***For Use During 2019***
***MODEL DATA REQUEST FORM*** ***08/05/19***

## *An Employer Tool for Improving Network Access for Mental Health and Substance Use Disorders* (MH/SUD)

## *A Recommendation by the NATIONAL ALLIANCE OF HEALTHCARE PURCHASER COALITIONS*

In response to employers' calls for improving network access for mental health and substance use disorders, the Mental Health Treatment and Research Institute LLC ("MHTARI"), a not-for-profit subsidiary of The Bowman Family Foundation, has funded the development of the Model Data Request Form ("MDRF") for use by self-insured employers. The MDRF provides instructions and data requests that employers can send to their TPAs (or consultants) to obtain meaningful data reporting, set forth in a specified format. This document may be updated from time to time. A current version of this MDRF can be found at http://www.mhtari.org/Model_Data_Request_Form.pdf

Using the MDRF, employers can have their TPAs report on 4 key parameters as recommended by the National Alliance of Healthcare Purchaser Coalitions and the American Psychiatric Association Foundation Center for Workplace Mental Health :

**(1) Out-of-Network Use** for MH/SUD versus medical/surgical services.

**(2) Reimbursement Rates** for MH/SUD and medical/surgical providers, for similar services.

**(3) Denial Rates** for MH/SUD versus medical/surgical services.

**(4) Network Directory Accuracy for Psychiatrists**, as indicated by the percentage of listed providers who treat few or no patients on an in-network basis.

The MDRF is intended to allow employers to (a) better understand the experience of their employees when seeking to access MH/SUD treatment as compared to medical/surgical treatment, (b) assess the adequacy and accuracy of their TPA's MH/SUD provider networks, and (c) request improvements as deemed necessary.

**DISCLAIMER - No Legal Advice: The MDRF is made available for informational purposes only and is not intended and should not be construed as providing legal advice. Each situation is highly fact specific. Therefore, each employer or other user ("User") of the MDRF should carefully consider: (1) whether the MDRF would achieve its intended purpose and (2) whether modifications to the MDRF are needed, for example, to address the User's specific circumstances. MHTARI disclaims any and all representations and warranties, express or implied, regarding the MDRF, including without limitation, the ability of the MDRF to achieve its intended purpose.**

The MDRF begins on the following page. After reviewing the **DISCLAIMER,** employers may send the MDRF (with appropriate modifications, if any) to their TPAs or consultants. Employers should indicate whether they want each data analysis conducted for one or more markets/ regions (separately), for all markets/regions (aggregated), or both.

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## *An Employer Tool for Improving Network Access for Mental Health and Substance Use Disorders* (MH/SUD)

## *A Recommendation by the NATIONAL ALLIANCE OF HEALTHCARE PURCHASER COALITIONS*

**MODEL DATA REQUEST FORM BEGINS HERE.**

[To TPA or consultant]:

Please provide the plan data analyses set forth below. This information will allow our executives to better understand the experience of our plan members when seeking to access mental health/substance use disorder ("MH/SUD") treatment as compared to medical/surgical ("M/S") treatment. For each of the four (4) sections set forth below, please provide the data analyses for one or more markets/regions (separately), for all markets/regions (aggregated), or both, as we will specify in separate correspondence.

The analyses should include the underlying data used in each calculation such that each calculation could be readily audited by an actuary (e.g., number of claims or denials, enrollment, etc.). Please provide all information in a manner compliant with HIPAA's Privacy Rule (45 CFR Part 164) and Confidentiality of Substance Use Disorder Records (42 CFR Part 2), as applicable.

### ***SECTION I - OUT-OF-NETWORK USE:***

For our plans that offer coverage for both In and Out-of-Network providers, utilizing total claims submitted for both In-Network and Out-of-Network services, provide a report for the aggregate of such plans with respect to the percentage of all claims submitted for Out-of-Network services. The report should be based on the number of claims submitted for patient admissions or visits for both MH/SUD and M/S, with separate information for inpatient facility, outpatient facility and office visits. *The analysis should be for Calendar Year 2018, or for the period January 1, 2018, through the latest month in 2018 for which reasonably complete claims data is available*. For purposes of this report:

*Inpatient facility* is defined as a hospital, non-hospital based facility or residential treatment facility and encompasses all medical and surgical admissions to general acute care hospitals, long-term acute care hospitals, inpatient rehabilitation facilities and skilled nursing facilities; all MH/SUD admissions to psychiatric hospitals, general acute care hospitals, non-hospital based inpatient facilities and residential treatment facilities.

*Outpatient facility* is defined as physical, occupational, speech, and cardiovascular therapy, surgeries, radiology, pathology and pharmacy services for medical or surgical care provided in an outpatient facility setting; intensive outpatient and partial hospitalization services for behavioral health conditions in an outpatient facility setting.

