



August 31, 2016

Cecilia Muñoz  
Director, Domestic Policy Council  
The White House  
1600 Pennsylvania Ave, NW  
Washington, DC 20500

Dear Ms. Muñoz,

On behalf of the members of the Parity Implementation Coalition (PIC), we are writing to applaud the President for establishing the Mental Health and Substance Use Disorder Parity Task Force and to inform the Task Force's recommendations due in October 2016.

The Parity Implementation Coalition is an alliance of addiction and mental health consumer and provider organizations. Members include the American Academy of Child and Adolescent Psychiatry, American Society of Addiction Medicine, Depression and Bipolar Support Alliance, Hazelden Betty Ford Foundation, MedPro Billing, Mental Health America, National Alliance on Mental Illness, National Association of Psychiatric Health Systems, National Association of Addiction Treatment Providers, Residential Eating Disorders Consortium, The Watershed Addiction Treatment Programs, Inc. and Young People in Recovery. In an effort to end discrimination against individuals and families who seek services for mental health and substance use disorders, many of these organizations have advocated for more than nineteen years in support of parity legislation and issuance of regulations. We are committed to the prompt and effective implementation of the Mental Health Parity and Addiction Equity Act (MHPAEA) and we submit these comments and recommendations on each of the Task Force's goals as outlined in the President's Memoranda.

Our recommendations are based on the last 6 years of experience in working with consumers, providers and health plans with respect to implementation of the law. We have attached real life stories of parity non-compliance that highlight the need for the additional regulations, guidance and enforcement actions included in our recommendations. (Appendix A).

#### **Task Force Goal 1: Promote compliance with parity best practices**

***Issue: Disclosure on the development and application of non-quantitative treatment limitations.***

Transparency is essential to ensure that plan participants and beneficiaries receive medically necessary health care coverage and access to treatment based on parity compliant benefit plan design, medical management protocols, and other non-quantitative treatment limitations (NQTLs). Therefore, proper disclosure of information is especially important to plan participants and beneficiaries seeking mental health/substance use disorder (MH/SUD) treatment and recovery support services and the providers who help them. This is true whether a patient is trying to understand an adverse benefit determination or challenging what appears to be an unlawful NQTL utilized by a health plan, either as written, as applied or both.

One of the most common barriers reported by the patients and providers the PIC serves is the lack of disclosure by health plans on the development and application of NQTLs. Parity compliance testing cannot be performed on coverage limitations such as prescription drug formulary design, medical and administrative management techniques, including restrictions based on facility type or provider specialty, without this information. For example, in order to determine whether a plan is in compliance with the law, consumers and providers may request medical management criteria and protocols, information on how these criteria and protocols are developed and applied (both as written and in operation), to MH/SUD and medical/surgical benefits. We have been made aware of hundreds of such requests by authorized provider representatives that have gone unanswered.

Additionally, over the past several years we have submitted to the Agencies hundreds of examples of plans' lack of responses to requests for disclosure pertaining to MHPAEA compliance (available upon request). We attach hereto recent examples of provider appeal letters requesting disclosure consistent with the Final Rule and sub-regulatory guidance, including recent FAQ #9 from FAQs about Affordable Care Act Implementation (Part 31) on MHPAEA Disclosure (Appendix B), to which only one plan has responded, although the information disclosed has no bearing on the plan's development and application of NQTLs. In these cases, the plans continue to ignore both the parity law challenge and the request for disclosure of documents and information for both behavioral and medical benefits pertaining to parity compliance as it relates to the adverse benefit determination. We are aware that the Departments of Labor (DOL) and Health and Human Services (HHS) have investigated many complaints over the past several years. Despite this effort, no plan has yet to comply with the disclosure requirements. It has thus become clear that further action is vitally needed. This is an area the White House Parity Task Force must address in its recommendations this fall. Without additional guidance and enforcement of the guidance already issued, the purpose of MHPAEA will never be realized.

### ***Recommendations:***

To address these issues, we make the following recommendations.

- Health plans should be required to file a compliance plan with federal and state regulators that includes NQTLs used by the plan and information describing how the plan develops and applies NQTLs to MH/SUD and medical/surgical disorders covered by the plan. The compliance plan should be made available to consumers and providers upon request.
- Health plans should be required to disclose a comprehensive list of the types of NQTLs that are applied to the MH/SUD benefit in the summary of benefits documents provided to policyholders. Without such a list, MH/SUD consumers have no way to know whether the policy they purchase is accessible and covers essential services for their mental health or addiction disorder.
- Plans that are not providing this disclosure must be subject to fines.

### ***Issue: FEHBP Parity Compliance***

The parity law requirements apply to Federal Employees Health Benefit Program (FEHBP) plans through Executive Order and incorporation of these requirements into the purchasing and coverage standards issued by the Office of Personnel Management (OPM). FEHBP explicitly adopted MHPAEA and its rules in the OPM issued carrier letters beginning in November 2008 and beyond. However, we have received reports from PIC provider members that over 2/3 of inpatient SUD rehabilitation treatment is being denied based on medical necessity, with presumably no comparable increase in denial rates on the medical/surgical side. In addition, residential levels of care and "residential treatment centers", which are ill-defined by the plan, are being excluded from plan coverage altogether.

The following are findings contained in a November 2013 [report](#) prepared by NORC at the University of Chicago for ASPE:

Evaluations of FEHBP parity found no significant increase in total behavioral health spending. Nor did evaluations find an increased probability of any MH/SUD service utilization resulting from parity. In fact, the quantity of MH/SUD services patients received may have decreased slightly after parity was introduced. A recent study by Goldman and colleagues found that beneficiaries in plans that were subject to FEHBP parity demonstrated larger reductions in overall behavioral health visits, medication management visits, psychotherapy visits, and prescriptions for behavioral health medications (which the authors assume resulted from increased use of utilization management techniques by plans) following the introduction of parity than did a matched comparison group not subject to FEHBP parity.

A separate study of the impact of parity on substance abuse treatment in FEHBP plans found that although the rate of out-of-pocket spending declined significantly for substance abuse treatment and more patients had new diagnoses of a SUD, there were no differences in rates of initiation and engagement in treatment under parity and total plan spending per user and average utilization of substance abuse services did not change.

Another study found that among enrollees who received MH treatment for a severe mental illness (e.g., schizophrenia, bipolar disorder, depression), the odds of using any MH/SUD services in subsequent years were more than 1.3 times greater than two matched control groups. The relative odds of using inpatient MH/SUD services in the parity group were 0.67 times that of the control groups, a decrease consistent with the hypothesis that managed care organizations might have guided patients toward more outpatient services in treating their severely ill enrollees.

Unfortunately, medical management under FEHBP plans has grown more and more stringent in the years since this report, following issuance of the Final Rules, especially with respect to behavioral health inpatient rehabilitative services

***Recommendation:***

- The Task Force should require:
  - An OPM audit of denial rates over the past 5 years for SUD inpatient rehabilitation treatment as compared with medical/surgical inpatient treatment;
  - An OPM request for data from its FEHB plans that tracks over the past 5 years the percentage of estimated savings from plan denials for MH/SUD treatment services, as compared with the percentage of overall plan spending on MH/SUD services.
  - OPM request for data from its FEHB plans that tracks over the past 5 years the percentage of estimated savings from plan denials for MH/SUD treatment services, as compared with percentage of estimated savings from denials overall.
  - An OPM Call Letter for the next benefit plan year requiring its plans to examine and correct benefit plan design language to provide a new definition of “Residential treatment centers.” The current definition includes the following overly broad and confusing language that conflates into one definition a broad spectrum of clinical as well as non-clinical services and settings as follows:

- “drug and alcohol treatment” (which could mean high-intensity residential services delivered by MDs and RNs in an inpatient non-hospital facility)
- “confidence building” (this is not a clinical service)
- “military-style discipline” (this is not a clinical service)
- “psychological counseling” (which would be part of high-intensity residential treatment services, oftentimes delivered by a PhD or masters level therapist)
- “offers intervention for troubled individuals” (this is not a clinical service)
- “therapeutic boarding school” (this is not a clinical service)
- “emotional growth academies” (this is not a clinical service)
- “boot camps” (this is not a clinical service)

The current definition also states: “No standardized definitions exist for RTCs or for the programs they administer.” Clearly, it is up to the plan to properly define the treatment services and settings the plan is excluding from coverage. We ask you to undertake a close review of parity compliance in FEHBP plans and require time-limited corrective action where non-compliance is found.

***Issue: Enforcement Actions Taken by Regulators***

Unfortunately, since the parity law was enacted in 2008, there has continued to be non-compliance with the law. Common types of parity non-compliance include:

- **Disclosure.** As addressed above, there is a lack of disclosure by plans on the development and application of NQTLs.
- **Network Adequacy.** Plans generally have fewer providers in their MH/SUD networks than they do in their medical/surgical networks due to a number of factors including low reimbursement rates, phantom networks and a “narrow network” approach by many plans. Consequently, a higher percentage of MH/SUD patients are treated by out-of-network providers as compared to medical/surgical patients, leading to higher out-of-pocket spending by MH/SUD patients.
- **Facility-type/Level of care restrictions.** Plans generally impose more restrictive limitations and exclusions on facility-types and clinically recognized levels of care for MH/SUD benefits than are imposed on medical/surgical benefits. Most notably, plans continue to exclude non-hospital based residential treatment and residential levels of care for SUDs and eating disorders.
- **Lack of Parity in Pre-authorization, Concurrent and Retrospective reviews.** Plans generally apply more stringent medical management techniques, both as written and/or as applied in operation, including pre-authorization, concurrent and retrospective review requirements, to MH/SUD benefits than to medical/surgical benefits.

We are very concerned that violations of MHPAEA will continue absent strong enforcement. We cannot emphasize this enough. In a recent [study](#) by the Health Care Cost Institute, the authors noted that MHPAEA had little to no effect on access and utilization of mental health services for individuals with bipolar depression or schizophrenia in a handful of states. The authors concluded that one reason for this is the lack of accountability and enforcement among state insurance regulators. The Departments should provide aggressive oversight and enforcement in the area of MHPAEA compliance and provide guidance to states on the same.

***Recommendations:***

- The Agencies must enforce the regulations, as clarified through additional sub-regulatory guidance on parity disclosure requirements and impose penalties on non-compliant plans.

Guidance should be provided to states regarding enforcement and application of penalties in non-compliant plans.

- Random audits should be utilized by federal and state regulators to improve compliance.
- Regulators should audit plans with at least 5 appeals based on allegations of non-compliance with MHPAEA.
- All enforcement actions and compliance correction plans should be made public on appropriate federal and state websites.
- Denial rates for each benefit classification for MH/SUD and medical/surgical for group health plans should be tracked, collected and made public on state and federal websites (including the plan's methodology for classifying and tracking such denial rates).
- The Centers for Medicare and Medicaid Services (CMS) and DOL's Employee Benefits Security Administration (EBSA) should issue a report on parity compliance and federal investigations of parity non-compliance. Such a report should include market data providing indicia of compliance and non-compliance, rather than merely complaint-driven reporting.

