ACCESSING CARE AND TREATMENT

Navigating Behavioral Health and Substance Use Disorder Care Through Your Health Insurance Plan

What you need to know about seeking approval for behavioral health or substance use disorder services.

State of Illinois
Illinois Department of Insurance

877-527-9431
www.insurance.illinois.gov

866-311-1119
https://getcovered.illinois.gov
Welcome to the Illinois Department of Insurance Consumer Guide. This booklet is designed to help you understand your rights regarding mental health and substance use disorder treatment and to help you navigate your health insurance plan when you are seeking care.

We have provided a glossary of terms that health insurers and providers use to help you through this process. Refer to the checklist (after page 6) for tips and important questions to ask your health insurer and your provider; knowing these answers will help if you receive a denial from your insurance carrier.

If you think you are experiencing a medical emergency, call your doctor or 911 immediately. This guide is for information purposes and is not designed to facilitate medical emergencies.

Make Informed Decisions
Learn the laws that protect you when you or your family member are seeking mental health and substance use disorder treatment. Your family doctor (or PCP) can be a good resource.

Research First
Contact your health insurer for assistance.
Ask your insurance company which doctors are “in-network,” Know what your benefits are for in or out of network doctors.

Understand Your Health Insurance Plan
It is important to know what types of care will need pre-authorization from your insurance company. Pre-authorization means that the insurance company must approve the service PRIOR to care.

Mental Health & Substance Use Disorder Parity
Mental health and substance use disorder (MH/SUD) treatment benefits are protected by federal and state parity laws (sometimes called MHPAEA). Parity is a law that mandates that your insurance company must provide an equal level of coverage for mental health and substance use disorder conditions as it does for medical and surgical conditions. Financial requirements like copayments, deductible, treatment limitations, out of network benefits and medical necessity determinations all must be equal for mental health and substance use disorders as they are for medical and surgical.

Appeal Denials for Service or Claim Payment
You have the right, to have an External Review, under specific circumstances. You can request the review of the denial, reduction, termination or failure to make payment, in whole or in part, under the health carrier’s health benefit plan.
Make Informed Decisions

The Illinois Department of Insurance wants to be sure you have the information you need to make informed decisions about behavioral health and substance use disorder care. This Toolkit is designed to help you.

Important Tips for Consumers

Begin the process by asking your primary doctor (PCP) to recommend other providers within the health plan’s network. Take notes, ask questions about the doctors that are being recommended.

- Research the providers in your area. Ask your health insurer which ones are in-network and which are out of network.
- Consider using a network provider. It provides the most consumer protection and it costs less for you.
- When possible, have services approved before you seek care (pre-authorized). It is more difficult to receive approval after care or treatment. Ask the person’s name every time you call. Make a note of the person’s name and the date and time of each call.
- Understand your rights around Mental Health and Substance Use Disorder Parity so that you know what steps to take if services or bills are denied.

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 Illinois Department of Insurance. Check with your employer to obtain specific information that pertains to your plan. If you have Illinois Medicaid contact your managed care organization directly.

Glossary of Important Terms

- **Allowed Amount** – Maximum amount a health insurer will pay for covered health services. The allowed amount is usually significantly lower than the billed charges.
- **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** – The amount you pay for a covered health care service. The amount can vary by the type of service (for example you may pay $20.00 for an office visit).
- **Cost Share** – 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, health care practitioners 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** – The facilities, health care practitioners and suppliers who do not 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.
- **Provider** – A physician licensed to practice medicine in all its branches, licensed clinical psychologist, licensed clinical social worker, licensed clinical professional counselor, licensed marriage and family therapist, licensed speech language pathologist, or other licensed or certified professional at a program licensed under the Illinois Alcoholism and Other Drug Abuse and Dependency Act.
- **Parity** – A law that mandates that your insurance company must provide an equal level of coverage for mental health and substance use disorder conditions as it does for medical and surgical conditions. Financial requirements like copayments, deductible, treatment limitations, out of network benefits and medical necessity determinations all must be equal for mental health and substance use disorders as they are for medical and surgical. More information can be found on page 5.
Whenever possible, contact your insurance carrier prior to needing care. Ask your insurance carrier what percentage does your plan cover for in-network compared to out of network providers and facilities.

