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# Health Insurance Coverage Information for

# Mental Health and Substance Use Disorder Treatment

This guide will help you understand health insurance coverage for mental health and substance use disorder treatment in New York.

**What kinds of plans does this guide cover?**

**Individual Coverage You Buy in New York.** You buy individual coverage through the New York State of Health Marketplace or from a broker or an insurer in New York.

**Group Coverage Your Employer Buys in New York.** Your employer buys a group insurance policy from an insurer in New York.

**What kinds of plans does this guide NOT cover?**

**Individual Coverage You Buy Outside New York.** You buy individual coverage in another state. The rules of that other state will apply.

**Group Coverage Your Employer Buys Outside New York.**  Your employer buys a group insurance policy in another state (for example, your employer’s main office is in another state). The policy may cover employees in New York, but New York protections don’t apply.

**Self-Funded Group Coverage.** Your employerself-funds the coverage, as many large employers do. An insurer may still process the claims, but New York protections don’t apply.

**What if I have Medicaid, Essential Plan or Child Health Plus?**

If you have **Medicaid** , **Child Health Plus**, or the **Essential Plan**, New York protections apply*,* but there are different rules. Check with the **NYS Department of Health (DOH)** at (800) 541-2831 for **Medicaid**, (800) 206-8125 for **Medicaid Managed Care** and **Child Health Plus**, and (855) 355-5777 for **Essential Plan** coverage.

**What if I have Medicare?**

If you have **Medicare**, different rules apply. Check with **Centers for Medicare & Medicaid Services** (CMS) at (800) MEDICARE, the **Medicare Rights Center** at (800) 333-4114, or <https://www.medicarerights.org/>

## Mental Health and Substance Use Services Your Insurer Must Cover

**Medically Necessary Treatment.** Your insurer must cover the diagnosis and medically necessary treatment of a mental health condition or substance use disorder (“SUD”).

* Your insurer must cover inpatient services (in a hospital or facility) and outpatient services (in a health care provider’s office or facility).
* Coverage may be limited to the types of providers and facilities listed in your health insurance policy that are in your insurer’s network (in-network provider).
* Your doctor may recommend treatment, but your insurer might not agree it is medically necessary. See below under Appealing Your Medical Necessity or Out-of-Network Provider Denial for a description of your rights if that happens.
* Check your health insurance policy. You can request a copy by calling the Member Services number on your health insurance ID card or asking your employer.

**Cost-sharing for Treatment.** You may have a deductible, copayment, or coinsurance.

* A deductible is the dollar amount that you need to pay before services will be covered by your insurer. If your deductible is $1,000, your health insurance policy won’t pay anything (except for preventive care) until you’ve paid $1,000 for covered services.
* You may also have a copayment (set dollar amount) or coinsurance (a percentage of the costs) that you will need to pay for treatment.
* Your insurer can’t apply annual limits or lifetime limits on treatment for mental health conditions or SUD.
* Check your health insurance policy because the deductibles, copayments, or coinsurance may be different depending on the services you are getting.

**Outpatient SUD Treatment (Large Group)**. If you are covered under a large group insurance policy (employer policies with more than 100 employees), your copayment or coinsurance for any outpatient SUD treatment from an in-network provider may not be more than the copayment or coinsurance that you would pay for a primary care office visit. If you receive outpatient SUD treatment in an in-network facility that is licensed or certified by New York State’s Office of Addiction Services and Supports (“OASAS”), you will only have one copayment for all services provided in a single day by the facility.

**Outpatient Mental Health Services.** If you are covered under an individual, small group, or large group insurance policy, your copayment or coinsurance for any outpatient mental health treatment you receive from an in-network provider may not be more than the copayment or coinsurance that you would pay for a primary care office visit.

**Out-of-Network Services.** If your policy has an out-of-network benefit (usually called PPO or POS coverage), you can get care from out-of-network providers who aren’t in your insurer’s network. Your cost-sharing will usually be higher for out-of-network services, and you will have to pay the difference between what your insurer pays for the service (allowed amount) and the provider’s actual charge.

