August 30, 2016

Via Electronic Mail

Ms. Amy Turner (turner.amy@dol.gov)
Office of Health Plan Standards and Compliance Assistance
Employee Benefits Security Administration
Room N-5653
United States Department of Labor
200 Constitution Avenue NW
Washington, DC 20210

Ms. Samara Lorenz (samara.lorenz@cms.hhs.gov)
Center for Consumer Information and Insurance Oversight
United States Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Ms. Karen Levin (karen.levin@irscounsel.treas.gov)
Internal Revenue Service
United States Department of the Treasury
Room 5205
1111 Constitution Avenue, NW
Washington, DC 20224

RE: Request for Additional Guidance Regarding Urgent Internal Claims and Appeals and Expedited External Review (Pursuant to the Federal External Review Process)

Dear Mses. Turner, Lorenz, and Levin:

Psych-Appeal, Inc., represents the interests of numerous beneficiaries of non-grandfathered, fully-insured and self-funded commercial health plans subject to the Affordable Care Act's claims and appeals provisions,[1] and works closely with the Kennedy

[1] *See* 42 U.S.C. §300gg-19 and its implementing regulations at 29 C.F.R. §2590.715-2719 and 45 C.F.R. §147.136, most recently amended by 80 Fed. Reg. 72192 (Nov. 18, 2015).

Forum,[2] Parity Implementation Coalition,[3] and constituents of the American Psychiatric Association.

As the Departments must appreciate, a patient's inability to receive prescribed care following an adverse benefit determination can result in decompensation, relapse, and death.[4] Particularly in the mental health context, patients whose adverse benefit determinations are not overturned through urgent appeals are unlikely to continue with treatment when they may need it most. Such individuals and their treating providers are unlikely to incur the substantial risks of non-reimbursement by continuing with prescribed treatment in the hope of overcoming denials after services have been rendered.

Because it is imperative that patients and their authorized representatives (who are often the treating providers in urgent cases) are permitted to exercise the right to not only facilitate urgent appeals soon after being issued adverse benefit determinations, but to also effectuate urgent appeals based on a meaningful review of claims files[5] and mental health parity analyses maintained by health plans,[6] we hereby ask the Departments to specifically address: (1) how long health plans may take to provide access to (a) claims files and (b) mental health parity analyses when requested for purposes of perfecting urgent appeals and (2) whether health plans may require treating providers acting as authorized representatives pursuant to 29 C.F.R. §2560.503-1(b)(4)[7] to obtain written patient consent to receive claims files and mental health parity analyses in urgent cases.

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[2] The Kennedy Forum, which advocates for institutional mental health reforms, was founded by the Honorable Patrick J. Kennedy, former U.S. Representative (D-RI) and co-sponsor of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.

[3] The Parity Implementation Coalition has advanced parity legislation for over fifteen years in an effort to end discrimination against individuals and families who seek services for mental health and substance use disorders and remains committed to its full implementation and enforcement. Its members include the American Academy of Child and Adolescent Psychiatry, American Society of Addiction Medicine, Hazelden Betty Ford Foundation, MedPro Billing, Mental Health America, National Association of Addiction Treatment Providers, National Alliance on Mental Illness, National Association of Psychiatric Health Systems, Residential Eating Disorders Consortium, The Watershed Addiction Treatment Programs, and Young People in Recovery.

[4] *See* CBS' 60 Minutes episode, "Denied," at http://www.cbsnews.com/news/mental-illness-health-care-insurance-60-minutes/, which aired on December 14, 2014 and highlighted fatal patient outcomes from abusive mental health utilization review practices.

[5] As used herein, "claims files" refers to the case management, utilization review, and appeals data maintained by group health plans and health insurance issuers with respect to individual beneficiaries.

[6] As used herein, "health plans" refers to group health plans and health insurance issuers.

[7] The requirements of 29 C.F.R. §2560.503-1, including the *de facto* designation of treating providers as authorized representatives for purposes of urgent internal claims and appeals, have been incorporated by reference into 29 C.F.R. §2590.715-2719 and 45 C.F.R. §147.136, and clarified by FAQ B-1, appearing at https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/benefit-claims-procedure-regulation.

Additionally, with respect to expedited external reviews under the Federal External Review Process, we also ask the Departments to clarify: (1) how long health plans may take to prequalify expedited external reviews and (2) transmit all relevant data to assigned Independent Review Organizations ("IRO") from the time they receive expedited requests for external review; (3) whether assigned IROs that do not receive completed data within the time frames applicable to either (1) or (2) may automatically reverse health plans' adverse benefit determinations (and whether additional factors should be considered by IROs in exercising discretion to terminate reviews); and (4) whether treating providers acting as authorized representatives pursuant to 29 C.F.R. §2560.503-1(b)(4) may seek expedited external reviews without patient consent.

1. Access to claims files and comparative analyses maintained by health plans in ***advance*** of ***urgent appeals***

Pursuant to 42 U.S.C. §300gg-19(a)(1)(C), "a group health plan and a health insurance issuer offering group or individual health insurance coverage shall implement an effective appeals process for appeals of coverage determinations and claims, under which the plan or issuer shall, at a minimum—***allow an enrollee to review their file***, to present evidence and testimony ***as part of the appeals process***, and to receive continued coverage pending the outcome of the appeals process."

Nonetheless, when urgent appeals must be pursued, health plans routinely fail to expedite requests for access to claims files and instead cite to HIPAA's outermost production limit of 30 days.[8] Likewise, requests for comparative information with which to evaluate potential mental health parity violations such as the ones listed in the Department of Labor's "Warning Signs- Plan or Policy Non-Quantitative Treatment Limitations (NQTLs) that Require Additional Analysis to Determine Mental Health Parity Compliance," if responded to at all, can also languish for upwards of 30 days, regardless of exigency (i.e., blanket level of care exclusions or fail first protocols barring urgent access to prescribed care).[9] Consequently, patients are deprived of the ability to expeditiously

[8] *See* 45 C.F.R. §164.524(b)(2)(i). Notably, this regulation was issued well before the enactment of 42 U.S.C. §300gg-19(a)(1)(C).

[9] *See* FAQs about Affordable Care Act Implementation (Part 31), Mental Health Parity and Addiction Equity Act of 2008, Disclosure, issued on April 20, 2016. ("The DOL claims procedure regulations, as well as the internal claims and appeals and external review requirement under section 2719 of the PHS Act, which apply to non-grandfathered group health plans and issuers of non-grandfathered group or individual health insurance coverage, set forth rules regarding claims and appeals, including the right of claimants (or their authorized representative) upon appeal of an adverse benefit determination (or a final internal adverse benefit determination) to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claimant's claim for benefits. ***This includes documents with comparative information on medical necessity criteria for both medical/surgical benefits and MH/SUD benefits, as well as the processes, strategies, evidentiary standards, and other factors used to apply an NQTL with respect to medical/surgical benefits and MH/SUD benefits under the plan.***

challenge: (a) improper rationales potentially embedded in their claims files and omitted from adverse benefit determination letters that are frequently mailed weeks late, if ever at all; and (b) unlawful non-quantitative treatment limitations and/or implementing processes/factors, which are ***never*** expressly identified along with comparative medical/surgical data in adverse benefit determination letters. Additionally, treating providers (acting as authorized representatives in urgent cases) with limited patient familiarity are also precluded from expeditiously reviewing and highlighting salient clinical data ignored by but otherwise available to health plans.

Since (a) requiring patients and/or their authorized representatives to wait up to 30 days for claims files and/or comparative mental health parity data or (b) allowing them access to this information ***after*** exhausting their urgent appeals undermines 42 U.S.C. §300gg-19(a)(1)(C), the Departments are requested to issue guidance with respect to the exact time frame(s) in which health plans must provide insureds access to (a) their claims files and (b) comparative mental health parity data after being informed that such access is necessary to perfect urgent appeals.

Additionally, since health plans routinely ignore requests by providers for access to claims files and (non-PHI bearing) mental health parity data without their patients' written consent, and since obtaining written patient consent is not feasible in many urgent cases, requiring providers who are acting as authorized representatives to obtain such written consent subverts the ability of authorized representatives to meaningfully participate in the urgent claims and appeals process. Therefore, the Departments are also asked to provide guidance on whether health plans may require treating providers acting as authorized representatives pursuant to 29 C.F.R. §2560.503-1(b)(4) to obtain written patient consent to receive claims files and mental health parity data from health plans in urgent cases.

2. Expedited External Reviews under the Federal External Review Process

    a. Timing of preliminary reviews for expedited external reviews and transmission of data to IROs; Automatic Reversals of Adverse Benefit Determinations

80 Fed. Reg. 72192 (Nov. 18, 2015) provides the Departments' most recent guidance with respect to the Federal External Review Process. Pursuant to this Final Rule and with respect to ***non-urgent*** cases, health plans must complete preliminary reviews of requests for external appeals within 5 business days.[10] Health plans must then provide to assigned IROs the documents and any information considered in making adverse benefit determinations within 5 business days. Assigned IROs are permitted to terminate external

[10] Although not stated in the Final Rule, health plans must presumably assign prequalified external appeals to IROs by the fifth business day.

reviews improperly delayed by health plans and to reverse adverse benefit determinations.[11]

With respect to expedited external reviews, however, the Final Rule merely indicates that health plans must "immediately" conduct preliminary reviews of requests for external review without specifying an exact time limit by which they must complete their reviews. Additionally, the Final Rule requires health plans to assign expedited reviews to IROs pursuant to the requirements for standard review,[12] suggesting that health plans may take up to 5 business days in which to transmit required data, albeit via an expeditious method such as fax or email. Last, the Final Rule does not specify if and when IROs may reverse adverse determinations in expedited cases in which health plans do not timely complete "immediate" preliminary reviews or transmit required data to the IROs. In practice, therefore, it is not uncommon for expedited external reviews to take upwards of two weeks to complete from the time of initial requests,[13] an unacceptable delay for patients who are all too frequently wrongly denied treatment by their health plans.[14]

Therefore, the Departments are asked to specify: (1) how long health plans may take to prequalify expedited external reviews; (2) how long health plans may take to transmit required data to IROs in expedited cases; (3) whether IROs may automatically reverse adverse benefit determinations when health plans fail to prequalify expedited external reviews within the time frame set by the Departments in response to (1); (4) whether IROs may automatically reverse adverse benefit determinations when health plans

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[11] Although the Final Rule suggests that IROs have the discretion to terminate external reviews and find in favor of claimants when health plans fail to timely transmit data, the Final Rule does not establish concrete factors or cite to specific examples when IROs should exercise their discretion.

[12] *See*, for example, 29 C.F.R. §2590.715-2719(d)(3)(ii)("Upon a determination that a request is eligible for expedited external review following the preliminary review, the plan or issuer will assign an IRO pursuant to the requirements set forth in paragraph ***(d)(2)(iii)*** of this section for ***standard review***.")

[13] The attached data, obtained on March 14, 2016 from the California Department of Managed Health Care ("DMHC") pursuant to the California Public Records Act, reveals that under the country's largest State External Review Process, for the period between January 1, 2010 and November 24, 2015, the average time between the DMHC's initial receipt of an expedited external review application and the DMHC's outcome notification was 18.62 calendar days in mental health cases – three times the limit set by California law and regulations. The data further reveal that during the same period, the average time between the DMHC's receipt of expedited external review requests and assignment of cases to MAXIMUS (the IRO selected by DMHC), was 10.43 calendar days in mental health cases. Finally, the data indicate that during the same period, the average time between the DMHC's assignment of expedited external reviews to MAXIMUS and the DMHC's receipt of MAXIMUS' determinations was 8.23 calendar days in mental health cases. Clearly this data raises troubling implications for the Federal External Review Process, which is entirely self-policing.

[14] *See* http://www.nbcbayarea.com/investigations/State-Finds-Mentally-Ill-Improperly-Denied-Coverage-for-Treatment-Nearly-Half-the-Time--379226091.html, indicating that since 2001, the DMHC has received nearly 13,000 requests for external reviews based on medical necessity, and that external reviews overturned more mental health denials than for any other type of medical condition or diagnosis. External reviews found health plans improperly denied coverage of mental health services in 48 percent of all cases.

fail to transmit required data within the time frame set by the Departments in response to (2); and (5) whether IROs should consider any factors other than strict adherence to time frames (i.e., such as the possibility that the IROs may not receive the same compensation for external reviews terminated due to delays as for clinically evaluated external reviews) in exercising their discretion to terminate expedited external reviews.

b. Treating providers as *de facto* authorized representatives with respect to expedited external reviews

Last, while the Final Rule is clear that health plans must permit treating providers to act as authorized representatives for purposes of urgent ***internal*** claims and appeals,[15] the Final Rule is silent as to whether treating providers may act as authorized representatives for purposes of expedited ***external*** reviews. Therefore, the Departments are requested to clarify their intent with respect to whether treating providers may act as ***de facto*** authorized representatives with respect to expedited external reviews under the Federal External Review Process.

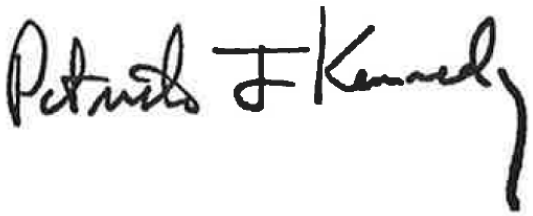
Respectfully,

Meiram Bendat, J.D. Ph.D.
President, Psych-Appeal, Inc.

Sam Muszynski, J.D.
Senior Policy Adviser and Director, Parity Implementation and Enforcement
American Psychiatric Association

[15] *See*, for example, 29 C.F.R. §2590.715-2719(b)(2)(i)("Minimum ***internal*** claims and appeals standards. A group health plan and a health insurance issuer offering group health insurance coverage must comply with all the requirements applicable to group health plans under 29 CFR 2560.503–1.")

Mark Covall, Co-Chair
Parity Implementation Coalition



Patrick J. Kennedy, Former U.S. Representative (D - RI)
Founder, Kennedy Forum

Enclosure: March 14, 2016 Data from California Department of Managed Health Care

cc: Hon. Sylvia M. Burwell, Secretary of the United States Department of Health and Human Services
Hon. Phyllis C. Borzi, Assistant Secretary, Employee Benefits Security Administration (United States Department of Labor)
Cecilia Munoz, Director of the Domestic Policy Council (White House) and Chair of the Mental Health and Substance Use Disorder Parity Task Force

Response to Oren Rosenthal's PRA Request
IMR Cases from January 1, 2010 through November 24, 2015

1) Average time between the Department of Managed Health Care's (DMHC's) initial receipt of an IMR application and the DMHC's notification to the enrollee of the IMR determination.
   a) Urgent and/or expedited IMRs: 16.54 calendar days
   b) Standard IMRs: 29.06 calendar days
   c) Urgent and/or expedited mental health (including substance abuse) IMRs: 18.62 calendar days
   d) Standard mental health (including substance abuse) IMRs: 45.82 calendar days
   e) Urgent and/or expedited medical (excluding mental health and substance abuse) IMRs: 16.15 calendar days
   f) Standard medical (excluding mental health or substance abuse) IMRs: 27.90 calendar days[1]

Note: The data set forth above, and in number 2 below, reflects the average duration between the DMHC's *initial* receipt of an IMR application, regardless of whether that application is complete or not. If the DMHC receives an incomplete application, such that the DMHC cannot determine whether the case qualifies for an IMR, the DMHC must gather other documents and information from the enrollee, providers, and/or the health plan before the DMHC can determine whether the IMR process applies and send the application to MAXIMUS. Once the DMHC has received sufficient information to determine whether the case qualifies for IMR (i.e., the DMHC has a complete application), the processing times for IMRs, as set forth in California Code of Regulations, title 28, section 1300.74.30, start to run.

2) Average time between the DMHC's receipt of an IMR application and the DMHC's assignment of the case to MAXIMUS.
   a) Urgent and/or expedited IMRs: 9.80 calendar days
   b) Standard IMRs: 21.83 calendar days
   c) Urgent and/or expedited mental health (including substance abuse) IMRs: 10.43 calendar days

[1] The averages set forth in number 1, above, include information for all closed IMR cases from January 1, 2010, through November 24, 2015. These averages include IMR cases where the health plans reversed their decisions, the enrollees withdrew their IMR requests, or the DMHC determined the IMR requests did not qualify or were ineligible for IMR. The DMHC used all closed IMR case data for the relevant time period because the PRA request did not specify whether it sought only data for cases the DMHC sent to MAXIMUS and for which MAXIMUS issued a determination. In contracts, the averages set forth in numbers 2 through 4 encompass only IMR cases the DMHC sent to MAXIMUS and for which MAXIMUS made a determination, because by their own terms these time frames only include requests the DMHC sent to MAXIMUS.

d) Standard mental health (including substance abuse) IMRs: 26.51 calendar days

e) Urgent and/or expedited medical (excluding mental health and substance abuse) IMRs: 9.67 calendar days

f) Standard medical (excluding mental health or substance abuse) IMRs: 21.31 calendar days

3) Average time between the DMHC's assignment of a case to MAXIMUS and the DMHC's receipt of MAXIMUS's determination (written or oral).

a) Urgent and/or expedited IMRs: 6.71 calendar days

b) Standard IMRs: 21.90 calendar days

c) Urgent and/or expedited mental health (including substance abuse) IMRs: 8.23 calendar days

d) Standard mental health (including substance abuse) IMRs: 23.92 calendar days

e) Urgent and/or expedited medical (excluding mental health and substance abuse) IMRs: 6.39 calendar days

f) Standard medical (excluding mental health or substance abuse) IMRs: 21.68 calendar days

The data set forth above includes the three business days (standard IMRs) and the one calendar day (urgent/expedited IMRs) that health plans have to send MAXIMUS "all information that was considered in relation to the disputed health care service, the enrollee's grievance and the health care service plan's determination. (Cal. Code Regs., tit. 28 § 1300.74.30, subd. (j).)

4) Average time between the DMHC's receipt of MAXIMUS's determination and the DMHC's notification to the enrollee of that determination.

a) Urgent and/or expedited IMRs: 1.65 calendar days

b) Standard IMRs: 2.10 calendar days

c) Urgent and/or expedited mental health (including substance abuse) IMRs: 1.82 calendar days

d) Standard mental health (including substance abuse) IMRs: 2.59 calendar days

e) Urgent and/or expedited medical (excluding mental health and substance abuse) IMRs: 1.62 calendar days

f) Standard medical (excluding mental health or substance abuse) IMRs: 2.05 calendar days