CONNECTICUT
INSURANCE DEPARTMENT

# Consumer Toolkit for Navigating Behavioral Health and Substance Abuse Care Through Your Health Insurance Plan

*What consumers need to know about seeking approval for behavioral health services*

800.203.3447 www.ct.gov/cid

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# State of Connecticut Insurance Department

We made this Consumer Toolkit to help you make good choices about getting the right care. We have provided a glossary of terms that health insurers use at the front of this toolkit to help you understand this process. We also made a checklist of the best things to ask your health insurer and your doctor so you get the right care paid for through your health plan.

## Make Informed Decisions

Know the facts and use this information to make informed decisions.

## Research First

Contact your health insurer for assistance.

Your insurer set up the best rate ahead of time with certain doctors and hospitals. These providers are called "in-network".

This Toolkit will explain why it can be a good idea to choose an in-network provider.

## Know Your Insurance Plan

Check to see what kinds of care are covered under your plan.

Your health insurer may want to okay certain kinds of care ahead of time. This is called "pre-authorization". Check to see what kinds of care needs to be pre-authorized.

This Toolkit will help you understand your health plan.

## Seek "Medical Necessity" Approval

Your health insurer needs to hear from your doctor that the care you receive is medically necessary. There are rules on how this is decided.

This Toolkit will explain how pre-authorization for medically necessary services works.

## Determine Your Out-of-Pocket Expenses

Usually you pay for part of the cost of the care out of your own pocket. You pay more when you use an out-of-network provider.

This Toolkit will help you compare how much the care will cost for in-network and out-of-network providers.

# Make Informed Decisions

The Connecticut Insurance Department wants to be sure you have all the facts and information you need before you make any choices on behavioral health and substance abuse care. This Toolkit is designed to help you.

## Important Tips for Consumers

Start with your treating physician and ask that provider to recommend other providers within the plan's network.

- Research the providers in your area with your health insurer.
- Consider using a network provider. It provides the most consumer protection and it costs less for you.
- Use a provider that is willing to be involved in pre-authorizing services for you.
- If the provider will not handle the pre-authorization for you, use the checklist in this Toolkit to help you talk to your health insurer about pre-authorization.
- Have services approved in advance if at all possible. It is always harder to receive approval after the fact.
- Use the glossary on this page to help you understand the terms that are used by your health insurer.

*Please Note: If you work for a large employer, your plan may be considered a self-insured plan. If so, your plan would not be under the authority of the Connecticut Insurance Department. Check with your employer to obtain specific information that pertains to your plan.*

## *Glossary of Important Terms*

***Allowed Amount*** *– Maximum amount on which payment is based for covered health care services.*

***Balance Billing*** *– The amount that a provider bills you for the difference between the provider's charge and the allowed amount.*

***Coinsurance*** *– Your share of the costs of a covered health care service, calculated as a percent (for example 20%) of the allowed amount for the service.*

***Copayment*** *– A fixed amount you pay for a covered health care service, usually when you receive the service.*

***Cost Shares*** *– The amount you pay for health care expenses that are not covered by your health insurer including copayments, deductibles, coinsurance and provider charges over the allowed amount.*

***Deductible*** *– The amount you owe for covered health care services before your health plan begins to pay.*

***In-Network Provider*** *– The facilities, providers and suppliers your health insurer has contracted with to provide health care services to you at a discounted price.*

***Medically Necessary*** *- Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.*

***Out-of-Network Provider*** *– A provider who doesn't have a contract with your health insurer to provide services to you. You will pay more to see an out-of-network provider.*

***Pre-authorization*** *- A decision by your health insurer that a health care service is medically necessary. This is sometimes called prior authorization, prior approval or pre-certification.*

## Research First

Whenever possible, members should consider using in-network providers. Using in-network providers gives you greater protection.

