

Requesting an In-Network Exception / Network-Gap Authorization

Specialized adolescent and eating-disorder medical care

Roots Rising: Center for Adolescent Medicine

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Important information

Roots Rising is an out-of-network practice unless your insurance plan confirms otherwise. This guide explains how you may request an exception that allows medically necessary services from an out-of-network clinician to be covered at your plan's **in-network** benefit level.

Plans use different names for this request, including **network-gap exception**, **gap authorization**, **out-of-network authorization**, **single-case agreement**, or **network-adequacy exception**. Approval is not guaranteed. Coverage depends on your individual plan, benefits, medical necessity, available in-network clinicians, and the insurer's authorization rules.

Please obtain **written authorization before non-emergency services** whenever possible. Insurance approval may not be retroactive.

Why this request may be appropriate

Eating disorders can cause medical complications involving nutrition, growth and puberty, heart rate and blood pressure, hydration, electrolytes, gastrointestinal health, bone health, reproductive/endocrine health, and mental-health safety.

Some adolescents and young adults need a clinician with specialized experience in **medical assessment and longitudinal management of eating disorders**, including, when clinically indicated:

- Comprehensive medical evaluation and physical examination
- Weight, height/growth, and orthostatic vital-sign assessment
- Assessment of malnutrition, dehydration, bradycardia, hypotension, syncope, purging-related risks, and medical instability
- Ordering and interpretation of laboratory studies and ECGs when appropriate
- Monitoring of delayed puberty, amenorrhea, endocrine/reproductive concerns, and nutritional deficiencies
- Medical risk assessment and recommendations regarding outpatient care versus a higher level of care
- Coordination with a primary-care clinician, therapist, dietitian, psychiatrist, school, and eating-disorder treatment program as appropriate

Therapists, dietitians, psychiatrists, pediatricians, family physicians, and treatment programs can all be important members of an eating-disorder treatment team. The question for the health plan is whether an in-network clinician is actually available within an appropriate time frame to provide the **specific specialized medical service** needed for the patient.

Before your first visit

1. Request a referral or medical-necessity letter

Ask your PCP, pediatrician, or other treating clinician for a referral or letter that includes:

- The eating-disorder diagnosis or clinical concern, if known
- Relevant medical concerns, if applicable: weight loss or malnutrition, bradycardia, hypotension/orthostatic symptoms, dehydration, vomiting/purging, abnormal laboratory findings, amenorrhea, delayed puberty, endocrine concerns, or psychiatric-safety concerns
- Why specialized medical eating-disorder assessment and monitoring are medically necessary

- Why timely specialty evaluation is needed
- Why the requested service is different from psychotherapy, nutrition counseling alone, or routine primary-care follow-up

A referral can support the request but does not itself guarantee coverage.

2. Contact your health plan before scheduling when possible

Call the Member Services number on the back of your insurance card. Ask to be connected to **Utilization Management, Prior Authorization, Case Management**, or the department that handles out-of-network/network-gap requests.

Write down:

- Date and time of the call
- Representative's name and ID number
- Call reference number
- The plan's name for the request
- Required forms and documents
- Fax, mailing address, portal-upload process, and turnaround time
- Whether your request qualifies for expedited review

3. Suggested call script

"I am requesting a network-gap exception, out-of-network authorization, or single-case agreement for medically necessary specialized adolescent/eating-disorder medical care. I need a clinician who can perform medical assessment and ongoing monitoring of eating-disorder complications, including physical examination, orthostatic vital signs, medical risk assessment, and laboratory or ECG evaluation when clinically indicated. Please identify appropriate in-network clinicians who are accepting new patients within a clinically appropriate time frame and who provide this specific medical service. Please tell me exactly how to submit this request and how I can obtain an authorization in writing."

If your clinician documents that delay could be medically harmful, ask whether an **expedited** decision is available.

Ask the plan for true in-network alternatives

Ask the health plan to provide a written list of in-network clinicians who are:

- Accepting new patients
- Located within a reasonable distance or available through clinically appropriate telehealth
- Available within a clinically appropriate appointment time frame
- Able to provide specialized **medical** assessment and monitoring of eating disorders
- Able to perform or arrange examination, orthostatic vital signs, laboratory testing, and ECG evaluation when clinically indicated
- Able to coordinate care with behavioral-health and nutrition professionals and make medical recommendations about level of care

Do not rely only on the insurer's directory. Call the listed offices. Ask whether the clinician provides the exact specialized medical eating-disorder service requested, accepts your exact plan, and has availability. Keep a log of the date, name of person contacted, and their response.

