Insurance Navigation Resources

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To apply for additional treatment access support, please visit www.theprojectheal.org/apply-for-support
Affordable Care Act (ACA): the name of the health care reform law finalized in March 2010 that allowed people to purchase their own insurance as individuals, regardless of pre-existing conditions.

Allowed Amount: the negotiated rate and maximum amount your insurance company and provider have agreed upon for a covered health care service. Your co-payments and co-insurance will be based on this amount. This may also be called “eligible expense,” “payment allowance,” or “negotiated rate.” If your provider charges more than the plan’s allowed amount, you may have to pay the difference.

Annual Limit: the amount an insurance plan will pay in total benefits over a year. Once you hit the cap, your policy will not pay again until the next year. The ACA prohibits annual limits on essential health benefits with the exception of grandfathered plans.

Balance Billing: when a provider bills you for the difference between the provider’s charge and the allowed amount. For example, if the provider’s charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider (in-network provider) may not balance bill you for covered services. Balance billing typically occurs when a provider is out-of-network.

Benefits: the healthcare items or services covered under a health insurance plan.

Co-Payment: the amount you pay when you receive care. The co-payment amount is set by the insurance company not the doctor’s office. This can be a percentage or flat rate amount. For example, the amount you pay may be $30.00 each time with the insurance company picking up the rest of the cost.

Co-Insurance: the amount you pay after you meet the plan’s deductible. For example, an 80/20 co-insurance rate means the insurance company pays 80 percent and you pay the remaining 20 percent. Co-Insurance usually does not start until you pay an amount equal to the deductible.

Deductible: the amount you pay out-of-pocket for medical expenses before your plan pays anything for the healthcare services you received. For example, if your deductible is $1,000, your plan won’t pay their portion for a covered service until you’ve hit your $1,000 limit. Premiums do not count toward meeting your deductible.
**Excluded Services:** services your health insurance company or specific plan doesn’t pay for.

**Exclusive Provider Organization (EPO) Plan:** this plan is similar to a HMO plan in that members are required to use network doctors. However, unlike a HMO plan, it is not necessary to select a PCP, you do need to contact a PCP for specialist referrals.

**Explanation Of Benefits (EOB):** an EOB is created after a claim payment has been processed by your health care plan. It explains the actions taken on a claim such as the amount that will be paid, the benefit available, discounts, reasons for denying payment and the claims appeal process. EOBs are available both as a paper copy and online.

**Formulary or Drug List:** a list of prescription drugs your health plan covers. Generic medications are typically covered in a formulary, whereas only some brand names are not.

**Flexible Benefits Plan:** a benefit program that gives employees a choice between cash, life insurance, vacations, retirement plans, and childcare. Although there are usually some requirements, flexible benefit plans offer a choice for the remaining benefits.

**Health Insurance:** a contract that requires your health insurer to pay for a portion (or all) of your healthcare services in exchange for a premium.

**Health Insurance Marketplace:** website where individuals, families, and businesses based in the US can research, compare and choose a health insurance plan that’s best for them.

**Health Maintenance Organization (HMO) Plan:** in this plan, your Primary Care Provider (PCP) is who you want to reach out to first. If you need care outside of what your PCP can offer, they will refer you to another provider.

**In-Network or Preferred Provider:** a physician, healthcare provider or healthcare facility that has a contract with your plan to provide their members services at a lower cost to the insurance company.

**Medical Necessity Criteria:** standards used by health plans to decide whether treatments or health care supplies recommended by your mental health provider are reasonable, necessary and appropriate. If the health plan decides the treatment meets these standards then the requested care is considered medically necessary.

**Network:** the contract between your insurance and your healthcare provider.
**Out-of-Network:** a physician, healthcare provider or healthcare facility that does not have a contract with your plan. Using healthcare services that are not covered in your plan will greatly increase the amount you have to pay.

**Out-of-Pocket Limit:** the amount you pay out of your own pocket when treatment or service is not covered by your plan. For example, some plans do not cover laboratory tests, x-rays, or medication.

**Out-of-Pocket Maximum:** the highest amount of money a person will have to pay during their plan period. It includes the money spent within the deductible amount, co-insurance, co-pays. Once you reach this limit, the insurance company will pay 100% of the allowable amount of costs for all covered benefits. Out-of-pocket maximum is higher than your deductible and does not include medication costs or services that are listed as excluded within your plan language. Today most plans have separate medication and medical out-of-pocket maximums.

**Point of Service (POS) Plans:** this kind of plan will allow you to pay less if you use in-network doctors or services.

**Preauthorization (aka: prior-authorization or pre-approval):** an insurance plan may require prior approval for certain services, drugs, or equipment to consider any charges. Preauthorization is not a guarantee that the insurance plan will cover the cost of the service, however, this is generally the first step for those requiring services that are not currently in-network with their insurance plan.

