

Resource Guide for Consumers

How to Access Mental Health and Substance Use Disorder Benefits

2020 Update



Franklin Pierce School of Law
Institute for Health Policy & Practice
Health Law & Policy

new**futures**→

Acknowledgements

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A Quick Guide on How to Access Mental Health and Substance Use Disorder Benefits

How Do I Get Treatment?

- Call 2-1-1 or visit www.thedoorway.nh.gov for help finding substance use disorder (often referred to as SUD) services.
- You should have an evaluation completed by a licensed professional. Call 2-1-1 or your health care provider for help getting the mental health or SUD treatment you need.
- **Be informed!** Call the number on the back of your insurance card for mental health or SUD services in order to find the right health care provider in your network.

If you or someone you know is at risk or in crisis, help is available 24/7.

Suicide Prevention Help

Call 1-800-273-TALK (8255)

Text 741741



Substance Use Disorder Help

Call 2-1-1



What Happens if I am Denied Treatment?

- Your health insurance plan may decide to not pay for your SUD or mental health treatment. This is called a “denial of coverage.” If this happens to you, get help and ask for an appeal.
- **Should I appeal? YES, and quickly!** Appeals are often successful! An appeal is where you (and your health care provider) dispute a decision by your health insurance plan to not pay for SUD or mental health treatment. There are no fees or costs to appeal!
- **Contact your provider or the NH Insurance Department at 1-800-852-3416 for help with your appeal.**
- **Call the number on the back of your insurance card for help with questions.**

Because of the new laws protecting access to SUD and mental health services, there is a good chance your health insurance plan will approve the services you need.

If you have questions about your health insurance and/or health insurance coverage for SUD or mental health services, call the NH Insurance Department Consumer Hotline at 1-800-852-3416 for assistance.

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Introduction

If you are experiencing a mental health or substance use disorder crisis, you are not alone. [Help is near you!](#) Once you get help, it's important to plan how you will afford the treatment and services you need by enrolling in health insurance. Health insurance can help pay for ongoing mental health and substance use disorder treatment so you can afford it. If you or your family feel overwhelmed – don't give up – this Guide can help!

Ask a friend, family member, or provider to help you use this Guide to make sense of your health insurance needs.

How do I use this Resource Guide?

This Guide provides a basic explanation of how to find treatment, enroll in insurance coverage, and make sure the treatment you need is covered and paid for. Almost all health insurance plans in New Hampshire include mental health and substance use disorder (often referred to as SUD) benefits. The term *health insurance* means a government or private health plan that covers mental health, substance use disorder, and medical care services.

This Guide will provide you with a better *understanding* of:

- What your health insurance means for you and your family;
- How to make sure your health insurance works for you and you get the recommended health services you need, including services for mental health and substance use disorders; and
- Who to contact if you need help with questions about health insurance.

Finding help near you!

Medical Emergency

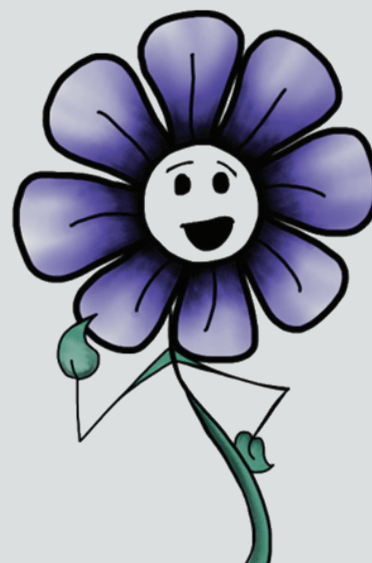
Call 9-1-1

Mental Health or SUD Crisis

Call 2-1-1

National Suicide Prevention Lifeline

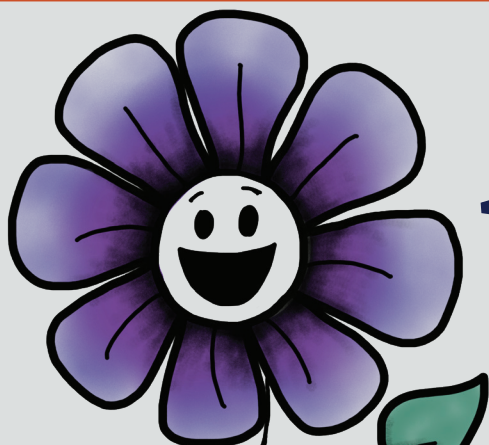
Call 1-800-273-TALK (8255)
or Text 741741



I am in crisis and need help for my SUD immediately. What do I do?

- If you are experiencing a medical emergency, call 9-1-1.
- If you are experiencing a mental health or SUD crisis, call 2-1-1 to connect with [The Doorway NH](#). A Doorway near you can help you access treatment and recovery services as well as other supports.
- The **National Suicide Prevention Lifeline** is available 24 hours a day to help, no matter what problems you are dealing with. Call **1-800-273-TALK (8255)** or text **741741** to connect with a skilled, trained counselor at a crisis center in your area.
- Mental health crisis intervention services are available 24 hours a day by calling a local hospital or a [community mental health center \(CMHC\)](#) near you.
 - Concord, NH is home to a walk-in [Behavioral Health Crisis Treatment Center](#) for adults with an urgent mental health need. Call 1-844-743-5748 for more information.
- Reach out to a family member, friend, health care provider, or peer to help you through this crisis.

If you are already under the care of a primary care physician (PCP), let them know what you need and ask questions. If you do not have a PCP, your health insurance company's consumer services representative will be able to help you find one.



If you have health insurance, call the number on the back of your insurance card if you have questions or need help.

There are two numbers on the back of most insurance cards.

- One number should be for **Member Services**
- One number should be for **Mental Health and Substance Use Disorder Services**

You can call either number to ask for help.

INSURANCE COMPANY NAME

Group Number: XXXXX-XXX

PLAN TYPE

NAME: JANE DOE
ID NUMBER: XXX-XX-XXX

Copayments \$XX.XX

Deductibles XXX-XX-XXX

Coinurance XX%

EFFECTIVE DATE

PERSCRIPTION GROUP # XXXXX

MEMBER SERVICES: 800-123-4567

Why do I need health insurance?

A health care crisis can happen any time. Health insurance will protect you and your family from financial hardship when you need services, such as when you require treatment for mental health or SUD. The law also requires you to have health insurance. Health insurance covers doctor visits, mental health therapy, SUD treatment, hospital stays, prescriptions, prenatal care, reproductive health care, and more. By federal and state law, most health insurance must include mental health and SUD benefits.

How do I find and enroll in health insurance?

Here are a few ways to get help finding and enrolling in health insurance:

1. Visit **NH EASY** – the Gateway to Services at nheasy.nh.gov or call the New Hampshire Department of Health and Human Services (DHHS) Division of Client Services at **1-844-ASK-DHHS (1-844-275-3447)**. Tell them about your condition so you get the benefits you need.
2. Visit your local [ServiceLink office](#).
3. Visit a hospital, [health clinic](#), [family planning clinic](#), or [NH Doorway](#), and let them know you need help finding health insurance.
4. If you have a computer, you can find a [Consumer Assistance Counselor or insurance broker near you](#) and get help finding insurance.

Enrolling in Insurance Through Your Work: Employer Sponsored Coverage

Health insurance is usually available through your work if you are working full-time. This type of insurance is called “group coverage” or “employer sponsored insurance.” If you have questions about your work’s health insurance, talk to your supervisor or someone in Human Resources. Make sure you ask when the open-enrollment period is for your employer sponsored insurance.

Enrolling in the New Hampshire Marketplace Exchange

If you are not able to enroll in health insurance through work, you may be able to purchase insurance on the [New Hampshire Marketplace Exchange](#). [Open enrollment](#) usually starts on November 1 every year!

If you enroll in a New Hampshire Marketplace Exchange health insurance plan, you may qualify for a [premium tax credit](#) that lowers your monthly insurance “premium” bill and/or [cost-sharing subsidies](#) that provide extra savings on out-of-pocket costs like [deductibles](#) and [copayments](#).

For an explanation of what health insurance words and terms mean, please visit [NH HealthCost website](#).

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Premium tax credits are available if your income is below 400% of the Federal Poverty Level (about \$104,800 for a family of four in 2020). Cost-sharing subsidies are also available to reduce your out-of-pocket costs if your income is below 250% of the Federal Poverty Level (about \$65,500 for a family of four in 2020). [How much you pay for your health insurance plan will be based on the income estimate and household information](#) you put on your Marketplace application.

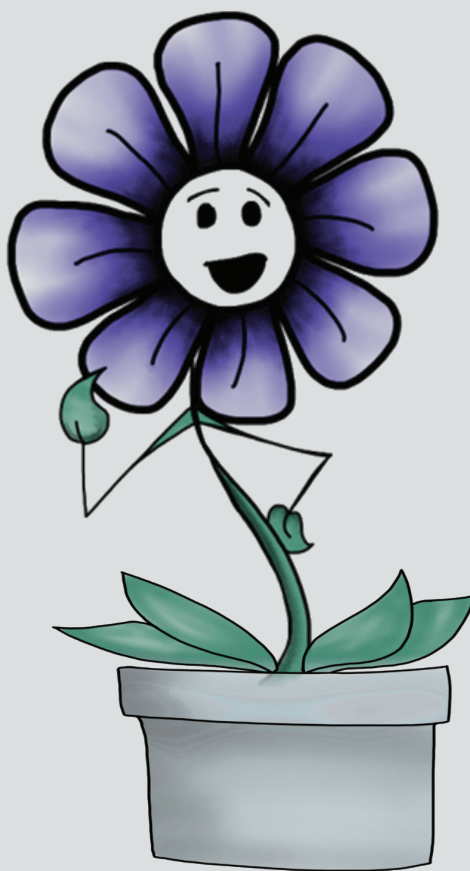
You can check with a broker or Consumer Assistance Counselors to find out if you are eligible for premium tax credits or cost sharing subsidies. To find local help with an agent/broker or assister, simply follow the instructions on localhelp.healthcare.gov.

Open Enrollment

Open Enrollment is when individuals may enroll in health insurance coverage or make changes to their existing coverage. Open Enrollment on the NH Insurance Marketplace Exchange usually begins on November 1 and ends on December 15, although this may change in the future so always check at healthcare.gov. Health insurance plans sold during the open enrollment period begin in January.

We all know health insurance can be complicated. Getting the right information makes all the difference in choosing the right health insurance for you and your family. Ask about how the offered plans are different and how much you might have to pay out-of-pocket for premiums, deductibles, and copayments.

You may need to have information about yourself and your income available when you sign up. It is helpful to have a family, friend, or Consumer Assistance Counselor help you, especially if you depend on certain health care services or prescriptions and want to be sure the health insurance you choose works best for you.





How do I get
assistance with
Medicaid?

[Visit NH EASY](#)

Enrolling in Insurance Through New Hampshire Medicaid Care Management and the Granite Advantage Program

NH Medicaid is a joint federal and state funded health care program that serves a wide range of individuals and families who meet certain eligibility requirements. If you and your family are eligible, NH Medicaid makes sure that you get treatment by enrolling you in a health insurance plan and paying for the health care you need. NH Medicaid also offers other assistance to individuals and families. This Guide explains NH Medicaid's health insurance plans. These health insurance plans are offered through its Medicaid Care Management (MCM) Program and include the Granite Advantage Program.

There are three organizations that offer health insurance as part of the MCM Program. If you enroll in the MCM Program, you will be able to pick one.

