**SECTION 1 ONLY**

**Introduction**

This Model Data Request Form (MDRF) was developed with funding by the [Mental Health Treatment and Research Institute LLC (MHTARI)](https://www.mhtari.org/) as a public service with the intention of enabling employers, regulators, plans, third party administrators and insurers to assess nonquantitative treatment limitation (NQTL) parity compliance and measure the adequacy of behavioral health provider networks, including any barriers to network access. MHTARI is a tax-exempt subsidiary of [The Bowman Family Foundation (BFF)](https://www.thebowmanfamilyfoundation.org/).

The MDRF was developed in 2017 and has been updated regularly. It provides definitions, instructions and data templates to obtain meaningful data for five (5) key measures which can be calculated with data typically available to insurers. The metrics herein have been utilized, in whole or in part, by multiple organizations, including state regulators and employer coalitions such as the [National Alliance of Health Care Purchaser Coalitions](https://www.nationalalliancehealth.org/) (National Alliance) and the [HR Policy Association](https://www.hrpolicy.org/). Feedback from insurers, regulators and employers using the MDRF has been incorporated into revisions of the metrics used in the MDRF. The MDRF was recognized by DOL/HHS in the 2023 MHPAEA Technical Release.

The out-of-network use and reimbursement analyses in the MDRF are based on multiple validated actuarial research analyses, such as the [2017](https://kr.milliman.com/-/media/milliman/importedfiles/uploadedfiles/insight/2017/nqtldisparityanalysis.ashx) and [2019](https://assets.milliman.com/ektron/Addiction_and_mental_health_vs_physical_health_Widening_disparities_in_network_use_and_provider_reimbursement.pdf) Milliman disparities studies and the [2024 RTI Report](https://dpjh8al9zd3a4.cloudfront.net/publication/behavioral-health-parity-pervasive-disparities-access-network-care-continue/fulltext.pdf). Additional research commissioned by MHTARI, such as the [2020 Milliman High Cost Report](https://www.milliman.com/-/media/milliman/pdfs/articles/milliman-high-cost-patient-study-2020.ashx) and the [2023 NORC Survey](https://www.filesbff.org/Survey_Conducted_by_NORC.pdf), provided evidence of significant problems with network access to behavioral health care, consistent with results frequently found from use of MDRF metrics. The same is true for network access analyses by the [Kaiser Family Foundation (2022)](https://www.healthaffairs.org/doi/10.1377/hlthaff.2022.01139), [National Alliance (2023)](https://higherlogicdownload.s3.amazonaws.com/NAHPC/3d988744-80e1-414b-8881-aa2c98621788/UploadedFiles/T514R490RouKpe2lnF9J_VOP%20Public%20Report_Finalized%203.pdf), and researchers [Susan H. Busch and Kelly A. Kyanko (2023)](https://filesmhtari.org/Busch_Kyanko_Research_Summary.pdf).

The five (5) key quantitative measures are:

1. **Out-of-Network Use** of mental health/substance use disorder (MH/SUD) services versus medical/surgical (M/S) services
2. **In-Network Reimbursement Rates for Office Visits** for MH/SUD versus M/S providers
3. **In-Network Provider Actual Participation** for Psychiatrists and other MH/SUD professionals
4. **Denial Rates** for MH/SUD services versus M/S services
5. **Utilization Review Frequency/Proportion Comparison** for MH/SUD versus M/S

***DISCLAIMER: The MDRF 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 “User” (defined as each employer, regulator, plan, third party administrator, insurer or other user) of the MDRF 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 or any information (including without limitation the formulas) contained in the MDRF. 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, including without limitation the ability of the MDRF to achieve its intended purpose, the accuracy and completeness of the MDRF, 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 third party administrator or other third party, and the relevance and applicability of the MDRF to any specific User.***