*Office visit* is defined as a non-facility based medical/surgical or MH/SUD office visit.

Please refer to the following Milliman report for further definitions regarding Out-of-Network analyses: http://www.milliman.com/uploadedFiles/insight/2017/NQTLDisparityAnalysis.pdf

Report on the Out-of-Network use as follows:

| | **Plan Data for January 1, 2018 through ______________** | | |
|---|---|---|---|
| **Setting** | **% OON claims submitted for Medical /Surgical Services** | **% OON claims submitted for MH/SUD Services** | **Action Plan to address level of disparity if absolute difference is greater than 5 percentage points** |
| Inpatient Facility Stays | | | |
| Outpatient Facility Visits | | | |
| Office Visits | | | |

If the absolute difference of Out-of-Network use for inpatient facility, outpatient facility or office visits, between M/S services as compared to MH/SUD services, is more than 5 percentage points, with the percentage for MH/SUD being higher, (e.g., M/S 2.0% versus MH/SUD 7.1%; or M/S 11.0% versus MH/SUD 16.1%), please provide a plan of improvement.

**END OF SECTION I. SECTION II BEGINS ON NEXT PAGE.**

## *SECTION II - REIMBURSEMENT RATES*:

For In-Network provider office visits only, for the four (4) CPT codes listed in the table provided below, and using the methodology described in the "Instructions for completing cells marked (a) through (g) of the table", please calculate for our plans the weighted average allowed amounts for the following four (4) groups of providers:

- *Primary Care Physicians, "PCPs",* defined as general practice, family practice, internal medicine, and pediatric medicine physicians.
- *Non-psychiatrist Medical/Surgical Specialist Physicians*, defined to include non-psychiatrist specialty physicians, such as orthopedic surgeons, dermatologists, neurologists, etc. This category excludes PCPs.
- *Psychiatrists*, including child psychiatrists.
- *Non-psychiatrist Behavioral Health ("BH") Professionals*, defined as psychologists and clinical social workers.

Complete a separate table for each of our plan types (PPO, POS and HMO, as applicable), as well as a table for the aggregate of all our plans. *The tables should include claims data for Calendar Year 2018, or for the period January 1, 2018, through the latest month in 2018 for which reasonably complete claims data is available.*

There is only one National Medicare Physician Fee Schedule allowed amount for all physicians participating in Medicare for the following four (4) codes for which data is requested: *99213, 99214, 90834 and 90837.* The fee schedule allowed amounts for 2018 for non-facility based services have been provided in the template table that follows.[1] National Medicare fee adjustments are sometimes made for non-physician providers. In this regard, the adjusted fee schedule allowed amount for clinical social workers has been provided in the template table below. Provider locality adjustments have not been taken into account for regional markets, as the testing herein is comparative, rather than absolute, and will thus yield useful allowed amount comparative information irrespective of region.

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[1] These amounts can be found at: **https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PFSlookup/** Click on **Medicare Physician Fee Schedule Look-up Tool**, click on "Start search," accept license for use, select the last complete calendar year, select "Pricing information," select "list of HCPCS codes," select "National payment amount," enter each of the four codes, select "All modifiers," and submit**. Please utilize the "Non-facility Price" column.** Also refer to the one page "Medicare Physician Fee Schedule (MPFS) Quick Reference Search Guide" for a step-by-step summary of how to use the MPFS. Also refer to "Medicare Claims Processing Manual," Chapter 12, "Physicians/ Nonphysician Practitioners" to verify any adjustments to the MPFS, at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf

| Plan Data for January 1, 2018 through ___________ | | | | | | | |
|---|---|---|---|---|---|---|---|
| | **Description** | **Col. A** | **Col. B** | **Col. C** | **Col. D** | **Col. E** | |
| | **In-Network Office Visits only (non-facility based)** | **CPT 99213** | **CPT 99214** | **CPT 90834** | **CPT 90837** | **Provider allowed amounts relative to National Medicare Fee Schedule Amounts, expressed as a percentage** | |
| 1 | Plan data: Weighted average allowed amount for primary care physicians ("PCPs") and non-psychiatrist medical/surgical specialist physicians (combined) | (a) | (a) | Data not required | Data not required | (b) 99213 | (c) 99214 |
| 2 | Plan data: Weighted average allowed amount for PCPs | (a) | (a) | Data not required | Data not required | Data not required | Data not required |
| 3 | Plan data: Weighted average allowed amount for non-PCP, non-psychiatrist medical/surgical specialist physicians | (a) | (a) | Data not required | Data not required | Data not required | Data not required |
| 4 | Plan data: Weighted average allowed amount for psychiatrists | (a) | (a) | Data not required | Data not required | Data not required | Data not required |
| 5a | Plan data: Weighted average allowed amount for psychologists | N/A | N/A | (a) | (a) | (d) 90834 | (e) 90837 |
| 5b | Plan data: Weighted average allowed amount for clinical social workers | N/A | N/A | (a) | (a) | (f) 90834 | (g) 90837 |
| 6 | National Medicare Fee Schedule allowed amount for participating physicians in Row 1 | $74.16 | $109.44 | Data not required | Data not required | | |
| 7a | National Medicare Fee Schedule allowed amount for participating psychologists | N/A | N/A | $88.56 | $132.84 | | |
| 7b | National Medicare Fee Schedule allowed amount for participating clinical social workers | N/A | N/A | $66.42 | $99.63 | | |