To find out whether you are eligible for a New Hampshire Medicaid health insurance plan, contact the [New Hampshire Department of Health and Human Services](#) at 1-844-ASK-DHHS (1-844-275-3447) or 603-271-4344. Or just apply through nheasy.nh.gov.

Medicaid Managed Care Organizations (MCOs):

[AmeriHealth Caritas New Hampshire](#)

Member Services

1-833-704-1177

1-855-534-6730 (TTY)



[NH Healthy Families](#)

Member Services

1-866-769-3085



[Well Sense Health Plan](#)

Member Services

1-877-957-1300

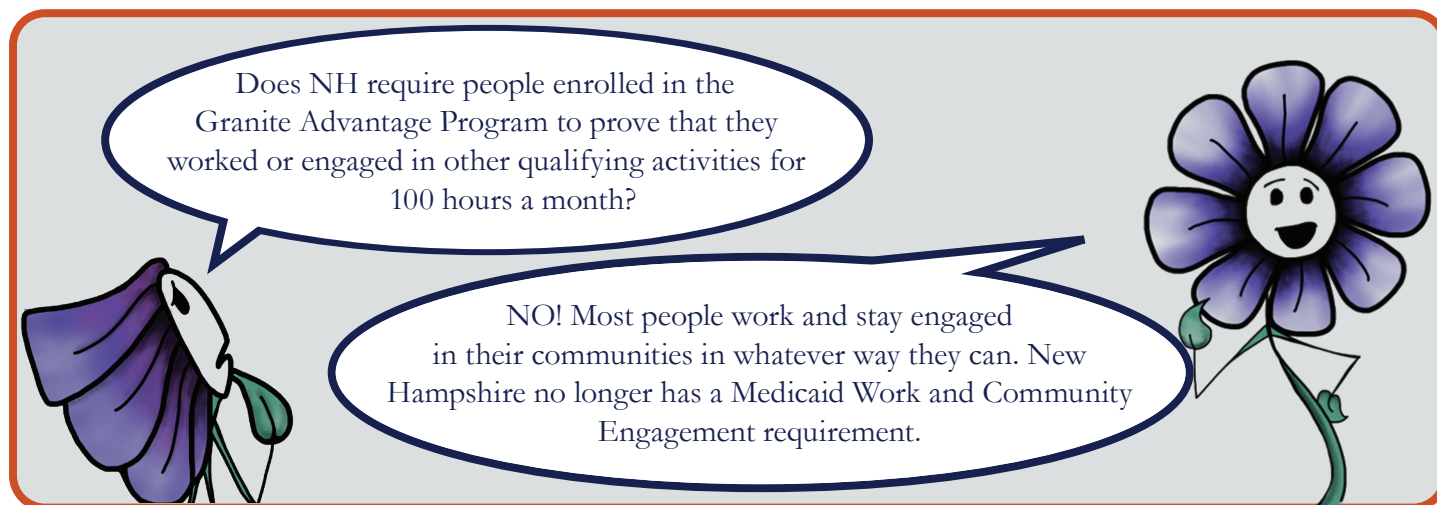


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Medicaid is available to people with low income levels. For example, adults ages 19 through 64 whose incomes fall at or below 138% of the federal poverty guidelines are eligible for health insurance coverage through [New Hampshire's Granite Advantage Program](#). Check with your health care provider and ask about the Granite Advantage Program and "[Presumptive Eligibility](#)." To find out your income level and eligibility, review the Federal Poverty Guidelines.

<u>Federal Poverty Guidelines for 2020</u>				
Persons in Household	Federal Poverty Guidelines for every U.S. State and D.C. except Hawaii and Alaska			
	100%	138%	250%	400%
1	\$12,760	\$17,609	\$31,900	\$51,040
2	\$17,240	\$23,791	\$43,100	\$68,960
3	\$21,720	\$29,974	\$54,300	\$86,880
4	\$26,200	\$36,156	\$65,500	\$104,800
5	\$30,680	\$42,338	\$76,700	\$122,720
6	\$35,160	\$48,521	\$87,900	\$140,640
7	\$39,640	\$54,703	\$99,100	\$158,560
8	\$44,120	\$60,886	\$110,300	\$176,480
(Add \$4,480 for each person over 8)				



Enrolling in Insurance Through Medicare

If you are 65 or older, or have a disability, you may be able to get Medicare. For more information on how to get Medicare, visit your local [ServiceLink](#). Pay attention to any notices you receive in the mail about enrolling in Medicare. The annual "open enrollment period" for Medicare plans is usually October 15 to December 7.

Refer to [NHCarePath](#) for more specific information on long term care options.

Accessing Veterans Affairs Benefits

If you have served in the United States Military, you may be eligible for services through the United States Department of Veterans Affairs (VA). The VA provides mental health and SUD treatment at its medical centers in Manchester and White River Junction, and at community-based outpatient clinics (CBOCs). The VA in Manchester has CBOCs in Conway, Portsmouth, Somersworth, and Tilton. The VA in White River Junction has centers in Littleton and Keene. Contact NH's Office of Veteran Services for more information about accessing services for NH Veterans at their [website](#) or call (603)-624-9230. The VA also has a **Veterans Crisis Line** (available to all Veterans regardless of enrollment status) through the National Suicide Prevention Hotline (call 1-800-273-TALK (8255)). Press 1 for Veterans and someone will answer right away. The [VA website](#) provides additional resources.

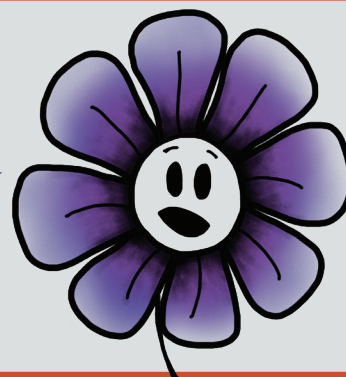
For questions about health insurance enrollment and/or coverage, you can also visit your local [ServiceLink](#). They have trained experts who understand veteran benefits.

How do I choose what health insurance is right for me?

There are four important things you *need* to think about when you choose health insurance.

1. Check that all your health care providers are in the network. (For example, your PCP could be in and therapist could be out.)
2. Check that your prescriptions are included on the prescription drug formulary (a list of drugs your insurance company will pay for).
3. Be aware of any out-of-pocket expenses that come with a plan, such as deductibles, copayments, and coinsurances. Visit [NH HealthCost Guide](#) to learn more.
4. Check which services are subject to the deductible.

It is important to find a health insurance plan that works for you and your family. For specific information on choosing a health insurance plan visit healthcare.gov.



Health insurance plans often require you to pay different amounts out of your own pocket. The terms defining these payment amounts can be complicated. These definitions may help you.

Copayment: This is the fixed amount that you must pay when you visit your provider or purchase a prescription. Copay amounts vary depending on your health insurance plan.

Deductible: The amount you must pay out-of-pocket before the insurance company will pay for your care. For example, if you visit the emergency room (ER) and your deductible is \$500, you must pay the \$500 deductible before your insurance company will cover any remaining charges associated with your emergency visit. You can always call the number on the back of your insurance card to find out your deductible.

Coinsurance as applied to medical services: This is where you pay for a percentage of the health care visit and the health insurance company pays the rest. It is calculated as a percentage of the amount of a service. You are responsible for paying the full amount of your coinsurance and your deductible. For example, if your plan allows for a \$100 health care checkup and you have paid your deductible, your coinsurance plan payment of 20 percent would be \$20. Your health insurance would pay the remaining \$80.

Coinsurance as applied to prescription drug plans: This is where you pay for a percentage of the actual cost of the medication and your health insurance company pays the rest. For example, if a prescription drug costs \$100 and the copay is \$10, the pharmacy would collect \$10. If the coinsurance is 20 percent, the pharmacy would collect \$20 from you.

Just Remember; Keep your health insurance updated! Make sure you notify your insurance plan with any changes in your address or information. Read any notices you receive from your health insurance and ask for help if you need it!

What if I need help and I can't find insurance quickly enough?

If you do not have health insurance and can't find it quickly enough, New Hampshire has health care providers, located at places such as health centers and family planning clinics, who will provide care to you at a reduced rate through a "sliding fee scale." Ask your health care provider about their charitable care policy. You may visit [Bi-StatePCA](#) or [Find a Health Center](#) to find your nearest health center.

You can call the New Hampshire Insurance Department at **1-800-852-3416** for help. If you are experiencing a crisis, call **9-1-1**, **2-1-1**, or the National Suicide Prevention Lifeline at **1-800-273-TALK (8255)**, or text **741741** for help.

How do I get treatment and services?

How do I choose what type of mental health or substance use disorder (SUD) treatment I need?

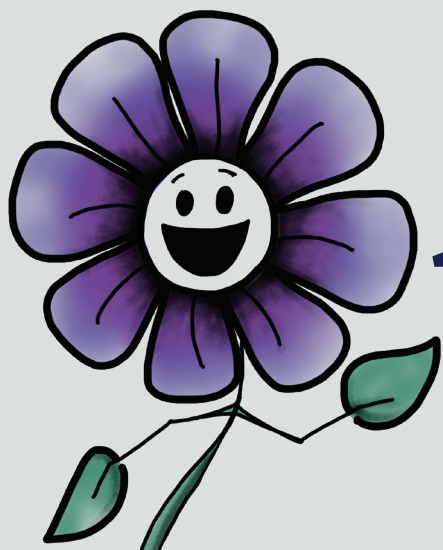
A health care provider is available to do an evaluation to assess what type of mental health, SUD or other services would be most helpful based on your needs.

Find a health care provider at:

- A NH Doorway, by calling 2-1-1 or going to the [website](#).
- Your primary care physician's office.
- Other places where treatment and services are available, such as community mental health centers, health centers, and mental health practices.

Your health care providers will ask you questions to find out more information about your needs. This is called an evaluation. Some questions are personal. The health care providers are there to help you, and the information you give will be kept confidential unless you agree to share it. The evaluation will help refer you to the right level of care. It is always important to talk with your health care provider about your options and contact your health insurance plan to make sure they are available.

If you are involved with the criminal justice system and have a SUD, contact your attorney or probation officer to ask about county drug courts and diversion programs. In some counties you may be able to access treatment as part of, or instead of, jail time. For more information about New Hampshire's drug or mental health court programs go to the court [website](#).



New Hampshire has an [Alcohol and Drug Treatment Locator](#) to help you find out more about SUD treatment options near you.

What if the health care provider I choose is not part of my health insurance network?

Ask your health insurance plan which health care providers are part of your plan network by calling the number on the back of your insurance card or visiting your health insurer's website. If a provider is in-network for mental health and SUD services, your health insurance plan will be able to pay the provider. Beware! If you receive services from an out-of-network provider, you may pay more of your own money for the services.

Sometimes it is hard to find a health care provider who can make time for you, especially for mental health or SUD services. If the *in-network* providers you need are full and can't take on new patients, call the number on the back of your health insurance card right away. Ask for a health care provider who can help you now! You may also be able to get permission to use an *out-of-network* provider.

What if my health insurance plan requires prior authorization before paying for treatment?

Your health insurance plan may require pre-approval before you can have certain treatments, services, or prescriptions. This is called [pre-authorization or prior authorization](#). Your health insurance plan will decide whether your treatment is "medically necessary." If you get treatment without prior authorization, your health insurance plan may not pay for your treatment. Remember your plan may need to pre-approve your prescriptions as well. Follow these steps:

- Call the number on the back of your insurance card and check your health insurance documents online to find out if you need prior authorization (pre-approval).
- Ask your health care provider to request prior authorization from your health insurance plan.