## **Task Force Goal 2: Support the development of tools and resources providing a roadmap to parity implementation and enforcement**

### **A. Regulatory Compliance Tools**

A Compliance Guide for Federal and State Regulators is being prepared by the American Psychiatric Association, The Kennedy Forum, Scattergood Foundation, with contribution from the PIC. This Guide seeks to provide specific and detailed tools for state and federal agency plan audits, as well as helpful examples of plan compliance and non-compliance with respect to plan analyses, documentation and testing of NQTLs. The PIC will be forwarding a copy of the Guide upon its completion (currently estimated to be in September 2016).

### **B. Consumer Resources**

Enrollees have limited knowledge of their rights and benefits under the parity law. A 2014 [survey](#) by the American Psychological Association found that only 4% of Americans said they were even aware of MHPAEA. Neither the Administration nor health plans have engaged in any major public awareness campaigns to inform enrollees about the law. The Substance Abuse and Mental Health Services Administration (SAMHSA) has provided information on its website and DOL and Center for Consumer Information and Insurance Oversight (CCIIO) have help lines, but the information provided on the help lines to consumers is too complicated and overly comprehensive for them to understand (e.g., legislative background on HIPAA and MHPAEA). In certain states, state officials have told enrollees that the state is not required to implement or enforce MHPAEA and have outdated information on their website about the law.

We have also found that when plan members are aware of the parity law and believe a plan has violated it, they struggle with how and where to file a complaint given the myriad of federal and state entities with enforcement authority over MHPAEA.

## ***Recommendations***

- A consumer parity portal on relevant state and federal websites should be developed within 6 months to allow consumers to easily access all publicly available parity information and submit complaints to a central online clearinghouse.
- A training curriculum for consumers on MHPAEA for DOL, the CCIIO and stakeholders should be geared towards 9<sup>th</sup> grade level of education and should be published within 6 months of release of Task Force recommendations. Regional or onsite technical assistance must be available upon request.
- Agencies should clarify how MHPAEA applies across various plan types including, appeals rights, timelines and agency responsible.
- In conjunction with DOL and HHS, SAMHSA should develop and disseminate materials for providers to help patients and families with appeals. SAMHSA consumer/provider grantees should be required to use and disseminate these materials. Materials would explain different types of appeals, timelines and how MHPAEA, Employee Retirement Income Security Act (ERISA), and Affordable Care Act (ACA) affect appeals for different plan types as well as to whom consumers should send complaints. The materials should clarify that providers should assist with patient appeals given the level of complexity of the appeals process and limited capabilities of many of their patients/clients. Insurance coverage and appeals documentation should be made available online to avoid lengthy delays with standard mail. Multiple incidences of lost documentation by the plans, especially if the delay results in failure to meet plan deadlines, should be a finable offense.

## **Task Force Goal 3: Develop additional agency guidance as needed to facilitate the implementation of parity**

As discussed above, problems with MHPAEA non-compliance, particularly around NQTLs, persist. To ensure compliance with MHPAEA, additional enforceable guidance or regulations should be released that clarify for plans what practices are and are not parity compliant and facilitate the implementation of parity.

## ***Recommendations***

The Agencies should issue guidance that includes specific examples of methods that group health plans may use for disclosing information in accordance with FAQ #9 including:

- Information regarding the analyses, documentation and testing performed to ensure that each NQTL is comparable and no more stringently applied to the MH/SUD benefit than to the medical/surgical benefit. Such information should include:
  - The specific plan language regarding the imposition of the NQTL (such as a preauthorization requirement);
  - The specific underlying processes, strategies, evidentiary standards, and other factors (including, but not limited to, all evidence) considered by the plan (including factors that were relied upon and were rejected) in determining that the NQTL will apply to this particular MH/SUD benefit;
  - Information regarding the application of the NQTL to any medical/surgical benefits within the benefit classification at issue;
  - The specific underlying processes, strategies, evidentiary standards, and other factors (including, but not limited to, all evidence) considered by the plan (including factors that were relied upon and were rejected) in determining the extent to which the NQTL will apply to any medical/surgical benefits within the benefit classification at issue; and

- Any analyses performed by the plan as to how the NQTL complies with MHPAEA.
- The guidance should include specific examples of NQTL analyses, documentation and testing that are compliant or non-compliant, with respect to NQTLs such as:
  - Medical management standards that limit or exclude benefits based on medical necessity, medical appropriateness or whether the treatment is experimental or investigative
  - Administrative management techniques such as geographic restrictions on locus of treatment not on par with access to other medical facilities
  - Prescription drug formulary
  - Fail first/step therapy or derivatives of such barriers
  - Network admission criteria
  - Provider reimbursement
  - Include illustrative specific factors that may be used by plans performing a NQTL analysis
  - Include illustrative specific evidentiary standards for defining such factors
  - Include an illustrative list of the types of documentation and data that should be provided to evidence appropriate comparative analyses and testing both as written and in operation.

**Conclusion**

Thank you again for the opportunity to provide comments. We look forward to working with the Task Force and the Administration in any way we can to ensure the Mental Health Parity and Addiction Equity Act is fully implemented and enforced so consumers have access to the non-discriminatory mental health and substance use disorder treatment as promised to them under the law. We pledge to do our part in disseminating the final White House Task Force recommendations to the consumer and provider communities.

Sincerely,



Mark Covall  
Parity Implementation Coalition Co-Chair



Beth Ann Middlebrook  
Parity Implementation Coalition Co-Chair

## Appendix A

### Real-Life Stories of Parity Non-Compliance

Below are real-life stories of parity non-compliance that have been shared with the Parity Implementation Coalition. As appropriate, names have been changed to protect patient privacy.

#### *Mark's Story – Discriminatory Medical Management (Retrospective Review)*

My 21 year old son is addicted to heroin. This monster has taken over his life and our whole family. On April 3, 2016 at 8:35pm I found my son shooting heroin. My son looked at me with relief to know that it was over - Mom knows now. She's got this. I said, "Are you ready to fix this?" and he said YES. I chose a treatment center in Florida and everything was a-go. I would put him on a plane leaving Albany, NY.

I thought my son had a second chance at life.

He was participating in meetings and group counseling when, 11 days into his treatment, a doctor for the health insurance company that has NEVER seen my son decides to play God with my son's life and decides he doesn't qualify for inpatient treatment. His counselor knew he was in no way ready to leave. Florida Recovery Center gave my son, an 8 year heroin user, a scholarship to a sober living center. If they hadn't, he would be back in New York and I would probably be burying my son.

Who gives anyone the right to play God with someone else's life? I am the voice for my son and will continue to do so."

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#### *Matt's story - Discriminatory Medical Management*

"My son, Matt, lost his life after being over prescribed opioids for pain relief after back surgery. Finding appropriate treatment was impossible. Fighting his insurance company became his daily routine. The doctors would continue to supply his monthly pills but gave no direction when he needed treatment to beat the addiction they caused. His insurance company would approve very short term stays, a week here and a few days there. Nothing long enough to make a difference in his recovery. There is no long term follow up in my state. Both the medical and insurance industry continue to treat those with SUD as disposable people. We must change the way we treat addiction. I used to wish Matt had cancer. At least he would have received timely, non-biased treatment."

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#### *Mary's story - Discriminatory Medical Management*

An insurance company denied coverage for "Mary" because she "isn't 'purging enough'" to warrant inpatient treatment for her bulimia. Mary binged and, after experiencing severe abdominal pain, went to the Emergency Room, where she was sent home by a doctor who told her to "go home and deal with the consequences of your behavior."

Mary was subsequently life-flighted to a different hospital only a few hours later because it turns out the pain she was experiencing was from her stomach having ruptured after she binged. Mary died from septic shock.

The insurance company paid for all of the emergency services that night, but would not pay for treatment of her eating disorder, the very disease that killed her.

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*Robin's story - Discriminatory Medical Management & Lack of Disclosure*

"Robin" was dealing with many severe symptoms when she was denied treatment by her insurer. The insurance representative said, "Well her functioning is okay." Robin's physician pointed out to insurer that Robin can't work, can't leave the house, and is sleeping the vast majority of the day. The insurer then said, "Well, she's not experiencing current Suicidal Ideation with persistent impulsivity." The physician responded that she was, in fact, reporting suicidal ideation every day, and was just discharged from the ER the weekend before for impulsively taking too many medications. These symptoms met accepted patient placement criteria used by comparable insurers, but her insurer denied benefits, citing length of stay as the reason and they have not disclosed their medical necessity criteria.

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*Jane's story - Discriminatory Use of "Fail First"*

"Jane" had been successfully treated for depression in the past, and had a recurrent episode when her hours were cut at work and she began having financial problems. Although she had a history of response to a particular antidepressant, her employer-sponsored health plan had a "fail first" formulary for antidepressants – it would not pay for the drug to which she had previously responded unless she previously had two documented failures on other medications.

As she went through those medication trials, Jane's depression worsened, her work performance suffered, and she was fired. She did not have the money to continue her insurance through COBRA, nor did she have the funds to pay her rent. After staying with friends and family for several months, and becoming more and more depressed, she made a suicide attempt.

After this, friends and family would no longer take her in, and she became homeless. While staying at a local shelter, she started treatment with a local public treatment center. They assisted her with getting the specific antidepressant she needed through a Patient Assistance Program and she began to improve.

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*Joe's story – Lack of Disclosure*

"Joe's" health plan approved the first 30 days of his treatment stay for his substance use disorder. On January 15th, they denied the second 30 days of treatment because they said it was not medically necessary for him to receive treatment at an inpatient facility. On the advice of his medical advisors and treatment counselors, his parents paid an additional \$12,000 to continue his treatment for another 30 days.

The health plan used the American Society of Addiction Medicine (ASAM) criteria for determining levels of care. The patient's mother received a list of the medical necessity criteria from the plan.

When she requested more information about the criteria used to make benefit determinations, her plan advocate told her that there were no copies of the ASAM manual on site and no additional information was available.

The mother did her own investigation and found the manual on Amazon.com.

Joe's mother said it would have been impossible to win their appeal without the information in the ASAM manual – information that she requested and was not made available to her.

## **Recent Examples of Plan Failure to Disclose Information and Documentation on Parity Compliance**

### **Ex. A – Tufts Health Plan**

LTR A(1) January 2016 – Health Law Advocates (HLA), as authorized representative of Tufts Health Plan member whose inpatient SUD treatment was denied for lack of medical necessity, submitted a written request for information and documents relied on in denying the claim pursuant to 29 CFR § 2560.503-1(m)(8) and § 2590.712(d)(3), for purposes of evaluating parity compliance.

LTR A(2) February 2016 – Tufts Health Plan responded by ignoring the request for disclosure of information and documents, and simply informed HLA that the plan member was eligible to seek an external review of the denied claim.

***No parity compliance information or documentation has been provided to date.***

### **Ex. B – Cigna/BAE Systems**

LTR B(1) March 16, 2016 - Health Law Advocates (HLA), as authorized representative of Cigna Plan member whose treatment was denied for lack of medical necessity, submitted a written request for information and documents related to the denied claim pursuant to 29 CFR § 2560.503-1(m)(8) and § 2590.712(d)(3), for purposes of evaluating and challenging parity compliance.

LTR B(2) March 28, 2016 – Cigna responded informing that the request for information and documents had been forwarded to the “appropriate processing unit,” and requested at least six weeks from receipt of the letter for processing time.

***No parity compliance information or documentation has been provided to date.***

### **Ex. C – Aetna/Dow Chemical**

LTR C(1) January 2015 – Health Law Advocates, as authorized representative of Aetna member whose residential SUD treatment was denied for lack of medical necessity, submitted written request for information and documents relied on in denying the claim pursuant to ERISA, 29 U.S.C. § 1132(c) & § 1024(b)(4) and 29 CFR 2560.503-1(g).

LTR C(2) March 2015 – Due to Aetna’s failure to respond, Health Law Advocates submits a written request for assistance to DOL/EBSA. DOL’s attorney intervention finally results in disclosure of the requested information and documents.

***DOL’s intervention resulted in disclosure of information and documents requested.***

### **Ex. D – United Behavioral Health**

LTR May 2016- Provider, as an authorized representative, submitted Level One Internal Appeal from medical necessity denial of member’s inpatient residential level of care treatment services, including a parity compliance challenge and request for disclosure of plan information and documents related to the denial of the claim and the plan’s parity law compliance. The request for disclosure tracked the language of Q9 in the FAQs about Affordable Care Act (Part 31) issued in April 2016.

***No parity compliance information or documentation has been provided to date.***

**Ex. E – Cigna**

LTR E(1) May 2016 – Provider, as an authorized representative, submitted Level One Internal Appeal from medical necessity denial of member’s inpatient residential level of care treatment services, including a parity compliance challenge and request for disclosure of plan information and documents related to the denial of the claim and the plan’s parity law compliance. The request for disclosure tracked the language of Q9 in the FAQs about Affordable Care Act (Part 31) issued in April 2016.

LTR E(2) June 2016 – Cigna upheld the denial based on lack of medical necessity, and informed member and provider that they are entitled to disclosure of the same information that had already been requested in the May 2016 appeal letter, but failed to provide the information requested.

***No parity compliance information or documentation has been provided to date.***

**Ex. F -Anthem**

LTR E (1) May 2016 - Provider, as an authorized representative, submitted Level Two Internal Appeal from medical necessity denial of member’s inpatient residential level of care treatment services, including a parity compliance challenge and request for disclosure of plan information and documents related to the denial of the claim and the plan’s parity law compliance. The request for disclosure tracked the language of Q9 in the FAQs about Affordable Care Act (Part 31) issued in April 2016.

LTR E (2) June 2016 –Anthem responded by acknowledging appeal letter, but ignored parity law compliance challenge, as well as request for disclosure of information and plan documents related to denial of the claim.

***No parity law compliance information or documentation has been provided to date.***

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January [redacted], 2016

VIA FACSIMILE (617-972-9509)

[redacted] Appeals and Grievances Specialist  
Tufts Health Plan  
705 Mount Auburn Street  
Watertown, MA 02472-1508

RE: [redacted] (DOB [redacted])  
Tufts Health Plan ID [redacted] Group Plan  
Request for documents re Tufts Health Plan denial October 9, 2015

Dear Ms. McCarthy:

Enclosed please find the Tufts Health Plan Authorization to Disclose Protected Health Information signed by B [redacted]. By letter dated October 9, 2015, Tufts issued a final adverse determination with respect to B [redacted]'s treatment at Gosnold at Cataumet. (Copy attached.) B [redacted] intends to file a request for external review by the deadline. **THIS LETTER DOES NOT CONSTITUTE THE APPEAL.**

B [redacted] hereby requests that copies of his claim file and all other documents relevant to the claim at issue be sent to me, including but not limited to:

- a) The reason for the denial of coverage of B [redacted]'s continued treatment;
- b) any rule, benefit provision, guideline, criteria or protocol upon which the adverse decision was based;
- c) billing and service code information; and
- d) communications within Tufts Health Plan and between Tufts Health Plan and others, including agents or employees of the [redacted] [redacted] Employee Health Benefit Plan.

This request covers all documents, records and information submitted, considered, or generated in the course of the benefit determination, *without regard to* whether such documents, records or information were relied upon in making the benefit determination. *See* 29 CFR § 2560.503-1(m)(8).

B [redacted] further requests, pursuant to 29 CFR § 2590.712(d)(3), disclosure of all information relevant to medical/surgical, mental health, and substance use disorder benefits for purposes of evaluating Tuft's compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA) in the handling of B [redacted]'s claim. This request includes documents with

information on medical necessity criteria for *both* medical/surgical benefits and mental health and substance use disorder benefits, and the processes, strategies, evidentiary standards, and other factors used by Tufts to apply a nonquantitative treatment limitation with respect to medical/surgical benefits and mental health or substance use disorder benefits under the plan.

B [REDACTED]'s request for external review is due on or about February 10. To afford my client the full and fair review to which he is entitled, kindly send me all of the requested documents as soon as possible via mail, fax or email. Please contact me by phone (617-275-2983) or email ([cmcgorrian@hla-inc.org](mailto:cmcgorrian@hla-inc.org)) if you have any questions about this request.

Sincerely yours,



Clare D. McGorrian  
Senior Staff Attorney  
Director, Commercial Insurance Appeals Program

Enclosures: [Release, adverse determination]

cc: [REDACTED]



705 Mount Auburn Street  
Watertown, MA 02472-1508  
617.972.9400  
tuftshealthplan.com

Eligibility Letter

February 19, 2016

Clare D. McGorrian  
Health Law Advocates  
One Federal Street  
Boston, MA 02110

RE: [REDACTED]

Dear Ms. McGorrian:

I am writing on behalf of Tufts Health Plan to inform you that the Appeals and Grievances Department, has reviewed your request received on February 18, 2016 for an independent external review of Tufts Health Plan's denial of continued coverage of acute residential treatment for opiate addiction at Gosnold Treatment Center, on behalf of B [REDACTED]

It has been determined that you are eligible for an external review. Please note that the appointed Independent Review Organization will contact you with additional information regarding the process.

If you or Mr [REDACTED] has any questions, please call me at 888-880-8699, extension 58160.

Sincerely,

*Bridget McCarthy*  
Bridget McCarthy  
Appeals and Grievances Specialist I

cc: File#: [REDACTED]  
B [REDACTED]

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**Administrative Staff**

**Chief Operating Officer**  
Robert MacPherson

**Program and Development**

**Associate**  
Emily Tabor

March [redacted], 2016

VIA FACSIMILE (877-815-4827)

Cigna Behavioral Health  
Central Appeals unit  
P.O. Box 188064  
Chattanooga, TN 37422

RE: [redacted] (DOB [redacted])  
SR #: [redacted]  
Request for documents re: Cigna denial November 27, 2015

To Whom It May Concern:

Enclosed please find the Cigna Authorization for Disclosure of Protected Health Information signed by [redacted]. By letter dated November 27, 2015, Cigna Health and Life Insurance Company, through its agent Cigna Behavioral Health (Cigna) issued a final adverse determination with respect to [redacted]'s treatment at Gosnold at Cataumet. (Copy of letter attached.) [redacted] intends to file a request for external review by the deadline. **THIS LETTER DOES NOT CONSTITUTE THE APPEAL.**

[redacted] requests that copies of his claim file and all other documents relevant to the claim at issue be sent to me, including but not limited to:

- a) the reason for the denial of coverage of [redacted]'s treatment;
- b) any rule, benefit provision, guideline, criteria or protocol upon which the adverse decision was based;
- c) billing and service code information; and
- d) communications within Cigna Behavioral Health and between Cigna Behavioral Health and other entities or individuals, including but not limited to Cigna Health and Life Insurance Company, regarding [redacted]'s treatment at Gosnold Inc.

This request covers all documents, records and information submitted, considered, or generated in the course of the benefit determination, *without regard to* whether such documents, records or information were relied upon in making the benefit determination. *See* 29 CFR § 2560.503-1(m)(8).

[redacted] further requests, pursuant to 29 CFR § 2590.712(d)(3), disclosure of all information relevant to medical/surgical, mental health, and substance use disorder benefits for purposes of evaluating Cigna's

compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA) in the handling of [REDACTED]'s claim. This request includes documents with information on medical necessity criteria for *both* medical/surgical benefits and mental health and substance use disorder benefits, and the processes, strategies, evidentiary standards, and other factors used by Cigna to apply a nonquantitative treatment limitation with respect to medical/surgical benefits and mental health or substance use disorder benefits under the plan.

[REDACTED]'s request for external review is due on or about March 27, 2016. To afford my client the full and fair review to which he is entitled, kindly send me all of the requested documents as soon as possible via mail, fax or email. Please contact me by phone (617-275-2983) or email ([cmcgorrian@hla-inc.org](mailto:cmcgorrian@hla-inc.org)) if you have any questions about this request.

Sincerely yours,

Clare D. McGorrian  
Senior Staff Attorney  
Director, Commercial Insurance Appeals Program

Enclosures: [Release, adverse determination]

cc: [REDACTED]

RECEIVED  
4-1-16

Regina Smith  
Central HIPAA Unit



March 28, 2016

P.O. Box 188014  
Chattanooga, TN 37422

HEALTH LAWS ADVOCATES  
ONE FEDERAL ST 5TH FL  
BOSTON, MA 02110

RE: Privacy Authorization Request for [REDACTED]

Dear Sir/Madam:

This letter is to inform you that we have implemented [REDACTED]'s written authorization request. Effective immediately, Clair Mc Gorrian is authorized to access information as noted in the authorization form submitted. This authorization is limited by any exclusions indicated on the authorization and as requested. This authorization will expire on 03/31/2017.

You also requested that we provide a copy of [REDACTED]'s information to the authorized recipient. That request has been forwarded to the appropriate processing unit. If you have questions about the status of your records request, you may e-mail our legal department at [chclegalliaisonnationalteam@cigna.com](mailto:chclegalliaisonnationalteam@cigna.com) or fax your status request to 1.860.731.3126. Please Note: Processing time varies depending upon the information requested. Please allow at least six weeks from receipt of this letter before checking status of your request.

If you have any questions regarding this privacy request, please contact me at 860-902-4786. I will be happy to assist you.

Sincerely,

*Regina Smith*

c: Customer File

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healthlawadvocates  
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Boston, MA 02110

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W www.healthlawadvocates.org

January [redacted], 2015

Aetna, Inc.  
Attn: National Accounts CRT  
P.O. Box 14001  
Lexington, KY 40512

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**Associate**  
Samantha Roy

Re: **Request for Copy of Claim File**  
Plan Sponsor: Union Carbide Corporation / Dow Chemical Co.  
Plan Number: [redacted]  
Subscriber: [redacted]  
Member: [redacted] (d.o.b [redacted])  
Member ID: [redacted]  
Service dates: 3/ [redacted] 2013 – 4/ [redacted] 2013

To Whom It May Concern:

Health Law Advocates (HLA) represents former Aetna member A [redacted] in all matters relating to Aetna's denial of coverage for residential substance abuse services from 3/ [redacted] 2013 – 4/ [redacted] 2013. Ms. [redacted] has previously submitted an Authorized Representative Designation form allowing HLA to act as her authorized representative.

**Please note that this letter is not an appeal.** At this time, we are requesting a complete copy of the Ms. [redacted]'s claim file related to this coverage denial. This includes, without limitation, the following documents:

- A complete copy of Ms. [redacted]'s Aetna health insurance policy applicable during the dates of service, including any and all attachments and amendments, summary plan descriptions and policies;
- All internal rules, guidelines, protocols, memorandum, training materials, etc. referenced or relied upon in making the decision in the Ms. [redacted]'s claim;
- All internal rules, guidelines, protocols, memorandum, training materials, etc., relating to the evaluation of health insurance claims at Aetna;
- Clinical criteria relied upon or otherwise utilized by Aetna to render a decision on Ms. [redacted]'s claim;
- All electronic and internal notes regarding Ms. [redacted]'s claim;

- All recordings (electronic or otherwise), records, notes and summaries of phone calls;
- All communications regarding Ms. [REDACTED], including without limitation, intranet, extranet, or emails exchanged;
- All correspondence relating to Ms. [REDACTED] including but not limited to correspondence to and from third parties regarding Ms. [REDACTED]'s claim;
- All information from third-party sources, such as consultants;
- All reviews, medical or otherwise conducted by Aetna personnel and third parties regarding Ms. [REDACTED]'s claim; and
- Any and all other documented information that may have influenced Aetna's decision to deny Ms. [REDACTED]'s claim.

#### Legal Basis for Request

##### I. 29 U.S.C. §1132(c)

ERISA's language and its implementing regulations reflect the intent of both Congress and the United States Department of Labor to require fiduciaries to disclose to beneficiaries the basis of its decisions and any documents it may or may not have relied upon in making that decision. The language of ERISA itself reflects Congress' intent to ensure that plan participants and beneficiaries are notified by fiduciaries as to all information that relates to the determination of their eligibility for benefits. For instance, 29 U.S.C. § 1132(c) requires plan administrators to disclose the plan document and pertinent documents relied upon by the administrator in evaluating the claim within 30 days of receiving a written request. In fact, a plan administrator who fails to comply with a request for information by a participant or beneficiary is liable to such participant or beneficiary in the amount of \$100 a day from the date of such failure or refusal. Specifically, 29 U.S.C. § 1132(c) states:

#### § 1132. Civil enforcement

(c) Administrator's refusal to supply requested information; penalty for failure to provide annual report in complete form

(1) Any administrator (A) who fails to meet the requirements of paragraph (1) or (4) of section 1166 of this title or section 1021(e)(1) of this title with respect to a participant or beneficiary, or (B) who fails or refuses to comply with a request for any information which such administrator is required by this subchapter to furnish to a participant or beneficiary (unless such failure or refusal results from matters reasonably beyond the control of the administrator) by mailing the material requested to the last known address of the requesting participant or beneficiary within 30 days after such request may in the court's discretion be personally liable to such participant or beneficiary in the amount of up to \$100 a day from the date of such failure or refusal, and the court may in its discretion order such other relief as it deems proper. For purposes of this paragraph, each violation described in subparagraph (A) with

respect to any single participant, and each violation described in subparagraph (B) with respect to any single participant or beneficiary, shall be treated as a separate violation.

II. 29 U.S.C. § 1024(b)(4)

29 U.S.C. § 1024(b)(4), mandates disclosure of “other instruments under which the plan is established or operated” to plan participants upon request. The U.S. Department of Labor Advisory Opinion Letter 96-14a interprets 29 U.S.C. § 1024(b)(4) in the following manner:

The legislative history of ERISA suggests that plan participants and beneficiaries should have access to documents that directly affect their benefit entitlements under an employee benefit plan. Consistent with this Congressional intent, it is the view of the Department of Labor that, for purposes of section 104(b)(2) and 104(b)(4), any document or instrument that specifies procedures, formulas, methodologies, or schedules to be applied in determining or calculating a participant’s or beneficiary’s benefit entitlement under an employee benefit plan would constitute an instrument under which the plan is established or operated, regardless of whether such information is contained in a document designated as the “plan document.” Accordingly, studies, schedules or similar documents that contain information and data, such as information and data relating to standard charges for specific medical or surgical procedures, that, in turn, serve as the basis for determining or calculating a participant’s or beneficiary’s benefit entitlements under an employee benefit plan would constitute “instruments under which the plan is . . . operated.”

The information sought by Ms. [REDACTED] is clearly “other instruments” that “serve as the basis for determining . . . a participant’s or beneficiary’s benefit entitlement” under his health insurance Plan. This is particularly true of any internal guidelines or protocols used by Aetna in evaluating Ms. [REDACTED]’s case. As such, Aetna is mandated to disclose these documents to the Member upon request.

III. 29 CFR 2560.503-1(g)

Ms. [REDACTED] is also requesting all documentation relied upon or in the possession of Aetna in making the decision to deny his claim, pursuant to 29 CFR 2560.503-1(g). Specifically, 29 CFR 2560.503-1(g) states the following:

(g) Manner and content of notification of benefit determination.

(1) Except as provided in paragraph (g)(2) of this section, the plan administrator shall provide a claimant with written or electronic notification of any adverse benefit determination. Any electronic notification shall comply with the standards imposed by 29 CFR 2520.104b-1(c)(1)(i), (iii), and (iv). The notification shall set forth, in a manner calculated to be understood by the claimant--

(i) The specific reason or reasons for the adverse determination;

(ii) Reference to the specific plan provisions on which the determination is based;

(iii) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;

(iv) A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of the Act following an adverse benefit determination on review;

(v) In the case of an adverse benefit determination by a group health plan or a plan providing disability benefits,

(A) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request; or

(B) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request. (Emphasis added).

Moreover, 29 CFR 2560.503-1(h)(2)(iii) requires as part of a full and fair review of a benefit denial, disclosure of all documents "relevant" to a beneficiaries claim for benefits. A document is "relevant" as defined in section (m)(8)(ii) if, *inter alia*, it "[w]as submitted, considered or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination." *See also*, Section 29 C.F.R § 2560.503-1(m)(8)(iv) (stating that documents relevant to a claimants' appeal include: "In the case of a group health plan or plan providing disability benefits, constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, *without regard to whether such advice or statement was relied upon in making the benefit determination.*" (Emphasis added).

In light of the explicit language of the regulations cited above, it is clear that Aetna must disclose to Ms. [REDACTED] the information requested in this letter.

#### Proprietary Information

In the event that Aetna seeks to make the argument that the requested information is proprietary, this argument has no merit under the new regulations. The questions and answers on the regulations posted by the Department of Labor state that proprietary material must be provided upon request, even if developed by a third party. Specifically, a bulletin issued by the Department of Labor Employee Benefits Security Administration (EBSA) state the following:

Q-C17: Is a plan required to provide a copy of an internal rule, guideline, protocol, or similar criterion when the applicable rule, guideline, protocol, or criterion was developed by a third party which, for proprietary reasons, limits the disclosure of that information?

A: Yes. It is the view of the Department that where a rule, guideline, protocol, or similar criterion serves as a basis for making a benefit determination, either at the initial level or upon review, the rule, guideline, protocol, or criterion must be set forth in the notice of adverse benefit determination or, following disclosure of reliance and availability, provided to the claimant upon request. However, the underlying data or information used to develop any such rule, guideline, protocol, or similar criterion would not be required to be provided in order to satisfy this requirement. *The Department also has taken the position that internal rules, guidelines, protocols, or similar criteria would constitute "instruments under which a plan is established or operated" within the meaning of section 104(b)(4) of ERISA and, as such, must be disclosed to participants and beneficiaries.* See 2560.503-1(g)(v) (A) and (j)(5)(i); 65 FR at 70251. Also see 2560.503-1(h)(2)(iii) and 2560.503-1(m)(8)(i); Advisory Opinion 96-14A (July 31, 1996). (Emphasis added).

Thank you. Please contact me should you have any questions or concerns.

Sincerely,



Laura Goodman, Esq.  
Phone: (617) 275-2917  
Email: lgoodman@hla-inc.org

Enclosures.

cc: [REDACTED] by mail

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**Associate**

Samantha Roy

March 6, 2015

Department of Labor  
Employee Benefit Security Administration (EBSA)  
JFK Federal Bldg  
15 New Sudbury St, Ste 575  
Boston, MA 02203

**RE: Request for Assistance**  
**Claim Fiduciary: Aetna, Inc.**  
**Plan Sponsor: Union Carbide Corporation / Dow Chemical Co.**  
**Plan Number:** [REDACTED]  
**Member Name:** [REDACTED]

Health Law Advocates (HLA) represents A [REDACTED] (the Member) in matters related to Aetna's denial of coverage for residential substance abuse treatment. HLA is designated as the Member's appeal representative in this matter. We are writing to request the Department of Labor's assistance in obtaining information related to the Member's denial matter. Aetna has failed to provide such information despite oral and written requests.

On or about October 28, 2014, Aetna issued a decision denying coverage for the Member's treatment on the basis that it was not medically necessary. The Adverse Benefit Determination letter states that the Member did not meet American Society of Addiction Medicine Treatment Criteria for Addictive, Substance-Related and Co-Occurring Conditions (ASAM Criteria, Third Edition, 2013), but did not provide a copy of those criteria. The letter did indicate that "[t]he clinical criteria upon which the decision was based are available free of charge upon request by calling [Aetna's] Member Services department..." See Aetna Adverse Benefit Determination, attached.

On or about November 4, 2014, Health Law Advocates contacted Aetna Member Services on the Member's behalf to request a copy of the relevant ASAM clinical criteria, per the instructions in Aetna's Adverse Benefit Determination. This attorney spent more than 40 minutes on the phone with various Aetna Member Services departments in an attempt to obtain the ASAM clinical criteria. However, no Member Services representatives were familiar with the clinical criteria used in the Member's case, nor the process by which members may request copies of such criteria.

Health Law Advocates  
 Request for Assistance  
 March 6, 2015  
 Page | 2

The following is an accounting of this attorney's telephone communication with Aetna Member Services on November 4, 2014:

*11.4.2014: [HLA] PC to Aetna, 800-736-9369*

*Went through phone tree to member behavioral health services.*

*-Asked for clinical criteria per instructions in denial letter; Aetna rep said I would have to speak with someone in medical services.*

*-transferred to pre-certification line: 877-810-8485*

*-Aetna rep: "I'm sorry, this is the medical pre-certification department"*

*-Transferred to Aetna behavioral health*

*- HLA asked for clinical criteria, "I'm sorry, you'll have to speak with another department - I'll transfer you there now."*

*-Transferred to provider line - because I do not have an NPI, could not speak with anyone. Automated system transferred me back to member services. After several minutes waiting on line, re-routed to same provider line.*

*-Again, automated message asking for NPI number.*

*-"please call back later when you have your NPI number."*

*Call disconnected.*

*15 minutes on phone.*

*HLA called back member services. Explained that we are looking for clinical criteria, and described the denial letter and instructions for requesting criteria*

*-Took ~10 minutes to pull up member info.*

*-Aetna rep pulled up Oct. 28 denial letter. "It would be a lot easier if they included the clinical criteria bulletin number." HLA advised that the letter states they use ASAM Criteria, but this info is not available to the public so we are requesting it thru Aetna.*

*-After several more minutes... "Oh, Aetna behavioral health team...have you talked to the Aetna Behavioral Health Team?"*

*-HLA advised that I contacted Aetna member services per the letter.*

*-Aetna rep does not know what ASAM criteria is. Can only pull up medical policies.*

*-She is going to request the clinical criteria from the team that issued this decision.*

*-"We normally don't get these requests, I apologize"*

*-Clinical criteria will be send to member at address on file. 7-10 business days. -She included in notes a request to fax copy of criteria to HLA, but can't guarantee they will do that.*

*26 minutes on phone.*

Health Law Advocates  
Request for Assistance  
March 6, 2015  
Page | 3

Neither the member nor Health Law Advocates received a copy of the requested clinical criteria following that conversation with Aetna Member Services. In order for Aetna to meet its federal obligations to make plan information and clinical criteria available to members, plan correspondence must include meaningful instructions for members to follow to obtain a copy of relevant clinical criteria and other plan information.

On January 20, 2015, Health Law Advocates submitted a written information request to Aetna. *See* Written Information Request, attached. As of March 6, 2015, Aetna has not provided the ASAM clinical criteria related to the October 28, 2014 denial, nor any of the other information requested in our January 20, 2015 written request.

By failing to provide the member with a copy of the clinical criteria relied upon in making an adverse benefit determination, as well as other requested information, the health plan is in violation of ERISA and MHPAEA disclosure requirements. *See* 29 U.S.C. § 1132(c); 29 U.S.C. § 1024(b)(4); 29 U.S.C. § 2560.503-1(g); and 29 U.S.C. § 2590.712(d). Due to Aetna's failure to provide this information, the member is at a disadvantage in appealing Aetna's denial of coverage because she does not know the specific criteria Aetna relied upon to deny coverage. Without this information, she cannot adequately challenge Aetna's denial of coverage.

Thank you for your attention to this matter. Please contact me with any questions at (617) 275-2917, or [lgoodman@hla-inc.org](mailto:lgoodman@hla-inc.org).

Sincerely,



Laura Goodman  
Staff Attorney

cc: [REDACTED] y mail

7/23/15

Health Law Advocates (HLA) represents health plan member A [REDACTED] (“the Member”) in matters related to Aetna’s denial of coverage for residential substance use disorder treatment. Previously, HLA sought the Department of Labor’s assistance in obtaining information that the Member’s health plan (Dow Chemical Company, administered by Aetna) was withholding from the Member. DOL/EBSA provided excellent assistance in that matter, and shortly after intervention by Attorney [REDACTED], Aetna released the requested documents. However, we are writing again to request the Department of Labor’s assistance with respect to the health plan’s handling of further appeals matters.

On or about October 28, 2014, Aetna issued an adverse benefit determination denying coverage for the Member’s residential substance use disorder treatment on the grounds that it was not medically necessary. The Member received that appeal decision on or about October 31, 2014. Pursuant to federal law, health plan members have 180 days from the date they receive an adverse benefit determination to submit an appeal request. 29 USC 2560.503-1(h)(3)(i). Because the Member received Aetna’s adverse benefit determination (dated October 28, 2014) on or about October 31, 2014, she had until April 29, 2015 to request an appeal.

HLA submitted an appeal request to Aetna on the Member’s behalf on April 23, 2015. The appeal was sent by certified mail, and USPS tracking information confirms Aetna received the appeal on April 27, 2015. See Delivery Confirmation, attached. The Member’s appeal was therefore timely submitted within 180 days from receiving notice of the adverse benefit determination.

On or about June 1, 2015, this attorney contacted Aetna to check on the status of the appeal request, as neither HLA nor the member had received an appeal decision. Aetna stated that they mailed out an appeal decision on May 21, 2015. HLA requested a copy of that decision, which was provided by fax the same day. The appeal decision, dated May 21, 2015 but not received by the Member or her appeal representative until June 1, 2015, dismisses the member’s appeal request for the reason that it was “too late to appeal.” See Appeal Decision (dated May 21, 2015), attached.

HLA immediately contacted Aetna’s member services department to contest the denial. Aetna staff person “Linda” agreed with the HLA attorney that the appeal was erroneously denied as untimely. On or about June 3, 2015, Linda stated to this attorney that she had “escalated” the appeal back to the appeals department, because she determined it was submitted within the timely filing date. HLA contacted Aetna again on June 24, 2015 to check on the status of the escalated appeal; on that date Aetna staff confirmed that the appeal had been escalated, but there was no further update.

HLA made additional attempts to contact Aetna on July 6, 2015 and July 23, 2015. Due to a lack of resolution following these inquiries, HLA now appeals to the Department of Labor for assistance. We appreciate your assistance investigating the erroneous denial of the Member’s appeal as untimely, as well as the failure of Aetna to issue a full and fair review of the Member’s appeal within the required timeframe.

I have enclosed a copy of the Member’s appeal request (excluding attachments) submitted to Aetna on April 23, 2015, which details the numerous violations of ERISA and MHPAEA observed in Aetna’s handling of the Member’s claim and appeal request. See Aetna Appeal (dated Apr. 23, 2015), attached.

Thank you for your attention to this matter. Please contact me with any questions at (617) 275-2917, or [lgoodman@hla-inc.org](mailto:lgoodman@hla-inc.org).



May [redacted], 2016

United Behavioral Health  
Attn: Grievance and Appeals Coordinator  
Post Office Box 30512  
Salt Lake City, Utah 84130

**REFERENCE:** Patient: [redacted]  
Date of Birth: [redacted]  
Member ID#: [redacted]  
Group: [redacted]  
Review Dates: 12/[redacted]/2015 – 12/[redacted]/2015 [Resid]  
Service Dates: 12/[redacted]/2015 – 12/[redacted]/2015  
Medical Dir: Rasha Lawrence, M.D.  
Records #: [redacted]

**Attestation Of Treatment Medical Necessity**

As a Diplomate in Psychiatry Accredited by The American Board of Psychiatry and Neurology, and as an Addictionologist Accredited by The American Board of Addiction Medicine and by the American Society of Addiction Medicine, I conducted a review of this case. It is my professional belief that the treatment services provided by [redacted] to [redacted] were medically necessary, and that [redacted] was capable of achieving therapeutic benefits as a result of these treatment services. Furthermore, I do not professionally believe that effective treatment services could have been provided at a lesser intensive level of care. Providing less intensive services would have placed [redacted] at significant and serious risk.

A separate case presentation has been prepared by our Clinical, Administrative and Legal Services Team; which I have reviewed and signed, and which is also being provided for your review.

Sincerely,

[redacted signature]

[redacted signature block]



[redacted footer]

[redacted footer]

[redacted footer]



May [redacted] 2016

United Behavioral Health  
Attn: Grievance and Appeals Coordinator  
Post Office Box 30512  
Salt Lake City, Utah 84130

**REFERENCE:** Patient: [redacted]  
Date of Birth: [redacted]  
Member ID#: [redacted]  
Group: [redacted]  
Review Dates: 12/[redacted] 2015 – 12/[redacted] /2015 [Resid]  
Service Dates: 12/[redacted] /2015 – 12/[redacted] /2015  
Medical Dir: [redacted]  
Records #: [redacted]

**Level One Appeal Review Request**

To Whom It May Concern:

As requested, we are providing copies of the requested materials from the patient medical records of [redacted] who received medically necessary treatment at [redacted] between the dates of 12/[redacted] /2015 Inpatient admission, and 12/[redacted] /2015 discharge to the Intensive Outpatient Program level of care.



**Case Presentation**

Patient: [REDACTED]  
Date of Birth: [REDACTED]  
Member ID#: [REDACTED]  
Group: [REDACTED]  
Review Dates: 12/ [REDACTED] /2015 – 12/ [REDACTED] /2015 [Resid]  
Service Dates: 12/ [REDACTED] /2015 – 12/ [REDACTED] /2015  
Medical Dir: [REDACTED]  
Records #: [REDACTED]

**Medical Necessity**

[REDACTED]

[REDACTED]

[REDACTED]

**Case Presentation**

Patient: [REDACTED]  
Date of Birth: [REDACTED]  
Member ID#: [REDACTED]  
Group: [REDACTED]  
Review Dates: 12/ [REDACTED] /2015 – 12/ [REDACTED] /2015 [Resid]  
Service Dates: 12/ [REDACTED] /2015 – 12/ [REDACTED] /2015  
Medical Dir: [REDACTED]  
Records #: [REDACTED]

[REDACTED]

[REDACTED]

**Parity Law Requirements**

[REDACTED] also appeals this adverse benefit determination based on what appears to be non-compliance with the Mental Health Parity and Addiction Equity Act of 2008, Interim Final Rules issued February 2, 2010, and Final Rules issued November 13, 2013 (collectively “MHPAEA”). Under MHPAEA, medical management standards limiting benefits based on medical necessity or medical appropriateness are a type of nonquantitative treatment limitation (“NQTL”) and must comply with the NQTL rule. Pursuant to the NQTL rule, under the terms of the plan or insurance coverage, as written and in operation, the processes, strategies, evidentiary standards or other factors used in applying the NQTL to either the inpatient or outpatient classification of substance use disorder benefits must be comparable to and applied no more stringently than the processes, strategies, evidentiary standards or other factors used in applying the NQTL to the same classification of medical/surgical benefits. 29 CFR 2590.712(c)(4).