**Preferred Provider Organization (PPO) Plan:** this plan provides the patient access to a network of preferred providers, also known as in-network doctors. This means the list of doctors have been approved by your health insurance plan. Your out-of-pocket expenses will be less if you use a provider within the plan, however if you use a doctor that is out of network, you will still receive some reimbursement. This type of plan is typically more expensive but they include a larger network of doctors, including specialty doctors.

**Premium:** the amount you pay monthly, quarterly or yearly for your health insurance plan. If you have insurance through the workplace, your employer may pay a portion of your premium on your behalf as part of your employee benefit package.

**Provider:** a physician, healthcare provider or healthcare facility licensed, certified or accredited as required by law.

**Specialist:** this type of provider focuses on a specific area of medicine or illness. Some specialists may not be in-network with your plan.
**Superbill:** A superbill is a detailed, itemized receipt given to clients by a healthcare provider when:

- The provider cannot or does not submit out-of-network claims to a client’s payer
- A client is self-pay for any reason, such as:
  - Benefits do not include medical nutrition therapy (MNT)
  - Their diagnosis is not a covered benefit
- The client does not have health insurance

A superbill may be used by clients for Health Savings Accounts (HSAs), Flexible Spending Accounts (FSAs), tax purposes, or to try to obtain reimbursement from their health plan.

A superbill does not guarantee an insurance provider will reimburse the client for the services provided. The ability of a health plan member to obtain reimbursement from a health plan is dependent on individual member benefits and coverage, as well as health plan policies regarding member reimbursement.

Medicare beneficiaries are unable to submit superbills for nutrition therapy provided by an out-of-network provider. For Medicare plans, outpatient nutrition sessions are only covered for diabetes, kidney disease, and three years following a kidney transplant.

**Utilization review (or utilization management):** process used by insurers to decide whether the requested mental health care is medically necessary, efficient and in line with accepted medical practice. In line with accepted medical practice means that the mental health treatment or service is proven to be effective based on scientific evidence.
Health insurance policies can be overwhelming and tricky. There is a lot of different information that varies by policy, and it can be confusing to understand what your plan does and does not cover, how much the cost is per service, etc.

**Q:** What do all the different payment terms mean?

**A:** A few different factors go into paying for treatment. Most insurance plans have a **premium**, which is a monthly fee that the patient pays for their insurance plan. Many patients also have an **insurance deductible**, which is a set amount that the patient has to pay out-of-pocket **before** their insurance benefits kick in. After the deductible is met, patients are typically responsible for a **copay** (a set dollar amount per visit) or **co-insurance** (a set percentage of the total cost of the visit) each time they receive treatment. Many insurance plans also have an **out-of-pocket maximum (OOPM)**, which is a cap on the amount that the patient pays per year in copays and/or co-insurance.

**Q:** What are common reasons an insurance company denies coverage of eating disorder treatment or payment for services?

**A:** While there are many reasons a health insurance plan may deny coverage of eating disorder treatment or payment for such services, there are some common reasons you may be experiencing, depending on your plan and the services you are seeking coverage for.

- Level of care (or services) deemed not “medically necessary”
- Not eligible for coverage of services requested under your health plan and/or lack of your plan including a benefit (such as eating disorder residential level of care)
- Failure to attempt treatment a lower level of care prior to requesting coverage for a higher level of care
- Not eligible for coverage of services requested until trying “X” services (generally preferred in-network option or one geographically closer)
- Eating disorders are not an explicitly named “row” of issues covered on your health plan’s Explanation of Benefits (EOB) and therefore quickly dismissed without adequate exploration by the payor
**Q: What is the difference between Medicare and Medicaid?**

**A:** Medicaid is a state-run health insurance for people whose income is below a certain level. Medicare is a federally-run health insurance for people above the age of 65 and who have certain qualifying disabilities. Medicaid coverage can vary by state and managed Medicaid plan, while Medicare is accepted in many states regardless of the plan.

**Q: What ED treatment do Medicare and Medicaid cover, and why is it so limited?**

**A:** Currently, most Medicare and Medicaid plans limit their coverage of eating disorder treatment to inpatient (hospital-based) and outpatient programs. It’s important, however, to keep in mind that every plan is different and that you should contact your insurance company to verify your benefits and coverage options.

The coverage of eating disorder treatment for those with Medicare and Medicaid is so limited because of how those programs have been designed. The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) is a federal law that generally requires group health plans and health insurance payors to provide mental health or substance use disorder benefits to have equal benefit coverage of mental health diagnoses as medical diagnoses. However, because medical issues are treated either in a hospital or via office visits, the MHPAEA limits mental health coverage to the same treatment options, i.e. inpatient or outpatient. This then excludes any other levels of care that are often required for mental health conditions like eating disorders, including residential, most partial hospitalization programs (unless they are hospital-based), and most intensive outpatient programs (unless they are hospital-based).