Instructions for completing cells marked (a) through (g) of this table follow:

- Cells marked "(a)" = Insert the weighted average allowed amount, (weighted by the proportion of claim payments made at each allowed amount level). This will provide the same result as calculating the sum of the allowed amounts for every claim paid to these providers, and dividing that sum by the total number of claims paid to such providers.
- Cell marked "(b)" = Insert the percentage calculated as: (Row 1 Column A / Row 6 Column A) x 100.

  *Example 1*: If the amount in Row 1 Column A is $80.09, and the amount in Row 6 Column A is $74.16, then the percentage is (80.09 / 74.16) x 100 = 108%.
  *Example 2*: If the amount in Row 1 Column A is $71.19, and the amount in Row 6 Column A is $74.16, then the percentage is (71.19 / 74.16) x 100 = 96%.
- Cell marked "(c)" = Insert the percentage calculated as: (Row 1 Column B / Row 6 Column B) x 100.
- Cell marked "(d)" = Insert the percentage calculated as: (Row 5a Column C / Row 7a Column C) x 100.
- Cell marked "(e)" = Insert the percentage calculated as: (Row 5a Column D / Row 7a Column D) x 100.
- Cell marked "(f)" = Insert the percentage calculated as: (Row 5b Column C / Row 7b Column C) x 100.
- Cell marked "(g)" = Insert the percentage calculated as: (Row 5b Column D / Row 7b Column D) x 100.

Comparisons to be conducted:

1. Compare the allowed amounts for "PCPs and non-psychiatrist medical/surgical specialist physicians (combined)" in Row 1 Column A and in Row 1 Column B, respectively, versus the allowed amounts to psychiatrists in Row 4 Column A and in Row 4 Column B, respectively.

   If there is any difference whatsoever between the allowed amount level for either CPT code 99213 or 99214, with "PCPs and non-psychiatrist medical/surgical specialists (combined)" given a higher allowed amount than psychiatrists, please provide an explanation for the disparity and a plan of correction.
2. If the Code 99213 percentage figure for "PCPs and non-psychiatrist medical/surgical specialist physicians (combined)" in Row 1 Column E is higher than the Code 90834 percentage figure for either psychologists in Row 5a Column E or for clinical social workers in Row 5b Column E, please provide an explanation for the disparity(ies) and a plan of correction.

   If the Code 99214 percentage figure for "PCPs and non-psychiatrist medical/ surgical specialist physicians (combined)" in Row 1 Column E is higher than the Code 90837 percentage figure for either psychologists in Row 5a Column E or for clinical social workers in Row 5b Column E, please provide an explanation for the disparity(ies) and a plan of correction.

**END OF SECTION II. SECTION III BEGINS ON NEXT PAGE.** →

***SECTION III - DENIAL RATES:*** For our plans for Calendar Year 2018, or for the period January 1, 2018, through the latest month in 2018 for which reasonably complete denial data is available, provide a breakdown of In-Network and Out-of-Network denials for MH/SUD and for M/S services. A **denial** is defined as a refusal to pay or reimburse for any or all parts of a service requested or performed in any of the following 3 settings: (1) inpatient facility; (2) outpatient facility; and (3) office visits, as those settings are defined in **Section I** entitled **Out-of-Network Use.**

Any "modified" authorizations, i.e., for lower-cost services than requested by the provider, are to be considered a denial.

Any "partial denials" i.e., number of days or visits approved are less than what the provider requested, are to be considered a denial unless subsequently approved on concurrent or retrospective review of the full requested amount.

Denials should be reported separately for (1) lack of medical necessity reasons and (2) any administrative reasons.

Please provide information on the number of denials and percent of denials for MH/SUD services compared to M/S services as follows:

**(A) Denials for which no claim was submitted** (i.e., authorization for coverage of service denied; service either not delivered or self-pay), shown as a percentage (%):

(1) *Numerator:* Pre-authorization and concurrent review denials based on *lack of medical necessity* for services requested in the particular setting noted.
*Denominator*: All pre-authorization and concurrent reviews conducted for the particular setting noted.