NOTE – If your health care provider is in-network, it is the health care provider's responsibility to get prior authorization for your treatment. **HOWEVER**, if the health care provider is out-of-network, it is **YOUR** responsibility to get prior authorization.

Help your health care provider help you! Sign a consent form to allow your health care provider to talk with your health insurance plan about your treatment. Health care providers are often able to clear up any confusion about needed services.

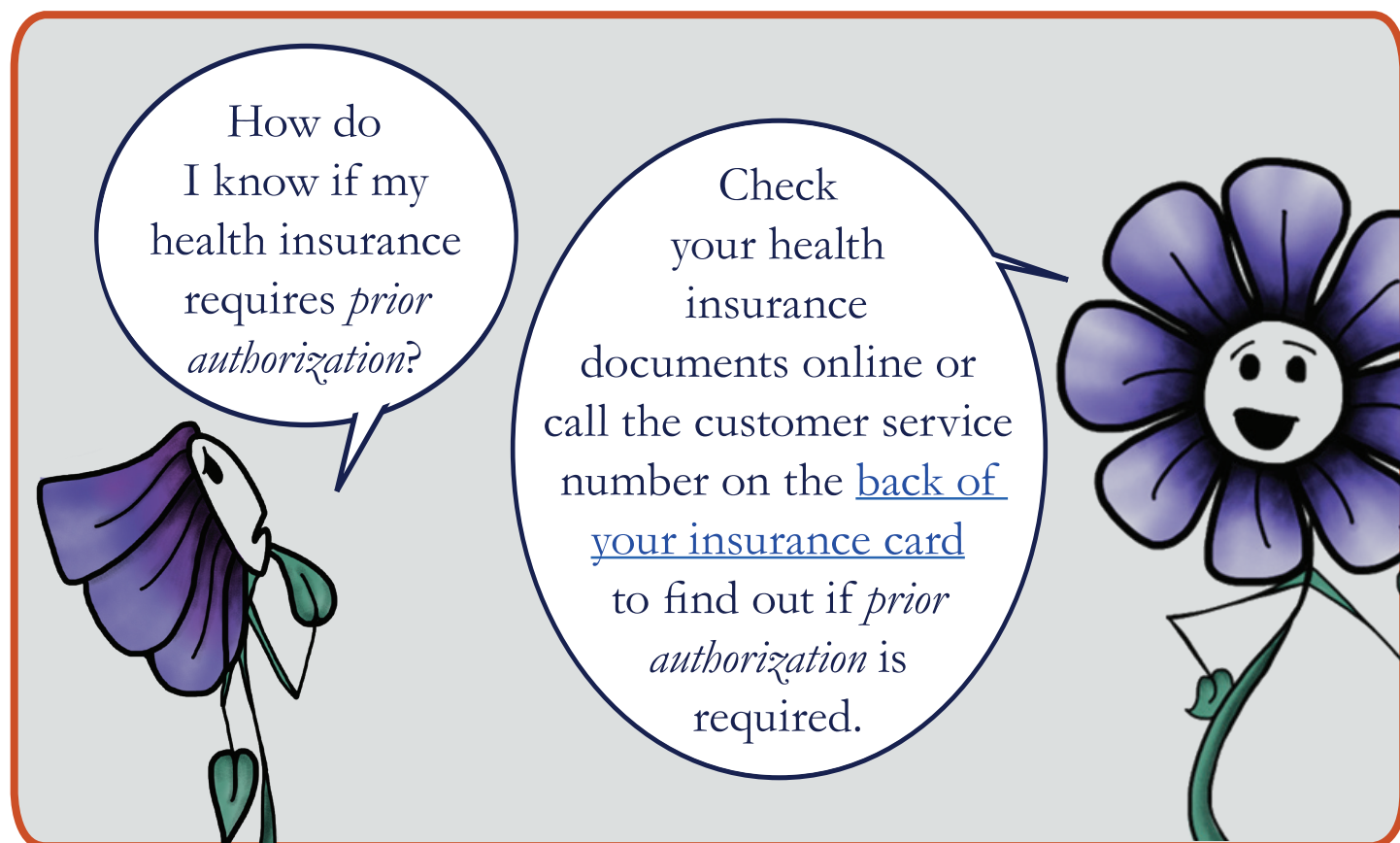
What type of mental health or substance use disorder services DO or DO NOT require prior authorization?

Your mental health or SUD treatment **does not always require prior authorization**. Examples of mental health or SUD treatment you can get **without [prior authorization](#)** include:

- Treatment by *in-network* providers for routine out-patient mental health and SUD treatment, therapy sessions, psychiatric consultations and evaluations, and medication management;
- Most pharmacy prescriptions by your health care provider for mental health support or for medically assisted treatment for your SUD (such as buprenorphine);
- Emergency or “acute” inpatient treatment for a mental health or SUD crisis, however, your health care provider must notify your health insurance plan as soon as possible about the emergency.

Many health insurance plans DO require prior authorization for intensive mental health or SUD services as well as for some prescription drugs. **Ask your health care provider to help you get prior authorization for intensive or non-routine mental health and SUD services.**

Each health insurance plan is different – see our [Provider Section](#) for more information about your health insurance plan.



What if I am enrolled in Medicaid and have questions? Do Medicaid plans require prior authorization?

Your Medicaid health plan will give you an insurance card that includes helpful phone numbers on the back and will have information on its website. See our [Additional Resources](#) section for more information. Be sure to check on any prior authorization requirements.

What if my prescriptions (Rx) are too expensive?

Most health insurance plans pay for prescription drugs. They have a list of drugs they will pay for called a prescription drug formulary. Not all prescription drugs are included on every *formulary*. When choosing a health insurance plan, it is important to make sure any prescription drugs you are taking are included on the formulary. Formularies have different “tiers,” or cost categories. Prescription drugs on higher tiers typically require you to pay more out of your own pocket (higher copayments or coinsurances). For instance, a brand name drug may be on a higher tier resulting in higher out-of-pocket costs to you versus the generic form of that same drug.

Call the number on the back of your insurance card if you have questions about a prescription you need filled. A health insurance plan must approve or deny your request for prescribed medications within 48 hours. New Hampshire law allows a pharmacist to provide a patient with a 72-hour emergency supply of a prescription drug. Refer to NH RSA 318:47-i.

Talk to your health care provider for a free sample of your prescription drugs. Some prescription drugs also have programs that can reduce the amount you pay. Ask your prescriber if they know of any discount programs for your medication. You can also search the internet for a “copayment coupon” offered to reduce the cost of an expensive brand name drug.

If you find that you cannot afford one or more of your prescription drugs due to high copayments or coinsurances, it is important to talk with your health care provider to see if there is a cheaper prescription that would still work for you.



Your pharmacist or health care provider can also offer you generic drugs, which usually cost much less than the brand name drugs.

Understanding Insurance Decisions and Appeals

Know your rights!

When you have health insurance, you have the right to:

- Ask for and receive information that is easy to understand, including available treatment options and alternatives;
- Participate in decisions about your health care;
- Get a second opinion;
- Be free from retaliation for exercising your rights;
- Voice complaints and appeal decisions; and
- Not be subject to surprise billing.



What if my health insurance plan makes a decision I don't understand?

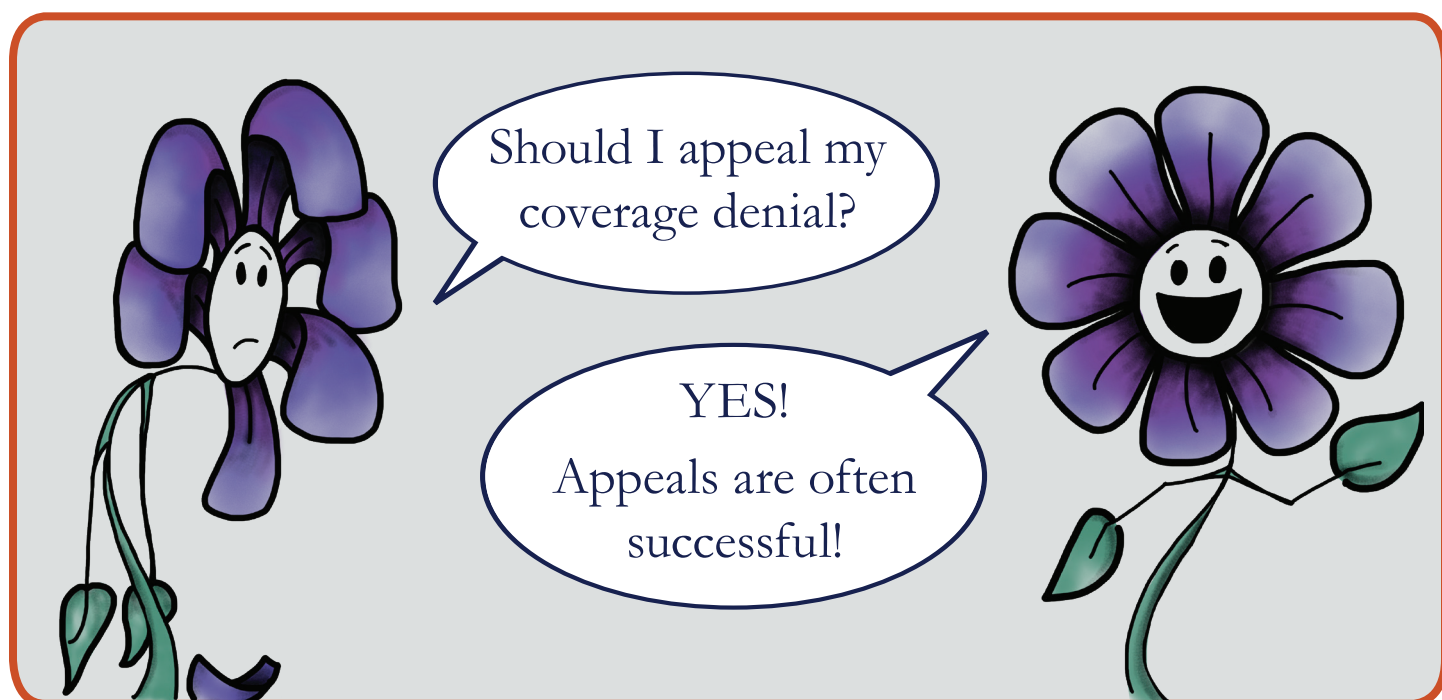
Health insurance plans sometimes make decisions we disagree with. If you have questions or concerns about your health insurance plan or a decision made by your health insurance plan, take the following steps:

- Step 1:** Call the number on the back of your insurance card. If that does not work go to Step 2 or 3;
- Step 2:** Call the New Hampshire Insurance Department Consumer Services Division at **1-800-852-3416**. The Insurance Department will tell you your next steps to address your concerns;
- Step 3:** If you are enrolled in Medicaid, call NH DHHS at **1-844-ASK-DHHS** (1-844-275-3447).

What should I understand about Mental Health Parity?

What if your health insurance plan covers your mental health or SUD treatment differently from your medical treatment? Health insurance is there to help you afford the treatment you and your family need. Health insurance plans in New Hampshire must pay for (or “cover”) mental health and SUD treatment in about the same way physical health treatment is covered. This is called **Mental Health Parity**. Federal and state laws prohibit your health insurance plan from discriminating against you because you have a mental health or substance use disorder. You are entitled to the treatment your health care provider says is necessary.