**Case Presentation**

Page Four

Patient: [REDACTED]  
Date of Birth: [REDACTED]  
Member ID#: [REDACTED]  
Group: [REDACTED]  
Review Dates: 12/ [REDACTED] /2015 – 12/ [REDACTED] /2015 [Resid]  
Service Dates: 12/ [REDACTED] /2015 – 12/ [REDACTED] /2015  
Medical Dir: Rasha Lawrence, M.D.  
Records #: [REDACTED]

In this case, it appears that the medical management standards may not be comparable to and/or may have been applied more stringently with respect to the substance use disorder benefit than with respect to the medical/surgical benefit. Under the “Availability of Plan Information” section of MHPAEA (29 CFR 2590.712(d)(1) and (2)), the substance use disorder medical necessity criteria and the reason for denial, in a form or manner consistent with 29 CFR 2560.503-1 (claims procedure regulations) must be disclosed. In addition, under 29 CFR 2590.712(d)(3), disclosure must also be made in accordance with ERISA section 104 and §2520.104b-1, which require disclosure of plan documents for ERISA plans, i.e., instruments under which the plan is established or operated, to plan participants or their authorized representatives within 30 days of request. Instruments under which the plan is established or operated include documents with information on medical necessity criteria for both substance use disorder and medical/surgical benefits, as well as the processes, strategies, evidentiary standards, and other factors used to apply an NQTL with respect to both medical/surgical benefits and substance use disorder benefits under the plan. In addition, 29 CFR 2560.503-1 and 29 CFR 2590.715-2719 (claims and appeals regulations) set forth the requirements for disclosure of these plan documents as well. Additionally, FAQs about Affordable Care Act Implementation (Part XXIX) and Mental Health Parity Implementation issued on October 23, 2015 (MHPAEA and Disclosure, Q12, Q13), provide that the “proprietary” nature of any document or criteria cannot be used to evade disclosure, and reinforce the disclosure requirements as set forth in the Final Rules. Moreover, FAQs about Affordable Care Act (Part 31) issued on April 20, 2016 (MHPAEA Disclosure, Q9) provide *specific guidance* on the plan information and documents that must be disclosed.

We anticipate your review of this case to result in a decision to issue payment of already submitted charges for services rendered in a timely manner. However, should any adverse benefit determination occur, per established law and regulations, the plan (or health insurance issuer) is required to provide us with the following plan instruments and information pursuant to MHPAEA, its 2010 Interim Final Rules, its 2013 Final Rules codified at 29 CFR 2590.712(d)(1),(2) and (3); ERISA section 104 and §2520.104b-1; the claims and appeals regulations, 29 CFR 2560.503-1 and 29 CFR 2590.715-2719; the 2015 FAQs on MHPAEA Disclosure; and the 2016 FAQ on MHPAEA Disclosure, within 30 days from the date of this request:

**Case Presentation**

Page Five

Patient: [REDACTED]  
Date of Birth: [REDACTED]  
Member ID#: [REDACTED]  
Group: [REDACTED]  
Review Dates: 12/ [REDACTED] /2015 – 12/ [REDACTED] /2015 [Resid]  
Service Dates: 12/ [REDACTED] /2015 – 12/ [REDACTED] /2015  
Medical Dir: [REDACTED]  
Records #: [REDACTED]

1. A Summary Plan Description (SPD) from an ERISA plan, or similar summary information that may be provided by non-ERISA plans;
2. The specific plan language regarding the imposition of the NQTL at issue in this case (e.g., preauthorization, concurrent review, retrospective review, etc.);
3. The specific underlying processes, strategies, evidentiary standards, and other factors (including, but not limited to, all evidence) considered by the plan (including factors that were relied upon and were rejected) in determining that the NQTL will apply to the SUD benefit classification at issue;
4. Information regarding the application of the NQTL to any medical/surgical benefits within the benefit classification at issue;
5. The specific underlying processes, strategies, evidentiary standards, and other factors (including, but not limited to, all evidence) considered by the plan (including factors that were relied upon and were rejected) in determining the extent to which the NQTL will apply to any medical/surgical benefits within the benefit classification at issue; and
6. Any analyses performed by the plan as to how the NQTL complies with MHPAEA.  
(See <https://www.dol.gov/ebsa/faqs/faq-aca31.html>, Q9).

In addition, as required by MHPAEA:

7. Should your review result in any subsequent denial, please disclose the substantive clinical evidence obtained from your review of the patient's medical record, that when matched with the medical necessity criteria, constitutes your reason for issuing any subsequent denial. Please also provide a copy of the specific medical necessity criteria (including the specific citation), utilized in reaching any such subsequent denial.
8. Identify all insurer designated reviewer(s) and or any other insurance carrier designated personnel involved in the review of this case, including their: full name; current accreditation; current professional licensure, and the state(s) in which such licensure is active; current professional practice; and current relationship to the insurer and/or their designated managed care provider.

**Case Presentation**

Patient: [REDACTED]  
Date of Birth: [REDACTED]  
Member ID#: [REDACTED]  
Group: [REDACTED]  
Review Dates: 12/ [REDACTED] /2015 – 12/ [REDACTED] /2015 [Resid]  
Service Dates: 12/ [REDACTED] /2015 – 12/ [REDACTED] /2015  
Medical Dir: [REDACTED]  
Records #: PB31501.5

[REDACTED]

[REDACTED]

Sincerely,

[REDACTED]

[REDACTED]

[REDACTED]



May [redacted] 2016

Cigna Behavioral Health  
Attn: Grievance and Appeals Coordinator  
Post Office Box 188064  
Chattanooga, Tennessee 37422

**REFERENCE:** Patient: [redacted]  
Date of Birth: [redacted]  
Member ID#: [redacted]  
Group: [redacted]  
Admit Type: Precertified Admission  
Review Dates: 12/[redacted]/2015 – 12/[redacted]/2015 [Resid]  
Service Date: 12/[redacted]/2015 – 12/[redacted]/2015  
Medical Dir: Rasha Lawrence, M.D.  
Records #: [redacted]

**Attestation Of Treatment Medical Necessity**

As a Diplomate in Psychiatry Accredited by The American Board of Psychiatry and Neurology, and as an Addictionologist Accredited by The American Board of Addiction Medicine and by the American Society of Addiction Medicine, I conducted a review of this case. It is my professional belief that the treatment services provided by Watershed Addiction Treatment Programs to [redacted] were medically necessary, and that [redacted] was capable of achieving therapeutic benefits as a result of these treatment services. Furthermore, I do not professionally believe that effective treatment services could have been provided at a lesser intensive level of care. Providing less intensive services would have placed Regis Trefelner at significant and serious risk.

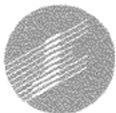
A separate case presentation has been prepared by our Clinical, Administrative and Legal Services Team; which I have reviewed and signed, and which is also being provided for your review.

Sincerely,

[Handwritten signature]  
[redacted signature block]

cc:

[redacted cc recipient]





May [redacted], 2016

Cigna Behavioral Health  
Attn: Grievance and Appeals Coordinator  
Post Office Box 188064  
Chattanooga, Tennessee 37422

**REFERENCE:** Patient: [redacted]  
Date of Birth: [redacted]  
Member ID#: [redacted]  
Group: [redacted]  
Admit Type: Precertified Admission  
Review Dates: 12/[redacted] 2015 – 12/[redacted]/2015 [Resid]  
Service Date: 12/[redacted] 2015 – 12/[redacted]/2015  
Medical Dir: Rasha Lawrence, M.D.  
Records #: [redacted]

**Level One Appeal Review Request**

To Whom It May Concern:

As requested, we are providing copies of the requested materials from the patient medical records of [redacted] who received medically necessary treatment at [redacted] between the dates of 12/[redacted]/2015 and 12/[redacted]/2015. [redacted] admission to [redacted] has previously been Precertified/Authorized as Medically Necessary by the insurance carrier's designated physician and nurse reviewers as a result of Precertification and concurrent case reviews.



**Case Presentation**

Patient: [REDACTED]  
Date of Birth: [REDACTED]  
Member ID#: [REDACTED]  
Group: [REDACTED]  
Admit Type: Precertified Admission  
Review Dates: 12 [REDACTED]/2015 – 12 [REDACTED]/2015 [Resid]  
Service Date: 12 [REDACTED]/2015 – 12 [REDACTED]/2015  
Medical Dir: Rasha Lawrence, M.D.  
Records #: [REDACTED]

**Medical Necessity**

[REDACTED]

[REDACTED]

[REDACTED]

**Case Presentation**

Patient: [REDACTED]  
 Date of Birth: [REDACTED]  
 Member ID#: [REDACTED]  
 Group: [REDACTED]  
 Admit Type: Precertified Admission  
 Review Dates: 12/[REDACTED]/2015 – 12/[REDACTED]/2015 [Resid]  
 Service Date: 12/[REDACTED]/2015 – 12/[REDACTED]/2015  
 Medical Dir: Rasha Lawrence, M.D.  
 Records #: [REDACTED]

[REDACTED]

[REDACTED]

**Parity Law Requirements**

[REDACTED] also appeals this adverse benefit determination based on what appears to be non-compliance with the Mental Health Parity and Addiction Equity Act of 2008, Interim Final Rules issued February 2, 2010, and Final Rules issued November 13, 2013 (collectively “MHPAEA”). Under MHPAEA, medical management standards limiting benefits based on medical necessity or medical appropriateness are a type of nonquantitative treatment limitation (“NQTL”) and must comply with the NQTL rule. Pursuant to the NQTL rule, under the terms of the plan or insurance coverage, as written and in operation, the processes, strategies, evidentiary standards or other factors used in applying the NQTL to either the inpatient or outpatient classification of substance use disorder benefits must be comparable to and applied no more stringently than the processes, strategies, evidentiary standards or other factors used in applying the NQTL to the same classification of medical/surgical benefits. 29 CFR 2590.712(c)(4).

