Depression and Bipolar Support Alliance

Comments on Model Form Revisions and Draft Frequently Asked Questions and Answers (FAQs) About Mental Health and Substance Use Disorder Parity Implementation

INTRODUCTION

The Depression and Bipolar Support Alliance is submitting these comments, suggested model form revisions and draft Frequently Asked Questions and Answers (FAQs) in response to the Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury (collectively, the Departments) June 16, 2017 joint request for comments in the "FAQs About Mental Health and Substance Use Disorder Parity Implementation and the 21st Century Cures Act Part 38." Our comments mirror those of the Parity Implementation Coalition and we are in strong support of the work being done by our partners in this process.

About DBSA

DBSA is the leading peer-directed national organization focusing on mood disorders: depression and bipolar disorder. Unlike any other organization of its kind, DBSA is created for and led by individuals who themselves live with a mood disorder, with our bylaws stipulating that more than 50 percent of both the governing board of directors and paid professional staff must be people who have, or have had, depression or bipolar disorder. This first-person lived experience informs everything that we do.

DBSA envisions wellness for people with mood disorders. And, we believe that an open and collaborative approach to treatment—one that accounts for a person's mental, emotional, and physical health—is what allows people to achieve what they personally define as wellness. DBSA has a long history of providing cutting-edge, interactive online tools and resources that allow individuals to understand, choose, manage, and evolve their treatment plans. Additionally our network of 300 chapters across the country offer more than 700 free, in-person support groups. These programs, enable DBSA to reach over three million people each year with current, readily understandable information about depression and bipolar disorder; connections to treatment and community resources; and the hope that wellness is possible.

Ultimately, we believe that our balanced, person-centered, wellness-oriented approach is what has allowed us to educate, empower, support, and inspire individuals to achieve the lives they want to lead for our more than 30 years in existence. It is from this perspective of experience and relationships that we believe that DBSA is uniquely positioned to provide comment and share stories from our participants.

DBSA continues its commitment to the prompt and effective implementation and enforcement of the *Mental Health Parity and Addiction Equity Act* (MHPAEA). DBSA is seeking to ensure that the Administration will continue efforts seeking full implementation and enforcement of MHPAEA. MHPAEA is a critical tool in combatting the in ensuring that all individuals and family who live with mood disorders have access to the treatment services that they need on a timely basis. Along with our colleagues in the Parity Implementation Coalition we have sought to offer comments that specifically addressed disclosure of documents necessary to perform a lawful non-quantitative treatment limit (NQTL) analysis and these recommendations continue that process.

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OVERVIEW OF COMMENTS

Per the Departments' request in the June 16, 2017 FAQ addressing Part 38 of the *21st Century Cures Act*, PIC's recommendations clarify how to improve the disclosure of plan information required under MHPAEA and other relevant laws. The Departments have already issued a substantial amount of sub-regulatory guidance on disclosure and NQTLs and we urge their enforcement. As of this date, we are unaware of any health plan that has fully complied with an NQTL disclosure request despite this guidance. Moreover, our members have not had a plan provide the evidentiary standards or comparative analysis for mental health/substance use versus medical/surgical for the development or implementation of NQTLs. While PIC members believe the most recent sub-regulatory guidance on NQTL/disclosure was reasonably explicit, we understand other stakeholders disagree. As such, for the development of further guidance, we have included:

- Attachment A
    - Suggested "tracked changes" to the Department's draft form "Request Documentation from an Employer-Sponsored Health Plan or an Insurer Concerning Treatment Limitations" as solicited in the June 17, 2016 FAQs;
- Attachment B
    - Sample FAQs that expand upon how to comply with the documentation required in the Department's model form;
    - Because specific examples of how various NQTLs are applied is often the clearest way to demonstrate compliant and non-compliant NQTLs analyses, the PIC's comments also include a non-exhaustive group of draft FAQs on a variety of the most common types of NQTLs our members see; and
- Attachment C (Note this is a separate Excel Document)
    - A suggested plan reporting format on application of NQTLs, both written and in operation, with a clear six step process and an accompanying spreadsheet. The six-step process for reporting on application of NQTLs to mental health/substance use and medical/surgical benefits, as well as examples of their application to specific NQTLs are intended to be useful tools to the Departments and state regulators as to how a plan could structure its NQTL analysis and report on it to regulators. The sixth step in the process is intended for use by plans and not consumers or providers.

DBSA would be pleased to discuss these recommendations in greater detail as federal and state regulators seek to fully implement the parity law in their jurisdictions. Our Vice President for Advocacy, Phyllis Foxworth can be reached at pfoxworth@dbsalliance.org

Sincerely,

Allen Doederlein

Allen Doederlein
President
Depression and Bipolar Support Alliance

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ATTACHMENT A: SUGGESTED CHANGES TO THE SAMPLE FORM

The American Psychiatric Association, Kennedy Forum, Parity Implementation Coalition and Watershed Treatment Programs Comments on Sample Form to "Request Documentation from an Employer-Sponsored Health Plan or an Insurer Concerning Treatment Limitations"

(OMB Control Number 1210-0138)
Expiration Date XX/XX/20XX

FORM TO REQUEST DOCUMENTATION FROM AN EMPLOYER-SPONSORED HEALTH PLAN OR AN INSURER CONCERNING TREATMENT LIMITATIONS

Background: This is a tool to help you request information from your employer-sponsored health plan or your insurer regarding limitations that may affect your access to mental health or substance use disorder benefits. Under the Mental Health Parity and Addiction Equity Act (MHPAEA), you can use this form to request general information about coverage limitations or specific information about limitations that may have resulted in denial of your benefits. Your plan is required by law to provide you this information in certain instances, and the information will help you determine if the coverage you are receiving complies with the law.