### Advantages of In-Network Providers

- In-network facilities are approved as eligible for payment for medically necessary stays.
- In-network providers handle the insurance paperwork for pre-authorization and claim submission for members.
- In-network providers do not bill for any charges other than your copayments, deductibles or coinsurance.
- In-network providers agree to accept a pre-negotiated rate from the health insurer.

### Considerations in Using Out-of-Network Providers & Facilities

- If the out-of-network facility does not meet the licensing requirements of your health plan, the treatment may not be eligible for coverage.
- Out-of-network providers and facilities may not be willing to request pre-authorization for services or be willing to advocate on your behalf.
- Out-of-network providers and facilities generally do not submit claims for you. This may make it difficult for you to provide enough information for your health insurer to approve the care or pay the claim.

**What is an In-Network Provider?**

In-network providers have agreed to a rate with the health insurer. In-network providers cannot bill you for more than the rate except for your copayment, deductible or coinsurance amounts.

**What is an Out-of-Network Provider?**

Out-of-network providers have not agreed on a rate with the health insurer. They can bill you for any amount beyond what the health insurer pays. This is called balance billing.

- Out-of-network providers or facilities can ask you to personally guarantee payment for service before they will treat you as a patient.
- Out-of-network providers or facilities are not limited in what they may charge you. Members may be balanced billed for the remaining provider charges after the health insurer pays its portion.

### Tips for Choosing the Appropriate Facility

- Discuss treatment options with your health insurer. Ask them for a list of in-network facilities in your area.
- Ask your treating physician to recommend a treatment facility/hospital.

### Important Questions to Ask an Out-of-Network Facility

- Ask the out-of-network facility what assistance they will provide you in obtaining pre-authorization, filing appeals and submitting claims to your health insurer.
- Contact the treating physician at the out-of-network facility to request their assistance in obtaining clinical approval for the services with your health insurer **prior** to treatment.

# Know Your Insurance Plan

It is important to know what is covered under your plan. Call your health insurer to verify the coverage that is available under your specific plan.

Information on your coverage is listed in your policy or certificate of coverage. Insurers also provide a Summary of Benefits and Coverage (SBC) that lists coverage and cost shares in an easy to read format.

## Plan Features

- ***Does your plan offer coverage for out-of-network providers?***

  Check to see if your plan offers out-of-network benefits. If it does not, you will need to seek services from an in-network provider.

- ***What are your out-of-pocket costs if you use an out-of-network provider?***

  If your plan has benefits for services through an out-of-network provider, you will pay a larger member cost share for using services through these providers. These cost shares include your deductible and the coinsurance, plus the amount that the provider bills you that is over the allowed amount set by your plan.

- ***Is the out-of-network facility properly licensed to meet the requirements under your plan?***

  If you choose an out-of-network facility, call your health insurer to determine if the facility meets the licensing requirements listed in your plan. The health insurer will need to contact the facility to learn more about their medical license and the treatment they provide.

## Pre-Authorization

- ***What services require pre-authorization under your plan?***

  Your SRQ\ RUcertificate of coverage will list WKH services that require prior authorization. Ask your treating provider to call the health insurer on your behalf if the services require pre-authorization.

- ***What is an in-network exception?***

  If you believe that the services that you need are only available through an out-of-network provider, you must make a special request to your health insurer. Services will only be paid at the in-network cost shares if you receive approval from your health insurer for an in-network exception.

  In order to receive approval for an in-network exception you must prove that there are no in-network providers that can provide these services and your health insurer must agree.

- ***What is the difference between pre-authorization and in-network exceptions?***

  When you pre-authorize services using an out-of-network provider, you will be responsible for the member cost share for out-of-network services.

  You will need to submit a separate request and be approved by your health insurer for an in-network exception, if you wish to have services paid at the in-network member cost shares.

## Seek "Medical Necessity" Approval

Health insurers approve services for covered benefits when they determine that services are "medically necessary".

Some services may require that you receive pre-authorization. This means that the health insurer requires you and your treating physician to seek a medical necessity approval prior to receiving services.

