**Introduction for Employers** (The MDRF begins on the following page)

In response to employers’ calls for improving in-network access to care for mental health and substance use disorders (MH/SUDs), this Model Data Request Form (MDRF) was developed with funding from MHTARI as a public service with the intention of enabling employers to: (a) measure the adequacy of their TPA’s current behavioral provider network, (b) assess any barriers to the network, including actual participation by psychiatrists in their TPA’s MH/SUD provider network(s), and (c) request improvements as necessary. The MDRF provides definitions, instructions and data requests that employers can send to their TPAs (or consultants) to obtain meaningful data reporting on four key and readily measurable areas, set forth in a specified format.

This document has been adopted as a best practice by the [National Alliance of Health Care Purchaser Coalitions](https://www.nationalalliancehealth.org/) and the [HR Policy Association](https://www.hrpolicy.org/). **It may be updated from time to time**. A current version of the MDRF can be found at [https://www.mhtari.org](https://www.mhtari.org/).

The MDRF focuses on five (5) key quantitative measures:

1. **Out-of-Network Use** of MH/SUD providers versus medical/surgical (M/S) providers
2. **In-Network Reimbursement Rates** for MH/SUD versus M/S providers
3. **Denial Rates** for MH/SUD versus M/S services
4. **Network Adequacy and Participation** for Psychiatrists and other MH/SUD professionals
5. **Operational Proportionality** for MH/SUD versus M/Sfor UM Protocols

When sending the MDRF (with appropriate employer-specific modifications, if any) to TPAs or consultants, employers should indicate in a cover letter which health plans (“Specified Plans” including at least one PPO) and geographic regions (“Specified Regions”) are to be analyzed. If, for example, 2 Specified Plans and 2 Specified Regions are identified, then 4 separate versions of MDRF tables should be completed, as well as a 5th “aggregate” version.

***DISCLAIMER: The MDRF and this introductory page (“MDRF Material”) is made available for informational purposes only and is not intended to and should not be construed as providing legal advice. Each situation is highly fact specific and requires knowledge of both state and federal laws. Therefore, each employer or other user (“User”) of the MDRF Material should receive legal advice from a licensed attorney when considering: (1) whether the MDRF would achieve its intended purpose and (2) whether modifications to the MDRF are needed, for example, to address the User’s specific circumstances. Each User assumes all risk from any use of the MDRF Material or any information contained herein. The Bowman Family Foundation, MHTARI and the authors shall have no responsibility or liability for any errors or omissions, and specifically disclaim any and all representations and warranties, express or implied, regarding the MDRF Material, including without limitation the ability of the MDRF to achieve its intended purpose, the accuracy and completeness of the MDRF Material, the suitability or impact of the MDRF with respect to any self-insured employer’s health plan or any agreement between such employer and a TPA, and the relevance and applicability of the MDRF Material to any specific User.***

End of Introduction. MDRF begins on the following page.

**MODEL DATA REQUEST FORM BEGINS HERE.**

[To TPA or consultant]:

Please provide the plan data analyses set forth below within days of today’s date. This information will allow our executives to better understand the experience of our plan members when seeking to access MH/SUD treatment as compared to medical/surgical (“M/S”) treatment. For each of the four (4) sections set forth below, please provide the data analyses for the health plans (“Specified Plans”) and geographic regions (“Specified Regions”) *identified in separate instructional correspondence,* and/or for all TPA covered lives in the Specified Region when indicated*.* Please also provide aggregate versions for Specified Plans and Specified Regions when requested. Please contact us with any questions.

Please provide all information in a manner compliant with HIPAA’s Privacy Rule (45 CFR Part 164) and Confidentiality of Substance Use Disorder Records (42 CFR Part 2), as applicable.

***SECTION I: OUT-OF-NETWORK USE (BASED ON CLAIMS SUBMITTED)***

For the Specified Plans that have Out-of-Network (“OON”) benefits, (i.e., PPO and/or POS plans, not including plans such as HMOs or plans with only “network gap exceptions”), utilizing total claims submitted for both In-Network (“INN”) and OON services, complete Table 1 with respect to the percentage of all submitted claims that were for OON services.