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Under a federal law called the Mental Health Parity and Addiction Equity Act, many health plans must make sure that there is "parity" between mental health and substance use disorder benefits, and medical and surgical benefits. This generally means that coverage limits applied to mental health and substance use disorder benefits can't be more restrictive than the coverage limits applied to medical and surgical benefits. In other words, coverage limits cannot be applied to mental health and substance use disorder benefits unless those limits are comparable to limits applied to medical and surgical benefits. The types of treatment limits covered by parity protections include:

- Financial requirements – such as deductibles, copayments, coinsurance, or out-of-pocket limits;
- Treatment limits– such as limits on the number of days or visits covered, or other limits on the scope or duration of treatment (for example, being required to get prior authorization).

If you, a family member, or someone you are helping obtains health coverage through a private employer health plan, federal law requires the plan to provide certain plan documents about your benefits, including coverage limitations on your benefits, at your request. For example, you may want to obtain documentation as to why your health plan is requiring pre-authorization for visits to a therapist before it will cover the visits. Generally, the plan must provide the documents you request within thirty (30) calendar days of the plan's receipt of your request.

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This form will help you request information from your plan about treatment limits. Many common types of treatment limits are listed on this form. If the type of treatment limit being imposed by your plan is not on the list, you may insert a description of the treatment limit you would like more information about under "Other."

Instructions:

Complete the attached form to request general information from your plan about coverage limitations or specific information about why your mental health or substance use disorder benefits were denied. This information can help you appeal a claim denial. You do not have to use this form to request information from your plan.

If you have any questions about this form and you are enrolled in a private employer health plan, you may visit the Employee Benefits Security Administration's (EBSA's) Website at www.dol.gov/ebsa for answers to common questions about your private employer health plan. You may also contact EBSA electronically at www.askebsa.dol.gov or call toll free 1-866-444-3272.

You can also use this form if you are enrolled in coverage other than through a private employer health plan, for example if you have individual health coverage or coverage sponsored by a public sector employer, like a city or state government. You may contact the Centers for Medicare & Medicaid Services at phig@cms.hhs.gov or 1-877-267-2323 ext. 6-1565 for questions about your individual health coverage or public sector health plan.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 1210-0138, which expires on XX XX, 20XX. The time required to complete this information collection is estimated to average 5 minutes per response, including the time to review instructions, gather the necessary data, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0138.

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[Insert Date]

Mental Health and Substance Use Disorder Parity Disclosure Request

To: _____ [*Insert name of the health plan or issuer]*

(If you are a provider or another representative who is authorized to request information for the individual enrolled in the plan, complete this section.)

I am an authorized representative requesting information for the following individual enrolled in the plan:

(Check the box to indicate whether your request is for general information or specific information related to your claim or denial for benefits.)

General Information Request

I am requesting information on the plan's limitations related to coverage for:

Mental health and substance use disorder benefits, generally.

The following specific condition or disorder: _____.

Claim/Denial Information Request

I was notified that a claim for coverage of _____ [*Insert mental health condition or substance use disorder*] was, or may be, denied or restricted for the following reason[s]:

(Check all that apply)

- o I was advised that the treatment was not medically necessary.
- o I was advised that the treatment was experimental or investigational.
- o The plan requires authorization before it will cover the treatment.
- o The plan requires ongoing authorizations before it will cover my continued

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treatment.

- o The plan is requiring me to try a treatment that is lower in cost before authorizing the treatment that my doctor recommends.
- o The plan will not authorize any more treatments based on the fact that I failed to complete a prior course of treatment.
- o The plan's prescription drug formulary design will not cover the medication my doctor is prescribing.
- o My plan covers my mental health or substance use disorder treatment, but does not have any reasonably accessible in-network providers for my mental health and/or substance use disorder treatment.
- o I am not sure the methods my plan uses to calculate payment for out-of-network services, such as its methods for determining usual, customary and reasonable charges, complies with parity protections.
- o Other: *(Specify basis for denial of, limitation on, or reduction in coverage)*:

_____

_____

_____

Because my health coverage is subject to the parity protections, coverage limits cannot be applied to mental health and substance use disorder benefits unless those limits are comparable to limits applied to medical and surgical benefits. Therefore, for the limitations or terms of the
benefit plan specified above, within thirty (30) calendar days of the date of this request, I request that the plan:

1. Provide the specific plan language regarding the limitation and identify all of the medical/surgical and mental health and substance use disorder benefits to which it applies in the relevant benefit classification;

2. Identify the factors used in the development of the limitation (examples of factors include excessive utilization, recent medical cost escalation, high variability in cost per episode of care, safety and efficacy of treatment modality);

3. Identify the evidentiary standards used to define and evaluate the factors;

Examples of factors and evidentiary standards that define such factors include:

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- Excessive utilization as defined by two standard deviations above average utilization per episode of care;
- Recent medical cost escalation as defined by medical costs for certain services increasing 10% or more per year for 2 years;
- High variability in cost per episode of care as defined by episodes of outpatient care being 2 standard deviations higher in total costs than the average cost per episode 20% or more of the time in a 12-month period;
- Safety and efficacy of treatment modality as defined by 2 random clinical trials required to establish a treatment is not experimental or investigational.

4. Identify the sources for each factor and evidentiary standard used (examples of sources include internal claims analyses, expert medical review, external research studies, etc.)

5. Identify the methods and analyses used in the development of the limitation;

Examples of methods and analyses may include:

- Results from analyses of the health plan's paid claims that established that the identified factors and evidentiary standards (e.g., recent medical cost escalation which exceeds 10% year) were present in a comparable manner in both MH/SUD and medical/surgical benefits subject to the limitation
- A defined process (e.g., internal claims analysis) for analyzing which medical/surgical and MH/SUD services within a specified benefits classification had "high cost variability" (defined by identical factors and evidentiary standards for all services) and, therefore, are subject to any prior authorization, concurrent review and/or retrospective review protocols.
- A market-based analysis of provider rates for both MH/SUD and medical/surgical services to establish that a fee schedule and/or usual and customary rates were the same

6. Provide any evidence to establish that the limitation is applied no more stringently, as written and in operation, to mental health and substance use disorder benefits than to medical and surgical benefits.

Examples of such evidence may include:

- Audits results that demonstrate that the frequency of mental health and substance use disorder vs. medical and surgical reviews within the same classifications of benefits were applied comparably and no more stringently.
- Results from analyses of whether out-of-network utilization by beneficiaries of medical/surgical benefits is similar to out-of-network utilization by beneficiaries of mental health and substance use disorder benefits in the same classifications for similar types of facilities or outpatient settings.
- Results from audits/reviews of denial rates by service or benefit category, by

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administrative vs. medical necessity, for medical/surgical and mental health and substance use disorder.

- Results of analyses of provider in-network participation rates for medical/surgical and mental health and substance use disorder.

_____

Printed Name of Individual Enrolled in the Plan or his or her Authorized Representative

_____

Signature of Individual Enrolled in the Plan or his or her Authorized Representative

_____

Member Number (*number assigned to the enrolled individual by the Plan)*

_____

Address

_____

Date

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ATTACHMENT B: SAMPLE FAQS

SPD and Specific Plan Language for MH/SUD Only

Q1: I am a provider acting as an authorized representative for an ERISA group health plan participant. The health plan performed a concurrent review (a type of NQTL) of outpatient psychotherapy office visits and denied all visits after the 8th visit as not medically necessary.

As an authorized representative for the plan participant, I did receive the medical necessity criteria for both MH/SUD and medical/surgical outpatient benefits as part of the denial letter, and I requested the following documents:

1. A Summary Plan Description (SPD) from the plan;
2. The specific plan language regarding the NQTL of concurrent review and identification of all of the medical/surgical and mental health and substance use disorder benefits to which this limitation applies in the relevant benefit classifications or sub-classifications;
3. Identify the factors that were, in fact, used in the development of the limitation (examples of factors include excessive utilization, recent medical cost escalation, high variability in cost per episode of care, safety and efficacy of treatment modality);
4. Identify the evidentiary standards used to define and evaluate the factors (examples include two standard deviations above average utilization per episode, medical costs increasing 10% or more per year for 2 years, episodes of outpatient care being 2 standard deviations higher than average cost per episode 20% or more of the time in a one year period, etc.)
5. Identify the sources for each factor and evidentiary standard used (examples include internal claims analyses, expert medical review, external research studies, etc.)
6. Identify the methods and analyses used in developing and applying concurrent review to the MH/SUD and medical/surgical outpatient office visits classification of benefits.
7. Provide any evidence to establish that the limitation is comparable and applied no more stringently, as written and in operation, to mental health and substance use disorder benefits versus medical and surgical benefits.

In response to my request, the plan DID provide me with:

1. The SPD and;
2. a) The specific plan language regarding concurrent review for outpatient MH/SUD benefits only.

The plan did NOT provide me with the following:

2. b) The specific plan language regarding the imposition of concurrent review for outpatient office visits for medical/surgical benefits;
3. The factors used in the development of the concurrent review protocol for both MH/SUD and medical/surgical outpatient office visits;
4. The evidentiary standards used to define and evaluate such factors in developing the concurrent review protocol for both MH/SUD and medical/surgical benefits in the outpatient office visit classification at issue;
5. The sources for each factor and evidentiary standard used;
6. Any methods and analyses conducted by the plan in developing and applying concurrent review to the MH/SUD and medical/surgical outpatient office visits classification of benefits;
7. Any evidence to establish that concurrent review is comparable to and applied no more stringently to mental health and substance use disorder benefits versus medical and surgical

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benefit, as written and in operation.

Is this a complete response by a plan?

No. This is an incomplete response. The plan is required to provide the authorized representative with the documents listed in items 2b) through 7 above.

Medical Necessity Criteria and Factors Only

Q2: I am a provider acting as an authorized representative for an ERISA group health plan participant. The health plan performed a concurrent review (a type of NQTL) of outpatient psychotherapy office visits and denied all visits after the 8th visit as not medically necessary.

As an authorized representative for the plan participant, I did receive the medical necessity criteria for both MH/SUD and medical/surgical outpatient benefits as part of the denial letter, and I requested the following documents:

1. A Summary Plan Description (SPD) from the plan;
2. The specific plan language regarding the NQTL of concurrent review and identification of all of the medical/surgical and mental health and substance use disorder benefits to which this limitation applies in the relevant benefit classifications or sub-classifications;
3. Identify the factors that were, in fact, used in the development of the limitation (examples of factors include excessive utilization, recent medical cost escalation, high variability in cost per episode of care, safety and efficacy of treatment modality);
4. Identify the evidentiary standards used to define and evaluate the factors (examples include two standard deviations above average utilization per episode, medical costs increasing 10% or more per year for 2 years, episodes of outpatient care being 2 standard deviations higher than average cost per episode 20% or more of the time in a one year period, etc.);
5. Identify the sources for each factor and evidentiary standard used (examples include internal claims analyses, expert medical review, external research studies, etc.);
6. Identify the methods and analyses used in developing and applying concurrent review to the MH/SUD and medical/surgical outpatient office visits classification of benefits;
7. Provide any evidence to establish that the limitation is comparable and applied no more stringently, as written and in operation, to mental health and substance use disorder benefits versus medical and surgical benefits.

In response to my request, the plan DID provide me with:

1. The SPD;
2. The specific plan language regarding concurrent review for outpatient MH/SUD and medical and surgical benefits; and,
3. A listing of the factors that were, in fact, considered in the development and application of concurrent review for both MH/SUD and medical/surgical outpatient office visit benefits. The factors listed and defined were high cost variability, recent increase in costs of outpatient office visit services, excessive utilization and lack of adherence to quality standards.

The plan did NOT provide me with the following:

4. The evidentiary standards used to define and evaluate each of these factors;
5. The sources for the factors and evidentiary standards;
6. The analyses of comparability in the development and application of concurrent review utilizing these factors and evidentiary standards for both MH/SUD and medical/surgical outpatient office

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visits; or,

7. Any documents or information regarding how this NQTL was implemented, in operation, in a comparable and no more stringent manner.

Is this a complete response by the plan?

No. This is not a complete response. The plan is obligated to provide the evidentiary standard for each factor as well as the specific analyses that demonstrate that these factors AND evidentiary standards were developed and applied comparably and no more stringently, both as written and in operation, to both MH/SUD and medical/surgical benefits in the outpatient office visits classification. In so doing, the plan's comparative analyses should demonstrate that the application of the NQTL to MH/SUD outpatient office visits is justified.

Medical Necessity Criteria, Factors and Evidentiary Standards Only

Q3: I am a provider acting as an authorized representative for an ERISA group health plan participant. The health plan performed a concurrent review (a type of NQTL) of outpatient psychotherapy visits and denied all visits after the 8th visit as not medically necessary.

As an authorized representative for the plan participant, I did receive the medical necessity criteria for both MH/SUD and medical/surgical outpatient benefits as part of the denial letter, and I requested the following documents:

1. A Summary Plan Description (SPD) from the plan;
2. The specific plan language regarding the NQTL of concurrent review and identification of all of the medical/surgical and mental health and substance use disorder benefits to which this limitation applies in the relevant benefit classifications or sub-classifications;
3. Identify the factors that were, in fact, used in the development of the limitation (examples of factors include excessive utilization, recent medical cost escalation, high variability in cost per episode of care, safety and efficacy of treatment modality);
4. Identify the evidentiary standards used to define and evaluate the factors (examples include two standard deviations above average utilization per episode, medical costs increasing 10% or more per year for 2 years, episodes of outpatient care being 2 standard deviations higher than average cost per episode 20% or more of the time in a one year period, etc.);
5. Identify the sources for each factor and evidentiary standard used (examples include internal claims analyses, expert medical review, external research studies, etc.);
6. Identify the methods and analyses used in developing and applying concurrent review to the MH/SUD and medical/surgical outpatient office visits classification of benefits;
7. Provide any evidence to establish that the limitation is comparable and applied no more stringently, as written and in operation, to mental health and substance use disorder benefits versus medical and surgical benefits.

In response to my request, the plan DID provide me with:

1. The SPD;
2. The specific plan language regarding concurrent review for outpatient MH/SUD and medical and surgical benefits;
3. A listing of the factors that were, in fact, considered in the development and application of concurrent review for both MH/SUD and medical/surgical outpatient office visit benefits. The factors listed were high cost variability, recent increase in costs of outpatient office visit services, excessive utilization and safety and efficacy of treatment modality.

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4. A description of each evidentiary standard used to define and evaluate each factor. The plan stated that the factor of high costs variability per episode of care had an evidentiary standard of episodes of outpatient office visits for either medical/surgical or MH/SUD that were 2 standard deviations higher in total costs than the average cost per episode of care more than 20% of the time in the past 2-month period measured. Recent increase in medical costs was defined as certain benefits in the medical/surgical and MH/SUD outpatient office visits class that had increased 10% or more over the last two years. Excessive utilization was defined as 2 standard deviations or more above average utilization per episode of care. Safety and efficacy of treatment modality was defined as 2 or more random clinical trials required to establish a treatment is not experimental or investigational.

The plan did NOT provide me with the following:

5. The sources for the factors and evidentiary standards.
6. The analyses of comparability in the development and application of concurrent review utilizing these factors and evidentiary standards for both MH/SUD and medical/surgical outpatient office visits.
7. Documents and information regarding how this NQTL was implemented, in operation, in a comparable and no more stringent manner.

Is this a complete response?

No. While the plan was responsive with respect to factors and evidentiary standards, the plan failed to provide the sources used for the factors and evidentiary standards, the analyses for developing and applying these factors and standards in a comparable and no more stringent manners, both as written and in operation, including a comparative analyses demonstrating that the application of the NQTL to MH/SUD outpatient office visits is justified.

Medical Necessity Criteria, Factors, Evidentiary Standards and Analyses of Application Only

Q4: I am a provider acting as an authorized representative for an ERISA group health plan participant. The health plan performed a concurrent review (a type of NQTL) of outpatient psychotherapy visits and denied all visits after the 8th visit as not medically necessary.

As an authorized representative for the plan participant, I did receive the medical necessity criteria for both MH/SUD and medical/surgical outpatient benefits as part of the denial letter, and I requested the following documents:

1. A Summary Plan Description (SPD) from the plan:
2. The specific plan language regarding the NQTL of concurrent review and identification of all of the medical/surgical and mental health and substance use disorder benefits to which this limitation applies in the relevant benefit classifications or sub-classifications;
3. Identify the factors that were, in fact, used in the development of the limitation (examples of factors include excessive utilization, recent medical cost escalation, high variability in cost per episode of care, safety and efficacy of treatment modality);
4. Identify the evidentiary standards used to define and evaluate the factors (examples include two standard deviations above average utilization per episode, medical costs increasing 10% or more per year for 2 years, episodes of outpatient care being 2 standard deviations higher than average cost per episode 20% or more of the time in a one year period, etc.);
5. Identify the sources for each factor and evidentiary standard used (examples include internal claims analyses, expert medical review, external research studies, etc.);
6. Identify the methods and analyses used in developing and applying concurrent review to the MH/SUD and medical/surgical outpatient office visits classification of benefits;

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7. Provide any evidence to establish that the limitation is comparable and applied no more stringently, as written and in operation, to mental health and substance use disorder benefits versus medical and surgical benefits.

In response to my request, the plan DID provide me with:

1. The SPD;
2. The specific plan language regarding concurrent review for outpatient MH/SUD and medical and surgical benefits;
3. A listing of the factors that were, in fact, considered in the development and application of concurrent review for both MH/SUD and medical/surgical outpatient office visit benefits. The factors listed were high cost variability, recent increase in costs of outpatient office visit services, excessive utilization and safety and efficacy of treatment modality.
4. A description of each evidentiary standard used to define and evaluate each factor. The plan stated that the factor of high costs variability per episode of care had an evidentiary standard of episodes of outpatient office visits for either medical/surgical or MH/SUD that were 2 standard deviations higher in total costs than the average cost per episode of care more than 20% of the time in the past 2-month period measured. Recent increase in medical costs was defined as certain benefits in the medical/surgical and MH/SUD outpatient office visits class that had increased 10% or more over the last two years. Excessive utilization was defined as 2 standard deviations or more above average utilization per episode of care. Safety and efficacy of treatment modality was defined as 2 or more random clinical trials required to establish a treatment is not experimental or investigational.
5. The plan provided the sources used to develop the factors and evidentiary standards, including _____.
6. The plan provided specific analyses and results from these analyses demonstrating that all medical services in this benefit classification that exhibited these factors as defined by the above evidentiary standards were subject to the concurrent review NQTL. The plan disclosed a summary of an internal claims analysis that documented that all physician office visits in the same classification for medical conditions had experienced increased medical costs and high cost variability as defined above. Further, the plan stated that all physician office visits in the same classification were subject to the same concurrent review procedures as were applied to outpatient psychotherapy office visits.

The plan did NOT provide me with the following:

7. However, the plan did **not** disclose any information about whether it applied this NQTL in a comparable and no more stringent manner, in operation. No audit or survey analyses or results were provided. For example, the plan did not provide any evidence, in the form of data or otherwise, that assured the concurrent review process was applied, in operation, with the same frequency for both MH/SUD and medical/surgical, and that these procedures were comparable in the amount of time required of the providers. The plan could have provided date such as frequency of denials between medical/surgical and MH/SUD resulting from these concurrent reviews that would assure the reviews were being conducted in a comparable and no more stringent manner.

Is this a complete response?

No. The plan was responsive with respect to identifying factors and evidentiary standards and the sources used to identify same. The plan also provided the analyses that were conducted to compare the MH/SUD and medical and surgical benefits that demonstrated that concurrent review was developed in a comparable manner. However, no documents or information were provided regarding how this NQTL was applied, in operation, in a comparable and no more stringent manner.

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Medical Necessity Criteria, Factors, Evidentiary Standards and Analyses of Application and Implementation

Q5: I am a provider acting as an authorized representative for an ERISA group health plan participant. The health plan performed a concurrent review (a type of NQTL) of outpatient psychotherapy visits and denied all visits after the 8th visit as not medically necessary.

As an authorized representative for the plan participant, I did receive the medical necessity criteria for both MH/SUD and medical/surgical outpatient benefits as part of the denial letter, and I requested the following documents:

1. A Summary Plan Description (SPD) from the plan;
2. The specific plan language regarding the NQTL of concurrent review and identification of all of the medical/surgical and mental health and substance use disorder benefits to which this limitation applies in the relevant benefit classifications or sub-classification
3. Identify the factors that were, in fact, used in the development of the limitation (examples of factors include excessive utilization, recent medical cost escalation, high variability in cost per episode of care, safety and efficacy of treatment modality);
4. Identify the evidentiary standards used to define and evaluate the factors (examples include two standard deviations above average utilization per episode, medical costs increasing 10% or more per year for 2 years, episodes of outpatient care being 2 standard deviations higher than average cost per episode 20% or more of the time in a one year period, etc.);
5. Identify the sources for each factor and evidentiary standard used (examples include internal claims analyses, expert medical review, external research studies, etc.);
6. Identify the methods and analyses used in developing and applying concurrent review to the MH/SUD and medical/surgical outpatient office visits classification of benefits;
7. Provide any evidence to establish that the limitation is comparable and applied no more stringently, as written and in operation, to mental health and substance use disorder benefits versus medical and surgical benefits.

In response to my request, the plan DID provide me with:

1. The SPD;
2. The specific plan language regarding concurrent review for outpatient MH/SUD and medical and surgical benefits;
3. A listing of the factors that were, in fact, considered in the development and application of concurrent review for both MH/SUD and medical/surgical outpatient office visit benefits. The factors listed were high cost variability, recent increase in costs of outpatient office visit services, excessive utilization and safety and efficacy of treatment modality.
4. A description of each evidentiary standard used to define and evaluate each factor. The plan stated that the factor of high costs variability per episode of care had an evidentiary standard of episodes of outpatient office visits for either medical/surgical or MH/SUD that were 2 standard deviations higher in total costs than the average cost per episode of care more than 20% of the time in the past 2-month period measured. Recent increase in medical costs was defined as certain benefits in the medical/surgical and MH/SUD outpatient office visits class that had increased 10% or more over the last two years. Excessive utilization was defined as 2 standard deviations or more above average utilization per episode of care. Safety and efficacy of treatment modality was defined as 2 or more random clinical trials required to establish a treatment is not experimental or investigational.
5. The plan provided the sources used to develop the factors and evidentiary standards.

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6. The plan provided specific analyses and results from these analyses demonstrating that all medical services in this benefit classification that exhibited these factors as defined by the above evidentiary standards were subject to the concurrent review NQTL. The plan disclosed a summary of an internal claims analysis that documented that all physician office visits in the same classification for medical conditions had experienced increased medical costs and high cost variability as defined above. Further, the plan stated that all physician office visits in the same classification were subject to the same concurrent review procedures as were applied to outpatient psychotherapy office visits.
7. With respect to application of the NQTL in operation, the plan provided analyses of audits that were performed, which demonstrated that the NQTL of concurrent review was applied for MH/SUD outpatient psychotherapy visits with the same frequency and with a comparable procedure as medical/surgical outpatient office visits in the same classification. Further, the plan provided data on the comparability of denial rates from outpatient concurrent reviews between MH/SUD and medical/surgical, as well as data that showed that the out-of-pocket costs to plan participants for out-of-network providers for outpatient office visits in the same classification were comparable between MH/SUD and medical/surgical benefits.

Is this plan response complete?

Yes. The plan has made complete disclosure for this NQTL. The plan was responsive with respect to identifying factors and evidentiary standards and the sources used to identify same. The plan also provided the analyses that were conducted to compare the MH/SUD and medical and surgical benefits that demonstrated that concurrent review was developed in a comparable manner. The plan also provided data that demonstrated that this NQTL was being applied, in operation, in a comparable and no more stringent manner.

Prior Authorization

Q6: A plan considers a wide array of factors in designing medical management techniques for both mental health and substance use disorder benefits and medical/surgical benefits. Factors may include cost of treatment; high cost growth; variability in cost and quality; elasticity of demand; provider discretion in determining diagnosis, type or length of treatment; clinical efficacy of any proposed treatment or service; licensing and accreditation of providers; and claim types with a high percentage of fraud.

Based on application of these factors in a comparable fashion, prior authorization is required for some (but not all) mental health and substance use disorder benefits, as well as for some medical/surgical benefits, but not for others. For example, the plan requires prior authorization for: outpatient surgery; speech, occupational, physical, cognitive and behavioral therapy extending for more than six months; durable medical equipment; diagnostic imaging; skilled nursing visits; home infusion therapy; coordinated home care; pain management; high-risk prenatal care; delivery by cesarean section; mastectomy; prostate cancer treatment; narcotics prescribed for more than seven days; and all inpatient services beyond 30 days.

The evidence considered in developing its medical management techniques includes consideration of an array of recognized medical literature, professional standards and protocols (including comparative effectiveness studies and clinical trials) and internal claims analyses. The plan documents that for each factor it considered, the plan identified the specific evidentiary standard used to define and evaluate such factor. The plan completed an analysis with results of each medical/surgical and mental health and substance use disorder benefit in the same classification for which prior authorization was applied and documented that each category of treatment services within the same classification of benefits met the comparable evidentiary standard. The plan also documented that prior authorization was applied, in operation, in a comparable and no more stringent manner by providing evidence of audits conducted such as comparison of denial rates for medical/surgical vs mental health and substance use disorder benefits in the same classification of benefits; comparison of out-of-network use for categories of services that required prior authorization in the same classification of benefits; and data that showed pre-

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authorizations were conducted with the same frequency in the same classification of benefits. The plan also conducted testing to ensure that the documentation required of providers was similar and that no peer to peer (physician to physician) interviews were required on either side.

Is this plan in compliance?

Yes. The plan complies with the nonquantitative treatment limitation rule.

The plan has demonstrated that the factors it used and disclosed were defined and evaluated by the comparable evidentiary standards, which were also disclosed. The plan also demonstrated that it conducted analyses to determine the comparability and no more stringent development and application of its pre-authorization requirement, both as written and in operation, to the categories of treatment services in each classification of benefits, for which pre-authorization was applied.