***SECTION 1: OUT-OF-NETWORK (OON) USE***

***Definitions for Section 1:***

* *Claim Line*: Each allowed billing code line item on a claim form.
* *All Claim Lines:* With respect to the type of Facility Services or Office Visit Professional Services being examined, “All Claim Lines” means every allowed Claim Line for All Codes in a submitted claim form.
* *All Codes*: For Office Visit Professional Services submitted claims (CMS-1500), “All Codes” means any allowed CMS-1500 Claim Line with any CPT or HCPCS billing code including any modifier and including Ancillary Services. For Facility Services submitted claims (UB-04), “All Codes” means any allowed **non-emergency** UB-04 Claim Line with any billing code, such as a Revenue Code, DRG, AP-DRG, APC, etc. and any modifier and including Ancillary Services.
* *Ancillary Services:* Services and items such as labs, diagnostics, pharmacy, supplies, etc.
* *Member*: Any person who was a member of the specified plan(s)/product(s) at any point during the specified year.
* *Out-of-Network (OON) Claim Line:* A Claim Line in a claim form that is “Allowed as OON” [[1]](#footnote-2). Note: Any Claim Line submitted by an OON provider that is allowed as an INN[[2]](#footnote-3) Claim Line is **not** counted as an OON Claim Line.
* *In-Network (INN) Claim Line:* Any Claim Line in a claim form that is allowed as an INN2 Claim Line.
* *Telehealth Claim Line*: Any Office Visit Professional Services Claim Line (a) that uses POSs 02 or 10 or (b) that uses any POS listed in the “Table of Office Visit Professional Services POSs” and has a telehealth billing code (e.g., 99451, T1014, G2012, etc.) and/or modifier (e.g., 93, 95, GQ, G0, GT, FQ, etc.).
* *In-Person Claim Line*: Any Claim Line for Office Visit Professional Services that is not a Telehealth Claim Line.
* *OON Use (Percentage):* For both Office Visit Professional Services and Facility Services claims, out-of-network use is the percentage of All Claim Lines (both OON and INN, combined) that were OON Claim Lines (i.e., the number of OON Claim Lines as a percentage of All Claim Lines (both OON and INN, combined).
* *Facility Services****:* Non-emergency** services provided in an Acute Inpatient, Sub-Acute Inpatient or Outpatient facility, as described below, and billed **using a UB-04 claim form**:

1. *Acute Inpatient Facility Services:*
   1. Medical/Surgical (M/S) Services: All inpatient services in M/S acute care hospitals and long-term acute care hospitals except services for patients with a primary MH/SUD diagnosis.
   2. Mental Health/Substance Use Disorder (MH/SUD) Services: (a) All inpatient services in MH/SUD psychiatric hospitals regardless of the primary diagnosis of the patients and (b) all services in M/S acute care hospitals and long-term acute care hospitals for patients with a primary MH/SUD diagnosis.
2. *Sub-acute Inpatient Facility Services:* 
   1. M/S Services: All inpatient services in M/S non-hospital based inpatient facilities including, for example, rehabilitation facilities and skilled nursing facilities except services for patients with a primary MH/SUD diagnosis.
   2. MH/SUD Services: (a) All inpatient services in MH/SUD non-hospital based inpatient facilities including, for example, MH/SUD residential treatment facilities regardless of the primary diagnosis of the patients and (b) all inpatient services in M/S non-hospital based inpatient facilities including, for example, rehabilitation facilities and skilled nursing facilities for patients with a primary MH/SUD diagnosis.
3. *Outpatient Facility Services:*
   1. M/S Services: All M/S services in an M/S outpatient facility such as physical, occupational, speech, and cardiovascular therapies, outpatient surgeries, interventional radiology, and infusion therapies. However, M/S Services do **not** include outpatient services in an M/S facility for patients with a primary MH/SUD diagnosis.
   2. MH/SUD Services: All MH/SUD services in an MH/SUD outpatient facility such as intensive outpatient (IOP) and partial hospitalization (PHP) services, applied behavioral analysis (ABA), opioid treatment programs (OTPs), eating disorder programs (ED), and medication-assisted programs (MATs), regardless of the primary diagnosis of the patients. MH/SUD Services **also** include outpatient services in an M/S facility for patients with a primary MH/SUD diagnosis.

**All non-emergency UB-04 Claim Lines for all Facility Services** described by one of the above inpatient or outpatient facility categories are to be included in the Section 1 analysis.