**Definitions.** For purposes of this MDRF:

* *Acute Inpatient facility* is defined as a hospital and encompasses (a) all M/S admissions to general acute care hospitals, long-term acute care hospitals; and (b) all MH/SUD admissions to psychiatric hospitals and general acute care hospitals.
* *Sub-acute Inpatient facility* is defined as a non-hospital based facility or residential treatment facility and encompasses (a) all M/S admissions to inpatient rehabilitation facilities, skilled nursing facilities and; (b) all MH/SUD admissions to non-hospital based inpatient facilities and residential treatment facilities.
* *Outpatient facility (other)* is defined as, for example (a) physical, occupational, speech, and cardiovascular therapy, outpatient surgeries, interventional radiology, and infusion therapies for M/S care provided in an outpatient facility setting; and (b) intensive outpatient and partial hospitalization services for MH/SUD conditions in an outpatient facility setting, applied behavioral analysis (ABA), opioid treatment programs (OTPs), medication-assisted programs (MATs).
* *Office visit* is defined as professional services (MH/SUD or M/S) provided in a non-facility based office setting.

*Please complete versions of Table 1 below for:* ***(a)*** *the employers’ members only, and* ***(b)*** *all TPA covered lives for self-insured plans in the Specified Region, with claims data for Calendar Year 2022 or for the period January 1, 2022 through the latest month in 2022 for which reasonably complete claims data is available***.**

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**Instructions for Completing Table 1:**

* In Rows 1–4, Columns A and B, insert the percentage of all submitted claims that were for OON services for M/S Providers (Column A) and for MH/SUD Providers (Column B) for acute inpatient facility stays, sub-acute inpatient facility stays, outpatient facility visits, and office visits, separately.

“Percentage of submitted claims” is to be based on volume of individual claims (including claims for services delivered via telehealth) and not based on dollar amounts. If there are multiple claims for an extended admission or treatment course, each claim should be counted individually.

For the percentages in question, the numerator and denominators are defined as:

1. Numerator for M/S for each setting: **# Out-of-Network** claims **submitted** for medical and surgical services for the specified time period

Denominator for M/S for each setting: **Total # claims** (In and Out-of-Network) that

were **submitted** for medical and surgical services for the specified time period

1. Numerator for MH/SUD for each setting: **# Out-of-Network** claims **submitted** for MH/SUD services for the specified time period

Denominator for MH/SUD for each setting: **Total # claims** (In and Out-of-Network)

**submitted** for MH/SUD services for the specified time period

* For each row in Column C, subtract the percentage in Column A from the percentage in Column B.
* For each row in Column D, divide the percentage in Column B by the percentage in Column A.

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|  |  | **Table 1 – Data for January 1, 2022 through , 2022** |
|  |  | **Column A** | **Column B** | **Column C** | **Column D** |
|  | **Setting** | **M/S Providers Percentage of all submitted claims that were for OON services** | **MH/SUD****Providers Percentage of all submitted claims that were for OON services** | **Percentage of all submitted claims for OON services for MH/SUD Providers minus percentage of all submitted claims for OON services for M/S****Providers** | **How many times more often MH/SUD****services were provided OON as compared to M/S services** |
| 1 | Acute Inpatient Facility Stays | % | % | pct points | x |
| 2 | Sub-acute Inpatient Facility Stays  | % | % | pct points | x |
| 3 | Outpatient Facility Visits | % | % | pct points | x |
| 4 | Office Visits | % | % | pct points | x |

**Table 1 Comparisons to be Conducted:**

For any version of Table 1, in Column C, if the percentage of all submitted claims for OON services for MH/SUD Providers minus the percentage of all submitted claims for OON services for Medical/Surgical Providers is 5 percentage points or more for acute inpatient facility, sub-acute inpatient facility, outpatient facility or office visits, please provide a **Plan of Improvement** in a separate report within days from the date of your response.

The **Plan of Improvement** should include: specific steps you will undertake to reduce OON use of MH/SUD providers, for example: increasing INN reimbursement rates, by how much and during what time period; reducing utilization review “hassle factors” such as frequency of reviews, time constraints within which peer to peer reviews must be conducted, paperwork (e.g., written treatment plans and updates) not required for M/S providers; overall micromanagement of cases resulting in increased provider administrative costs; length of time it takes for a provider to be admitted to the network; other delays in network provider admission; restraints on appeals for denied care; etc.

***SECTION II: IN-NETWORK REIMBURSEMENT RATES***

For In-Network provider office visits only, for the CPT codes provided in Tables 2A, 2B(1) and 2B(2) below, provide the weighted average allowed amounts for the following four (4) groups of providers:

* *Primary Care Physicians, “PCPs”,* defined as general practice, family practice, internal medicine, OBGYN and pediatricians.
* *Non-psychiatrist Medical/Surgical Specialist Physicians*, defined to include non-psychiatrist specialty physicians, such as cardiologists, oncologists, orthopedic surgeons, dermatologists, neurologists, etc. This category excludes PCPs*.*
* *Psychiatrists*, including child psychiatrists.
* *Psychologists and Clinical Social Workers*, defined to include psychologists and clinical social workers who are licensed, credentialed, practice independently and are eligible to be reimbursed for MH/SUD services billed. Other Masters-level MH/SUD clinicians, nurses and psychiatric nurse practitioners should be excluded.

