Mental Health Parity and Addiction Equity Act Disclosure
In-Network Provider Reimbursement Frequently Asked Questions

This document includes standard responses to questions related to Mental Health Parity (MHP) and Non-Quantitative Treatment Limitations (NQTL). This communication is not intended, nor should it be treated as legal advice. Federal and state laws and regulations are subject to change. The content provided is for informational purposes only and is not medical advice. Decisions about medical care should be made by the doctor and patient. Please note, your plan documents govern all benefit determinations and in the case of conflict with this document, your plan controls. Always refer to your plan documents for specific benefit coverage and limitations or call the toll-free member phone number on the ID card.

The following explanations apply to both medical/surgical benefits and mental health/substance use disorder benefits unless stated otherwise.

What does it mean if something is in-network?

Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits
In-network care means getting health care received from a provider who has a contract with your Plan. In-network care costs less because you get a discount on the provider's charges.	

How does my Plan decide what to pay in-network providers?

Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits

Here are the factors and sources used to decide how much to pay an in-network individual or group provider:

- **Provider Type and Specialty**:
  - **Sources**: Provider's application for in-network status. This includes their license, board certification, education, and training.
- **Services and Procedures Provided**:
  - Sources:
    - Current industry standard code sets (like CPT and HCPCS)
    - Centers for Medicare & Medicaid Services (CMS) reimbursement guidelines
    - CMS Resource-Based Relative Value Scale (RBRVS)
    - CMS Relative Value Unit (RVU) for services
    - FairHealth Medicare Gap Fill Database
    - CMS Clinical Lab Fee Schedule
    - CMS Durable Medical Equipment, Prosthetics/Orthotics, and Supplies (DMEPOS) Fee Schedule
    - CMS Average Sales Pricing (ASP) and RJ Health ASP (for drug pricing)
    - CMS Ambulance Fee Schedule

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- Optum RBRVS (for codes not priced by CMS)
- CMS Carrier Priced Fees (for codes priced by local carriers)

- **Market Dynamics**:
  - Sources:
    - Market research
    - Provider directory
    - Claims data
    - State reimbursement rates
    - Network adequacy reports

Here are the factors and sources used to decide how much to pay a facility:

- **Facility assessment:**
  - Sources:
    - Facility licensure
    - Certification
    - Accreditation

- **Service(s) offered and/or diagnoses/conditions treated by the facility**
  - Sources:
    - Most current version of industry standard code sets, e.g., revenue, Medicare Severity Diagnosis Related Groups (MS-DRG), CPT, HCPCS, etc.

- **Market dynamics such as network need and facility-member volume, etc.**
  - Sources:
    - Market research
    - Facility directory; network adequacy reports; member reported access data
    - Internal claims data
    - CMS reimbursement guidelines
    - CMS value-based programs
    - Internally developed value-based programs

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Does your Plan treat mental health/substance use disorder in-network provider reimbursement differently than medical/surgical in-network provider reimbursement "as written?" Are mental health/substance use disorder decisions about in-network provider reimbursement made any differently than medical/surgical decisions in practice ("in operation")?

Medical/Surgical Benefits	Mental Health / Substance Use Disorder Benefits
No. Your Plan found that rules and processes for paying in-network providers are the same for mental health/substance use disorder providers. This means the rules are not stricter for mental health/substance use disorder services "as written" and "in operation."	