* *Office Visit Professional Services:* **Non-emergency** professional services provided in an office visit setting that meet the following 4 criteria*:*

1. Are billed using CPT codes or HCPCS codes **using a CMS-1500 claim form**,
2. The CMS-1500 identifies the professional rendering provider (either in the Rendering Provider field, or if that field is blank, in the Billing Provider field),
3. The CMS-1500 indicates one of the following Place of Service (POS) Codes:

**Table of Office Visit Professional Services POSs**

|  |  |
| --- | --- |
| POS Codes | POS Names |
| **02** | Telehealth Provided Other than in Patient’s Home |
| **10** | Telehealth Provided in Patient’s Home |
| **11** | Office |
| **12** | Home |
| **15** | Mobile Unit |
| **17** | Walk-In Retail Health Clinic |
| **49** | Independent Clinic |
| **50** | Federally Qualified Health Center |
| **57** | Non-residential Substance Abuse Treatment |
| **58** | Non-residential Opioid Treatment Facility |
| **65** | End-Stage Renal Disease Treatment Facility |
| **71** | Public Health Clinic |
| **72** | Rural Health Clinic |

**and** (iv) Are provided by one of the following categories of professional providers:

* *Office Visit Professionals:*
  + - *The following licensed M/S Providers:*
    - Primary Care Physicians: This category consists of all General Practice, Family Practice, Internal Medicine, OB/GYN and Pediatric Physicians
    - M/S Specialist Physicians (excluding Psychiatrists and Primary Care Physicians): This category consists of all Physicians listed in Tables 1(C) and 1(D) under “M/S Specialist Physician Sub-categories”, including “Other M/S Specialist Physicians”.
    - M/S Physician Assistants
    - M/S Nurse Practitioners
    - *The following licensed MH/SUD Providers:*
    - Psychiatrists (all of whom are physicians), including Child Psychiatrists
    - Psychologists, including Child Psychologists
    - Licensed MH/SUD Providers such as Licensed Clinical Social Workers (LCSW), Master’s Level MH/SUD Counselors/Therapists, and Marriage and Family Therapists
    - Psychiatric Nurse Practitioners

Claim Lines that do not meet all 4 criteria in “(i)” - “(iv)” under “Office Visit Professional Services” above are **not** to be included in any Office Visit Professional Services OON analysis.

**All CMS-1500 Claim Lines which satisfy the above 4 criteria, for every professional provider** described by one of the above categories, are to be included in the Section 1 analysis. Each professional provider is to be included in **only one** of the above provider categories.

Note: If more than one section of the MDRF is being completed, each professional provider type is to be **defined consistently** in all sections for purposes of placing each professional provider in a category or subcategory.

***Instructions for Section 1 (USING TERMS AS DEFINED ABOVE):***

The tables for Section 1 are in the embedded Excel spreadsheet below:



1. Complete Tables 1(A) and 1(C) for the identified specified plan(s)/product(s) that have substantial out-of-network (OON) benefits – for example, typical PPOs and Point of Service plans.
2. Complete Tables 1(B) and 1(D) for the identified specified plan(s)/product(s) that do not have substantial OON benefits – for example, typical HMOs.
3. Identify the specified plan(s)/product(s) at the top of the table.
4. Enter the number of total Members and the specified year at the top of the table.
5. Include both non-capitated and capitated[[3]](#footnote-4) Claim Lines.
6. For all specified plan(s)/product(s) in the specified year, and with respect to all Members, include All Claim Lines for all providers described above which had one or more Claim Lines.
7. Use:
8. All Claim Lines (non-emergency) on all UB-04 claim forms for Facility Services; and
9. All Claim Lines with one of the POS codes in the “Table of Office Visit Professional Services POSs” on a CMS-1500 claim form for Office Visit Professional Services.
10. Office Visit Professional Services provided by M/S providers are to be counted as M/S professional services, and Office Visit Professional Services provided by MH/SUD providers are to be counted as MH/SUD professional services.
11. **For Tables 1(A) and 1(B)** – Reported for Acute Inpatient, Sub-acute Inpatient and Outpatient Facility Services; and Office Visit Professional Services (In-Person and Telehealth, combined; In-Person Only; and Telehealth Only):
    * Enter the “Number of OON Claim Lines” for M/S Services (Column A) and MH/SUD Services (Column B)
    * Enter the “Number of All Claim Lines (both OON and INN, combined)” for M/S Services (Column C) and MH/SUD Services (Column D)
    * The “OON Use: Percentage of All Claim Lines that were OON Claim Lines” columns will be auto-filled by an embedded formula using the numerators and denominators below:
12. M/S Services OON Use (Column E):
    * Numerator: **Number of OON Claim Lines** for M/S services (Column A) in the specified facility or professional service category
    * Denominator: **Number of All Claim Lines (both OON and INN, combined)**, for M/S services (Column C) in the specified facility or professional service category
13. MH/SUD Services OON Use (Column F):
    * Numerator: **Number of OON Claim Lines** for MH/SUD services (Column B) in the specified facility or professional service category
    * Denominator: **Number of All Claim Lines (both OON and INN, combined)**, for MH/SUD services (Column D) in the specified facility or professional service category
    * “Percentage higher OON Use for MH/SUD Services compared to M/S Services” (Column G) will be auto-filled by an embedded formula and is calculated as follows (expressed as a percentage):