**Q: How do I know which providers are in-network?**

**A:** In-network providers are those who are “preferred” or covered by your insurance plan. To find who is in your network, it may be easier to call your Member Services number and request a list to be emailed to you, listing in-network providers you are looking for (Therapist, dietitian, psychiatrist, etc.).
These providers may be available on the insurance website when entering your area code in
a search tool, and if you are purchasing an insurance plan on the Insurance Marketplace,
you can enter your providers in a tool to show which plans match your current providers.
Another way to check if your providers take your specific plan is to call your selected
provider’s office, and they will inform you if they are in- or out-of-network and provide a
benefits check before your scheduled appointment.

Q: My insurance plan does not have any in-network outpatient specialized eating disorder
therapists. Is there anything I can do to avoid paying a provider out-of-pocket?

A: Depending on the specific insurance plan, there are likely steps you can take to avoid
taking on out-of-pocket costs. Specifically, you will want to follow up with a representative
from your insurance company who can let you know whether or not your plan has an option
to coordinate a single case agreement (SCA) or special coverage agreements. An SCA is a
contract between an insurance company and an out-of-network health care provider for a
specific patient that enables the patient to receive in-network coverage for an out-of-
network provider for an established period of time. Calling the Member Services number,
typically located on the back of your insurance card, will connect you to an insurance
representative.

Q: What do I need to do to see a provider out-of-network?

A: If you do need to see a provider who is not in your network or, out-of-network, due to
the services you are seeking not being available in-network or in your area, there are
additional and different steps you may need to take per your plan’s out-of-network policy.

If your plan has an out-of-network benefit, this will likely be covered by the plan, but this
will usually be at a higher deductible and/or co-pay. Often if out-of-network benefits are
available, there may be a $4,000 deductible, for in-network services, for example, and a
$8,000 deductible for out-of-network. Your in-network copay may be $25 to see your PCP,
whereas the out-of-network copay may be $50.

It is often the case that eating disorder providers or treatment centers will be out-of-
network (a frequent and understandable frustration). Eating disorder providers may be out-
of-network if your insurance plan does not cover eating disorder services, or there are no
specialists available in your area or network.
In these cases, if it is an outpatient provider you are seeking for an eating disorder and they are out-of-network, this will often have to be paid out-of-pocket. Many outpatient providers offer a sliding scale, and you may be able to discuss with them a smaller amount they are willing to bill for your sessions. If an eating disorder treatment center is out-of-network, many plans will allow a Single Case Agreement, a one-time, negotiated contract between provider and insurance payor to set up coverage for your treatment. The amount billed and paid for this service will be discussed ahead of time.

Q: What is pre-authorization and utilization review?

A: A pre-authorization review occurs when your health insurance company reviews a patient’s request for treatment. During the authorization request, your health insurance company will decide whether they are able to cover the requested treatment. A utilization review, typically completed by your treatment facility and/or provider, is a request for continued stay and additional days in treatment. During the utilization review, your insurance company will request information to meet medical necessity criteria according to The Milliman Care Guidelines ("MCG"), a set of health industry best practices, guidelines and diagnostic criteria published by MCG Health for providers and health plans.

Q: What are my options if my health insurance denied pre-authorization for my treatment or covering treatment services already rendered?

A: If your insurance company denies coverage for treatment services, you can submit an appeal for your health insurance to review their decision. The appeal process differs by health insurance company; you can find more information on your health insurance’s appeal process on their website or by calling Member Services. You can find more information about health insurance appeals here and here. If your appeal is denied, you may want to resubmit. If you believe the denial was unfair to the point of being illegal, you should consult an attorney (see list of legal practices that might be able to help LINK).

Q: How do I submit a Single Case Agreement (SCA)?

A: The process of coordinating a SCA varies by insurance provider. However, since SCAs involve both your insurance and your treatment provider, it is recommended to be in touch with both parties throughout the process so that everyone is on the same page.
Q: Will my health insurance cover treatment expenses from a facility located in a state different from where I live?

A: It depends on your insurance provider. Most insurance providers’ websites have a list of all of their in-network treatment providers, so it’s important to check there before your first treatment appointment.

Q: What is the Mental Health Parity and Addiction Equity Act (MHPAEA)?

A: The MHPAEA is a federal law that was signed in 2008. This law requires that insurance companies provide equivalent coverage for mental health and substance use services that they would for other health services. This law paved the way for in-network mental health coverage. However, it is underenforced. It is also proving insufficient for eating disorder treatment because medical care only includes hospital visits or office visits, while eating disorder treatment also includes residential, PHP, and IOP, which are not included under parity.

