company to provide you with a list of available providers
- Ask the insurer to investigate and confirm the availability of providers in its network
- Look for another type of mental health provider within the network who might provide the service your child needs
- Ask the insurance company to approve and pay for services from a mental health provider who is available but who is not in the network
- Switch to a different insurance plan
- File a complaint with the Massachusetts Division of Insurance (DOI)
- If all else fails: consult with a lawyer who is knowledgeable about mental health advocacy

Advocacy Tip

If your plan refuses to cover a service, you are entitled to know why, and the plan should provide a detailed explanation.

Adequate access can come up as a problem when you have insurance through a public program as well. However, the standards for adequate access in the public sector are complex, and this makes them difficult to enforce. Be sure to get a list of available providers and explore your alternatives as much as you can. Unfortunately, litigation is often required in this situation.

Denial of eligibility for a public program

If you have filed a MassHealth Medical Benefit Request (MBR) form and if you have been notified that you are not eligible for any MassHealth or other public program, you can appeal this decision through the Fair Hearing Appeals process. The best way to request a hearing is to fax your request to the Board of Hearings at the Office of Medicaid.

Denial of service

Another problem you might encounter is a “denial of service” or “denial of benefits,” where the insurance plan tells you that a mental health service that your child needs is not covered and/or the plan refuses to pay for this service. If your child is denied benefits, you have the right to appeal the insurance plan’s decision. Both public and private insurance plans are required by law to have a grievance or appeal process. The appeal process (and the rights you have) will vary depending on how the insurance plan is structured.

You may be able to obtain free legal help when appealing a denial of benefits. The list of legal resources at the end of this

Advocacy Tip

If you receive a bill charging you for services you believe are covered by your plan, be sure to check in with your plan. The bill may simply be a mistake or a copy for your records—not a denial of services.

Guide may help you find free legal services in your area.

The insurance plan is required to provide you with a written description of the appeals process, the reason for the denial of coverage of services, and a phone number you can call for assistance. It is important to call the insurance plan and/or visit your employer’s human resources department to get as much information as you can about the specific appeals process.

Appealing a denial by a private insurance plan

In general, if you want to appeal a denial of service by a private insurance plan, the following guidelines will apply:

- You will file a formal written complaint or “grievance” with the insurance plan as soon as possible, using its internal grievance procedure. You don’t want to miss the deadline.
- A private insurance plan must acknowledge your grievance in writing within 15 days and resolve it within 30 days, also in writing. If your child needs urgent medical care and/or the situation is an emergency, the insurance plan must resolve the grievance much more quickly.
- If you go through the insurance plan’s internal grievance procedure and your child is still denied benefits, you may request a review of the insurance plan’s decision by the Department of Public Health’s Office of Patient Protection (OPP). Again, this request needs to be made promptly. Be sure to proceed in a timely manner.

Advocacy Tip

Insurance plans frequently base denials of payment on the claim that the services provided to a child are not “medically necessary.”

Advocacy Tip

Only your insurance plan—and not a provider—has the authority to deny coverage under your plan.

Note that if your private insurance is a “self-insured” plan (which means your employer—usually a large company—pays directly for your health care services), then your right to appeal a denial of benefits is limited. The OPP process mentioned above will not be available to you. A self-insured plan is required to provide a grievance procedure, but your right to appeal under this type of plan is governed exclusively by federal law. For more information about self-insured plans, contact the Employee Benefits Security Administration of the U.S. Department of Labor.

Appealing a denial by a public program

In general, if you want to appeal a denial of benefits by a MassHealth plan, the following guidelines will apply:

For an MCO grievance

- You must file an “internal grievance” with the plan within 30 days of the denial of benefits.
- If your child is receiving services and you file your grievance within 10 days of the denial, your child may continue receiving those services until the grievance is decided.
- If your child is receiving emergency services and has not been discharged yet, you can ask for an expedited grievance decision that will be handed down in 60 minutes (one hour).
- You can also ask for the 60-minute expedited decision if your child’s life or health might be seriously endangered by a delay in the grievance procedure.

Advocacy Tip

Whether a service is medically necessary (and covered by your insurance plan) is a matter of expert opinion. Getting the support of your child’s doctor is essential if you want to challenge a denial of coverage based on medical necessity.

- Usually, outpatient grievances are decided within five business days. All other grievances are usually decided within two business days.

Note that your MCO can ask your health care provider for information relating to your appeal. If this request for information is made, the deadline for the decision about your appeal will be measured from the time when the MCO receives this information.