**MH/SUD Services OON Use** (Column F) – **M/S Services OON Use** (Column E)

**M/S Services OON Use** (Column E)

For example, if M/S Services OON Use is 2% and MH/SUD Services OON Use is 5%, the “Percentage higher OON Use for MH/SUD services compared to M/S services” is 150% (i.e., (0.05 – 0.02) / 0.02) = 1.5 x 100 = 150%).

A negative percentage indicates that MH/SUD services did not have a higher percentage of OON Use than M/S services.

* + “Times higher OON Use for MH/SUD Services compared to M/S Services” (Column H) will be auto-filled by an embedded formula and is calculated as follows:

**MH/SUD Services OON Use** (Column F)

**M/S Services OON Use** (Column E)

For example, if M/S Services OON Use is 2% and MH/SUD Services OON Use is 5%, the “Times higher OON Use for MH/SUD Services compared to M/S Services” is 2.5x (i.e., 0.05 / 0.02 = 2.5).

A number less than 1.0 indicates that MH/SUD services did not have a higher percentage of OON Use than M/S services.

1. **For Tables 1(C) and 1(D)** – Reported for Office Visit Professional Services, In-Person and Telehealth, combined:
   * Enter the “Number of OON Claim Lines” (Column A)
   * Enter the “Number of All Claim Lines (both OON and INN, combined)” (Column B)
   * The “OON Use: Percentage of All Claim Lines that were OON Claim Lines” column (Column C) will be auto-filled by an embedded formula using the numerator and denominator below:

* Numerator: **Number of OON Claim Lines** (Column A) for the specified Professional Service Category
* Denominator: **Number of All Claim Lines** **(both OON and INN, combined)**, (Column B) for the specified Professional Service Category
  + “Percentage higher OON Use for [Psychiatrists (Column D) or Psychologists (Column E)] compared to each M/S Professional Service Category” will be auto-filled by embedded formulas and are calculated as follows (expressed as a percentage):

([**Psychiatrist** or **Psychologist**] **OON Use** – **Specified Professional Service Category OON Use**)

**Specified Professional Service Category OON Use**

Note: All OON Use percentages are from Column C.

For example, if Anesthesiology OON Use is 2% and Psychiatrist OON Use is 5%, the “Percentage higher OON Use for Psychiatrists compared to Anesthesiology” is 150% (i.e., (0.05 – 0.02) / 0.02) = 1.5 x 100 = 150%).

A negative percentage indicates that the specified professional service category or M/S Specialist Physician Sub-category did not have a higher percentage of OON Use than [Psychiatrists or Psychologists].

* “Times higher OON Use for [Psychiatrists (Column F) or Psychologists (Column G)] compared to each M/S Professional Service Category” will be auto-filled by an embedded formula and are calculated as:

[**Psychiatrist** or **Psychologist**] **OON Use**

**Specified Professional Service Category OON Use**

Note: All OON Use percentages are from Column C.

For example, if Anesthesiology OON Use is 2% and Psychiatrists OON Use is 5%, the “Times higher OON Use for Psychiatrists compared to Anesthesiology” is 2.5x (i.e., 0.05 / 0.02 = 2.5).

A number less than 1.0 indicates that [Psychiatrists or Psychologists] did not have a higher percentage of OON Use than the specified M/S Professional Service Category.

Many of the definitions and methodological approaches in this section are aligned with those used and recommended by RTI in the [2024 RTI Report](https://dpjh8al9zd3a4.cloudfront.net/publication/behavioral-health-parity-pervasive-disparities-access-network-care-continue/fulltext.pdf).

1. Sometimes referred to as “Paid OON”. [↑](#footnote-ref-2)
2. Sometimes referred to as “Paid INN”. [↑](#footnote-ref-3)
3. Capitated Claim Lines are paid according to a fixed, pre-determined amount per patient for a prescribed period of time. [↑](#footnote-ref-4)