(2) *Numerator*: Pre-authorization and concurrent review denials based on *administrative reasons* for services requested in the particular setting noted.
*Denominator*: All pre-authorization and concurrent reviews conducted for the particular setting noted.

**(B) Claim denials** (i.e., authorization for coverage of service denied; service delivered; claim submitted and not paid), shown as a percentage (%) (counted as one denial for each unique claim, not counting denials on resubmissions of the same claim):

(1) *Numerator*: Claims denied for *lack of medical necessity*, including upon pre-authorization, concurrent review and retrospective review in the particular setting noted. *Denominator*: Total claims submitted for the particular setting noted.

(2) *Numerator*: Claims denied for *administrative reasons*, including upon pre-authorization, concurrent review and retrospective review in the particular setting noted. *Denominator:* Total claims submitted for the particular setting noted.

Insert percentages in the two tables below. Complete a pair of tables for each of our plan types (PPO, POS, and HMO, as applicable), as well as a pair of tables for the aggregate of all

our plans, for In-network treatment. Separately, prepare the same pair of tables for the aggregate of all our plans, for Out-of-network treatment.

| **Denials for which no claim submitted**<br>**Percentages** | | | | |
|---|---|---|---|---|
| **Plan Data for January 1, 2018 through _____________** | | | | |
| **Setting** | **Medical Necessity** | | **Administrative** | |
| | **Med/Surg** | **MH/SUD** | **Med/Surg** | **MH/SUD** |
| Inpatient Facility Stays | | | | |
| Outpatient Facility Visits | | | | |
| Office Visits | | | | |

| **Claim Denials**<br>**Percentages** | | | | |
|---|---|---|---|---|
| **Plan Data for January 1, 2018 through _______________** | | | | |
| **Setting** | **Medical Necessity** | | **Administrative** | |
| | **Med/Surg** | **MH/SUD** | **Med/Surg** | **MH/SUD** |
| Inpatient Facility Stays | | | | |
| Outpatient Facility Visits | | | | |
| Office Visits | | | | |

If there is a disparity in any category of denial rates for M/S compared to MH/SUD that is more than 5 percentage points (e.g., 10.0% denials for M/S versus 15.1% for MH/SUD; or 15.0% denials for M/S compared to 20.1% for MH/SUD), please provide a plan of improvement.

**END OF SECTION III. SECTION IV BEGINS ON NEXT PAGE.**

***SECTION IV – NETWORK DIRECTORY ACCURACY*:** Please provide the following information regarding your MH/SUD provider networks applicable to each of our plans in the table below, including inpatient facility, outpatient facility and office visit settings (combined):

| | **Description** | **Response** |
|---|---|---|
| 1 | Total number of psychiatrists (including child psychiatrists) who were listed as participating in your provider network during the **last month** of the most recent 6 months in Calendar Year 2018 for which reasonably complete claims data is available ("**Most Recent 6 Months in 2018**"): | |
| 2 | Number of psychiatrists (including child psychiatrists) who submitted zero in-network claims for any of your commercially insured beneficiaries during the Most Recent 6 Months in 2018: | |
| 3 | Number of psychiatrists (including child psychiatrists) who submitted in-network claims for 1 to 4 of your commercially insured beneficiaries (unique individuals) during the Most Recent 6 Months in 2018: | |
| 4 | Number of psychiatrists (including child psychiatrists) who submitted in-network claims for 5 or more of your commercially insured beneficiaries (unique individuals) during the Most Recent 6 Months in 2018: | |
| 5 | Please add the numbers in Rows 2 - 4, which should total the same number as entered in Row 1: | |
| 6 | Number of psychiatrists who are child psychiatrists: | |
| 7 | Total number of your commercially insured covered lives (unique individuals): | |
| 8 | Ratio of psychiatrists (including child psychiatrists) to commercial lives, indicated as 1:xxx (calculating xxx by dividing Row 7 by Row 1): | |
| 9 | What is your network adequacy standard, e.g., 1 psychiatrist for every xxx members, every yy miles (based on urban/suburban/rural): | |

If the number of psychiatrists (including child psychiatrists) who submitted zero claims (Row 2) added to the number of psychiatrists (including child psychiatrists) who submitted claims for 1 - 4 unique individuals (Row 3), constitutes more than 10% of the number of psychiatrists (including child psychiatrists) listed as participating in your provider network during the **last month** of the Most Recent 6 Months in 2018 (Row 1), please provide a plan of improvement.

**MODEL DATA REQUEST FORM ENDS HERE.**