**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 and can ask for 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 balance billed for the remaining provider charges after the health insurer pays its portion, resulting in greater out-of-pocket costs than anticipated.

**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.

**Can There Be 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 rates if you receive approval from your health insurer for an exception that states benefits will be paid at no greater out-of-pocket expense than had an in-network provider been used.
- In order to receive approval for an exception, you must prove that there are no in-network providers that can provide these services and your health insurer must agree.

**The Managed Care Act in Illinois**
- When the type of specialist physician or other health care provider needed to provide ongoing care for a specific condition is not represented in the health care plan’s provider network, the PCP shall arrange for the enrollee to have access to a qualified non-participating health care provider within a reasonable distance and travel time at no additional cost beyond what the enrollee would otherwise pay for services received within the network.
- The referring physician shall notify the plan when a referral is made outside the network.
Understanding Your Health Insurance Plan

It is important to know what is covered under your health insurance plan. The policy is a contract between you and your insurance company. Know what’s covered, what’s excluded and what the deductibles are. Call your health insurer to verify treatment benefits that are 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. The insurance carrier’s customer service department is also a good resource for information. Write down information about your telephone and in-person contacts, including the date, name and title of the person you spoke with and what was said.

Your insurance premium, is the dollar amount that you pay monthly to maintain insurance. The insurance premium payment is paid directly to the insurance carrier. If you have insurance through your employer there may be a portion of the premium deducted from your pay each week. Paying your premium monthly and on time is critical; when you miss a payment the insurance carrier has the right to terminate your plan all the way back to the month you first missed a payment, even if you have paid subsequent months or made partial payment.

Plan Features

- Do you have an HMO plan or a PPO plan?

It is important to know what type of plan you have or want to choose in the future. There are different types of health insurance plans designed to meet different needs. An Health Maintenance Organization (HMO) plan requires referrals from a Primary Care Physician to doctors who also contracted with the HMO. While a Preferred Provider Organization (PPO) offers some level of coverage for doctors that are outside of the preferred network. For information about other types of plans you can visit healthcare.gov, key word: plan types.

- How much will you have to pay at the time of service?

Copayments are due at the time of service. You can find the amount of your copay listed on your insurance card. An office visit copay is paid when visiting your Primary care physician also called a PCP. A specialist copay would apply when visiting a specialist like a surgeon, a dermatologist, psychiatrist, or ear/nose/throat doctor for example.

Coinsurance is typically billed to you, by the provider, after the insurance company has paid their portion. It’s also important to know how much your health plan’s deductible is and if prescription medicine is separate from your deductible or applied to your deductible.

Pre Authorization

- What services require pre-authorization under your plan?

Your policy or certificate of coverage will list the services that require prior authorization. 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. Your physician can provide the clinical background, treatment records and has the medical expertise to show the medical necessity of the requested services.
Mental Health & Substance Use Disorder Parity

Mental health and substance use disorder (MH/SUD) treatment benefits are protected by federal and state parity laws (sometimes called MHPAEA).

Illinois has had mental health parity insurance laws in effect for specified group health insurance policies HMO plans since 2011. In 2014 the ACA required that most individual and small employer health insurance plans include ten Essential Health Benefits, including mental health and substance use disorder services. These laws have been put in place to make sure that mental health and substance use disorder treatment is considered equal to the treatments of physical conditions like, high blood pressure or diabetes (for example).

Parity means that your insurance company must provide an equal level of coverage for mental health and substance use disorder conditions as it does for medical and surgical conditions. Financial requirements like copayments, deductible, treatment limitations, out of network benefits and medical necessity determinations all must be equal for mental health and substance use disorders as they are for medical and surgical.