Sometimes health insurance plans have limits on how many visits or how much treatment you are allowed. For example, you may only be allowed four visits to a mental health provider under your health insurance plan. Find out whether your health insurance plan has any treatment limitations for mental health or SUD benefits. Your health insurance plan is required by law to provide you this information. This information may help you if you need to appeal a [coverage denial](#). The U.S. Department of Labor has created a [form](#) you can use to request information about treatment limits that may affect your access to mental health or SUD treatments.



You have a right to appeal – take action!

Do not give up! This Guide outlines the steps to start the appeal process. If your health insurance plan takes an action or makes a decision that you do not agree with, you have the right to appeal that action. Many appeals are successful, meaning you can get treatment you need.

If you have an urgent need for treatment, follow the instructions for an **expedited** (or “urgent”) **appeal**. Otherwise, start an **internal appeal** with your health care provider’s help. If that does not work, you and your provider should pursue a more formal **external appeal**.

What “actions” by my health insurance plan can I appeal?

You can ask your health insurance plan to reconsider almost any decision they make. Call the number on the back of your insurance card to find out what to do. You can always contact the New Hampshire Insurance Department Consumer Services Division at **1-800-852-3416** with questions.

Here are a few actions by a health insurance plan that you may want to appeal:

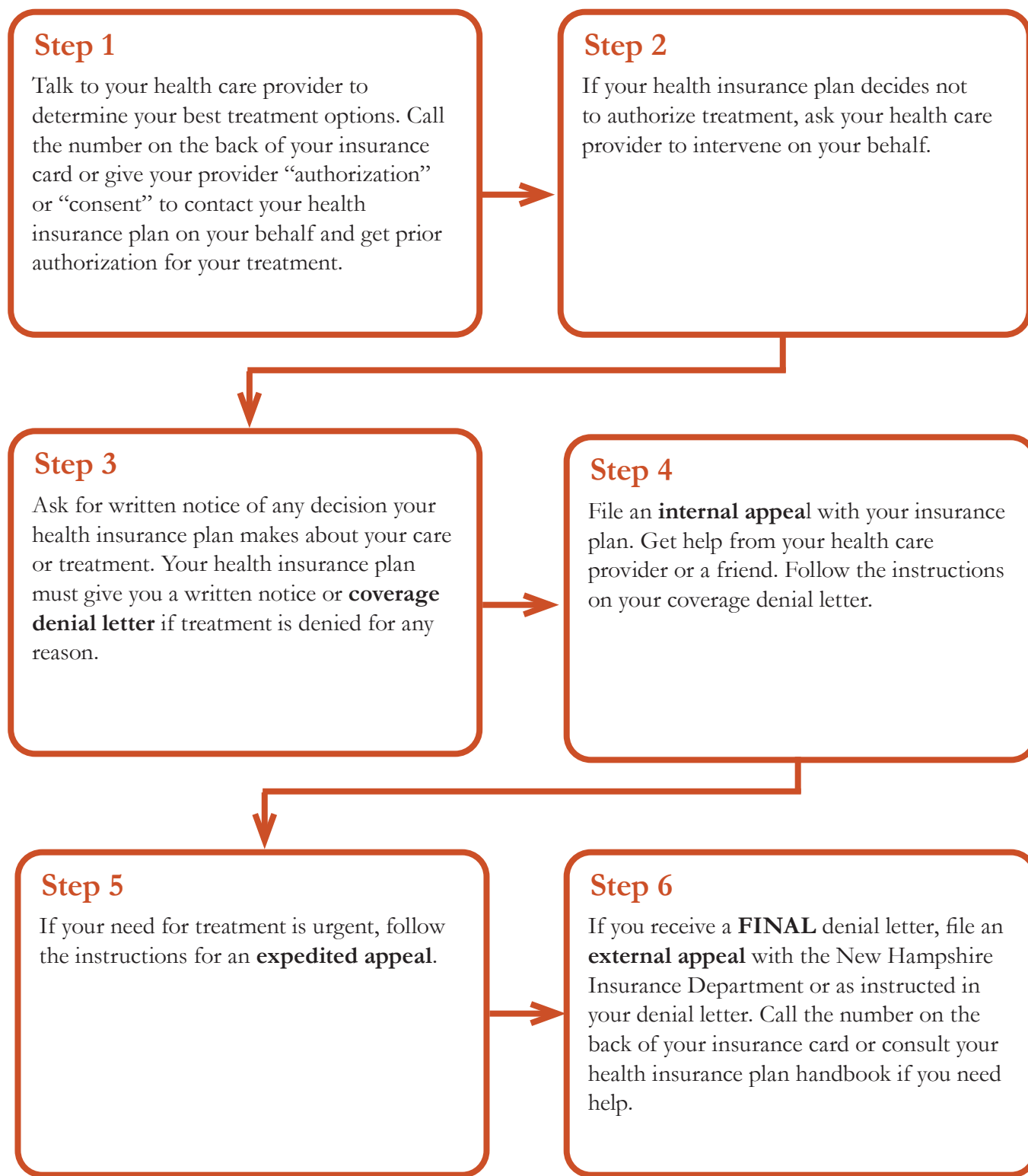
- A decision to deny or limit your health care service;
- A decision to deny a request for prior authorization;
- For Medicaid enrollees, a decision to reduce, suspend, or end health care service that you are getting or were previously authorized to get;
- A dispute about what you must pay for a service out of your own pocket;
or
- When your health insurance plan does not respond when they promised to.

It is always important to ask *why*. Your health insurance plan may have decided to deny services because they require prior authorization, your doctor is “out-of-network,” or the health insurance plan does not believe the services are **medically necessary**. You can still get services if you ask for help, so call the number on the back of your insurance card.

If you did not receive a denial letter, but you believe recommended treatment was denied, call your health insurance plan and ask for a copy of the denial letter.

If you’re enrolled in a Medicaid health plan, such as AmeriHealth Caritas New Hampshire, NH Healthy Families, or Well Sense Health Plan, please also review the [I am enrolled in Medicaid](#) section of this Guide.

Follow these appeal steps to make sure your treatment is covered by your health insurance plan.



How will I know if my services are denied?

A *coverage denial* occurs when a health insurance plan refuses to honor your claim, or request to pay, for mental health or SUD treatment. An *appeal* is the process where you (or your health care provider) challenge a coverage denial by your health insurance plan. If your claim for mental health or SUD treatment is denied by your health insurance plan, take the next step and appeal the decision!

Always ask your health insurance plan to explain its decision. Your health insurance plan will send a denial letter, and the reason for the denial must be included in the denial letter you receive. A health insurance plan usually denies coverage because it believes your treatment is not medically necessary. Ask your health insurance plan for its definition of medical necessity and discuss it with your health care provider. During this conversation, be sure to ask your health care provider to talk to your health insurance plan about the medical necessity of your treatment.

Medically Necessary/ Medical Necessity:

Criteria health insurance companies use to determine if health care services should be covered. A medical service generally meets medical necessity criteria when it is consistent with general medical care standards, a patient's diagnosis, and the least expensive option available.

Health insurance plans in New Hampshire are **required** to send you something in writing explaining their decision and the steps to appeal.

- Be sure to ask your health insurance plan representative to send or email you a copy of any denial letter.
- A sample final denial letter is available for reference in the Appendix. (See Appendix Form 1 [Sample Final Denial Letter](#)).
- The denial letter will explain four important things:
 - Why your service was denied;
 - Who conducted the internal review;
 - What appeal rights you have; and
 - Deadlines and instructions you must follow.
- **Give your health care provider written consent to talk to your health insurance plan!** Your health care provider can explain why treatment is needed and may be able to get your treatment immediately.
- **Keep track of your progress with your health insurance plan.** Keep a notebook and write down the name of the person you speak to, the date of the call, and the topics you discuss. Always keep copies of documents you receive from your health insurance plan.

What are the three types of appeals?

There are three types of appeals: **expedited**, **internal**, and **external**. Each one of these is explained in detail in its own section. Below is a brief explanation of each.

- 1) An **internal appeal** is a review done by your health insurance plan. This appeal is called a “standard” appeal or an “appeal through the plan.” Your health insurance plan must decide your appeal within 30 days of your request. You may make your appeal request over the phone, but you should follow up in writing. In general, your health insurance plan must provide you at least one internal appeal for every unfavorable decision they make. You have at least 180 days to file an internal appeal from the date you received the coverage denial letter, but your health insurance plan sets the exact time frame.
- 2) An **expedited appeal** is used when you have an immediate or urgent need for treatment. Your health insurance plan must decide your expedited appeal within 72 hours of receiving your request either by phone or in writing.
- 3) The final level of appeal is an **external appeal**, sometimes called a “second level” appeal. An external appeal is available only if your health insurance plan denied you treatment because it was not **medically necessary**. You have 180 days to file an external appeal from the date of the final denial decision (in other words, the date of the final denial of the requested treatment after all internal appeals are completed).

If you have questions about which type of appeal to file, call the number on the back of your insurance card or contact the New Hampshire Insurance Department (NHID):

- **Consumer Hotline:** 1-800-852-3416
- **TTY/TDD Relay Services:** 1-800-735-2964
- **Email:** consumerservices@ins.nh.gov

What is an internal appeal?

If your health insurance plan refuses to pay a claim or ends your coverage for a treatment, the plan must provide you with an internal appeal if requested. Your health care provider must help you with the internal appeal.

- Your health insurance plan may tell you that your treatment was denied for the following reasons: (1) because the treatment was not *medically necessary* according to the health insurance company; (2) because the type of treatment requested was not an appropriate level of care; or (3) because the type of treatment was not in an appropriate health care setting.
- If you ask for an internal appeal, your health insurance plan must conduct a full and fair review of its decision.
- This type of **internal** review is available **for ALL** treatment denials. The person reviewing the decision will not be the same person who initially denied you.
- An internal appeal is easy. You or your health care provider can begin your internal appeal process by calling or writing a letter to your health insurance plan. Be sure to include information about your health insurance and the treatment recommended for you.
- A sample internal appeal request is available in the Appendix. (See Appendix Form 2 [Sample Internal Appeal Request](#)).

Authorize your health care provider to contact your health insurance plan directly during an internal appeal process. Give your health care provider any information about your health insurance plan he or she requests.

When should I receive a response from my health insurance plan on my internal appeal?

Generally, you should receive a response from your health insurance plan within 30 days of the date you filed your first appeal.

If your health insurance plan provides two levels of appeal, the first level will be complete within 15 days and the second within 30 days of the date of your first appeal.

What is an expedited appeal?

I think my claim is URGENT, what should I do? Ask your health insurance plan for an expedited appeal process, so that you receive a final decision within 72 hours.

Expedited appeals for urgent cases must be resolved as soon as possible but may never take longer than 72 hours. This means your health insurance plan must approve or deny your requested mental health or SUD treatment within 72 hours of your request. If your case involves ongoing urgent treatment, your health insurance plan will continue to pay for your treatment until the review is complete.

Talk to your health care provider right away about your need for URGENT treatment. If you believe a delay in services would seriously jeopardize your life or health, ask your health care provider to help you with an expedited appeal. For your appeal to be expedited, your health care provider must certify that your need for treatment is urgent. (See Appendix Form 5 [Provider Certification Form for Expedited Review](#)). Call the Insurance Department for additional instructions at 1-800-852-3416.

What is an external appeal?