## Case Presentation

Page Four

Patient: [REDACTED]  
Date of Birth: [REDACTED]  
Member ID#: [REDACTED]  
Group: [REDACTED]  
Admit Type: Precertified Admission  
Review Dates: 12/[REDACTED]/2015 – 12/[REDACTED]/2015 [Resid]  
Service Date: 12/[REDACTED]/2015 – 12/[REDACTED]/2015  
Medical Dir: Rasha Lawrence, M.D.  
Records #: [REDACTED]

In this case, it appears that the medical management standards may not be comparable to and/or may have been applied more stringently with respect to the substance use disorder benefit than with respect to the medical/surgical benefit. Under the “Availability of Plan Information” section of MHPAEA (29 CFR 2590.712(d)(1) and (2)), the substance use disorder medical necessity criteria and the reason for denial, in a form or manner consistent with 29 CFR 2560.503-1 (claims procedure regulations) must be disclosed. In addition, under 29 CFR 2590.712(d)(3), disclosure must also be made in accordance with ERISA section 104 and §2520.104b-1, which require disclosure of plan documents for ERISA plans, i.e., instruments under which the plan is established or operated, to plan participants or their authorized representatives within 30 days of request. Instruments under which the plan is established or operated include documents with information on medical necessity criteria for both substance use disorder and medical/surgical benefits, as well as the processes, strategies, evidentiary standards, and other factors used to apply an NQTL with respect to both medical/surgical benefits and substance use disorder benefits under the plan. In addition, 29 CFR 2560.503-1 and 29 CFR 2590.715-2719 (claims and appeals regulations) set for the requirements for disclosure of these plan documents as well. Additionally, FAQs about Affordable Care Act Implementation (Part XXIX) and Mental Health Parity Implementation issued on October 23, 2015 (MHPAEA and Disclosure, Q12, Q13), provide that the “proprietary” nature of any document or criteria cannot be used to evade disclosure, and reinforce the disclosure requirements as set forth in the Final Rules. Moreover, FAQs about Affordable Care Act (Part 31) issued on April 20, 2016 (MHPAEA Disclosure, Q9) provide *specific guidance* on the plan information and documents that must be disclosed.

We anticipate your review of this case to result in a decision to issue payment of already submitted charges for services rendered in a timely manner. However, should any adverse benefit determination occur, per established law and regulations, the plan (or health insurance issuer) is required to *provide us with the following plan instruments and information* pursuant to MHPAEA, its 2010 Interim Final Rules, its 2013 Final Rules codified at 29 CFR 2590.712(d)(1),(2) and (3); ERISA section 104 and §2520.104b-1; the claims and appeals regulations, 29 CFR 2560.503-1 and 29 CFR 2590.715-2719; the 2015 FAQs on MHPAEA Disclosure; and the 2016 FAQ on MHPAEA Disclosure, within 30 days from the date of this request:

**Case Presentation**

Page Five

Patient: [REDACTED]  
Date of Birth: [REDACTED]  
Member ID#: [REDACTED]  
Group: [REDACTED]  
Admit Type: Precertified Admission  
Review Dates: 12/[REDACTED]/2015 – 12/[REDACTED]/2015 [Resid]  
Service Date: 12/[REDACTED]/2015 – 12/[REDACTED]/2015  
Medical Dir: Rasha Lawrence, M.D.  
Records #: [REDACTED]

1. A Summary Plan Description (SPD) from an ERISA plan, or similar summary information that may be provided by non-ERISA plans;
2. The specific plan language regarding the imposition of the NQTL at issue in this case (e.g., preauthorization, concurrent review, retrospective review, etc.);
3. The specific underlying processes, strategies, evidentiary standards, and other factors (including, but not limited to, all evidence) considered by the plan (including factors that were relied upon and were rejected) in determining that the NQTL will apply to the SUD benefit classification at issue;
4. Information regarding the application of the NQTL to any medical/surgical benefits within the benefit classification at issue;
5. The specific underlying processes, strategies, evidentiary standards, and other factors (including, but not limited to, all evidence) considered by the plan (including factors that were relied upon and were rejected) in determining the extent to which the NQTL will apply to any medical/surgical benefits within the benefit classification at issue; and
6. Any analyses performed by the plan as to how the NQTL complies with MHPAEA.  
(See <https://www.dol.gov/ebsa/faqs/faq-aca31.html>, Q9).

In addition, as required by MHPAEA:

7. Should your review result in any subsequent denial, please disclose the substantive clinical evidence obtained from your review of the patient's medical record, that when matched with the medical necessity criteria, constitutes your reason for issuing any subsequent denial. Please also provide a copy of the specific medical necessity criteria (including the specific citation), utilized in reaching any such subsequent denial.
8. Identify all insurer designated reviewer(s) and or any other insurance carrier designated personnel involved in the review of this case, including their: full name; current accreditation; current professional licensure, and the state(s) in which such licensure is active; current professional practice; and current relationship to the insurer and/or their designated managed care provider.

**Case Presentation**

Patient: [REDACTED]  
Date of Birth: [REDACTED]  
Member ID#: [REDACTED]  
Group: [REDACTED]  
Admit Type: Precertified Admission  
Review Dates: 12/[REDACTED]/2015 – 12/[REDACTED]/2015 [Resid]  
Service Date: 12/[REDACTED]/2015 – 12/[REDACTED]/2015  
Medical Dir: Rasha Lawrence, M.D.  
Records #: [REDACTED]

[REDACTED]

[REDACTED]

Sincerely,

[REDACTED]

[REDACTED] PN

cc: [REDACTED]



June 23, 2016

Cigna Behavioral Health, Inc.  
 Central Appeals Unit  
 P.O. Box 188064  
 Chattanooga, TN 37422  
 www.cigna.com

[REDACTED]

RE: Denial of Medical Necessity Appeal from Cigna Behavioral Health on behalf of Cigna Health and Life Insurance Company  
 Date Issue Received at Cigna Behavioral Health: 05/ /2016  
 Date(s) of Service Requested: 12/ /2015 - 12/ /2015  
 Date(s) of Service Denied: 12/ /2015 - 12/ /2015  
 Date(s) of Service Authorized: Zero (0)  
 Issue ID: [REDACTED]

Dear [REDACTED],

Cigna Behavioral Health, Inc., a licensed utilization review agent, reviews certain health care services for medical necessity for Cigna Health and Life Insurance Company. We received a grievance request on 05/ /2016 for [REDACTED] for the following service/procedure(s): Residential Substance Use Disorders Treatment rendered by [REDACTED]. After a review of the information submitted and the terms of your benefit plan, we have decided to uphold the original decision not to authorize the requested services. Cigna's Peer Reviewer, Liebe Gelman, M.D., (FL: MF91927), a board certified psychiatrist, has determined that the requested services are not covered. This decision was based on the following:

- The clinical basis for this decision is: Based upon the available clinical information received initially and with this appeal, your symptoms did not meet Cigna's Behavioral Health Medical Necessity Criteria for continued stay at Residential Substance Use Disorders Treatment level of care from 12/ /2015 - 12/ /2015 as the information provided described you as being able to understand information presented to you and being in behavioral control. There was no report of any physical instability or psychosis driving your behaviors. There was no evidence of threat to anybody. As there was nothing proposed requiring around-the-clock intervention, there was nothing suggesting that you would not be able to successfully and safely use structured outpatient services to continue working on your recovery rather than an extended stay in an around-the-clock setting as long as you were truly motivated for working on that goal.

Claim #: [REDACTED]

Claim Amount: [REDACTED]

- “Cigna Medical Necessity Criteria for Treatment of Behavioral Health and Substance Use Disorders,” which can be accessed via the Internet with an Adobe Reader at:

<http://apps.cignabehavioral.com/web/basic/site/media/consumer/educationAndResourceCenter/medicalNecessityCriteria.pdf>

Scroll through the Table of Contents and click on the Medical Necessity Criteria for Residential Substance Use Disorders Treatment to view. If you do not have access to the Internet you may obtain a hard copy of the guideline free of charge by calling 800.241.4057, ext. 7962009.

- Please refer to your plan documents for requirements regarding medical necessity determinations.

This coverage decision is not a treatment decision or a medical consultation. Decisions about your medical care are yours to make along with your treating behavioral health care professional. We want you to make an informed decision, so please discuss your treatment options with your behavioral health care professional. If you choose to proceed with the requested service(s), any claims associated with the denied request will not be considered for payment. Please refer to your benefit plan documents for details about your benefit plan coverage.

You have the right to appeal this decision directly through the Cigna External Review Program, which provides an independent review of your appeal by an external independent review organization that is external and independent from Cigna, also known as an Independent Review Organization or (IRO). The IROs utilized by Cigna for this program are separate companies, not connected to Cigna professionally or financially. The decision of the IRO will be binding on Cigna. There is no charge to you for this review. To be eligible for this program, you must request a review by an IRO within 180 days of the date of this letter.

Cigna uses three independent review organizations. Once the review is complete, you will be notified in writing of the decision. If you wish to appeal through this external review program, please complete and sign the attached Request for IRO Review and Release form and send to the address below.

Cigna Behavioral Health  
Central Appeals Unit  
P.O. Box 188064  
Chattanooga, TN 37422

Your decision will not affect your rights to any other benefits under the plan. Further information about the process for selection of the IRO, its impartiality or relationship with any party to the review is available upon request.

If you choose not to use an IRO, this is the final step of the internal appeal process.

Page 3

[REDACTED]

If you would like the Department of Insurance to review this matter, you can contact their consumer division at the Florida Office of Insurance Regulation, 200 East Gaines Street, Tallahassee, Florida, 32399-0322, 800.342.2762.

This decision represents the final step of the internal review process. However, if your plan is governed by ERISA, you also have the right to bring a legal action under Section 502 (a) of ERISA.

For questions about your appeal rights or for assistance, you can contact the Employee Benefits Security Administration at 1.866.444.EBSA (3272) or [www.askebsa.dol.gov](http://www.askebsa.dol.gov).

If you are not satisfied with the final internal review, you may be able to ask for an independent, external review of our decision, as determined by your plan and any state or federal requirements.

You are entitled to receive free of charge, copies of, all documents, records and other information relevant to your appeal for benefits, including the benefit provision, guideline or protocol upon which the decision was based. If you want to request copies or if you have any questions, please write to us at Cigna Behavioral Health, Central Appeals Unit, P.O. Box 188064, Chattanooga, TN 37422 or contact us by facsimile at 877.815.4827 or call our department at 800.241.4057 ext. 7962009. One of our representatives will be happy to help you.