Health Plans that **MUST** follow parity:
- Group health plans for employers with 51+ employees
- Most group health plans for employers with 50 or fewer employees unless they have been “grandfathered,” which means it was created before the federal parity laws went into effect
- The Federal Employees Health Benefits Program
- Medicaid Managed Care Plans (MCOs)
- State Children’s Health Insurance Programs (S-CHIP)
- Some state and local government health plans
- Any health plans purchased through the Health Insurance Marketplaces
- Most individual and group health plans purchased outside the Health Insurance Marketplaces unless “grandfathered”

Health plans that **do NOT** have to follow parity:
- Medicare (except for Medicare’s cost-sharing for outpatient mental health services do comply with parity)
- Medicaid fee-for-service plans
- “Grandfathered” individual and group health plans that were created and purchased before March 23, 2010.
- Plans who received an exemption based on increase of costs related to parity

*Read more on the MHPAEA here*
Q: Who can I talk to when I have questions about billing, coverage, etc.?

A: When having questions related to billing or coverage of your insurance plan, it is best to call the Member Services number on the back of your insurance card. Depending on your plan, there may be different Member Services numbers to call, a separate one for medical and one for behavioral health. If you need to reach a separate department, a customer service representative will transfer you to the appropriate department.

Q: How to obtain a copy of my insurance benefits?

A: A copy of your insurance benefits with the plan you have chosen should often be provided to you when you first enroll in your plan. This will often be in the form of a PDF, outlining the covered services, costs, premium, etc. If you do not have a copy of this, try looking on your insurance website, or speaking to your employer’s HR department (if insurance is through work), to obtain a copy. You may also call Member Services to request this document be emailed to you.

Q: My insurance does not cover pre-existing conditions and considers my eating disorder a pre-existing condition. How do I get treatment covered?

A: As of 2014, Obamacare will prohibit insurance companies from excluding anyone with a pre-existing medical condition from coverage. If your insurance companies still reports they will not cover a pre-existing condition, you can seek help from a legal aide or other treatment advocate to assist in fighting for your eating disorder treatment to be covered.
How Do I Know What My Health Insurance Covers?

Figuring out what your plan covers can be an overwhelming and exhausting process and overall, a lot of work. Every insurance plan is different. Here are some ways you can find out what your insurance plan covers:

- If you have access to it, read your insurance manual. There should be a Summary of Benefits section that lists out covered services, costs, etc.

- Visit your health plan’s website. Your mental/behavioral health benefits should be listed under covered benefits on the site. Your insurance card may include the web address. If you do not already have one, you may need to create an online account to view your plan information.

- Call your insurance company’s Member Services number, a toll-free number typically listed on the back of your insurance card. Ask to speak to a customer representative about coverage for mental health services. Ask them to explain your benefits. If you have a diagnostic code, that may help you get accurate information. Diagnosis codes are a combination of numbers and letters typically used by treatment providers and insurance companies to identify covered benefits, claims, and payment. If you have a provider, you can ask them what your diagnosis code is for insurance purposes. Please remember – you are not your diagnosis. There labels are used to help describe, for insurance, and not to define.

- Questions to ask when you call for insurance benefits:
  - Is mental health a covered benefit?
  - Is mental health covered for outpatient and higher levels of care such as Intensive Outpatient, Partial Hospital, Residential, and Inpatient?
  - Is there coverage specific for eating disorder treatment?
  - Is nutritional counseling covered? (Sometimes, this is referred to as medical nutritional therapy – MNT)
  - Are there a limited number of visits covered (for mental health therapy, medical nutrition therapy, inpatient, etc.)?
  - What is my copay for (service requested)?
  - What is my deductible?
  - What is my out-of-pocket max?
  - Do I have out-of-network benefits?
  - Can you explain to me what my benefits are (for requested service)?
> Can you send me a copy of my benefits, and/or can I access it on the insurance website?
> Ask for a copy of the guidelines your insurance company uses to determine the level of care (they're required to give it to you).

- You can also call a treatment center or provider and provide your health insurance information. They will reach out to insurance for you and run a “Verification of Benefits” and break down what your benefits look like and what is covered.

**What is a medical necessity? Is that different from a covered service?**

Medical necessity is a term you may come across when seeking mental health and eating disorder treatment. Medical necessity is not the same as a covered medical benefit.

A medical benefit is something that your insurance plan has agreed to cover. Medical necessity is treatment, such as higher levels of care of eating disorder treatment, that your provider feels is necessary for you to receive. Insurance may not agree with what is medically necessary. Insurance companies often deny coverage for medically necessary eating disorder treatment or approve treatment only for a lower level of care.

If your insurance company denies your treatment, you have the right to appeal their decision. If working with a provider, they can help guide you through the appeal process. Your insurance company will also provide you information needed to appeal their decision yourself. Be persistent and advocate for yourself as much as possible.

*Denials can be reversed. Do not give up!*
AFFORDABLE CARE ACT (ACA) &
THE INSURANCE MARKETPLACE

What is the Insurance Marketplace?

First – What is the Affordable Care Act (ACA)?