The *external appeal* is one of the final steps in the appeals process.

- If your health insurance plan denies your services because they are not *medically necessary*, you can file an *external appeal*.
- If you are enrolled in New Hampshire Medicaid, your external appeal is a State Fair Hearing. See the [I am enrolled in Medicaid](#) section below for more information.
- With an external appeal, an independent third party will review the denial. The independent reviewer will decide whether your health insurance plan properly denied your services.

How do I file an external appeal?

- You have **180 days to file an external appeal** from the final denial decision, but do not wait! File your appeal as soon as possible. Acting quickly can prevent unnecessary delays in your treatment.
- Follow the instructions given to you in writing by your health insurance plan. If you can't find them, call the number on the back of your insurance card. Your health insurance plan will also have instructions and timelines in its handbook or online instructions about appeals.
- **External Appeal Forms:** The forms you will need to file an external appeal are provided in the Appendix. (See Appendix Form 3 [External Review Application Instructions](#) and Form 4 [External Review Application Form](#)). These [forms](#) are also available on the New Hampshire Insurance Department website.
- **Submit documents and records with your appeal:** You should submit any documents and medical records supporting your need for treatment with your appeal. You can submit documents **even if** your health insurance plan did not have them when making its initial denial. If you forgot to submit necessary information with your appeal, **do not worry!** Provide the information as soon as you can. Your health insurance plan may also ask you to submit additional information. Respond to the request and provide the information quickly and ask for help if you need it.
- **Ask for documents from your health insurance plan:** You may request copies of any information your health insurance plan considered when making its initial denial. If you make this request, your health insurance plan must provide the information to you.
- **Seek input from your health care provider:** Your health care provider will be important in your appeal. With your written consent, your health care provider may discuss your case with your health insurance plan or an independent reviewer. Your health care provider should provide a statement explaining why the recommended treatment is medically necessary. There is a special place on your appeal form (Section V) for your health care provider's information. (See Appendix Form 5 [Provider Certification Form](#)).
- **Get help from a friend:** A friend or a loved one can help you work with your health insurance plan. Ask if you can designate someone to act as your personal representative. You will have to sign a written consent form. Your selected representative can talk with your health insurance plan for you and can also help with your appeal by writing letters of support for your treatment.

I am enrolled in Medicaid. Does that make a difference in my appeal?

Yes. If you are enrolled in a Medicaid Managed Care plan, you have different rights and deadlines. If you have questions about your health insurance or something done by your Medicaid Managed Care plan, call the number on the back of your insurance card. You can also call the **New Hampshire Department of Health and Human Services (DHHS)** at **1-844-ASK-DHHS (1-844-275-3447)**.

The Medicaid Managed Care numbers to call for help are here:

<p>AmeriHealth Caritas New Hampshire: 1-833-704-1177 1-855-534-6730 (TTY)</p> 	<p>NH Healthy Families: 1-866-769-3085</p> 	<p>Well Sense Health Plan*: 1-877-957-1300</p> 
<p>* If you have a Well Sense Health Plan, call Beacon Health Strategies (Beacon) for questions about mental health or substance use disorder services. Beacon: 1-855-834-5655 (free language interpreter services available). This number is available 24/7.</p>		

- If you need help with the application process for enrollment or recertification, contact **DHHS** or call **2-1-1** to find an agency who can help with enrollment. If you have a disability, **ServiceLink** may be able to help you.
- Finally, if you disagree with a decision about enrollment, eligibility, coverage for a service, or need to request a hearing/appeal, contact **New Hampshire Legal Assistance (NHLA)** by calling the **Legal Advice and Referral Center (LARC)** at **1-800-639-5290** or by applying online.

Coverage Termination by Your Medicaid Managed Care Plan

- If you receive a notice of termination or denial of Medicaid eligibility, ask for a hearing as soon as possible!
- While waiting for the result of your appeal, you may have a right to request continuation of your benefits from your plan during your appeal. **You may have to request the continuation within 10 days if you want your coverage to continue!** Check your plan handbook to determine how soon you need to request continuation. Your health care provider cannot request continuation of benefits for you. If you lose your appeal, you may be responsible for the cost of continued benefits provided by the plan during the appeal period. For help, contact the **Administrative Appeals Unit (AAU)** at **(603) 271-4292** or **1-800-852-3345, ext. 4292**. You can also go to the [AAU's website](#) for more information.

Follow these steps to make sure your treatment is covered by your Medicaid Managed Care Plan.

Step 1

Talk to your health care provider about what treatment you need. Give your health care provider “authorization” to contact your Medicaid Managed Care plan on your behalf and get prior authorization for your treatment.

Step 2

If your Medicaid Managed Care plan does not authorize treatment or takes an action you disagree with, ask your health care provider to talk to your Medicaid Managed Care plan.

Step 3

Ask for written proof of any decision your Medicaid Managed Care plan makes about your care or treatment. Your Medicaid Managed Care plan must give written proof, also known as a **coverage denial letter**, if treatment is denied for any reason.

Step 4

File an **internal appeal** with your Medicaid Managed Care plan. Get help from your health care provider or a friend. Follow the instructions on your coverage denial letter.

Step 5

If your need for treatment is urgent, follow the instructions for an **expedited appeal**.

Step 6

If you receive a FINAL denial letter, file a **State Fair Hearing appeal** with the **New Hampshire Department of Health and Human Services Administrative Appeals Unit (NH DHHS AAU)** or as instructed in your denial letter. Contact the AAU at 1-603-271-4292 or 1-800-852-3345, ext. 4292 or email DHHS.AAU@dhhs.nh.gov if you need help. An [appeal request form](#) is also available through NH DHHS AAU.

An appeal process is used when your Medicaid Managed Care plan makes a coverage decision or takes an action that you disagree with.

A grievance process is used when you do not like something else about your insurance, like the quality of services you received or how a health care provider treated you. Check their website or handbook for details.

You do have the right to talk to the **New Hampshire Department of Health and Human Services (NH DHHS)** if you are unhappy with the result of your appeal or grievance. Contact the NH DHHS at 1-844-ASK-DHHS (1-844-275-3447) (TDD Access Relay: 1-800-735-2964).

Medicaid Managed Care plans may have different deadlines for filing your appeal from standard coverage! Check your Medicaid plan handbook for more information on appeal submission dates.

For Providers

Navigating health insurance is hard!

You can help patients navigate their health insurance plans and access the treatment they need!

Review this Guide and share with your patients!

- Tell your patient that you are their advocate!
- Show your patients the phone numbers on their insurance card, including the numbers for *member services*, *mental health services*, and *substance use disorder services*, and explain the information on the card.
- Prior authorizations can be frustrating and time consuming. Nonetheless, it is your contractual responsibility to help patients navigate prior authorizations! Help your patient obtain the appropriate prior authorizations by communicating with your patient's health insurance plan.
- Be prepared to contact your patient's health insurance plan and explain the medical necessity for services. Do not exaggerate! Be clear about the diagnosis and the reasons for the recommended treatment.
- Encourage your patient to execute a consent form authorizing you, as a health care provider, to contact the health insurance plan to help coordinate mental health or SUD treatment and coverage.
- As a health care provider, certifying the need for treatment is essential to your patient's success in appealing a coverage denial. (See Appendix Form 5 [Provider Certification Form](#)).
- Provide your patient the contact information for the **New Hampshire Insurance Department Consumer Hotline 1-800-852-3416** or **call them yourself**. If your patient is enrolled in a Medicaid plan, provide them with contact information for the **New Hampshire Department of Health and Human Services at 1-844-ASK-DHHS (1-844-275-3447)**.

Do the Mental Health Parity laws help my patients?

Mental health parity requirements help ensure individuals can access necessary treatment through their health insurance plan. Mental health parity laws require most health insurance plans to cover mental health and SUD treatment in about the same way as they cover physical health. In 2008, **The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (Parity Law)** made mental health parity a legal requirement for all health plans that include mental health benefits. Because most plans now include coverage for mental health and SUD, this law makes a difference.

Parity Law requirements are complicated. The New Hampshire Insurance Department reviews commercial fully insured health plans to ensure they meet basic parity requirements, and NHID can conduct market examinations to ensure insurers meet parity requirements in practice. The United States Department of Labor does the same for commercial self-funded health plans, and NH Department of Health and Human Services enforces parity for Medicaid Managed Care plans.

If you have any questions about Parity Law that are not answered by the [Additional Resources section](#), contact the **New Hampshire Insurance Department Consumer Hotline 1-800-852-3416** or a member of the NHID Advisory Committee on Mental Health and Addiction Services. The NHID also has useful mental health and SUD coverage information on its [website](#).

How do Parity Laws measure Mental Health Parity?

Health insurance plans cannot impose greater financial requirements (such as higher copays or deductibles), or greater treatment limitations (such as visit limits), on mental health or SUD benefits than on medical benefits.

Insurance practices should apply consistently to both, including:

- deductibles, copays, coinsurance, and out-of-pocket maximums;
- limits on the use of services, such as limits on the number of inpatient days or outpatient visits that are covered;
- the use of tools by the health insurance plan to manage care;
- prescription drug list structure, including copayments;
- payment for services by out-of-network providers; and
- criteria for deciding whether a service is medically necessary.

If a health care provider recommends medically necessary mental health or SUD treatment, the health insurance plan should allow access. Parity does not mean that treatments for medical conditions and mental health or SUD need to be covered in the exact same way. Parity does mean that the copays and coverage amounts should be about the same. For example, if health insurance requires an individual to pay higher copays for substance use disorder or mental health therapy services than for physical therapy services, or places annual limits on the number of substance use disorder or mental health therapy visits without doing so for physical therapy, the health insurance plan may be violating rights under Parity Law.

The [New Hampshire Insurance Department \(NHID\)](#) has the authority to enforce parity obligations for health insurance offered by regulated companies in New Hampshire. The [U.S. Department of Labor \(DOL\)](#) regulates mental health parity for self-funded employer plans. The [New Hampshire Department of Health and Human Services \(DHHS\)](#) regulates Medicaid plans. These regulators provide information and detailed guidance on how to comply with the Parity Law for different health plans in New Hampshire.

How can I identify a potential parity violation?

As a health care provider, if you think your patients are not receiving coverage for mental health or SUD treatment in the same way as medical services, call your patient's health insurance plan with them to ask for help. If this does not work, you may also make a grievance or complaint to the New Hampshire Insurance Department Consumer Hotline at 1-800-852-3416, or [online](#). If your patient is enrolled in a Medicaid plan, call the New Hampshire Department of Health and Human Services at (603) 271-4344 or 1-844-ASK-DHHS (1-844-275-3447).

Your patient may be enrolled in a Medicaid Managed Care Plan (often referred to as a managed care organization or MCO). Each of these Managed Care Plans must include information about parity and coverage for mental health and SUD in their handbooks or on their website.

For Information on Medicaid Managed Care Plans:

AmeriHealth Caritas New Hampshire: 1-833-704-1177 1-855-534-6730 (TTY) New Hampshire Medicaid Care Management Program Member Handbook	NH Healthy Families: 1-866-769-3085 New Hampshire Medicaid Care Management Program Member Handbook	Well Sense Health Plan: 1-877-957-1300 Well Sense Health Plan Member Handbook
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Helping Patients with Appeals and Parity

- As a health care provider, your help is critical to any patient seeking coverage and payment for mental health and SUD treatments. Review this Guide and support your patient to secure prior authorizations, internal appeals, and external appeals. Often a call to the health insurance plan from the treating health care provider supporting the medical necessity of the recommended treatment will make the difference. If it doesn't, let the NH Insurance Department or the Department of Health and Human Services know about your problems so they can help you help your patients.
- Your advocacy makes a difference! If you witness repeated activity by a health insurance plan limiting coverage or payment of mental health or SUD treatment, call the NHID Consumer Hotline with the details of when, why, and how treatment was denied.

