EATING DISORDER CENTER OF MONTANA

Patient Advocacy

As a patient of EDCMT and as a member of your insurance company, you have the right to advocate for the coverage your team recommends and that you wish for yourself. Please refer to the below steps as a guideline for how to make your case to your insurance company.

1. Speak to your broker/HR who initiated the policy/group plan
2. File a complaint on the Montana Insurance Commissioner's website: https://csimt.gov/insurance-complaints-fraud/
3. Make a call to the Policy Holder Services department at the Montana Insurance Commissioner for health insurance. Contact: Sharon Richetti (406-444-2894)
4. Post on the insurance company's Facebook page
5. Call your local senator
6. Study the American Psychiatric Association's Guidelines for standards in terms of how specifically, Table 8 illustrates criteria for levels of care by contrast to the determination made by the insurance review: https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/eatingdisorders.pdf
7. Mental Health Parity states that insurance companies must honor not only the physical/medical symptoms of eating disorders, but must also equally evaluate and treat the mental health symptoms. Please refer to the "Mental Health Parity Advisory Memorandum" (below) for more information. Unfortunately, many insurance companies do not honor Mental Health Parity and are therefore breaking the law. Our UR team can let you know what the criteria the insurance reviewer provided for the denial and you can compare it with the red flags in the document.
8. Kantor & Kantor is a law firm in the Los Angeles area with some good success with Mental Health Parity cases. 19839 Nordhoff Street, Northridge, California 91324. Phone (818-886-2525 x6030), Fax, (818-350-6272), Email (tahsing@kantorlaw.net). Their Eating Disorder blog also has some helpful articles about this issue: https://www.kantorlaw.net/blog/

COMMISSIONER OF SECURITIES & INSURANCE

MONICA J. LINDEEN
COMMISSIONER

OFFICE OF THE MONTANA
STATE AUDITOR

ADVISORY MEMORANDUM

To: All Major Medical Health Insurers and Mental Health Providers

From: Monica J. Lindeen, Commissioner of Securities and Insurance

Re: Mental Health Parity and Non-Quantitative Treatment Limitations

Date: December 29, 2016

MENTAL HEALTH PARITY AND NON-QUANTITATIVE TREATMENT LIMITATIONS

In 2008, Congress passed the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) (29 USC 1185a). This Act applies only to large employer plans that offer mental health coverage. In 2014, with the passage of the Patient Protection and Affordable Care Act (ACA), treatment for mental health and substance use disorders (MH/SUD) became an essential health benefit for individual and small employer group health plans. Those plans also became subject to full parity with physical illness generally.

Since that time, the Office of the Commissioner of Securities and Insurance (CSI) has ensured that policy forms are in compliance with the requirements of federal regulations regarding the prohibition on quantitative treatment limitations described at 45 CFR 146.136, 45 CFR 147.160 and 29 CFR 2590.715-2719. Quantitative treatment limitations (QTLs) are numerical in nature (such as visit limits and the cost-sharing imposed by the plan) and are fairly easy to identify through policy form review. Non-quantitative treatment limitations (NQTLs) are non-numerical limits on the scope or duration of benefits and are much more difficult to identify in a form filing. NQTLs are the primary focus of this advisory memorandum.

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840 Helena Ave., Helena MT 59601 Website: www.csi.mt.gov E-Mail: csi@mt.gov

The U.S. Department of Labor (USDOL) issued guidance concerning the identification of NQTLs in June 2016: https://www.dol.gov/ebsa/pdf/warning-signs-plan-or-policy-nqtls-that-require-additional-analysis-to-determine-mhpaea-compliance.pdf

This guidance lists provisions that can serve as "red flags" that a health plan or insurer may be imposing an impermissible NQTL, indicating that further review is necessary. Further review requires a determination of whether or not limits imposed are also applied to medical/surgical (med/surg) benefits and if the limits applied to MH/SUD and med/surg benefits in a manner that complies with MHPAEA. This agency does not have the power to enforce MHPAEA directly. However, the CSI may coordinate with the Center for Medicare Medicaid Services (CMS) and the U.S. Department of Labor (USDOL) to carry out enforcement actions and consumer complaints may be forwarded directly to those federal agencies.

The purpose of this memorandum is to discuss complaints received by this agency concerning health insurer practices that may be considered "red flags." The following list contains de-identified examples of complaints received by this agency, along with explanations concerning why these policies/practices may be prohibited non-quantitative treatment limitations under MHPAEA:

Example No. 1:

- Insurer imposes a requirement that all out-patient mental health therapy be re-justified with a new treatment plan every 90 days after an initial pre-determined number of visits. The treatment plan must demonstrate improvement in the condition before additional visits will be covered. The insurer does not have a process that allows for exceptions to its policy of a set visit limit followed by the requirement of a new treatment plan every 90 days and does not take into account the severity or diagnosis of the mental illness being treated.
- A similar provision requires that an in-patient stay for mental illness or substance use disorder be re-authorized every 5 days, regardless of the nature or severity of the illness being treated.