The Affordable Care Act, also known as “Obamacare,” was developed to help individuals access affordable health insurance through a health insurance Marketplace. The Affordable Care Act helps create a competitive private health insurance market, designed to put people in charge of their health coverage and care. These State-based, competitive marketplaces provide millions of Americans and small businesses with "one-stop shopping" for affordable coverage.

To purchase a plan through the insurance marketplace, sign up must be during open enrollment (a period each year when you can sign up for health insurance or change your plan). You may still be eligible to sign up for a plan outside of open enrollment if you had a qualifying life event (changing jobs, losing a job, getting married/divorced, moving, having a baby, etc).

The marketplace has several health insurance companies with many pros and cons varying in provider networks, deductibles, and other costs. The marketplace is set up to compare each plan and the pros and cons easily on the site.
Source: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Markplaces

So, what is the Marketplace?

The health insurance Marketplace are organizations, varying in plans by state, through which people can purchase health insurance. You can view and compare insurance for coverage and affordability, due to the ACA.
Common questions answered by the Marketplace on healthcare.gov:

Q: Can I apply for insurance through the Marketplace any time?

A: Marketplace plans can be purchased during:

1. Open Enrollment
2. Special Enrollment Period
3. Eligible for Medicaid or CHIP
4. Applied for Medicaid or CHIP during open enrollment and find out ineligible after open enrollment ends

The Open Enrollment Period typically occurs at the end of the year November 1 through January 15. Coverage will begin the first day of the month after you sign up.

With a Special Enrollment Period. If you lose job-based coverage, have a baby, get married, move, or have certain other life changes, you can enroll. If eligible, you may qualify for help paying for coverage, even if you weren’t eligible in the past. Learn more about lower costs.

Through Medicaid or the Children's Health Insurance Program (CHIP). You can apply any time and can enroll immediately if you’re eligible. If you are denied coverage and deemed ineligible for Medicaid or CHIP after open enrollment ends, you will be able to apply for a new insurance plan through the Marketplace.

Q: How do I report changes to my income, family, or address?

A: You can report changes to the Marketplace 3 ways: online, by phone, or in person — not by mail.

It’s important to report any changes as soon as possible. These changes may affect your coverage and savings.

Q: How do I submit documents?

A: You can upload the documents online, which is the fastest and easiest way to get them processed. Or you can mail copies instead.
Q: How do I pay my monthly premium to complete my enrollment?

A: When you have Marketplace insurance, you'll pay your premiums directly to the insurance company — not to the Health Insurance Marketplace®. Your coverage won't start until you pay your first premium.

Get more information on completing your enrollment.

Q: How do I choose an insurance plan on the Marketplace?

A: If you are qualified for a health plan through the Affordable Care Act (through open enrollment or a qualifying life event), you can start by going to, you can apply for health coverage in several ways:

- Online at healthcare.gov
- By phone
- With the help of someone in your community
- Through an agent/broker
- Through certified enrollment partner websites
- With a paper application
- The most common, and easiest, way to review and choose a health plan is to go to healthcare.gov. This will allow you to visually view health plans side-by-side to compare coverage.

Health Plan Categories:

**Bronze Plan** – Estimated to cover 60% of medical bills, leaving the insured member to pay the remaining 40% up to established out-of-pocket maximum.

**Silver Plan** – Estimated to cover 70% of medical bills up to established out-of-pocket maximum.

**Gold Plan** – Covers 80% of medical bills up to established out-of-pocket maximum.

**Platinum Plan** – Estimated to cover 90% of medical bills up to established out-of-pocket maximum.

Plans will be available and vary by income.
Step-by-Step Guide to apply for insurance on the Marketplace:

- Apply online by going to healthcare.gov

- Click on “See If I can Enroll”

- If you are not sure if you qualify, you can type in your zip code to see if you qualify to change or add new health coverage in a special Open Enrollment Period. If it is an Open Enrollment Period (these dates will be available on the website), you should be able to qualify for new coverage.

- Once entering your zip code, you will be routed to the appropriate page for your state.

- The shop and compare tool will allow you to search for different monthly premiums, preferred providers, and eligibility for financial help towards your health insurance.

- You then will be prompted to create an account, if you do not already have one, and complete an application for eligibility, being Open Enrollment or a qualifying life event—the site will show eligible life events to choose form.

- Once completing your application and confirming your eligibility, you will click on “Shop for Plans.”

- All plans within your eligibility will appear on the site. You have the option to enter in your providers, to see if they accept the available health policies, and to filter preferences to narrow down the plans.

- Once choosing one that works best for you, you will select the plan, pay your first month’s premium, and set up a way to continue paying monthly.

- This can be a difficult and overwhelming decision. If you feel you need additional guidance before selecting your plan and would like to ask some questions, you may call 1-800-318-2596 or (TTY 1-855-889-4325) – available 24/7, other than on holidays.