When I help a patient, does it matter what type of plan my patient is enrolled in?

Fully Insured v. Self-Funded?

No, you do not need to worry about whether your patient is enrolled in a full-insured or self-funded plan through their employer to support your patient in navigating coverage. It's important to advocate for your patient's treatment needs no matter what type of coverage your patient has.

The NHID regulates *fully insured* plans, while the U.S. DOL regulates *self-funded* plans. *Fully insured* plans are where an employer pays a fixed monthly premium for an employee's participation. *Self-funded* plans are offered by employers or unions who directly assume the costs of the health services for their employees or members. *Self-funded* plans almost always hire a third-party claims administrator — typically a licensed insurance company — to administer the benefits, so the insurance card for a self-funded plan may look very similar to the card for a fully insured plan.

The type of insurance plan a patient is enrolled in can be found on his or her insurance card. IF the NHID phone number is on the back of the card, the patient is enrolled in a *fully insured* plan regulated by the NHID. However, **the NHID phone number is not always on the back of the card for a fully insured plan.** Your patients can always ask their employer if their plan is fully insured or self-funded.

What is my responsibility to confirm treatments I recommend are pre-authorized?

Health care providers are typically contractually obligated to seek prior authorization from a patient's health insurance plan when recommending treatment. Prior authorizations are supposed to be a quality assurance tool to help make sure treatments are medically appropriate and necessary. Although seeking prior authorizations can be frustrating and time consuming, it helps your patient get the treatment they need.

This Guide includes many of the numbers to call to ensure your patient has the right prior authorization for treatment, including contacts for patients enrolled in Medicaid Care Management programs and commercial plans.

Call the **New Hampshire Insurance Department Consumer Hotline** at **1-800-852-3416** if you are frustrated and have exhausted communication options with your patient's health insurance plan. Ask for help – it makes a difference! If your patient is enrolled in a Medicaid health plan, call the number on the back of their insurance card or the Division of Client Services at **1-844-ASK-DHHS (1-844-275-3447)**.

Prior Authorization Contact Information

Medicaid information about prior authorization for services and pharmacy

For information about prior authorizations by Medicaid Managed Care Plans, including AmeriHealth Caritas New Hampshire, NH Healthy Families and Well Sense Health Plan, see below. Behavioral Health Services in this context includes both mental health and substance use disorder services.

Medicaid Organization	Prior Authorization Contact Information for Behavioral Health Services	Prior Authorization Contact Information for Behavioral Health Prescription Drugs
AmeriHealth Caritas New Hampshire	1-833-472-2264 for business hours (M – F, 8:00 a.m. to 5:00 p.m.); after hours 1-833-704-1177, 1-855-534-6730 (TTY) https://www.amerihhealthcaritasnh.com/provider/resources/physical-prior-auth.aspx	1-888-765-6394 for business hours (M – F, 8:00 a.m. to 5:00 p.m.); after hours 1-888-765-6383 https://www.amerihhealthcaritasnh.com/provider/resources/pharmacy-prior-auth.aspx
NH Healthy Families	https://www.nhhealthyfamilies.com/members/medicaid/benefits-services/Prior-Authorization.html 1-866-769-3085	Pharmacy: https://www.nhhealthyfamilies.com/members/medicaid/benefits-services/pharmacy.html 1-866-769-3085 Call to receive a copy by mail, fax, or email. The PDL can be found on NH Healthy Families provider portal
Well Sense Health Plan (Beacon Health Options)	Well Sense Providers: https://www.beaconhealthoptions.com/providers/forms-and-resources/ 1-855-834-5655 To reach Beacon’s Physician Decision Support Line, call 1-877-241-5575. To request prior authorization for behavioral health services , call Beacon at 1-866-444-5155 or visit their website . Beacon Health Strategies developed a toolkit to assist PCPs in the diagnosis and treatment of mental health and substance use disorders	Well Sense Providers: https://www.wellsense.org/providers 1-877-957-1300; 711 (TTY/TDD for hearing impaired)

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How to Access Mental Health and Substance Use Disorder Benefits

Commercial Health Insurance information about prior authorizations for services and pharmacy

There are many commercial health insurance plans in New Hampshire. This list is not inclusive of all possible commercial insurers in New Hampshire. If your patient's insurer is not listed, call the number on the back of your patient's insurance card with questions about prior authorizations. Behavioral Health Services in this context includes both mental health and substance use disorder services.

Organization	Prior Authorization Contact Information for Behavioral Health Services	Prior Authorization Contact Information for Behavioral Health Prescription Drugs
Ambetter	https://ambetter.nhhealthyfamilies.com/contact-us.html 1-844-265-1278	https://ambetter.nhhealthyfamilies.com/provider-resources/pharmacy.html 1-844-265-1278
Anthem	Contact the member or provider services number on the back of the patient's ID card	Contact the member or provider services number on the back of the patient's ID card
Cigna	https://www.cigna.com/individuals-families/understanding-insurance/what-is-prior-authorization https://www.cigna.com/individuals-families/member-resources/claims-authorizations-eob 1-800- Cigna24 (1-800-244-6224)	https://www.cigna.com/individuals-families/understanding-insurance/what-is-prior-authorization https://www.cigna.com/individuals-families/member-resources/claims-authorizations-eob 1-800- Cigna24 (1-800-244-6224)
Harvard Pilgrim/ Optum	https://www.providerexpress.com/content/ope-provexpr/us/en/contact-us/nmContacts/nh.html https://www.providerexpress.com/content/ope-provexpr/us/en/about-us/prior-authorization-of-service.html#maincontent_title Optum Network Management: 1-877-614-0484 Providers can also contact HPHC/Optum's Authorization line at 1-800-888-2998.	Beginning 1/1/20 , prior authorization requests for BH Rx drugs can be submitted as follows: Commercial members: Phone: 1-855-258-1561; Fax: 1-844-403-1029 Medicare Advantage Members: Phone: 1-855-524-0380 Fax: 1-844-403-1028 Mail (all lines of business) Optum Prior Authorization Department P.O. Box 25183 Santa Ana, CA 92799
Tufts	1-800-547-5186	For questions regarding prior authorization, providers may contact Provider Services at 1-888-884-2404.

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Glossary

Addiction and Mental Health: The study of emotions, behaviors, and biology relating to a person's mental well-being. It includes the assessment, diagnosis, treatment, and prevention of medical illness and addiction/substance use disorders.

Appeal/Appealing a Claim/Appeal Process: The process that you (or your health care provider) can use to fight a denied insurance claim or termination of your requested services. There are no fees or costs related to the appeals process.

Carrier: The health care service plan or health insurance plan that issues your health insurance coverage.

Claim: A bill that your health care provider sends to your health insurance plan after you receive health care services. Insurance claims are reviewed by the plan (health insurance or health plan) to determine whether the services are covered and whether the health insurance will pay for the services.

Classifications of Benefits: There are 6 categories of benefits within which all mental health and substance use services must be classified: (1) inpatient in-network, (2) inpatient out-of-network, (3) outpatient in-network, (4) outpatient out-of-network, (5) emergency care, and (6) prescription drugs.

Copayment: A flat dollar amount that you will usually pay at the time you receive services. It may vary by service type. Copay amounts vary depending upon your health insurance plan.

Coinsurance as applied to medical services: This is where a patient pays for a percentage of the health care visit and the health insurance company pays the rest. It is calculated as a percentage of the amount of a service. You are responsible for paying the full amount of your coinsurance and your deductible. For example, if your plan allows for a \$100 health care checkup and you have paid your deductible, your coinsurance plan payment of 20 percent would be \$20. Your health insurance would pay the remaining \$80.

Coinsurance as applied to prescription drug plans: This is where a patient pays for a percentage of the actual cost of the medication and the health insurance company pays the rest. For example, if a prescription drug costs \$100 and the copay is \$10, the pharmacy would collect \$10. If the coinsurance is 20 percent, the pharmacy would collect \$20.

Deductible: A specific dollar amount that insured individuals must pay out-of-pocket before the insurance company will make payments. For example, if you visit the emergency room (ER) and your deductible is \$500, you must pay the \$500 deductible before your insurance company will cover any remaining charges associated with your emergency visit. You can call the number on the back of your insurance card to find out your deductible.

Denied Medical Claim: When a health insurance plan refuses to grant an individual's request for payment of health care services.

Employee Assistance Programs (EAPs): Mental health and substance use disorder counseling services that are sometimes offered by health insurance or employers. EAPs are intended to help employees deal with personal problems that might adversely impact their job performance, health, and well-being.

Exclusions: Specific conditions, services, or treatments listed in your health insurance documents that are not covered.

Explanation of Benefits: A statement the health insurance plan provides that lists services billed by providers, how charges were processed, and how much a patient will need to pay.

External Review (Appeal): This is the final step in the appeals process. If you are not satisfied with the results of your internal appeal, you have the right to request an independent third-party review. The third party will review the documentation to determine whether the insurance company should pay for the treatment.

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How to Access Mental Health and Substance Use Disorder Benefits

Fail First Protocol: A strategy used to reduce health care costs. A health insurance plan will only pay for a more expensive treatment if a less expensive option fails. For example, an individual might be prescribed a generic medication before coverage of a brand name medication is provided.

Financial Requirements: Financial requirements for the patient include deductibles, copayments, coinsurance, and other out-of-pocket expenses. Examples of other out-of-pocket expenses include but are not limited to out-of-network charges and the maximum out-of-pocket costs.

Fully Insured Plans: Traditional employer-based health plan coverage where the employer pays fixed premiums to the insurance carrier plan, and the carrier plan assumes the risk and responsibility of providing health coverage for insured events. Employees would be responsible for paying premiums, deductibles, coinsurance, out-of-network amounts, copays, and maximum out-of-pocket expenses according to the policy.

Generic Drug: A prescription drug that is comparable to a brand name prescription drug in dosage form, strength, quality, performance characteristics, and intended use. Generic drugs are usually less expensive than brand name drugs.

Health Insurance Plan: An insurance plan secured by individuals or groups that provides coverage and payment for health benefits. Licensed insurance companies, unions, and self-insured employer groups with the assistance of third-party administrators offer health insurance.

Health Insurance Portability and Accountability Act (HIPAA): Provides privacy standards to protect patients' medical information provided to health insurance, doctors, hospitals, and other health care providers.

In-Network: A set of providers and facilities that provide care under an insurance policy at a discounted rate. For some types of plans, services (other than emergency services) are covered only if you use an in-network provider, so it is important to check with your health insurance plan to see whether a provider is in-network for you before seeking care.

Inpatient: Care received that requires admittance to a hospital and an overnight stay.

Medicaid: A program operated jointly by the state and federal governments to provide health coverage for qualifying low-income individuals or families. New Hampshire Medicaid includes coverage through Medicaid Managed Care organizations (as of September 2019, Well Sense Health Plan, NH Healthy Families and AmeriHealth Caritas New Hampshire) and the Granite Advantage Program. The three Medicaid Managed Care organizations cover the same NH Medicaid services, but may have different provider networks and prior authorization requirements. Call the number on your insurance card to ensure you have access to needed health care services through the Medicaid program.