"Red Flag" indications:

  - There is no consideration given to the fact that certain mental health conditions are chronic and cannot be "cured." Bi-polar disorder or schizophrenia cannot be treated in the same way as situational depression.
  - Chronic mental illness should have treatment options that are similar to or the same as those available for the treatment of chronic physical illness. Medically necessary ongoing treatment should not be denied without appropriate review. The medical necessity for each mental health claim should be analyzed individually and not be subject to a process that imposes "one size fits all" approach. For instance, bi-polar disorder should not be treated differently than a chronic physical illness, such as diabetes.

Ongoing access to medically necessary office visits, medication, etc should be authorized without placing an undue burden on the member or mental health provider.

- Excessive pre-authorization and frequent "treatment plan" renewal requirements may be viewed as harassment by mental health providers and appear to be unduly burdensome. This has resulted in complaints indicating that some providers are refusing to accept insurance as payment—even while they continue to accept Medicaid.
- See the DOL "Warning Signs" guidance, paragraphs I, III and IV.

Example No. 2:

- Out-of-state treatment options for mental illness or substance use disorders are seldom or never authorized even when there are no appropriate treatment options available locally. As a result, patients go without medically necessary treatment because appropriate treatment options are not available locally.

  "Red Flag" indication:

  - Out-of-state treatment options are readily available for members with a physical illness who need specialized treatment for diseases such as cancer.
  - See the DOL "Warning Signs" guidance, paragraph V.

Example No. 3:

- The insurer or plan has an inadequate network of mental health providers. The plan maintains high levels of participating health care providers and facilities that treat physical illness, but consistently maintains much lower numbers of participating mental health professionals and mental health treatment facilities in its network.

  "Red Flag" indications:

  - Although there is a mental health provider workforce shortage in Montana, certain insurers refuse to allow additional licensed mental health providers into their network in the grounds that their network is "full."
  - Appropriate levels of network adequacy cannot be maintained because the insurer is reimbursing mental health providers at very low rate, compared to other types physical healthcare providers.
  - Insurer refuses to allow certain mental health providers into the network at all, such as licensed addiction counsellors.
  - See the preamble to the MHPAEA, page number 68246 at http://webapps.dol.gov/FederalRegister/PdfDisplay.aspx?DocId=27169

Example No. 4:

- Insurer continues to deny claims or refuses pre-authorization for mental health treatment, even after an IRO decision has issued an opinion that indefinite ongoing access to out-patient therapy is necessary to maintain the mental health of the member because of a diagnosed chronic mental illness.

  "Red Flag" indication:

  - The insurer continues to deny treatment on the same basis for which a treatment denial was overturned on appeal.

Example No. 5:

- Insurer refuses to continue payment for out-patient therapy because progress has not been "proven" by the provider.

  "Red Flag" indication:

  - This practice was identified as a red flag in the DOL Warning signs guidance, paragraph III.
  - Similar requirements are not placed on chronic physical conditions.
  - See the DOL "Warning Signs" guidance, paragraphs II and III.

Example No. 6:

- Insurer refuses to pay for therapy relating to a co-occurring mental illness while a member is receiving in patient treatment for substance use disorder.

"Red Flag" indications:

- 70% of patients with substance use disorder also suffer from a mental illness.
- A patient hospitalized for a physical illness would always receive treatment for a co-occurring physical illness. An insured individual hospitalized for a heart condition would still receive treatment for a co-occurring physical condition, such as diabetes.

Example No. 7:

- Insurer refuses to pay for higher cost therapies until lower cost therapy is proven ineffective, despite evidence supporting the medical necessity for more intensive treatment; for instance, requiring proof that out-patient therapy is ineffective before authorizing in-patient treatment.

"Red Flag" indication:

- A similar requirement is not place for treatment for physical illness.
- This practice was identified as a red flag in the DOL Warning signs guidance, paragraph II.

Example No. 8:

- Insurer or health plan excludes payment for certain types of therapy without any medical necessity analysis, such as:
  - Play therapy for children; out-patient sessions lasting longer than 50 minutes; any type of "group" therapy involving peers or other family members.
  - Insurer will pay for in-patient residential treatment and out-patient therapy, but refuses to authorize intermediate stages of care, such as partial hospitalization (acute or sub-acute) or intensive outpatient therapy.

  "Red Flag" indication:

  - These types of blanket exclusions may prevent the member from receiving medically necessary treatment when acute care settings would not meet medical necessity requirements, but out-patient therapy is not sufficient.
  - Less acute care setting are generally authorized for physical conditions, such as a skilled nursing facility.

The examples provided above describe warning signs, but each complaint would require additional analysis based on the specific facts of each case. Further investigation is required before an actual NQTL violation could be established.

Consumer complaints concerning possible MHPAEA violations can be directed to the State Auditor's Office at www.csimt.gov or to CMS for self-funded government plans: NonFed@cms.hhs.gov or for individual health plans: healthinsurance@cms.hhs.gov or for all employer health plans (except self-funded government health plans) to the USDOL: https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa.