**SECTION 4 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 4: DENIAL RATES***

***Definitions for Section 4:***

* *Utilization Review (“UR” or “Review”)*: Includes Prior Authorization Review, Concurrent Review, and Retrospective Review at any stage of the Utilization Review process and/or upon or after claims submission, including Reviews of claims in whole or in part.
* *Denial*: A determination not to authorize, allow or reimburse any or all parts of a service requested or performed in any benefit classification.
* *Denial* is defined separately for:
  + - 1. *Denials on Utilization Review for which* ***NO*** *claim form was submitted.* Typically, this data would be contained in the Utilization Review database.
* With respect to *Denials on Utilization Review for which* ***NO*** *claim form was submitted,* *Denials* are defined to **include** all of the below:
* **Complete Denials**, i.e. Denials of the entire request (e.g., Facility Services, Professional Services, Ancillary Services, etc.).
* “**Partial Denials**” (e.g., number of days, visits or services approved are less than what the provider requested), unless subsequently approved on Prior Authorization Review, Concurrent Review or Retrospective Review for the full requested number of days, visits or services.
* “**Modified**” authorizations (e.g., for any alternative services, such as lower-cost or less intensive-level of care or services than requested by the provider).
* *Denial* datais to be provided separately for:
* *Medical Necessity determination*: Based on clinical reviews using clinical/medical criteria.
* *Administrative determination*: Not involving a clinical or medical necessity review. Do **not** include denials based on member ineligibility due to lack of coverage.
  + - 1. *Denials for which a claim form* ***WAS*** *submitted*. Typically, this information would be contained in the Claims Database.
* With respect to *Denials on Utilization Review for which a claim form* ***WAS*** *submitted,* *Denials* are defined to **include** all of the below:
* **Complete Denials**, i.e., Denials of entire Claim Lines.
* “**Partial Denials** **of Claim Lines**”: Denials of more than 10% of the allowed amount of a Claim Line in a claim form.
* “**Modified**” authorizations (e.g., for any alternative services, such as lower-cost or less intensive-level of care than requested by the provider).
  + **Note:** Resubmission of identical Claim Lines that were previously denied should not count as additional Denials.
* *Denial* data is to be provided separately for:
* *Medical Necessity determination*: Based on clinical reviews using clinical/medical criteria.
* *Administrative determination*: Not involving a clinical or medical necessity review. Do **not** include denials based on member ineligibility due to lack of coverage.
* *Denial* rates analyses are to be conducted with respect to each Claim Line.
* *Claim Line*: Each billing code line item on a claim form.
* *All Claim Lines:* With respect to the type of Inpatient and Outpatient Facility, Facility-Based Professional Services, and Office Visit Professional Services being examined, “All Claim Lines” means every Claim Line for All Codes in a submitted claim form.
* *All Codes*: For Facility-Based Professional Services and Office Visit Professional Services submitted claims (CMS-1500), “All Codes” means any **non-emergency** 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 **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.
* “*Partial Denials of Claim Lines*” are denials of more than 10% of the allowed amount of a Claim Line in a claim form.
* *Prior Authorization Review:* Includes Pre-service and Pre-treatment Reviews. Do **not** include data for “notifications”, as that term is defined by the carrier or plan.
* *Concurrent Review:* Denials are to be counted separately for each Review conducted during the course of an admission, stay or episode of treatment. Do **not** include data for “notifications”, as that term is defined by the carrier or plan.
* *Retrospective Review:* Denials are to be categorized **separately** for:
* *Pre-Claim Payment Review:* Retrospective Review that occurs before the claim has been paid.
* *Post-Claim Payment* Review: Retrospective Review that occurs after the claim has been paid.
* *Member*: Any person who was a member of the specified plan(s)/product(s) at any point during the specified year.
* *In-Network (INN) Prior Authorization Review, Concurrent Review, Retrospective Review, Claim, or Claim Line*: Any Prior Authorization Review, Concurrent Review, Retrospective Review, claim, or Claim Line that relates to an INN Provider.
* *In-Network (INN) Provider*: A provider (that offered In-Person, Telehealth, or both types of services) listed in any directory of providers that was made available to any Members of a specified plan/product at the time that a Prior Authorization Review, a Concurrent Review, or a Retrospective Review was conducted, or a claim was submitted.
* *Out-of-Network (OON) Prior Authorization Review, Concurrent Review, Retrospective Review, Claim, or Claim Line*: Any Prior Authorization Review, Concurrent Review, Retrospective Review, claim, or Claim Line that relates to an OON Provider.
* *Out-of-Network (OON) Provider*: A provider (that offered In-Person, Telehealth, or both types of services) that was not an INN Provider at the time that a Prior Authorization Review, a Concurrent Review, or a Retrospective Review was conducted, or a claim was submitted.
* *Telehealth Claim Line*: Any Facility-Based Professional Services or Office Visit Professional Services Claim Line (a) that uses POSs 02 or 10 or (b) that uses any POS 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 Facility-Based Professional Services or Office Visit Professional Services that is not a Telehealth Claim Line.
* *Professional Providers*: In this Section 4, Professional Providers are defined as:
* *All of the following licensed Medical/Surgical (M/S) Providers, combined:*
* Primary Care Physicians: This category consists of General Practice, Family Practice, Internal Medicine, OB/GYN and Pediatric Physicians
* M/S Specialist Physicians: This category consists of all M/S Physicians other than Psychiatrists and Primary Care Physicians
* M/S Physician Assistants
* M/S Nurse Practitioners
* *All of the following licensed Mental Health/Substance Use Disorder (MH/SUD) Providers, combined:*
* 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

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.

* *Professional Services*: **Non-emergency** services by Professional Providers (**as defined above**) in either a facility setting (i.e., Facility-Based Professional Services) or an office visit setting (i.e., Office Visit Professional Services).
* *Facility Services:* **Non-emergency** services in an Acute Inpatient, Sub-Acute Inpatient or Outpatient facility, as described below:
* Types of facilities:

1. *Acute Inpatient Facility Services and Facility-Based Professional Services (as defined below):*
2. M/S Services: All inpatient services in M/S acute care hospitals and long-term acute care hospitals (including both Facility Services and Facility-Based Professional Services) except services for patients with a primary MH/SUD diagnosis.
3. MH/SUD Services: (a) All inpatient services in MH/SUD psychiatric hospitals (including both Facility Services and Facility-Based Professional Services) 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.
4. *Sub-acute Inpatient Facility Services and Facility-Based Professional 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 (including both Facility Services and Facility-Based Professional Services) 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 (including both Facility Services and Facility-Based Professional Services) 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.
5. *Outpatient Facility Services and Facility-Based Professional 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 (including both Facility Services and Facility-Based Professional Services). 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), (including both Facility Services and Facility-Based Professional Services) 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.

* ***Facility-Based*** *Professional Services:*

1. When a claim has not been submitted (i.e., with respect to Prior Authorization Reviews and Concurrent Reviews): **Non-emergency** Professional Services by a Professional Provider in one of the facility categories described above and for which a separate Review occurs (not to include Office Visit Professional Services)
2. When a claim has been submitted (i.e., with respect to any Review): **Non-emergency** Professional Services provided in one of the facility categories described above 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 does **not** indicate one of the following Place of Service (POS) Codes:

**Table of Excluded POS Codes**

|  |  |
| --- | --- |
| POS Codes | POS Names |
| **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 any Professional Provider (as defined above).

* ***Office Visit*** *Professional Services:*

1. When a claim has not been submitted (i.e., with respect to Prior Authorization Reviews and Concurrent Reviews): **Non-emergency** Professional Services by a Professional Provider in an office visit setting and for which a separate Review occurs (not to include Facility-Based Professional Services).
2. When a claim has been submitted (i.e., with respect to any Review): **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 |
| **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 any Professional Provider (as defined above).

***Instructions for Section 4 (USING TERMS AS DEFINED ABOVE):***

The tables for Section 4 are in the embedded Excel spreadsheet below:



1. Identify the specified plan(s)/product(s) at the top of the table.
2. Enter the number of total Members and the specified year at the top of the table.
3. Include both non-capitated and capitated[[1]](#footnote-2) Claim Lines for both In-Person and Telehealth, combined.
4. All Reviews and All Claim Lines for **Facility Services**, **Facility-Based Professional Services** and **Office Visit Professional Services**, as defined above, are to be included in the Section 4 analysis.
5. **Office Visit** **Professional Services** by M/S providers are to be counted as M/S professional services, and **Office Visit** **Professional Services** by MH/SUD providers are to be counted as MH/SUD professional services.
6. Enter the requested data, and percentages will be auto-filled with an embedded formula.
7. **In Tables 4(A) and 4(B)** for Prior Authorization Review Denial Rates (INN (Table 4(A)) and OON (Table 4(B)), separately), data for M/S services and MH/SUD services is to be provided separately for *Medical Necessity determinations* and *Administrative determinations.*

Data is also to be provided separately for:

1. *Denials (as defined above) on Utilization Review for which* ***NO*** *claim form was submitted*
2. *Denials (as defined above) for which a claim form* ***WAS*** *submitted.* Such denials are to be counted based on each Claim Line.
3. **In** **Tables 4(C) and 4(D)** for Concurrent Review Denial Rates (INN (Table 4(C)) and OON (Table 4(D)), separately), data for M/S services and MH/SUD services is to be provided separately for *Medical Necessity determinations* and *Administrative determinations.*

Data is also to be provided separately for:

1. *Denials (as defined above) on Utilization Review for which* ***NO*** *claim form was submitted,*
2. *Denials (as defined above) for which a claim form* ***WAS*** *submitted.* Such denials are to be counted based on each Claim Line.
3. **In** **Tables 4(E) and 4(F)** for Retrospective Review Denial Rates (INN (Table 4(E)) and OON (Table 4(F)), separately), data for M/S services and MH/SUD services is to be provided separately for *Medical Necessity determinations* and *Administrative determinations.* Such Denials are to be counted based on each Claim Line.

Denial data is also to be provided separately for:

* + 1. *Pre-Claim Payment* Retrospective Review (prior to payment of a claim)
    2. *Post-Claim Payment* Retrospective Review (after payment of a claim)

1. Capitated Claim Lines are paid according to a fixed, pre-determined amount per patient for a prescribed period of time. [↑](#footnote-ref-2)