*Please complete versions of Tables 2A, 2B(1) and 2B(2) for* ***(a)*** *the employers’ members only, and* ***(b)*** *all TPA covered lives for self-insured plans in the Specified Region, with claims data for Calendar Year 2022 or for the period January 1, 2022 through the latest month in 2022 for which reasonably complete claims data is available.*

**Instructions for Completing Table 2A:**

* In Rows 1–4, insert the weighted average in-network allowed amounts (weighted by the proportion of claims allowed at each allowed amount level) for Column A (CPT Code 99213) and Column B (CPT Code 99214). This calculation will provide the same result as calculating the sum of the allowed amounts for every in-network 99213 and 99214 claim, separately, that was allowed for these providers, and dividing each sum by the total number of such claims allowed for such providers.
* In Rows 5, 6 and 7, insert the percentage amount (if any) by which the in-network reimbursement for PCPs, other non-psychiatrist M/S specialist physicians, and both (combined) was greater than for psychiatrists: i.e., ((Row 3 / Row 4) – 1) x 100 = %. If this calculation results in zero or a negative number, there was no “higher In-Network reimbursement”.

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|  | **Table 2A – Data for January 1, 2022 through , 2022 Medical/Surgical Physicians compared to Psychiatrists** |
|  | **Description** | **Column A** | **Column B** |
|  | **For In-Network Office Visits Only (non-facility based)** | **CPT Code 99213** | **CPT Code 99214** |
| 1 | Weighted average allowed amount for primary care physicians (PCPs) – general practice, family practice, internal medicine, and pediatric medicine physicians | $ | $ |
| 2 | Weighted average allowed amount for non-PCP, non-psychiatrist M/S specialist physicians | $ | $ |
| 3 | Weighted average allowed amount for PCPs and non-psychiatrist M/S specialist physicians (combined) | $ | $ |
| 4 | Weighted average allowed amount for psychiatrists, including child psychiatrists | $ | $ |
| 5 | Percentage by which in-network allowed amounts for PCPs were higher compared to psychiatrists | % | % |
| 6 | Percentage by which in-network allowed amounts for non-psychiatrist M/S specialist physicians were higher compared to psychiatrists | % | % |
| 7 | Percentage by which in-network allowed amounts for PCPs and non-psychiatrist M/S specialist physicians (combined) were higher compared to psychiatrists | % | % |

**Table 2A Comparisons to be Conducted:**

If, in any version of Table 2A, the percentage in Row 5, 6 or 7, Column A and/or B is a positive number, (indicating that PCPs, or non-psychiatrist M/S specialist physicians, or both combined receive higher allowed amounts than psychiatrists), and/or there are disparities in OON use as shown in Section I, or other metrics of network adequacy, provide a **Plan of Improvement** in a separate report within days from the date of your response.

Your **Plan of Improvement** should address the comparability of reimbursement rates, as well as the adequacy of MH/SUD rates if there are disparities in OON use as shown in Section I, or other metrics of network adequacy. Please include specific actions you plan to take, such as increasing in-network reimbursement rates that would address lack of comparability in rates and/or high MH/SUD OON use.

**Instructions for Completing Tables 2B(1) and 2B(2):**

* In Rows 1–3, Column A, insert the plan weighted average in-network allowed amounts (weighted by the proportion of claims allowed at each allowed amount level) for the CPT Codes listed. This calculation will provide the same result as calculating the sum of the allowed amounts for every in- network 99213, 99214, 90834, and 90837 claim, separately, that was allowed for these providers, and dividing each sum by the total number of such claims allowed for such providers.
* There is only one National Medicare Physician Fee Schedule allowed amount for all providers participating in Medicare for the following four (4) CPT codes for which data is requested: *99213, 99214, 90834 and 90837.* The Medicare fee schedule allowed amounts for 2022 for non-facility based services have been provided in Column B of the template tables that follow and can be verified by following the instructions in the footnote.[1](#_bookmark0) National Medicare fee adjustments are sometimes made for non-physician providers. In this regard, the adjusted fee schedule allowed amount for clinical social workers has been provided in the template tables. Provider locality adjustments have not been taken into account for regional markets, as the testing herein is comparative (MH/SUD vs. M/S), rather than absolute, and will thus yield useful allowed amount comparative information irrespective of region.
* Rows 1–3, Column C, insert the plan weighted average in-network allowed amount as a percentage of the Medicare Fee schedule amount.
* In Rows 2–3, Column D, insert the percentage by which in-network allowed amounts for PCPs and non-psychiatrist M/S specialist physicians (combined) (indexed to Medicare) were higher compared to psychologists and clinical social workers (indexed to Medicare). If this calculation results in zero or a negative number, there was no “higher In-Network reimbursement”.
	+ For Psychologists: ((Column C Row 1 / Column C Row 2) – 1) x 100 = %
	+ For Clinical Social Workers: ((Column C Row 1 / Column C Row 3) – 1) x 100 = %

1 The Medicare Physician Fee Schedule can be found at: [https://www.cms.gov/apps/physician-fee-](https://www.cms.gov/apps/physician-fee-schedule/search/search-criteria.aspx) [schedule/search/search-criteria.aspx.](https://www.cms.gov/apps/physician-fee-schedule/search/search-criteria.aspx) Select the last complete calendar year, select “Pricing information,” select “List of HCPCS codes,” enter each of the four codes, select “All modifiers,” select “National payment amount,” and click the “Search fees” button**. Please utilize the “Non-facility Price” column.** Also refer to the one page “[Medicare Physician Fee Schedule (MPFS) Quick Reference Search Guide](https://www.cms.gov/files/document/2020-physician-fee-schedule-guide.pdf)” for a step-by-step summary of how to use the MPFS. Also refer to “[Medicare Claims Processing Manual,” Chapter 12, “Physicians / Nonphysician](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf) [Practitioners](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf)” to verify any adjustments to the MPFS.

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| **Table 2B(1) – Data for January 1, 2022 through , 2022 Medical/Surgical Physicians compared to Psychologists and Clinical Social Workers****for CPT Codes 99213 & 90834, Indexed to National Medicare Fee Schedule** |
|  |  |  | **Column A** | **Column B** | **Column C** | **Column D** |
|  | **Provider Type For In-Network Office Visits Only****(non-facility based)** | **CPT****Codes** | **Plan Weighted Average Allowed Amount** | **National Medicare Fee Schedule Amount** | **Plan Weighted Average****Allowed Amount as a****Percentage of Medicare** | **Percentage by which In-Network allowed amounts for PCPs and non-psychiatrist M/S specialist physicians (combined) (indexed to Medicare) were higher compared****to psychologists and clinical social workers (indexed to Medicare)** |
| 1 | PCPs and non- psychiatrist M/S specialist physicians (combined) | 99213 | $ | $92.05 | % |  |
| 2 | Psychologists | 90834 | $ | $102.78 | % | % |
| 3 | Clinical Social Workers | 90834 | $ | $77.09 | % | % |

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| **Table 2B(2) – Data for January 1, 2022 through , 2022 Medical/Surgical Physicians compared to Psychologists and Clinical Social Workers****for CPT Codes 99214 & 90837, Indexed to National Medicare Fee Schedule** |
|  |  |  | **Column A** | **Column B** | **Column C** | **Column D** |
|  | **Provider Type For In-Network Office Visits Only****(non-facility based)** | **CPT****Codes** | **Plan Weighted Average Allowed Amount** | **National Medicare Fee Schedule Amount** | **Plan Weighted Average Allowed****Amount as a Percentage of Medicare** | **Percentage by which In-Network allowed amounts for PCPs and non-psychiatrist M/S specialist physicians (combined) (indexed to Medicare) were higher compared****to psychologists and clinical social workers (indexed to Medicare)** |
| 1 | PCPs and non- psychiatrist M/S specialist physicians (combined) | 99214 | $ | $129.77 |  |  |
| 2 | Psychologists | 90837 | $ | $150.88 |  | % |
| 3 | Clinical Social Workers | 90837 | $ | $113.16 |  | % |

**Tables 2B(1) and 2B(2) Comparisons to be Conducted:**

If, in any version of Tables 2B(1) and 2B(2), the percentage in Column D is a positive number (indicating that PCPs and non-psychiatrist M/S specialist physicians (combined) receive higher allowed amounts relative to the National Medicare Fee Schedule than psychologists and/or clinical social workers), and/or there are disparities in OON use as shown in Section I, or other metrics of network adequacy, provide a **Plan of Improvement** in a separate report within days from the date of your response.