### Important Facts About Pre-authorization & "Medical Necessity"

Pre-authorization is a system put in place to verify that the health insurer's medical necessity guidelines have been met prior to receiving services.

- It is important that your treating physician is involved in this process.
- Treating physicians typically provide the following information to the insurance company when seeking pre-authorization:
  - Patient Name, Member ID#
  - Health Plan Name
  - Treating Physician's Name & Tax ID#
  - Date, type and place of service
  - CPT Code (service/procedure code)
  - ICD-9-CM Code (primary diagnosis)
  - Brief history of present illness
- The health insurer will want to discuss with your treating physician your medical records, the nature of your symptoms, their duration and current medical management.
- If your health care professional is unable to request pre-authorization from your health insurer by phone, ask them to help you complete the Consumer Toolkit Checklist in this booklet.
- It is critical that you have assistance from a health care professional who can provide the clinical background, treatment records and has the medical expertise to show the medical necessity of the requested services.

### Appealing "Medical Necessity" Denials

- You have a right to appeal the denial of services by your health insurer.
- When a health insurer sends you a pre-authorization denial notice, they must also notify you of your rights to appeal this decision.
- Appeal rights are outlined in detail in the health insurer's denial letter. This includes information on how to file an appeal and where the appeal request should be sent.
- Appeals must be filed within a certain timeframe so read the letter from the health insurer carefully to be sure that you file your appeal on time.
- If you complete all of the appeals available to you with the health insurer, you may request an independent review of this decision through the State of Connecticut External Review Program.
- Contact your health insurer or the State of Connecticut Insurance Department if you have any questions on how to file an appeal or about applying for an External Review.

## Determine Your Out-of-Pocket Expenses

Before proceeding with out-of-network services, it is important to understand all of your out-of-pocket expenses prior to services being delivered.

- Call your health insurer to be sure that your plan offers the option to use out-of-network providers.
- If you choose to use an out-of-network facility, call your health insurer to determine if the facility meets the licensing requirements for the services you need. If not, the services will not be reimbursable under your plan.
- Ask your health insurer what your out-of-pocket cost shares are when using out-of-network services. These will include deductibles, coinsurances and the billed charges in excess of the allowed amount set by your plan.
- Be sure to ask the health insurer how they determine the allowed amount paid to out-of-network providers and facilities. Health plans use different methods for setting out-of-network reimbursements. Verify this information ahead of time with your health insurer.
- Remember, any charges that exceed the allowed amount as set by your health insurer are your responsibility!

## For Assistance

You have resources available to you through the Connecticut Insurance Department.

Please contact the Insurance Department for any information that you may need so that you have all the facts to make an informed decision.


Connecticut Insurance Department

P.O. Box 816
Hartford CT 06142

Website: www.ct.gov/cid

Email: cid.ca@ct.gov

Fax: 860-297-3872

Consumer Affairs Unit: 860-297-3900



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# State of Connecticut Insurance Department
# BEHAVIORAL HEALTH & SUBSTANCE ABUSE CARE
# CHECKLIST of INFORMATION
## For use in discussing your health care needs with your insurer

**Tip # 1** Contact your insurer before you start care so you can verify coverage and provider status. Ask your health care provider to call your insurer so that insurer can get complete medical information directly from the treating provider.

**TIP #2** Contact your insurer for assistance if your provider is unable or unwilling to contact your insurer for you.

**TIP #3** If your behavioral health services are denied, this checklist can be helpful in organizing the information you will need to appeal the denial.