**No Discrimination.** Your insurer can’t discriminate against you because of your mental health condition or SUD.

* Your insurer can’t refuse to cover you, terminate your coverage, or charge you higher premiums.
* Your insurer must provide a similar level of benefits for your mental health condition and SUD as provided for medical and surgical care.

## Services May be Denied for Different Reasons and You Have Appeal Rights for These Denials

**Medical Necessity.** Insurers may deny services as not medically necessary (including experimental or investigational services) through their utilization review process. Insurers use clinical review criteria (medical guidelines), which may vary among insurers, to make these determinations.

* **Clinical Review Criteria.** You have a right to request a copy of the clinical review criteria (medical guidelines) your insurer used to make its decision from your insurer at any time. For mental health and SUD treatment, insurers are required to use State-approved tools to decide if care is medically necessary.
* **Clinical Peer Reviewer.** A clinical peer reviewer is the health care professional who decides if a service is medically necessary. For determinations involving mental health or SUD treatment, the clinical peer reviewer must specialize in behavioral health and have experience in mental health or SUD treatment.

**Out-of-Network Provider.** You may ask for your care to be provided by an out-of-network provider because there is no in-network provider with the training and experience to meet your health care needs (“referral-denial”) or because your insurer can’t cover the treatment you requested in-network but will cover a similar treatment (“service denial”).

**Off-Formulary Prescription Drugs.** You may request coverage of a prescription drug that is not on your insurer’s list of covered drugs (“formulary”), including a prescription drug to treat a mental health condition or a SUD, and your insurer must review these requests.

## When Insurers Can’t Require Preauthorization (Prior Approval)

Preauthorization or prior approval is how your insurer decides whether a health care service, treatment, or prescription drug is medically necessary before you can get it. Insurers can’t require preauthorization in the following situations involving mental health care services and SUD treatment.

**Inpatient Treatment of SUD**. If you need inpatient treatment for a SUD, your insurer may not require that you or your provider get the treatment preauthorized if the treatment is provided in an in-network facility that is certified or licensed by OASAS.

* After you are admitted, your insurer can’t review the services for medical necessity during the first 28 days if the facility notifies your insurer of both the admission and the treatment plan within two business days of admission.
* If your inpatient treatment is denied retrospectively (meaning after your treatment has ended), you will not have to pay any amount for the treatment other than the copayment, coinsurance, or deductible otherwise required under your policy.

**Outpatient Treatment of SUD.** If you need outpatient treatment for a SUD, your insurer may not require that you or your provider get the treatment preauthorized if the treatment is provided in an in-network facility that is certified or licensed by OASAS.

* Once you begin your outpatient treatment, your insurer can’t review the services for medical necessity during the first four weeks (not more than 28 visits) if the facility notifies your insurer of both the start of treatment and the treatment plan within two business days.
* If your outpatient treatment is denied retrospectively (meaning after your treatment has ended), you will not have to pay any amount for the treatment other than the copayment, coinsurance, or deductible otherwise required under your policy.

**Prescription Medications to Treat a SUD.** Insurers may not require you to get a prior approval for certain prescribed medications to treat a SUD. Check your health insurance policy for more information.

**Inpatient Admission for Mental Health Condition for Individuals under 18.** If you are under the age of 18 and you need inpatient treatment for a mental health condition, your insurer may not require that you or your provider get the treatment preauthorized if the treatment is provided in an in-network facility that is licensed by OMH.

* Once you are admitted, your insurer can’t review the services for medical necessity during the first 14 days if the facility notifies your insurer of both the admission and the treatment plan within two business days of admission, performs daily clinical review of your case, and consults with your insurer.
* If your inpatient treatment is denied retrospectively (meaning after your treatment has ended), you will not have to pay any amount to the facility for the treatment other than the copayment, coinsurance, or deductible otherwise required under your policy.