Benefits and Protections Under Illinois Insurance Laws & the ACA

Plans subject to Illinois laws and the ACA must contain two primary requirements:

- The policy must cover mental health benefits and substance use disorder benefits;
- The policy cannot establish any terms, conditions or benefits that place a greater financial burden on an individual to obtain mental health benefits than for diagnosis and treatment of medical benefits.

Examples of Treatment Limitations

MHPAEA requires that insurers meet mental health parity standards in two areas, quantitative limits and non-quantitative limits as they relate to benefit design and treatment limitations.

The requirements for non-quantitative treatment limits (NQTLs) are different than those for financial and quantitative limits. Plans and issuers may not apply NQTLs on MH/SUD benefits more stringently than on medical/surgical benefits. NQTLs are defined as “limits on the scope or duration of treatment that are not expressed numerically (such as medical management techniques like prior authorization, network adequacy, facility-type limits, provider reimbursement rates, tiered networks and scope or duration of benefits for services). For example, a plan or issuer may not require preauthorization for mental health outpatient services if it does not require a pre-authorization for outpatient medical/surgical services.

Policy provisions that are subject to these standards include:

a) Medical management standards
b) Formulary design for prescriptions drugs;
c) Standards for provider admission to participate in network,
d) Plan methods used to determine usual, customary, and reasonable fee charges
e) Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols);
f) Exclusions based on failure to complete a course of treatment;
g) Network tier design
You have the right, to have an External Review, under specific circumstances. Review for the denial, reduction, termination or failure to make payment, in whole or in part, under the health carrier’s health benefit plan on the basis that:

- The request for benefits does not meet the health carrier’s requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of the health care service; or
- The health carrier considers the drug, procedure or therapy to be experimental and/or investigational; or
- The health carrier has determined that the request for benefit involves a pre-existing health condition; or
- The health carrier has rescinded coverage due to a reason other than failure to timely pay required premiums or contributions towards the cost of coverage.

Appealing Denials for Services or Claim Payment

- When a health insurer sends you a pre-authorization denial notice, they must also notify you of your rights to appeal the decision.
- Appeal rights are outlined in detail in the health insurer’s denial letter.
- Document your phone calls by noting the name of the person you speak to, the date of the call and a brief summary of the conversation. Keep copies of all written communications.
- If you are not satisfied with the results you receive, contact the Department of Insurance for assistance. Insurance analysts are available to answer general questions by phone at our toll-free Consumer Assistance Hotline (866) 445-5364. However, complaints MUST be submitted in writing.

For Assistance

You have resources available to you through the Illinois Department of Insurance. When you submit a complaint, the following occurs:

- When your complaint is received, a file number will be assigned and you will be sent written notification of that number.
- A copy of the complaint will be sent to the insurance company.
- Illinois law allows 21 days for an insurer or agent to respond to a complaint.
- When a response to complaint is received from the company or producer, an analyst will review the complaint and response.
- If the complaint has been resolved, the complaint will be closed and you will be sent a letter.

There are several potential actions based on the nature of the complaint, the urgency and the response from the insurer. At this point you would be notified of next steps whether it be the resolution or potential for external review. Visit the page below for a complete guide.

CONSUMER TOOLKIT

BEHAVIORAL HEALTH & SUBSTANCE USE DISORDER CARE

CHECKLIST of INFORMATION
Illinois Department of Insurance  
BEHAVIORAL HEALTH & SUBSTANCE USE DISORDER 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 the 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 or substance use disorder 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  □ Residential Treatment  □ Residential/Inpatient
- □ Withdrawal Management  □ Partial Hospitalization  □ Intensive Outpatient  □ Outpatient

Diagnosis: ____________________________

Planned Dates of Treatment/Confinement/ Estimated Number of Sessions 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 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 or substance use disorder screenings/assessments? 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 or substance use disorder 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) ____________________________

Substance Use Disorder, Division of Alcoholism and Substance Abuse (DASA) Treatment License Number (if applicable): ____________________________

Provider Credentials: NPI Name ____________________________

Provider Signature: ____________________________

Telephone Number ( ) ____________________________ Date: ____________________________
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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 use disorders, 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 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: ____________________________
# Insurance Communication Log

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