Your **Plan of Improvement** should address the comparability of reimbursement rates, as well as the adequacy of MH/SUD rates if there are disparities in OON use as shown in Section I, or other metrics of network adequacy. Please include specific actions you plan to take, such as increasing in-network reimbursement rates that would address lack of comparability in rates and/or high MH/SUD OON use.

***SECTION III: DENIAL RATES***

Using the definitions and instructions below, in Tables 3A, 3B and 3C, provide a breakdown of In-Network (INN) and Out-of- Network (OON) denial rates for MH/SUD and for M/S services.

A denial is defined as a refusal to authorize, allow or reimburse **any or all parts** of a service requested or performed in any of the following four benefit classifications as defined by the Carrier: (1) Acute Inpatient facility; (2) Sub-acute Inpatient Facility; (3) Outpatient Other (Facility); and (4) Outpatient Office Visit (non-facility based). (Do **not** include as a denial claims for which less than 5% of the cost value of the entire claim was denied. Do **not** count denials on resubmissions of the same claim).

A **denial** is further defined as follows:

* Any “**modified**” authorizations (e.g., for any alternative services, such as lower-cost or less intensive-level than requested by the provider), are considered to be a denial.
* Any “**partial denials**” (e.g., number of days or visits approved are less than what the provider requested), are to be considered a denial unless subsequently approved on concurrent or retrospective review for the full requested number of days or visits.

*Please complete the tables below for:* ***(a)*** *the employer’s members only, and* ***(b)*** *all TPA covered lives for self-insured plans in the Specified Region, with claims data for Calendar Year 2022, or for the period January 1, 2022 through the latest month in 2022 for which reasonably complete claims data is available.*

**Instructions for Completing Tables 3A, 3B and 3C:**

1. Follow instructions on each tab of the spreadsheet below.
2. [OPTIONAL ADDITIONAL DATA REQUEST: Attach separately: Provide the number and percentage of denials based on each reason code relied for each of the four categories below: (For example, if reason code X was relied on 10 times out of 100 denials for category (1), please provide the number 10 and the percentage of 10% for that reason code).
3. MH/SUD Medical Necessity denials
4. MH/SUD Administrative denials
5. Med-Surg. Medical Necessity denials
6. Med-Surg. Administrative denials

Also provide the Carrier's list of all reason codes relied on with the description of the meaning of each reason code (legend).]



**Comparisons to be Conducted:**

If there is a disparity of \_\_\_\_\_\_\_\_\_ in any category of denial rates for M/S compared to MH/SUD in which MH/SUD denial rates are higher than M/S denial rates please provide a **Plan of Improvement** within days from the date of your response.

Your **Plan of Improvement** should describe how you will address these disparities, including: a review of the reasons for these disparities, such as the use and application of level of care guidelines or criteria; UR practices such as frequency of reviews, duration of care authorized, application of clinically appropriate guidelines matching specific level of care requested; elimination of exclusions for residential provider types and/or levels of care; elimination of more stringent geographic exclusions or limitations than for M/S benefits, etc.

***SECTION IV: NETWORK ADEQUACY AND PARTICIPATION FOR PSYCHIATRISTS, PSYCHOLOGISTS AND MASTERS LEVEL BEHAVIORAL HEALTH PROVIDERS***

Using Table 4, provide information regarding your MH/SUD provider network in the Specified Region. Complete a separate version of Table 4 for each Specified Plan in each Specified Region.



**Table 4 Comparisons to be Conducted:**

If the percentage listed in Row 11 for psychiatrists and/or psychologists, and/or Row 10 for masters level providers is above 20%, provide a **Plan of Improvement**.

Your **Plan of Improvement** should describe how you will address network provider adequacy, such as modifying your network adequacy standards, monitoring actual provider network participation, and improving and ensuring compliance with such network adequacy standards, including wait times, etc. to ensure sufficient and timely access to network providers, etc.

***SECTION V. OPERATIONAL PROPORTIONALITY***

Using Table 5A and 5B for the Specified Plans in the Specified Regions, provide information for MH/SUD and M/S In-network and Out-of-network Inpatient and Outpatient operational proportionality of prior authorization and concurrent review UM protocols.

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**Table 5A and 5B Comparisons to be Conducted:**

If there is any disparity in the frequency of reviews and/or average number of days/visits approved,

provide your **Plan of Improvement.**

**MODEL DATA REQUEST FORM ENDS HERE**.