## Timeframes for Insurers to Make Medical Necessity and Out-of-Network Provider Decisions

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|  | **Medical Necessity Decisions**  **– Utilization Review –** | **Out-of-Network Provider Decisions**  **– Grievance–** |
| **Urgent Inpatient SUD Treatment** | 24 hours of receipt of your request if made at least 24 hours before discharge from an inpatient admission. If request is not made at least 24 hours prior to discharge, then 1 business day of receipt of necessary information. |  |
| **Urgent *(including services that may be subject to court ordered treatment)*** | 72 hours of receipt of your request for treatment. | 72 hours of receipt of your request for treatment. |
| **Pre-Service – *for care you have not received yet*** | 3 business days of receipt of necessary information or 60 days if no information is received. Your insurer must ask for any information within 3 business days of receiving your preauthorization request, and you and your provider have 45 days to submit the information. | 15 days of receipt of necessary information or 60 days if no information is received. Your insurer must ask for any information within 15 days of receiving your request, and you and your provider have 45 days to submit the information. |
| **Concurrent – *for an ongoing course of treatment*** | 1 business day of receipt of necessary information or 60 days if no information is received. Your insurer must ask for any necessary information within 1 business day, and you and your provider have 45 days to submit the information. |  |
| **Post-Service – *for care you received*** | 30 days of receipt of necessary information or 60 days if no information is received. Your insurer must ask for any information within 30 days, and you and your provider have 45 days to submit the information. | 30 days of receipt of necessary information or 60 days if no information is received. Your insurer must ask for any necessary information within 30 days, and you and your provider have 45 days to submit the information. |

## Appealing Your Medical Necessity or Out-of-Network Provider Denial

**Denial notice.** Your insurer must send you written notice if your treatment is denied. In urgent cases, your insurer must also contact you by telephone. If you don’t get a notice, you can file a complaint with DFS.

**Timeframes.** You have 180 days to appeal with your insurer.

**Out-of-Network Provider Appeal (referral denial)**. Your doctor must (1) send a written statement to your insurer that the in-network providers recommended by your insurer do not have the training and experience to meet your health care needs; and (2) recommend an out-of-network provider with the training and experience to meet your health care needs who is able to provide the service.

**Out-of-Network Provider Appeal (service denial)**. Your doctor must (1) send a written statement to your insurer that the out-of-network service is materially different from the health service the insurer approved; and (2) provide two documents of medical evidence that: (i) the out-of-network service is likely to be more clinically beneficial to you than the in-network service your insurer recommended; and (ii) the risk of the requested health service would not be increased over the in-network health service.

## Timeframes for Insurers’ Medical Necessity and Out-of-Network Provider Appeal Decisions

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| **Inpatient SUD Services** | 24 hours if initial request made at least 24 hours before discharge from an inpatient admission. |
| **Urgent *(including services that may be subject to court ordered treatment)*** | The earlier of 72 hours of receipt of the appeal or 2 business days of receipt of necessary information. |
| **Pre-Service – *for care you have not received yet*** | 30 days if your insurer has one level of internal appeal or  15 days if your insurer has two levels of internal appeal. |
| **Post-Service – *for care you received*** | 60 days if your insurer has one level of internal appeal or, beginning in 2021, 30 days of receipt of necessary information, if earlier, or  30 days if your insurer has two levels of internal appeal. |

## Formulary Exception Process for Prescription Drugs

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| **Timeframes** | **Standard.** 72 hours for insurer decision. | **Expedited.** 24 hours for insurer decision when your health, life, or ability to regain maximum function is in danger, or if you are currently being treated with a non-formulary prescription drug. |

**Final Denial.** If your insurer denies your formulary exception request, it’s a final adverse determination. You do not have to appeal with your insurer. You can request an external appeal with DFS.

**Applicability.** Individual and small group coverage and, beginning on renewal in 2020, large group coverage.

## External Appeals

**Right to an External Appeal.** If your insurer makes a determination (usually on appeal) that your treatment is not medically necessary (including cosmetic denials, an experimental or investigational treatment, an out-of-network service, an out-of-network referral, or a non-formulary prescription drug), you have a right to an external appeal with medical experts that are independent from your insurer.

**Timeframe to Request an External Appeal.** You must send your external appeal request to DFS four months from the date of:

* The final adverse determination from the first level of appeal with your insurer;
* Notice that your insurer said you didn’t need to go through the internal appeal process; or
* The first denial of your formulary exception request.

If your insurer offers a second-level internal appeal, you do not have to file one but if you do, you must still send an external appeal to DFS within four months of the first appeal decision.

