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Comment On: EBSA-2009-0010-0409
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Submitter Information

Address: United States,

General Comment

Dear department:
RE: Mental Health Parity Act / Insurance PREAUTHORIZATION Requirements

I would like to share a recent situation concerning mental health benefits. I am a clinical psychologist and am licensed in the state of Illinois.

Attachments

EBSA-2009-0010-DRAFT-0554.1: Comment on FR Doc # 2010-2167

Dear department:

RE: Mental Health Parity Act / Insurance PREAUTHORIZATION Requirements

I would like to share a recent situation concerning mental health benefits. I am a clinical psychologist and am licensed in the state of Illinois.

On Friday, February 26, 2010 a new patient came into the office for a 5:00 p.m. appointment (after insurance business hours) for an initial diagnostic session. This patient has health insurance with United Healthcare. The behavioral health benefits are handled through United Behavioral Health. It is a PPO plan with an effective date of January 1, 2010. I am not contracted with United Behavioral Health so this patients benefits are processed as "Out of Network".

The insurance company was called the next business day (Monday, March 1, 2010) since they were already closed at the time of the office visit. I was given benefit & eligibility information and was also told that this patient's policy requires preauthorization for services. I explained the situation and requested that the preauthorization date be effective on February 26, 2010, however, I was told firmly that preauthorization for services cannot be backdated. I was given a preauthorization for service beginning March 1, 2010. This preauthorization is for (10) sessions. I was also told that I must complete & submit a Treatment Request form prior to using all (10) sessions. Also, I must submit this form to United Behavioral Health on a continual basis as each subsequent preauthorization expires. My patient is currently being treated by me on a weekly basis.

Recently I received an explanation of benefits for the February 26th claim. This claim was in fact denied indicating that "no notification was received for this service; therefore, benefits are not available".

I contacted the claims department regarding the denial. I questioned whether a medical office visit also requires preauthorization. I was told "no". I then asked if this policy was exempt from the parity law & was told that it was not exempt. I indicated that according to my understanding of the parity law that it prohibits a health insurance plan from applying any financial requirement or treatment limitation to mental health or substance use disorder benefits that is more restrictive than the financial requirement or treatment limitation applied to all medical/surgical benefits in the same classification. Also that treatment limitations include both quantitative and nonquantitative. I further stated that nonquantitative limitations include medical management (such as preauthorization, concurrent review, retrospective review, case management and utilization review) and that the parity regulations further state that "Any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in a classification must be comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical surgical/benefits in the classification".

The claims representative replied by saying that the parity law does not specifically state that requiring preauthorization is a violation & that the claim was processed correctly. As it stands, the patient has been denied benefits for this claim & is 100% responsible for the charge.

Within recent months I have seen changes in the handling of mental health benefits and claims. A number of insurance companies appear to be using methods to deny payment for claims. They have basically turned PPO policies into managed healthcare plans by requiring continual management of treatment & stringent guidelines. In previous years these insurance companies were somewhat more flexible with preauthorization dates. Most now will not backdate a preauthorization for even (1) day. Many patients are unaware that their plan may require preauthorization for an office visit with a behavioral health provider.

These nonquantitative limitations are not applied to the medical/surgical benefits. This is unfair to patients and behavioral health providers. Furthermore, healthcare management is not billable by behavioral health providers; however, medical providers are reimbursed by billing E&M (evaluation and management) codes. The Health Parity Act should clearly prohibit these nonquantitative treatment limitations by including specific language in the act. Insurance companies are otherwise left with potential loopholes to deny benefits.