Provider Reimbursement Rates

Q7: I am an in-network psychiatrist for an insurance plan subject to ERISA and am an authorized representative for a plan participant who is receiving in-network outpatient care. The plan recently reduced my fees by 20% and I am considering leaving in-network participation with this plan. I have requested that the plan disclose the processes, strategies, evidentiary standards and factors they are using to set my reimbursement rates as compared to other non-psychiatric physicians.

The plan provided me with the following information: The plan reported that non-psychiatric physician reimbursement rates were established by using a percentage increase based on Medicare Allowable benchmark rates and an annual survey of network access such as patient wait times. The plan stated that psychiatrists' reimbursement rates were established by using an adjustment to Medicare Allowable benchmark based on a market survey of what other psychiatrists and non-psychiatrist mental health professionals were being reimbursed by other payers in the same market. Is this compliant with the NQTL rule?

No. The plan is not compliant with the NQTL rule. The plan is using non-comparable methodologies and evidentiary standards to determine provider reimbursement rates.

Collaborative Care Exclusion

Q8: A plan generally covers medically appropriate treatments for medical/surgical conditions. The plan automatically excludes coverage for collaborative care interventions (such as case management and mental health consultation) for behavioral disorders in primary care settings even though this intervention has an established payment code and is recognized as a best practice by many expert groups. The plan routinely provides coverage for case management for many medical conditions through Primary Care Medical Homes, also referred to as Patient Centered Medical Homes (PCMH). Is the plan compliant with the nonquantitative treatment limitation rule?

No. The plan violates the NQTL rules of paragraph (c)(4). Although the same nonquantitative treatment limitation--medical appropriateness--is applied to both mental health and substance use disorder benefits and medical/surgical benefits, the plan's unconditional exclusion of collaborative care payments for all mental health and substance use disorders while reimbursing for similar services for common medical conditions is noncompliant.

Experimental vs Non-Experimental Determinations

Q9: I am a psychiatrist who has been providing TMS (Transcranial Magnetic Stimulation) for depressed patients. **A plan denied coverage for this established treatment (FDA approved, with over 10 RCTs and a specific CPT code for billing) and stated that this was an experimental treatment and wasn't covered in their benefit plan. Upon request for how the plan compared experimental and non -experimental treatments between mental health/substance use disorder (MH/SUD) and medical/surgical, the plan responded with this information.**

The plan stated that it had the same criteria for determining experimental status for both MH/SUD and medical/surgical. The plan's criteria requires 1) two positive randomized controlled research (RCT)

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studies published in a referred journal and 2) that a panel of internal medical experts at the plan made these decisions. The plan stated that even though TMS had over 10 RCTs published in journals, the panel had determined that these studies were not of sufficient quality to be considered as meeting the plans' criteria for non-experimental status. The plan stated that the medical review panels had other criteria they used to determine which articles were adequate but that these criteria weren't public. Further, the plan stated that while it reviewed all new technology with these criteria it didn't impose these reviews on medical treatments that were in use for many years and weren't considered new. Is the plan in compliance?
No. In this example the plans response isn't complete or compliant. It is using secret and proprietary criteria to make experimental and non-experimental determinations. The process leads to a non-comparable and more stringent application of the NQTL. Further, in monitoring of these criteria are being implemented in operation in a compliant manner the plan can't assure that they are reviewing all medical/surgical and MH/SUD treatments whether new or old in a comparable manner.

Network Access

Q10: I am a consumer who has been unable to find an in-network psychiatrist who can see me within the next 2 months as a new patient. The psychiatrist who can see me within the next two months requires a 45-minute commute. I complained to my insurance plan and asked them to disclose how they establish standards for access to MH/SUD providers as compared to medical/surgical providers as I have not had these access problems when seeing my primary care doctor or my cardiologist. I contacted several psychiatrists who were not in network but I couldn't afford to pay their rates and they told me that the plan pays so poorly that they don't want to be in network.

The plan responded by saying that they use a number of different network access factors and evidentiary standards to monitor and establish 1) how medical/surgical and MH/SUD providers are reimbursed, 2) how many provides are included in the network and 3) where providers are located. The plan stated that they used the same method of setting rates for psychiatrists and other physicians using Medicare rate schedules. Documents provided to me indicated the plan makes adjustments to the provider rates if there are insufficient providers based on standards like wait times for appointment and drive times for consumers. The plan stated that they updated these reimbursement levels on an annual basis but that they did not provide any information about how frequently they have updated fee schedules for the last three years for MH/SUD providers nor did they provide any information on out-of-network spending that was incurred by consumers of MH/SUD care vs medical/surgical care. Is this plan in compliance?
No. The plan has not provided a complete response to this consumer as they have not provided information that would assure that these network standards are being applied in a comparable and no more stringent manner in operation. Given the continued national evidence of a shortage of in-network psychiatrists and other MH/SUD professionals it is the responsibility of the plan to monitor (with the same frequency as medical/surgical providers) the access of MH/SUD consumers to providers and to make adjustments in reimbursement rates and numbers of providers to ensure comparable access to care between medical/surgical and MH/SUD.

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INSTRUCTIONS: Complete a chart for the application of the NQTL to each classification of benefits. If the NQTL is applied differently for a different benefit package, complete charts for each NQTL for each benefit package. If the NQTL is not applied to MH/SUD benefits within a classification, stop and do not complete the sheet for that benefit classification. Conversely, if the NQTL does not apply to medical/surgical benefits within a classification but is applied to MH/SUD benefits within that classification, the NQTL will violate MHPAEA and must either be eliminated or applied to medical/surgical benefits. See the accompanying guide for more information.