Sincerely,

James M., Appeals Coordinator  
Cigna Behavioral Health

Copy sent to:

[REDACTED] [REDACTED]

Enclosure(s): Important Additional Information  
Request for IRO Review and Release form



May [redacted], 2016

Anthem UM Services, Inc.  
Attn: Level Two Appeals Coordinator  
Post Office Box 105568  
Atlanta, Georgia 30348-5568

**REFERENCE:** Patient: [redacted]  
Date of Birth: [redacted]  
Member ID#: [redacted]  
Group#: [redacted]  
Review Dates: 10/ [redacted] 2015 – 10/ [redacted] 2015 [Resid]  
Service Dates: 10/ [redacted] 2015 – 10/ [redacted] 2015  
Medical Dir: [redacted]  
Records #: [redacted]

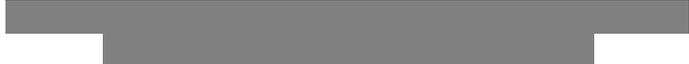
**Attestation Of Treatment Medical Necessity**

As a Diplomate in Psychiatry Accredited by The American Board of Psychiatry and Neurology, and as an Addictionologist Accredited by The American Board of Addiction Medicine and by the American Society of Addiction Medicine, I conducted a review of this case. It is my professional belief that the treatment services provided by [redacted] to [redacted] were medically necessary, and that [redacted] was capable of achieving therapeutic benefits as a result of these treatment services. Furthermore, I do not professionally believe that effective treatment services could have been provided at a lesser intensive level of care. Providing less intensive services would have placed [redacted] at significant and serious risk.

A separate case presentation has been prepared by our Clinical, Administrative and Legal Services Team; which I have reviewed and signed, and which is also being provided for your review.

Sincerely,

[redacted signature block]





May [redacted], 2016

Anthem UM Services, Inc.  
Attn: Level Two Appeals Coordinator  
Post Office Box 105568  
Atlanta, Georgia 30348-5568

**REFERENCE:** Patient: [redacted]  
Date of Birth: [redacted]  
Member ID#: [redacted]  
Group#: [redacted]  
Review Dates: 10/[redacted] 2015 – 10/[redacted]/2015 [Resid]  
Service Dates: 10/[redacted]/2015 – 10/[redacted]/2015  
Medical Dir: [redacted]  
[redacted] PB37009.2

**Level Two Appeal Review Request**

To Whom It May Concern:

As requested, we are providing copies of the requested materials from the patient medical records of [redacted] who received medically necessary treatment at [redacted] between the dates of 10/[redacted]/2015 Inpatient admission, and 10/[redacted]/2015 discharge to the Partial Hospitalization Program level of care.



**Case Presentation**

Patient: [REDACTED]  
Date of Birth: [REDACTED]  
Member ID#: [REDACTED]  
Group#: [REDACTED]  
Review Dates: 10/ [REDACTED] /2015 – 10/ [REDACTED] /2015 [Resid]  
Service Dates: 10/ [REDACTED] /2015 – 10/ [REDACTED] /2015  
Medical Dir: [REDACTED]  
Records #: [REDACTED]

**Medical Necessity**

[REDACTED]

[REDACTED]

[REDACTED]

**Case Presentation**

Patient: [REDACTED]  
Date of Birth: [REDACTED]  
Member ID#: [REDACTED]  
Group#: [REDACTED]  
Review Dates: 10/2015 – 10/2015 [Resid]  
Service Dates: 10/2015 – 10/2015  
Medical Dir: [REDACTED]  
Records #: [REDACTED]

[REDACTED]

[REDACTED]

**Parity Law Requirements**

[REDACTED] also appeals this adverse benefit determination based on what appears to be non-compliance with the Mental Health Parity and Addiction Equity Act of 2008, Interim Final Rules issued February 2, 2010, and Final Rules issued November 13, 2013 (collectively “MHPAEA”). Under MHPAEA, medical management standards limiting benefits based on medical necessity or medical appropriateness are a type of nonquantitative treatment limitation (“NQTL”) and must comply with the NQTL rule. Pursuant to the NQTL rule, under the terms of the plan or insurance coverage, as written and in operation, the processes, strategies, evidentiary standards or other factors used in applying the NQTL to either the inpatient or outpatient classification of substance use disorder benefits must be comparable to and applied no more stringently than the processes, strategies, evidentiary standards or other factors used in applying the NQTL to the same classification of medical/surgical benefits. 29 CFR 2590.712(c)(4).

## Case Presentation

Page Four

Patient: [REDACTED]  
Date of Birth: [REDACTED]  
Member ID#: [REDACTED]  
Group#: [REDACTED]  
Review Dates: 10/ [REDACTED] /2015 – 10/ [REDACTED] /2015 [Resid]  
Service Dates: 10/ [REDACTED] /2015 – 10/ [REDACTED] /2015  
Medical Dir: [REDACTED]  
Records #: [REDACTED]

In this case, it appears that the medical management standards may not be comparable to and/or may have been applied more stringently with respect to the substance use disorder benefit than with respect to the medical/surgical benefit. Under the “Availability of Plan Information” section of MHPAEA (29 CFR 2590.712(d)(1) and (2)), the substance use disorder medical necessity criteria and the reason for denial, in a form or manner consistent with 29 CFR 2560.503-1 (claims procedure regulations) must be disclosed. In addition, under 29 CFR 2590.712(d)(3), disclosure must also be made in accordance with ERISA section 104 and §2520.104b-1, which require disclosure of plan documents for ERISA plans, i.e., instruments under which the plan is established or operated, to plan participants or their authorized representatives within 30 days of request. Instruments under which the plan is established or operated include documents with information on medical necessity criteria for both substance use disorder and medical/surgical benefits, as well as the processes, strategies, evidentiary standards, and other factors used to apply an NQTL with respect to both medical/surgical benefits and substance use disorder benefits under the plan. In addition, 29 CFR 2560.503-1 and 29 CFR 2590.715-2719 (claims and appeals regulations) set forth the requirements for disclosure of these plan documents as well. Additionally, FAQs about Affordable Care Act Implementation (Part XXIX) and Mental Health Parity Implementation issued on October 23, 2015 (MHPAEA and Disclosure, Q12, Q13), provide that the “proprietary” nature of any document or criteria cannot be used to evade disclosure, and reinforce the disclosure requirements as set forth in the Final Rules. Moreover, FAQs about Affordable Care Act (Part 31) issued on April 20, 2016 (MHPAEA Disclosure, Q9) provide *specific guidance* on the plan information and documents that must be disclosed.

We anticipate your review of this case to result in a decision to issue payment of already submitted charges for services rendered in a timely manner. However, should any adverse benefit determination occur, per established law and regulations, the plan (or health insurance issuer) is required to provide us with the following plan instruments and information pursuant to MHPAEA, its 2010 Interim Final Rules, its 2013 Final Rules codified at 29 CFR 2590.712(d)(1),(2) and (3); ERISA section 104 and §2520.104b-1; the claims and appeals regulations, 29 CFR 2560.503-1 and 29 CFR 2590.715-2719; the 2015 FAQs on MHPAEA Disclosure; and the 2016 FAQ on MHPAEA Disclosure, within 30 days from the date of this request:

**Case Presentation****Page Five**

Patient: [REDACTED]  
Date of Birth: [REDACTED]  
Member ID#: [REDACTED]  
Group#: [REDACTED]  
Review Dates: 10/ [REDACTED] /2015 – 10/ [REDACTED] /2015 [Resid]  
Service Dates: 10/ [REDACTED] /2015 – 10/ [REDACTED] /2015  
Medical Dir: [REDACTED]  
Records #: [REDACTED] ?

1. A Summary Plan Description (SPD) from an ERISA plan, or similar summary information that may be provided by non-ERISA plans;
2. The specific plan language regarding the imposition of the NQTL at issue in this case (e.g., preauthorization, concurrent review, retrospective review, etc.);
3. The specific underlying processes, strategies, evidentiary standards, and other factors (including, but not limited to, all evidence) considered by the plan (including factors that were relied upon and were rejected) in determining that the NQTL will apply to the SUD benefit classification at issue;
4. Information regarding the application of the NQTL to any medical/surgical benefits within the benefit classification at issue;
5. The specific underlying processes, strategies, evidentiary standards, and other factors (including, but not limited to, all evidence) considered by the plan (including factors that were relied upon and were rejected) in determining the extent to which the NQTL will apply to any medical/surgical benefits within the benefit classification at issue; and
6. Any analyses performed by the plan as to how the NQTL complies with MHPAEA.  
(See <https://www.dol.gov/ebsa/faqs/faq-aca31.html>, Q9).

In addition, as required by MHPAEA:

7. Should your review result in any subsequent denial, please disclose the substantive clinical evidence obtained from your review of the patient's medical record, that when matched with the medical necessity criteria, constitutes your reason for issuing any subsequent denial. Please also provide a copy of the specific medical necessity criteria (including the specific citation), utilized in reaching any such subsequent denial.
8. Identify all insurer designated reviewer(s) and or any other insurance carrier designated personnel involved in the review of this case, including their: full name; current accreditation; current professional licensure, and the state(s) in which such licensure is active; current professional practice; and current relationship to the insurer and/or their designated managed care provider.

**Case Presentation**

Patient: [REDACTED]  
Date of Birth: [REDACTED]  
Member ID#: [REDACTED]  
Group#: [REDACTED]  
Review Dates: 10/ [REDACTED] /2015 – 10/ [REDACTED] /2015 [Resid]  
Service Dates: 10/ [REDACTED] /2015 – 10/ [REDACTED] /2015  
Medical Dir: [REDACTED]  
Records #: [REDACTED]

[REDACTED]

[REDACTED]

Sincerely,

[REDACTED]

[REDACTED]

cc: [REDACTED]

Anthem Blue Cross and Blue Shield  
Grievances and Appeals  
P.O. Box 105568  
Atlanta GA 30348-5568



June [REDACTED] 2016

[REDACTED]

Case number: [REDACTED]  
Member name: [REDACTED]  
Member ID number: [REDACTED]  
Date appeal received: June [REDACTED] 2016

Dear [REDACTED]:

Anthem UM Services, Inc. is a separate company providing utilization review services on behalf of Anthem Blue Cross and Blue Shield. We received a request submitted on your behalf from [REDACTED] for an appeal. [REDACTED] asked us to review our coverage decision for: the inpatient substance abuse residential treatment center (RTC) admission for dates of services October [REDACTED], 2015-October [REDACTED], 2015.

It's important that we have all relevant information that supports the appeal to ensure a full and fair review. You or your authorized representative may give us more information. It can be given to us by mail, fax or over the phone.

- By mail:  
Grievances and Appeals  
P.O. Box 105568  
Atlanta GA 30348-5568
- By fax: (877) 487-7394
- By phone: Call Member Services at the phone number on your ID card.

We may also contact you or your doctors for more information.

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If you have any questions about this letter, call Member Services at the phone number on your ID card. We'll finish our review within 30 calendar days from the date we received the request.

Best regards,

Shannon Murphy  
Grievances and Appeals Analyst  
Grievances and Appeals

CC: [REDACTED]

Providers: You are required to return, destroy or further protect any PHI received on this document pertaining to members that you are not currently treating. Providers are required to immediately destroy any such PHI or safeguard the PHI for as long as it is retained. In no event are you permitted to use or re-disclose such PHI.