Last updated April 2022
# EATING DISORDER TREATMENT

## Levels of Care

<table>
<thead>
<tr>
<th>LEVEL OF CARE</th>
<th>HOW DOES THE PATIENT QUALIFY</th>
<th>WHAT THE PATIENT CAN EXPECT</th>
<th>DOES INSURANCE PROVIDE COVERAGE</th>
</tr>
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| INPATIENT (IP)                    | • Patient is medically unstable  
• Patient needs 24/7 supervision to stay safe                                                   | • Average stay stay ranges from 7 days – 1 month  
• All meals and snacks are supervised  
• Locked bathrooms  
• Most therapy and nutrition sessions are group-based  
• Patient lives on-site                                                                  | • Yes, but prior authorization is needed                                                   |
| RESIDENTIAL (RES or RTC)          | • Patient is medically and/or psychologically stable, but they need a structured environment away from home in order to recover | • Average length of stay ranges from a few weeks to one year  
• All meals and snacks are supervised  
• Program is a mix of group and individual therapy and nutrition sessions  
• Patient lives on-site                                                                  | • Often private insurance only, and prior authorization is needed  
• SCA possible for private and public health plans, depending on plan and program         |
| PARTIAL HOSPITALIZATION PROGRAM (PHP or Day Treatment) | • Patient is physically and psychologically stable, but they need daily support to keep from declining | • Average length of stay is 4–8 weeks  
• Program meets 5–7 days per week during the day  
• At least two supervised meals per day  
• Program is a mix of group and individual therapy and nutrition sessions  
• Patient lives off-site                                                                  | • Private insurance does  
• Government funded typically when the program is hospital-based  
• Prior authorization is often needed  
• SCA possible for private & public health plans                                             |
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<th>LEVEL OF CARE</th>
<th>HOW DOES THE PATIENT QUALIFY</th>
<th>WHAT THE PATIENT CAN EXPECT</th>
<th>DOES INSURANCE PROVIDE COVERAGE</th>
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<tbody>
<tr>
<td>INTENSIVE OUTPATIENT (IOP)</td>
<td>• Patient no longer needs daily support, but they still need a structured environment for recovery</td>
<td>• Average length of stay is 6-12 weeks</td>
<td>• Yes – often private insurance only, and prior authorization might be needed</td>
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<td>• Program meets 3 days per week for 3 hours at a time</td>
<td>• SCA possible for private and public health plans</td>
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<td>• One supervised meal per session</td>
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<td>• Therapy and nutrition sessions may be individual and/or group-based</td>
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<td>• Patient lives off-site</td>
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<td>OUTPATIENT (OP)</td>
<td>• Patient needs support to recover, but can function in their day-to-day life with low risk</td>
<td>• Treatment is ongoing, from a few months to a few years</td>
<td>• Yes, but it is usually limited to in-network providers and there is rarely a mechanism to search for eating disorder specialists</td>
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<td>• Treatment includes:</td>
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<td>○ Individual therapy</td>
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<td>○ Nutrition/dietitian therapy</td>
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<td>○ Psychiatry appointments</td>
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<td>○ Medical appointments</td>
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<tr>
<td>INTENSIVE FAMILY TREATMENT (IFT)</td>
<td>• Patient is 24 or younger and lives with family of origin</td>
<td>• Entire family is included in treatment</td>
<td>• Rarely</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• One-week intensive</td>
<td></td>
</tr>
<tr>
<td>FAMILY-BASED THERAPY (FBT)</td>
<td>• Patient is an adolescent or an adult who lives with family</td>
<td>• Treatment is therapist-led</td>
<td>• Rarely</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Focused on empowering parents to feed their child</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Typically runs for 20 sessions</td>
<td></td>
</tr>
</tbody>
</table>

**Source:** Nationaleatingdisorders.org
SINGLE CASE AGREEMENTS (SCAs)

What is a SCA?

A Single Case Agreement (SCA) is a one-time contract between an insurance company and an out-of-network provider so the patient can see that provider using their in-network benefits. It is essentially an exception to the network so that the patient will only have to pay their routine in-network co-pays for sessions after meeting their in-network deductible (if any). The fee per session that will be paid by the insurance company is negotiated by the insurance company and the provider as part of the SCA.

SCAs can be justified when:

- The outpatient provider/treatment program has a clinical specialty, which is not available among any in-network provider
- The in-network provider does not treat people of your age, gender, or religious preference
- The geographical location of the patient does not have any in-network providers
- A patient who has recently changed their insurance plan or is stepping down to a different level of care at the same facility (continuity of care)
- All in-network providers are full and have no availability
- There is proof that the available in-network providers are inappropriate or would cause harm (e.g. the patient is transgender and they need a provider with expertise in transgender expertise)
- If a plan does have out-of-network benefits, the deductible, out-of-pocket max, and/or co-pay may be too costly financially
- SCAs can be obtained and are often needed Medicaid plans, when there are often no in-network options and no out-of-network benefits are available. This is especially common in Medicaid plans when residential level-of-care is being requested
- SCAs are possible for some Medicare plans, but it may be more difficult to obtain a SCA with Medicare than private plans or Medicaid plans - the best first step to request a SCA for Medicaid and Medicare is to request a behavioral health case manager (or Medicaid/Medicare may refer to case manager as case coordinators)

How do I set up a SCA?