Medicare: A federal health insurance program for people over 65 and people with certain disabilities who are younger than 65.

Medically Necessary/Medical Necessity: Criteria health insurance companies use to determine if health care services should be covered. A medical service generally meets medical necessity criteria when it is consistent with general medical care standards, a patient's diagnosis, and the least expensive option available.

Out of Network/Out of Plan: These are providers not listed by an insurance policy. Costs may not be covered or may cost more out-of-pocket than an in-network provider's costs.

Outpatient Care: Any care or treatment that does not require an overnight stay in a hospital or similar treatment facility.

Parity: Similar costs and benefits for mental health, substance use disorder, and medical treatments. The costs and benefits do not have to be exactly equal to meet parity standards— just similar.

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Pre-Authorization/Prior Authorization/Prior Approval/Pre-Certification: When health insurance plans decide that certain services, treatment plans, and medications are “medically necessary” before coverage will be granted.

Pre-Existing Condition: A medical condition that existed prior to obtaining an insurance policy from a specific company. Having a pre-existing condition no longer changes treatment options or coverage for that condition.

Preferred Provider Organization (PPO): A type of health plan that contracts with health care providers, including doctors, clinics and hospitals, to create a network of participating providers. With a PPO, you have the flexibility to schedule an appointment with any health care provider you want, inside or outside of your network. You will pay less if you use health care providers that are in the plan’s network.

Self-Funded Plan: Commonly called self-insured, this is a type of plan where the employer collects premiums or contributions from enrollees and assumes the responsibility of paying for medical claims. Employers typically contract with Third Party Administrators which are usually insurance companies (e.g. Anthem, Cigna, United Healthcare, etc.) for insurance services such as enrollment, claims processing, care management, and provider networks. These plans are governed by the Employee Retirement Income Security Act of 1974 (ERISA) and regulated by the Department of Labor (DOL). The Boston District Office of the DOL provides coverage to the state of New Hampshire.

Contact Information:

Boston Regional Office
JFK Federal Building
15 New Sudbury St, Rm 575
Boston, MA 02203
Tel: (617) 565-9600

Small Group: Employer-based insurance plans that have between 1 and 50 eligible employees.

State-Mandated Benefits: Specific benefits a health insurance plan must offer under state law.

Surprise Billing: Occurs when a patient receives an unexpected charge (usually requiring them to pay more than expected) for a service, even though the patient received treatment through an in-network provider or facility.

Learn more about balance billing and surprise billing [here](#)

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Additional Resources

Mental Health Parity and Substance Use Equity Resources

- The American Psychiatric Association Mental Health Parity Poster: <https://www.psychiatry.org/psychiatrists/practice/parity>
- Community Catalyst Resources: <http://www.communitycatalyst.org/resources/publications/document/Parity-Basics-FINAL.pdf>
- The Kennedy Forum Parity Resource Guide for Addiction & Mental Health Consumers, Providers, and Advocates: <http://www.thenationalcouncil.org/capitol-connector/wp-content/blogs.dir/2/files/2015/08/Parity-Appeal-Guide-Winter-2015.pdf>
- Legal Action Center, A Guide to the Federal Parity Law: <http://lac.org/parity-guide-explains-right-to-health-insurance-coverage-for-addiction-mental-health-care/>
- What is Mental Health Parity: A Consumer Guide to the Evaluating State Mental Health and Addiction Parity Statutes Report: <https://wellbeingtrust.org/wp-content/uploads/2019/06/evaluating-state-mental-health-report-wbt-for-web.pdf>
- NH Department of Health and Human Services (DHHS): <https://www.dhhs.nh.gov/ombp/medicaid/parity.htm>; email at nhparity@dhhs.nh.gov
- New Hampshire Insurance Department (NHID): <https://www.nh.gov/insurance/consumers/substance-use-disorder-coverage.htm>

Federal Government Resources

- U.S. Department of Labor: <https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity>
- U.S. Department of Labor form to request information about treatment limits that affect access to mental health or substance use disorder benefits: <https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/mhpaca-disclosure-template.pdf>
- U.S. Department of Veterans Affairs: <https://www.va.gov/health-care/health-needs-conditions/mental-health/>
- SAMHSA Mental Health Parity page: <https://store.samhsa.gov/system/files/sma16-4971.pdf>

New Hampshire Health Insurance Resources

- The New Hampshire Insurance Department has a consumer line available to take your calls:
 - Consumer Hotline: 1-800-852-3416
 - TTY/TDD Relay Services 1-800-735-2964
- Center for Consumer Information and Insurance Oversight form to request documentation from an employer-sponsored health plan or an insurer concerning treatment limitations: <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Model-Form-to-Request-MH-SUD-Treatment-Limitation-information.pdf>
- For an explanation of what health insurance words and terms mean, visit NH HealthCost website: <https://nhhealthcost.nh.gov/summary-how-read-your-health-insurance-card>
- For more information about how to manage your costs, visit the NH HealthCost Guide to Health Insurance: <https://nhhealthcost.nh.gov/guide>
- For more information about open enrollment in health insurance visit: <https://www.healthcare.gov/quick-guide/>
- For more information on long term care options, visit NHCarePath: <https://www.nhcarepath.dhhs.nh.gov/partner-resources/consumer-booklets.htm>
- For information and resources about health insurance and other services, find a ServiceLink: <http://www.servicelink.nh.gov/>
- Get assistance with NH Medicaid at: <https://nheasy.nh.gov/#/> or Ask DHHS (603) 271-4344 or 1-844-275-3447
- Health Insurance Subsidies: <https://www.kff.org/health-reform/issue-brief/explaining-health-care-reform-questions-about-health/>
- If you are not enrolled in health insurance through work, you may be able to purchase insurance by visiting the New Hampshire Marketplace Exchange: <http://www.healthcare.gov/>
- If you disagree with a determination about enrollment, eligibility, or coverage for a service, or need to request a hearing/appeal, apply online at: <https://nhlegalaid.org/get-help>

Questions About Mental Health or Substance Use Disorder Benefits

- The National Suicide Prevention Lifeline is available 24/7 at 1-800-273-TALK (8255) or text 741741.
- 2-1-1 New Hampshire can find help if you or someone you know is experiencing a mental health or addiction crisis. You can also visit the Doorway website: <https://thedoorway.nh.gov/>
- For information about a qualified health center near you and other nonprofit providers in Vermont and New Hampshire, visit Bi-State Primary Care Association: <https://bistatepca.org/community-resources/nh-health-centers-2>
- If you have questions about available community services, call 211 or visit: <http://www.211nh.org>
- Mental health crisis intervention services are also available 24 hours a day by calling your local hospital or a community mental health center (CMHC) near you. For a list of CMHCs, visit the website: <http://www.dhhs.nh.gov/dcbcs/bbh/centers.htm>

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How to Access Mental Health and Substance Use Disorder Benefits

- The National Alliance on Mental Illness can provide information and resources by phone at 1-800-242-6264 and online at <https://www.naminh.org/>
- Find a NH Alcohol and Drug treatment center near you at: <https://nhtreatment.org/>

NH Insurance Department Guidance for Consumers on Appeals

- Consumer Guide to External Appeal: https://www.nh.gov/insurance/consumers/documents/ex_rev_guide.pdf
- General Appeals Information: <https://www.nh.gov/insurance/consumers/appeals.htm>
- Independent External Review: https://www.nh.gov/insurance/consumers/documents/ex_rev_app.pdf

NH Managed Care Laws

- Grievance Procedures: <http://www.gencourt.state.nh.us/rsa/html/XXXVII/420-J/420-J-5.htm>
- Right to External Review: <http://www.gencourt.state.nh.us/rsa/html/XXXVII/420-J/420-J-5-a.htm>
- Standard External Review: <http://www.gencourt.state.nh.us/rsa/html/XXXVII/420-J/420-J-5-b.htm>
- Expedited External Review: <http://www.gencourt.state.nh.us/rsa/html/XXXVII/420-J/420-J-5-c.htm>
- Certification of Independent Review Organizations: <http://www.gencourt.state.nh.us/rsa/html/XXXVII/420-J/420-J-5-d.htm>
- General Provisions Regarding External Review: <http://www.gencourt.state.nh.us/rsa/html/XXXVII/420-J/420-J-5-e.htm>

Definitions

- Copayments: <https://www.healthcare.gov/glossary/co-payment/>
- Cost-sharing subsidy: <https://www.healthcare.gov/glossary/cost-sharing-reduction/>
- Deductibles: <https://www.healthcare.gov/glossary/deductible/>
- Premium tax credit: <https://www.healthcare.gov/glossary/premium-tax-credit/>
- Surprise Billing: https://www.nh.gov/insurance/consumers/documents/balance_billing_surprise_billing.pdf

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Appendix

Form 1: Sample Final Denial Letter

Form 2: Sample Internal Appeal Request Letter

Form 3: External Review Application Instructions

Form 4: External Review Application Form

Form 5: Provider Certification Form for Expedited Review

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Form 1:

Sample Final Denial Letter

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Company Letterhead
Company Name
Mailing Address
City, State, Zip Code

Company Logo

Date

Insured Member's Name
Address
City, State, Zip Code

Member/Patient Name:
Insurance Plan Number:
Claim/Case Number:

Dear **Member Name**:

Insurance Company Name has finished reviewing your appeal for **Substance Abuse Subacute/RTC Rehabilitation level of care** at **Name of Treatment Facility**. Coverage for the requested services remains denied, because **they are not considered medically necessary**.

This case was reviewed by **Name of Medical Provider, including a description of his/her credentials**.

Based on the medical records given to us by **Name of Treatment Facility**, your doctor wanted you to receive **inpatient treatment for Substance Use Disorder (SUD)**. We do not believe this level of treatment is medically necessary, because **studies show outpatient treatment is appropriate for you condition**.

This is our final decision. Your internal appeal rights are exhausted. We've included details with this letter. If you have any questions about this letter, please call customer service at the phone number on your ID card.

What other rights do I have?

You may be eligible to have this decision reviewed by a nationally accredited, independent, medical review ...

You have 180 days from the date of this letter to ask for an external appeal. If you need help or have any questions about external appeal, you may call the Insurance Department at 1-800-852-3416 and speak with a consumer services officer.

Other helpful resources:

You may contact the New Hampshire Department of Insurance for assistance at any time.

Address: New Hampshire Department of Insurance
21 South Fruit Street, Suite 14
Concord, NH 03301
Phone: 1-800-852-3416
Email: consumerservices@ins.nh.gov
Online: www.nh.gov/insurance

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Form 2:

Sample Internal Appeal Request Letter

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FORM 2: SAMPLE INTERNAL APPEAL REQUEST

For use as an internal appeal request directly to your insurance company. This is not a substitute for the External Appeal Application included as Form 3.

Date

Insured Member's Name

Address

City, State [Zip Code]

Patient/Member Name:

Insurance Plan and Number:

Re. Appeal for [type of treatment] requested

To Whom It May Concern:

I am a member of [HEALTH PLAN NAME] and I am writing to appeal your decision to deny coverage for **[state the name of the treatment[s] or service[s] denied]**.

It is my understanding based on your communication **[by letter/phone/email]** on **[date of denial]** that you denied the treatment because **[state the reasons given for the denial of coverage or state that no reasons were given]**.

My provider **[name of provider]** is a qualified **[type of provider]** and recommends **[the treatment/service]** as treatment for me. **[Provide any details about the need for treatment you feel comfortable providing]**.