For a PCC plan/Partnership grievance

- You can try calling and discussing your complaint with a Partnership staff member. If the complaint is not resolved, you can send a written grievance to the Partnership.
- The Partnership's Quality Management Department will review and resolve the grievance within 15 days and will send you a letter explaining how the Partnership will respond to your grievance.
- If you are not satisfied with the Quality Management Department's decision, you may appeal that decision by filing a written appeal (or by calling in and appealing by telephone) within 30 days of the date on the Quality Management Department's letter.
- If you are appealing a change in the services your child is already receiving, you must file your appeal (in writing or by telephone) within 10 days of the date on the letter in order to avoid an interruption of services.

(For more information about the Massachusetts Behavioral Health Partnership, or "the Partnership," see the earlier section of this chapter titled "Subcontracted mental health services.")

**State-
mandated
benefits for
children**

Appealing a public program's final decision

If you file an internal appeal for a denial of benefits and the appeal is decided against you, you will receive a notice of denial containing specific information about why the request was denied. If you want to appeal further, you may request an appeal with the Office of Medicaid Board of Hearings.

- You will need to file a request in writing within 30 days of the date on the denial notice.
- If you are appealing a change in the services your child is already receiving, you must file your appeal within 10 days of the date on the denial notice in order to avoid an interruption of services.
- When filing an appeal, it will be helpful to the Board of Hearings if you attach a copy of the denial notice you received.

The Mental Health Parity Law

Some private insurance plans—including most plans provided by employers—are governed by the Mental Health Parity Law. Under this law, an insurer is required to provide children who have substantial functional impairments or biologically-based mental health conditions (such as bipolar disorder or schizophrenia) with certain “medically necessary” health care benefits. Under this law, children are entitled to more expansive services than adults. If you and your child have been denied benefits, you may want to call a health law attorney to find out whether the Mental Health Parity Law might help you.

Advocacy Tip

The appeal process—although challenging—can lead to a positive result. For example, by clarifying the situation for your insurance plan, you may discover that additional coverage is available.

Advocacy Tip

If you feel that your plan is not providing a service that your child needs, asking for that service in writing will improve the chances that the plan will honor your request.

Additional benefits

You and your child have a right to all of the specific services covered by your insurance company. Your insurance plan is a contract between you and the insurance company, and—under this contract—you have paid for the services and are entitled to receive them. A law known as the HMO Reform Act of 2000 also ensures that you and your child can receive the following benefits:

- **Emergency services:** If your child is experiencing a mental health emergency and you seek emergency services for him or her, your insurer or HMO must pay for these services. Generally, this is true even if the services are not pre-authorized and even if they are provided by a non-network provider.
- **Continued coverage of disabled adult children:** If you have private family coverage, your disabled child may be eligible to remain on your plan as an adult and receive payments after the insurance coverage would normally terminate for children.
- **Provider is not a member of new plan:** If your child has been seeing a mental health care provider, and you switch to an insured health plan with a network of providers that doesn't include your child's provider, your insurance plan will typically continue to pay for your child to see the old provider for up to 30 days for an ongoing course of treatment. The provider must agree to comply with the terms of your new insurance plan.
- **Referral for ongoing care:** Many insurance plans require you to get a referral for specialist care (which includes virtually all mental health services) from your child's primary care provider. If your child is covered by an insured plan and has a mental health condition that requires ongoing care, the primary care provider may make a single "standing referral" (instead of providing a separate referral for each service) that allows you to receive payments for ongoing care from a participating mental health specialist.

Advocacy Tip

If you get advice or information over the phone from your plan, remember to ask for this information in writing. The information your plan provides in writing may be more clear—and is the only information you can truly rely on, particularly in a dispute.

**Summary
and things to
remember**

Sometimes, dealing with health insurance can be time-consuming, frustrating, and even infuriating. The health care system in our country is far from perfect—but on the other hand, insurance plans do help people obtain and pay for the health services their families need. If your child needs mental health care, having health insurance will probably—in the long run—be worth all of your effort and frustration.

It is important to keep in mind that health insurance plans are complicated organizations, and most of them employ people who have a genuine interest in helping you sort through the complications. You might find that your plan's employees are the key to understanding the plan's benefits, procedures, and method of handling mental health services.

However, it is equally important to remember that sometimes you need to have an ally on your side when dealing with an organization as complicated as a health insurance plan. The list of resources in the back of this guide can help you locate a mental health advocate in your area.

As mentioned in Chapter 2, there are some mental health care services that will be provided to your child without cost regardless of whether you and your child are covered by an insurance plan. These services are designed for very specific situations and will have some limitations. In the next chapter, you will find information about one of these specific situations: the mental health services that can be provided to your child by his or her school.