SCAs are typically negotiated directly between your healthcare provider and your insurance company. When you first reach out to your healthcare provider for treatment, you can ask them whether they would be willing to negotiate a SCA with your insurance company. Be prepared to provide details about your medical history and whether you have received eating disorder treatment in the past. The stronger your case is that your chosen provider is the best care for you, the more likely your insurance company will agree to a SCA.
How long does a SCA last?

SCAs typically last for the length of your treatment. However, if you complete treatment with your provider and decide to resume treatment at a later date, you would need to negotiate a new SCA with your insurance company.

Steps to set up and advocate for a SCA:

- Start by contacting member services at your insurance company (behavioral/mental health number will often be on the back of your insurance card) to request a list of in-network (INN) providers/treatment facilities that specialize in eating disorders.

- If there are no INN providers available, ask if you have out-of-network benefits. Many insurance plans do not have out-of-network benefits. In this case, ask who you can speak to to determine if a single case agreement is possible. Inform them you have “exhausted all resources” and “there are no known residential eating disorder facilities INN” with your plan that meets ________ needs.

- When speaking with your insurance company, ask to be assigned a behavioral health case manager, if you do not already have one. This is a free enrollment, and your case manager will be your advocate from inside the insurance company, helping connect you to INN resources. Your case manager will be your point of contact at the insurance company. Tell the representative on the call this is urgent and contingent on you finding immediate treatment - this will hopefully lead to them getting back to you sooner rather than later. If you haven’t heard back in 1-2 weeks, do not be afraid to call back and be a squeaky wheel!

- If you do not have INN providers that meet your needs, research and call eating disorder treatment admissions to ask if they will work with your insurance by requesting a SCA. This will often vary by plan, and certain facilities will not work with Medicaid. Start will in-state or closer-by facilities, if possible - these are sometimes more likely to be approved for a SCA.

- Once you find a treatment center willing to work with your insurance, they will guide you through next steps in the process to be assessed and request the SCA.

- If you have outpatient providers (therapist/dietician/psychiatrist/PCP), it may be helpful to have them communicate with the treatment center to provide more rationale for your recommendation to a higher level of care and the need for a SCA. This may be helpful in gathering more information for insurance to meet “medical necessity criteria” for a SCA.
APPEALING INSURANCE DENIALS

If your health insurance denies coverage for your treatment, you can submit an appeal. There are two types of insurance appeals:

- **Internal appeal**: your insurance company does a “full and fair review” of its decision to deny coverage for treatment. You can learn more about internal appeals here.

- **External review**: an independent third party determines whether your insurance company should have denied coverage for treatment. You can learn more about external reviews here.

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**Appeal Letter Template 1** (source: University of Rochester Medical Center)

Dear [Appeals Analyst]:

I am writing, on behalf of [name of Plan member if other than yourself], to appeal the [name of Health Plan] decision to deny [name of service, procedure, or treatment sought] for [name of Plan member if other than yourself].

It is our understanding that [name of Health Plan] is denying coverage on the basis that "[cite Health Plan's language in the denial letter]." [Attach denial letter.] We believe that [name of service, procedure, or treatment sought] is medically necessary to treat [name of Plan member if other than yourself]’s medical condition and that [name of service, procedure, or treatment sought] is a covered plan benefit.

[Name of Health Plan] covers medically necessary services that are not expressly excluded, which are described in the Evidence of Coverage and which are authorized by the member’s PCP and in some cases approved by an Authorized Reviewer. [Attach relevant section from Evidence of Coverage.]

The entire treatment team has recommended that [name of service, procedure, or treatment sought] is medically necessary. [Attach supporting medical letter.]

Contrary to your letter, [name of service, procedure, or treatment sought] is a covered service. [Name of service, procedure, or treatment sought] is stated as a covered benefit in your HMO Member Handbook, is implicitly covered in the Evidence of Coverage, and is not expressly excluded as a covered service in the Evidence of Coverage. [Quote from Member Handbook and Evidence of Coverage to establish that the service, procedure, or treatment is a covered benefit and not expressly excluded.] [Cite your state’s mandated benefit laws requiring that the health plan provide this coverage.]
APPEALING INSURANCE DENIALS

[Describe member’s health condition, and why the service, procedure, or treatment would benefit the member and the consequences if the patient does not receive this treatment.]

[If the treatment is out-of-network, establish that there are no comparable services offered within the network.]