**INSURANCE INFORMATION**

Member/Insured Name:_____

Member/Insured Address: _____

Please give us your preferred contact information (phone# or email address)_____

May we leave a message? ☐Yes ☐No

**INSURANCE INFORMATION** *(Make sure you are using your current ID card)*

Insurance Company/Health Plan Name: _____

Member/Insured Name: _____ Member/Insured Insurance ID #: _____

Coverage is:□ Individual Plan □ Group Plan - Employer Name: _____

| **PATIENT INFORMATION** | |
|---|---|
| Name: | DOB: |

| **PROVIDER INFORMATION** | |
|---|---|
| Name: | |
| Address: (Street, City, State, Zip) | |
| Clinical Contact Person: | Preferred Contact Information: |
| Billing Contact Person: | Preferred Contact Information: |

| **SERVICE REQUESTED** | |
|---|---|
| □ Inpatient<br>□ Residential Treatment<br>□ Partial Hospitalization<br>□ Intensive Outpatient | Diagnosis:<br><br>Planned Dates of Treatment/Confinement/ Estimated Number of Sessions Being Requested: |

**BENEFIT AND PROVIDER INFORMATION**

- Are there local facilities that are in network that can provide the treatment I need?
- What are my benefits?
- Do I have out of network benefits on my plan?
- If the facility I want to use is out of network, is it licensed and eligible for reimbursement under my plan?
- Will the out of network facility handle pre-authorization and concurrent RQJRLQJ review requests for me?
- I don't know what level of care my family member needs. Is there a clinician I can talk to at the insurer for help?

## TREATMENT INFORMATION

Is the member in crisis/imminent danger?

Is the member currently getting treatment? If yes:

- Type of treatment _____
- How frequently_____
- Who is the provider? Name_____Phone Number_____
- Is the provider willing to discuss the treatment with the insurance company?

Has the member had any recent behavioral health evaluations? If yes:

- Who is the provider? Name_____Phone Number_____
- Is the provider willing to discuss the treatment with the insurance company?

Is the patient currently using substances? ☐Yes ☐ No

What substances _____

How much and how often_____

Is the member disoriented, confused, or has there been a change in behavior?_____

For eating disorders, how much does the patient weigh? _____

## CLINICAL INFORMATION (ask the provider to complete for you)

DX (DSM-5 code)

Reason for Treatment/Presenting Symptoms (specify physical and/or functional impairments)_____

_____

_____

Relevant History (personal resources, mental health treatment history, relevant new information): _____

_____

_____

Medications, prescribed by: ☐PCP ☐PMHNP/APRN ☐Psychiatrist

Previous (dosage & length of time on medication) _____

Current (dosage & length of time on medication) _____

| Treatment Goals (behaviorally defined): | Progress made toward each goal: |
|---|---|
| | |

Termination Criteria (observable, measurable, and related to symptoms):

Estimated Number of Sessions to Termination of Current Episode of Treatment:

Additional Information:

Provider Name: (please print)

| Provider Credentials: | NPI | TIN# |
|---|---|---|
| Provider Signature: | Telephone Number (  ) | Date: |

## AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

## I UNDERSTAND THIS AUTHORIZATION IS VOLUNTARY

I hereby authorize _____ to disclose PHI concerning the identified patient.
(provider name)

The purpose of this authorization is to permit disclosure of any and all requests for PHI to be used for utilization review, grievances and appeals, case/care management, and claim processing. The PHI may be pertaining to diagnosis and treatment information for behavioral health conditions, substance abuse, eating disorders, or other acute or chronic diseases.

The following is the type of information to be provided:

☐ Medical Records

☐ Treatment Plans

The following entity or person is authorized to receive the PHI:

Name:_____ Company Name:_____

This authorization expires:_____
(enter date)

If no date is provided, this authorization will expire one year from the date of the signature authorizing the release of PHI.

Person authorizing the release of PHI:

Relationship to Patient: ☐Self ☐Parent/Legal Guardian ☐Legal Representative

If the authorization is being submitted by other than the Patient, the insurer may require you to submit verification of your authority to act as a representative for the Patient.

_____ Date:_____
Signature of person authorizing release of PHI

Please Print Name: _____

Member or Authorized Representative Signature:_____ Date:_____

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Connecticut Insurance Department

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