[Attach a letter from your provider explaining when and why the provider recommends the treatment/service or summarize the reasons the treatment/service has been recommended. If you do not have a letter, ask your provider to contact your insurance company].

[State whether or not your need for services is URGENT to prevent harm to you].

Please provide me with a release form immediately so that my provider and I can communicate directly with you about my treatment needs. Please also provide me with:

- 1) A complete explanation of why services/treatments have been denied and why
- 2) A copy of my summary plan description including any descriptions for mental health or substance use disorder services coverage;
- 3) Please identify any specific provisions that support your denial of treatment
- 4) Please explain what steps I should take and any time periods that apply in order for me to be sure my appeal is promptly addressed.

Thank you. If you have any questions or need any documents or information, please contact me both by email and by phone as follows:

Phone

Email

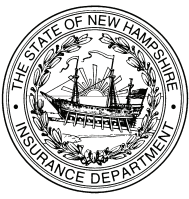
Sincerely, [NAME]

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Form 3:

External Review Application Instructions

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The State of New Hampshire Insurance Department

21 South Fruit Street, Suite 14; Concord, NH 03301
Tel.: (603) 271-2261 Fax: (603) 271-1406 TDD Access Relay NH: 1-800-735-2964

INDEPENDENT EXTERNAL REVIEW

Appealing a Denied Medical or Dental Claim

New Hampshire law gives individuals who are covered by fully-insured, health or dental insurance plans the right to have a nationally-accredited, independent, medical review organization (IRO), which is not affiliated with his/her health insurance company, review and assess whether the company's denial of a specific claim or requested service or treatment is justified. These reviews are available when a recommended service or treatment is denied on the basis that it does not meet the insurer's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness. This review is called Independent External Appeal, External Health Review or simply **External Review**.

There is no cost to the patient for an external review.

To be eligible for **Standard External Review**, the patient must (1) have a fully-insured health or dental insurance plan, (2) have completed the insurer's internal appeal process, and (3) have received a final denial of services from the insurer. A standard external review must be submitted to the Insurance Department within 180 days of the insurance company's final denial and may take up to 60 days for the IRO to make its decision.

To be eligible for **Expedited External Review**, the patient must (1) have a fully-insured health or dental insurance plan, and (2) the treating provider must certify that delaying treatment will seriously jeopardize the life or health of the patient or will jeopardize the patient's ability to regain maximum function. IROs must complete expedited reviews within 72 hours. An expedited external review may be requested and processed at the same time the patient pursues an expedited internal appeal directly with the insurance company.

For more information about external reviews, see the Insurance Department's [Consumer Guide to External Review](#), available at www.nh.gov/insurance, or call 800-852-3416 to speak with a Consumer Services Officer.

Have a question or need assistance?

**Staff at the Insurance Department is available to help.
Call 800-852-3416 to speak with a consumer services officer.**

SUBMITTING A REQUEST FOR EXTERNAL REVIEW

To request an external review, please provide the following documents to the New Hampshire Insurance Department at the address below:

- ☐ The enclosed, completed application form - signed and dated on page 6.
**** The Department cannot process this application without the required signature(s) ****
- ☐ A photocopy of the front and back of the patient's insurance card or other evidence that the patient is insured by the health or dental insurance company named in the appeal.
- ☐ A copy of the Health Insurance Company's letter, denying the requested treatment or service at the final level of the company's internal appeals process.
- ☐ Any medical records, statements from the treating health care provider(s) or other information that you would like the Independent Review Organization to consider in its review.
- ☐ If requesting an Expedited External Review, the treating Provider's Certification Form.

If you have questions about the application process or the documentation listed above, please call the Insurance Department at 1-800-852-3416.

Mailing Address:

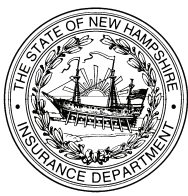
New Hampshire Insurance Department
Attn: External Review Unit
21 South Fruit Street, Suite 14
Concord, NH 03301

Expedited External Review applications may be faxed to (603) 271-1406 or sent by overnight carrier to the address above. If you wish to email the application package, please call the Insurance Department at 1-800-852-3416.

Form 4:

External Review Application Form

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The State of New Hampshire Insurance Department

21 South Fruit Street, Suite 14; Concord, NH 03301
Tel.: (603) 271-2261 Fax: (603) 271-1406 TDD Access Relay NH: 1-800-735-2964

EXTERNAL REVIEW APPLICATION FORM

Request for Independent External Appeal of a Denied Medical or Dental Claim

Section I – Applicant Information

Patient's Name: _____ Patient's Date of Birth: _____

Applicant's Name: _____ Applicant's Email: _____

Applicant's Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Applicant's Phone Number(s): Daytime: (____) _____ Evening: (____) _____

Section II – Appointment of Authorized Representative

**** Complete this section, only if someone else is representing the patient in this appeal ****

You may represent yourself or you may ask another person, including your treating health care provider, to act as your personal representative. You may revoke this authorization at any time.

I hereby authorize _____ to pursue my appeal on my behalf.

Signature of Enrollee (or legal representative – Please specify relationship or title)

Date

Representative's Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Representative's Phone Number(s): Daytime: (____) _____ Evening: (____) _____

Section III - Insurance Plan Information

Member's Name: _____ Relationship to Patient: _____

Member's Insurance ID #: _____ Claim/Reference #: _____

Health Insurance Company's Name: _____

Insurance Company's Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Insurance Company's Phone Number: (____) _____

Name of Insurance Company representative handling appeal: _____

Is the member's insurance plan provided by an employer? Yes ____ No ____

- Name of employer: _____
- Employer's Phone Number: (____) _____
- Is the employer's insurance plan self-funded? Yes* ____ No ____

*** If you are not certain, please check with your employer. Most self-funded plans are not eligible for external review. However, some self-funded plans may provide external review, but may have different procedures.**

Section IV – Information about the Patient's Health Care Providers

Name of Primary Care Provider (PCP): _____

PCP's Mailing Address: _____

City: _____ State: _____ Zip Code: _____

PCP's Phone Number: (____) _____

Name of Treating Health Care Provider: _____

Provider's clinical specialty: _____

Treating Provider's Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Treating Provider's Phone Number: (____) _____

Section V – Health Care Decision in Dispute

Describe the health insurer company's decision in your own words. Include any information you have about the health care services, supplies or drugs being denied, including dates of service or treatment and names of health care providers. Explain why you disagree.

Please attach the following:

- Additional pages, if necessary;
- Pertinent medical records;
- If possible, a statement from the treating health care provider indicating why the disputed service, supply, or drug is medically necessary.

[illegible]

Section VI – Expedited Review

**** Complete this section, only if you would like to request expedited review ****

The patient may request that the external review be handled on an expedited basis. To request expedited review, the treating health care provider must complete the attached Provider Certification Form, certifying that a delay would seriously jeopardize the life or health of the patient or would jeopardize the patient’s ability to regain maximum function.

Do you request an expedited review? Yes ____ No ____

Section VII – Request for a Telephone Conference

**** Complete this section, only if you would like to request a telephone conference ****

If the patient, the authorized representative or the treating health care provider would like to discuss this case with the Independent Review Organization and the insurer in a telephone conference, select “Yes” below and explain why you think it is important to be allowed to speak about the case. If you do not request a telephone conference, the reviewer will base its decision on the written information only. The request for a telephone conference will be granted only if there is a good reason why the written information would not be sufficient.

**** Telephone conferences often cannot be completed within the timeframe for expedited reviews ****

Do you request a telephone conference? Yes ____ No ____

My reason for requesting a phone conference is:

VIII – Authorization and Release of Medical Records

I, _____, hereby request an external review and authorize the patient's insurance company and the patient's health care providers to release all relevant medical or treatment records to the Independent Review Organization (IRO) and the New Hampshire Insurance Department. I understand that the IRO and the Department will use this information to make a determination to either reverse or uphold the insurer's denial. I also understand that the information will be kept confidential. I further understand that neither the Commissioner nor the IRO may authorize services in excess of those covered by the patient's health care plan. This release is valid for one year.



Sign Here

Signature of Enrollee (or legal representative – Please specify relationship or title)

Date

Before submitting this application, please verify that you have ...

- ☐ Completed all relevant sections of the External Review Application Form
 - If appointing an authorized representative, the patient must complete Section II.
 - If requesting an Expedited External Review, Section VI must be completed and the Provider Certification Form must be submitted.
 - If requesting a telephone conference, Section VII must be completed.
- ☐ Signed and dated the External Review Application Form in Section VIII.
- ☐ Attached the following documents:
 - A photocopy of the front and back of the patient's insurance card or other evidence that the patient is insured by the health or dental insurance company named in the appeal.
 - A copy of the Health Insurance Company's letter, denying the requested treatment or service at the final level of the company's internal appeals process.
 - Any medical records, statements from the treating health care provider(s) or other information that you would like the Independent Review Organization to consider in its review.
 - If requesting an Expedited External Review, the treating Provider's Certification Form.

Applications for Expedited External Review may be faxed to (603) 271-1406 or sent by overnight carrier to the address on the top of this form. To email the appeal, please call the Insurance Department at 1-800-852-3416 for additional instructions.

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Form 5:

Provider Certification Form for Expedited Review

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The State of New Hampshire Insurance Department

21 South Fruit Street, Suite 14; Concord, NH 03301
Tel.: (603) 271-2261 Fax: (603) 271-1406 TDD Access Relay NH: 1-800-735-2964

PROVIDER'S CERTIFICATION FORM

For Expedited Consideration of a Patient's External Review

NOTE TO THE TREATING HEALTH CARE PROVIDER

The New Hampshire Insurance Department administers the external review process for all fully-insured health and dental plans in New Hampshire. A patient may submit an application for External Review, when his/her health or dental insurer has denied a health care service or treatment, including a prescription, on the basis that the requested treatment or service does not meet the insurer's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness.

The time frame for receiving a decision from an Independent Review Organization (IRO) for a Standard External Review is up to 60 days. Expedited External Review is available, **only if** the patient's treating health care provider certifies that, in his/her professional judgment, adherence to the time frame for standard review **would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function.**

The time frame for receiving a decision from an IRO for an Expedited External Review is within 72 hours. An Expedited External Review may be requested and processed at the same time the patient pursues an Expedited Internal Appeal directly with the insurance company.

**** Expedited External Review is not available, when services have already been rendered ****

GENERAL INFORMATION

Name of Treating Health Care Provider: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: (____) _____ Fax Number: (____) _____

Email Address: _____

Licensure and Area of Clinical Specialty: _____

Name of Patient: _____

PROVIDER CERTIFICATION

I hereby certify that I am a treating health care provider for _____ (hereafter referred to as “the patient”); that adherence to the time frame for conducting a standard review of the patient’s external review would, in my professional judgment, seriously jeopardize the life or health of the patient or would jeopardize the patient’s ability to regain maximum function; and that for this reason, the patient’s appeal of the denial by the patient’s health insurer of requested medical services should be processed on an expedited basis.

I am aware that the Independent Review Organization (IRO) may need to contact me during non-business hours for medical information and that a decision will be made by the IRO within 72 hours of receiving this Expedited External Review request, regardless of whether or not I provide medical information to the IRO.

During non-business hours I may be reached at: (_____) _____.

I certify that the above information is true and correct. I understand that I may be subject to professional disciplinary action for making false statements.

Treating Health Care Provider’s Name (Please Print)

Signature

Date

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