[Finally, if you feel they won’t cover the service because of the precedent, ask them to consider covering it as an extra-contractual benefit, and to pay for the service, procedure, or treatment out of the Health Plan’s catastrophic payment pool.]

[If the member requires immediate treatment for the condition, request an expedited hearing – request that they respond within 72 hours of mailing of the letter. Note that ACA now requires a 72-hour expedited internal review for urgent care. This time frame is required for plan years or policy years beginning on July 1, 2012.]

[Attach a letter from your treating physician describing the person’s condition.]

Thank you for your immediate attention to this matter.

Sincerely,

[Your name]

cc: [Possible people to whom you should consider sending copies of your letter including Health Plan Medical Director; Medical Group: Medical Director; Your primary care or treating physician; Your state representative if you expect more denials]
Appeal Letter Template 2 (source: Journal of Psychiatric Practice: Providing a Routine Medical Necessity Letter to Improve Access to Care for Our Patients)

By Joseph Feldman, MBA Mark DeBofsky, JD Eric M. Plakun, MD Cheryl Potts, MBA

TEMPLATE FOR A MEDICAL NECESSITY LETTER

Date:
To Whom It May Concern:

This letter describes my clinical assessment and the medically necessary treatment for my patient [patient]. I have been treating [patient] since approximately [date].

[Provider credentials and practice]— include a brief summary of your training, medical or other professional school, residency, fellowship and internship training, hospital affiliations, years in practice, peer-reviewed publications in the area in question, relevant specialties relevant to the specific patient, and any other description of your qualifications that inform your professional judgment. The information included here will establish your qualifications to make the clinical determination to be described below.

[Substantiated clinical assessment]— include a brief summary of your diagnosis/assessment, focusing on the particulars relevant to the medically necessary treatment that you have determined is appropriate including:

• Related observations that informed your determination of the treatment plan.

• Peer-reviewed standards and medical treatment guidelines that informed your judgment. (Guidelines may include LOCUS,8 CALOCUS,8 ASAM,9 DSM-5,13 Psychiatry Online guidelines,10 AACAP primary case guidelines,11 Nice (UK) guidelines,12 and institutional guidelines.) To the extent that this particular patient’s needs vary from or are atypical vis-à-vis standards and guidelines, it would be helpful to include relevant commentary.

• Considerations related to standards of care and other references based on the Wit v United Behavioral Health lawsuit (see Appendix B “Suggested Text for Potential Inclusion in a Medical Necessity Letter”). (It is neither necessary nor appropriate (a) to speculate on the probability of success with any particular course of treatment, (b) to explore any “what ifs” regarding the potential evolution of the treatment, or (c) to assess whether or not the insurance policy will cover the treatment. Your current assessment is sufficient.)
[Course of treatment]—description of the course of treatment that you have determined to be medically necessary, including:

- Summary rationale for your medical decision-making.

- When possible, link your recommendation for medically necessary treatment to a professional society multidimensional assessment instrument, such as the Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS) or the Child and Adolescent Level of Care Utilization System (CALOCUS) developed by the American Association of Community Psychiatrists or the American Society of Addiction Medicine (ASAM) criteria. Also include reference to the relevant elements of effective treatment from the Wit lawsuit (specific suggestions are provided in Appendix B to this article).

- Be sure to use the words “determined to be medically necessary”; leave no doubt that “medically necessary” is the standard for your treatment decision.

- Identify (a) specific harms that could occur, (b) avoidable risks that could be mitigated, and/or (c) clinical gains that could be lost absent your planned course of treatment.

- This letter is neither a recommendation for approval nor the persuasive presentation of evidence for evaluation by others. Rather, it introduces you and your expertise, summarizes your relationship with and assessment of the patient, and your (by now, obviously qualified) determination.

Sincerely,

[Signature]
Legal Practices that Work on Eating Disorder Litigation

- Berger & Green (PA)
- Disability Insurance Law Group (FL)
- Kantor & Kantor, LLP (CA, OR, and WA)
  - Q & A with Lisa Kantor: How to Get Coverage for the Treatment of My Eating Disorder
- Law Offices of Scott Glovsky (CA)

Legal Practices that Deal with Health Insurance and Parity Violations

- The Kennedy Forum
- Crowell & Moring LLP (Kathy Hirata Chin in particular), (NY)
- DeBofsky Sherman Casciari Reynolds P.C. (IL)
- Dickinson Wright LLP (AZ, CA, FL, KY, MI, OH, NV, TN, TX, and Washington DC)
- Epstein Becker & Green (CA, CT, FL, IL, MD, MI, NJ, NY, TN, TX, and Washington DC)
- Hall Render Killian Heath & Lyman (AK, CO, IN, MD, MI, NC, TX, WA, WI, and Washington DC)
- Napoli Shkolnik PLLC (Matthew Lavin in particular) (Washington DC)
- Psych Appeal (CA)
- Zuckerman Spaeder (FL, MD, NY, and Washington DC)