NQTL Name (Not required for NQTL 1 List)	Plan's Description of NQTL
Retrospective Review	Provide the documentation of and results of the comparative analyses that substantiate that the processes, strategies, evidentiary standards, and factors are comparable and no more stringently applied, as specified in each step

Column 1 - Prompt	Inpatient Benefits		Outpatient Benefits		Emergency Benefits	Prescription Drugs
	Column 2 - In network	Column 3 - out-of-network	Column 4 - In network	Column 5 - Out-of-network	Column 6 - Emergency Benefits	Column 7 - Prescription Drugs
Benefit/Service(s) to which retrospective review applies.	[List the services to which retrospective review applies]	[List the services to which retrospective review applies]	[List the services to which retrospective review applies]	[List the services to which retrospective review applies]	[List the services to which retrospective review applies]	[List the services to which retrospective review applies]
Step 1: Describe the NQTL's requirements and associated procedures						
• Describe the retrospective review procedures for both MH/SUD benefits and medical/surgical benefits. Include each step, associated triggers, timelines, forms and requirements. • Are the required qualifications/training for persons performing retrospective review for MH/SUD benefits and medical/surgical benefits comparable? If not, provide a rationale (i.e., state law requirements, etc.).	[Provide the Step 1 documentation and answer the question]	[Provide the Step 1 documentation and answer the question]	[Provide the Step 1documentation and answer the question]	[Provide the Step 1 documentation and answer the question]	[Provide the Step 1 documentation and answer the question]	[Provide the Step 1 documentation and answer the question]
Step 2: Describe the reason for applying the NQTL						
Provide the comparative analysis demonstrating that comparable factors were used to determine the applicability of retrospective review for the identified MH/SUD benefits as were used for medical/surgical benefits, including the sources for ascertaining each of these factors. List factors that were relied upon but subsequently rejected and the rationale for rejecting those factors. Examples of factors for determining that retrospective review is appropriate include (these examples are merely illustrative and not exhaustive): ☐ Excessive utilization ☐ Recent medical cost escalation ☐ Lack of adherence to quality standards ☐ High levels of variation in length of stay ☐ High variability in cost per episode of care ☐ Clinical efficacy of the proposed treatment or service ☐ Provider discretion in determining diagnoses ☐ Claims associated with a high percentage of fraud ☐ Severity or chronicity of the MH/SUD condition • Examples of sources for data to identify factors: ☐ Internal claims analyses ☐ Internal quality standard studies ☐ Expert medical review	[Provide the Step 2 documentation]	[Provide the Step 2 documentation]	[Provide the Step 2 documentation]	[Provide the Step 2 documentation]	[Provide the Step 2 documentation]	[Provide the Step 2 documentation]
Step 3: Identify and describe evidentiary standards and other evidence relied upon						
Provide the comparative analysis demonstrating that the evidentiary standard(s) used to define factors identified in Step 2 and any other evidence relied upon to establish the retrospective review protocols for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard(s) used to define factors and any other evidence relied upon to establish the retrospective review protocols for medical/surgical benefits. Describe evidentiary standards that were considered, but rejected. Please note, the term "evidentiary standards" is not limited to a means for defining "factors". Evidentiary standards also include all evidence considered in designing and applying its retrospective review protocols such as recognized medical literature, professional standards and protocols (including comparative effectiveness studies and clinical trials), published research studies, treatment guidelines created by professional guild associations or other third-party entities, publicly available or proprietary clinical definitions, and outcome metrics from consulting or other organizations. Examples of evidentiary standards and their sources are provided in the toolkit.	[Provide the Step 3 documentation]	[Provide the Step 3 documentation]	[Provide the Step 3 documentation]	[Provide the Step 2 documentation]	[Provide the Step 3 documentation]	[Provide the Step 3 documentation]
Step 4: Processes and strategies used to design NQTL as written						
Provide the comparative analysis demonstrating that the processes and strategies used to design the retrospective review protocols, as written, for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies used to design the retrospective review protocols, as written, for medical/surgical benefits. These processes may include, but are not limited to, the composition and deliberations of decision-making staff, e.g. the number of staff members allocated, time allocated, qualifications of staff involved, breadth of sources and evidence considered, deviation from generally accepted standards of care, consultations with panels of experts, and reliance on national treatment guidelines or guidelines provided by third-party organizations.	[Provide the Step 4 documentation]	[Provide the Step 4 documentation]	[Provide the Step 4 documentation]	[Provide the Step 4 documentation]	[Provide the Step 4documentation]	[Provide the Step 4 documentation]
Step 5: Processes in implementation of NQTL in operation						
Provide the comparative analysis demonstrating that the processes and strategies used in operationalizing retrospective review for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies used in operationalizing retrospective review for medical surgical benefits. Processes and strategies may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion,adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.	[Provide the Step 5 documentation]	[Provide the Step 5 documentation]	[Provide the Step 5 documentation]	[Provide the Step 5 documentation]	[Provide the Step 5 documentation]	[Provide the Step 5 documentation]
Step 6: Summary conclusion of how plan or issuer has determined overall compliance						
Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose retrospective review on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose retrospective review on medical/surgical benefits in each classification of benefits in which prior authorization is imposed.	[Provide the Step 6 documentation]	[Provide the Step 6 documentation]	[Provide the Step 6 documentation]	[Provide the Step 6 documentation]	[Provide the Step 6 documentation]	[Provide the Step 6 documentation]