A clinician who provides psychotherapy, nutrition therapy, psychiatric medication management, general primary care, or a treatment program may be valuable, but may not provide the same specialty medical service. Describe the particular service you need accurately and respectfully.

Information that may support the request

Submit only records that are accurate and relevant to your situation. Your request may include:

- A referral or medical-necessity letter
- Relevant clinical notes, hospital discharge summaries, growth charts, vital signs, laboratory results, ECG findings, or treatment records
- A description of the medically necessary service requested
- Information showing that listed in-network clinicians are unavailable, are not accepting new patients, lack the required specialized service, have an excessive wait, are too distant, or cannot safely manage the clinical need
- Roots Rising clinician/practice information, if requested by the plan:

- Practice: Roots Rising KC, Professional Association / Roots Rising: Center for Adolescent Medicine
- Clinician: Deepika Parmar, MD, MPH
- NPI: 1336522952
- EIN: 41-2897039
- Kansas license: 04-52069
- Phone: 913-513-4441
- eFax: 913-404-1533
- Email: drparmar@rootsrisingkc.com
- Website: rootsrisingkc.com

Procedure and diagnosis codes must be individualized to the patient and the services actually provided. Do not represent that a code is guaranteed to be billed or covered before care is delivered.

Ask for written approval

Before proceeding with non-emergency care, request written confirmation showing:

- Authorization/reference number
- Approved clinician and practice
- Approved service(s)
- Approved dates of service and number of visits/units
- Whether services will process at the in-network benefit level
- Your deductible, copay, and coinsurance responsibility
- Whether you must submit claims, whether the practice may submit claims, and what documents are required
- Whether prior authorization is required for laboratory studies, ECGs, telehealth, or other components of care

Keep copies of all letters, portal messages, forms, faxes, and call logs.

If the request is denied

1. **Ask for the denial in writing.** Request the clinical and network basis for the decision and the deadline and instructions for appeal.
2. **Request details about any proposed in-network alternative.** Ask for the clinician's name, location, specialty, earliest available appointment, confirmation of plan participation, and confirmation that they provide the specific service requested.
3. **File an internal appeal promptly.** Include the referral/medical-necessity letter, supporting clinical records, and documentation of unavailable or inadequate in-network alternatives.
4. **Request expedited review when medically appropriate.** Your treating clinician may provide documentation explaining why delay could jeopardize health or safety.
5. **Seek state-plan assistance if appropriate.** The appropriate agency depends on your insurance type and state. Your denial letter should identify applicable external-review rights.

Kansas and Missouri considerations

This guide may be used for Kansas and Missouri commercial plans, Medicaid managed-care plans, and Medicare Advantage plans, but each has its own process.

- **Kansas:** Ask the insurer whether it calls the request a network-gap exception, out-of-network authorization, medical-necessity exception, or single-case agreement. For a fully insured plan, the Kansas Insurance Department may be able to help with consumer complaints after you use the plan's internal process. Self-funded employer plans may be governed by federal ERISA rules instead.
- **Missouri:** Network-adequacy protections and complaint pathways can depend on the policy type; Missouri has historically applied state network-adequacy requirements most directly to HMOs. Ask your insurer about its specific out-of-network authorization and appeal rules. The Missouri Department of Commerce and Insurance may assist with eligible insurance complaints after the plan's process is used.
- **Missouri MO HealthNet managed care:** If a medically necessary service is not available in network, ask the managed-care plan about prior authorization for out-of-network care. Document the plan's instructions and ask about the member appeal process.

- **Medicare Advantage:** Ask the plan for a coverage organization determination/prior authorization and its process when an appropriate in-network specialty service is unavailable.

For any plan, coverage is plan-specific. A written approval is the best evidence of what is authorized and what you may owe.

Questions to ask the insurer

- What is the exact name of the request I need to make?
- Is prior authorization required before the first appointment?
- What forms, records, diagnosis/procedure information, and provider information do you need?
- What is the standard decision time, and is expedited review available?
- Can you identify an in-network clinician accepting new patients who provides specialized **medical** eating-disorder care—not only therapy, nutrition counseling, or general behavioral-health care?
- If you identify an in-network clinician, what is their earliest appointment and which medical services do they actually provide?
- If approved, will Roots Rising services be processed at my in-network benefit level?
- Which services, dates, and number of visits are approved?
- What will I owe for deductible, copay, or coinsurance?
- How do I appeal a denial, and what are the deadlines?

Important reminder

A network-gap authorization is not automatic and may not be retroactive. Contact your insurer early, use accurate descriptions of your needs, and obtain written approval whenever possible. In an emergency, seek emergency care immediately; do not delay emergency treatment while waiting for insurance authorization.