**Timeframe for the External Appeal Agent to Make a Determination.**

* **Standard.** 30 days (or 72 hours for a formulary exception).
* **Expedited.** 72 hours (or 24 hours for a formulary exception), even if all your medical information has not yet been submitted to the external appeal agent.

**Request an External Appeal.** Complete the New York State External Appeal Application on the DFS website at [www.dfs.ny.gov/complaints/file external\_appeal](http://www.dfs.ny.gov/complaints/file%20external_appeal). There may be a $25 fee. Your fees won’t be more than $75 in a year if you request more than one external appeal. There is no fee if you are covered under Medicaid, Child Health Plus, Essential Plan, or if the fee will pose a hardship. The fee will be returned to you if the external appeal agent overturns the denial. You can also request help from **Community Health Advocates**, NY State’s insurance consumer advocacy group, at (888) 614-5400 and/or <http://www.communityhealthadvocates.org/> .

## Information on Surprise Bills

A surprise bill happens when:

* **Hospital or Surgical Center.**  You receive services from an out-of-network doctor at an in-network hospital or surgical center and (1) an in-network doctor was not available; (2) you did not know the doctor was out-of-network; or (3) an unexpected medical situation happened when your health care services were provided. It is not a surprise bill if you chose to receive services from an out-of-network doctor instead of from an available in-network doctor.
* **Referral.** You are referred by your in-network doctor to an out-of-network provider and you did not sign a paper saying that you knew the services would be out-of-network and would result in costs not covered by your insurer. A referral to an out-of-network provider happens if (1) during a visit with your in-network doctor, an out-of-network provider treats you; (2) your in-network doctor takes a specimen from you in the office (for example, blood) and sends it to an out-of-network laboratory or pathologist; or (3) for any other health care services when referrals are required by your insurer.

You will be protected from a surprise bill and will only be responsible for your in-network copayment, coinsurance, or deductible if you sign the assignment of benefits form after receiving a surprise bill and return it to your insurer and out-of-network provider. The assignment of benefits form is available at [www.dfs.ny.gov/IDR](http://www.dfs.ny.gov/IDR).

## When You or Your Provider Submit a Claim to Your Insurer

Your insurer is required to send you an “explanation of benefits” form when it does not pay your claim in full. The explanation of benefits must include the following information.

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| Provider name. | Date of service and description of service. | Provider’s charge. | Amount your insurer will pay after deductible, copayments, or coinsurance. | Explanation of any denial or reason for not paying the full amount. | Insurer’s telephone number and information on how to appeal any denial of benefits. |

## Questions and Complaints

**Questions.** If you have questions, call DFS at (800) 342-3736 (available Monday through Friday, 8:30 AM to 4:30 PM). Local calls can be made to (212) 480-6400 or (518) 474-6600.

**Complaints.**  You can file a complaint with DFS, DOH, or an independent ombudsman program depending on the type of coverage you have.

* **If you are covered by an insurer or HMO.** File a complaint with DFS online at [www.dfs.ny.gov/Complaint](http://www.dfs.ny.gov/Complaint). DFS will investigate your complaint. DFS may share a copy of your complaint with your insurer or refer it to another state agency, if applicable.
* **If you have Medicaid, Essential Plan, or Child Health Plus coverage.** File a complaint with DOH. You may contact the NYS Department of Health at (800) 541-2831 for Medicaid, (800) 206-8125 or NYSDOH.BCS.Behavioral.Health.Complaints@health.ny.gov for Medicaid Managed Care, (800) 698-4543 or locally at (518) 473-0566 for Child Health Plus, and (855) 355-5777 for Essential Plan coverage.
* **If you are covered by an insurer or HMO or you have Medicaid, Essential Plan, or Child Health Plus.** You may also ask for help fromNew York’s independent Behavioral Health Ombudsman Program if you have questions, a complaint, or want to file an appeal for denied treatment with your insurer or HMO. The Community Health Access to Addiction & Mental Healthcare Project (“CHAMP”) helpline can be reached by calling 888-614-5400 Monday-Friday, 9:00 AM-4:00 PM or by sending an email to: ombuds@oasas.ny.gov.