Below is the advocacy letter that was submitted on appeal and then as a government complaint. It further outlines the necessity of a clinically accurate definition for eating disorder medical nutrition therapy CPT 97802,97803,97804. “Nutritional counseling” is not a medical term and continues to lead to arbitrary restrictions on a medically necessary standard of care treatment.

Please note that BCBSNC’s practices indicate a lack of awareness or concern regarding the following issues:

BCBSNC’s infrastructure appears to be fragmented, with one department strictly adhering to the terms of fully insured plans, while another department provides self-funded plans like those offered to Duke with a template Summary Plan Description (SPD) that potentially violates the Mental Health Parity and Addiction Equity Act (MHPAEA). This is not a minor oversight. Prior to BCBSNC’s template change in 2023, “nutritional counseling” had specific visit limits (e.g., 6 visits, 30 visits). The updated template now includes an option for “mental illness or does not,” effectively allowing clients to choose whether to comply with the law.

BCBSNC’s programming framework appears to incorporate this flexibility, with visit limits being auto-processed. Customer service representatives can see these limits on their portals, and denial letters automatically include standardized language based on automated processing rather than manual review. This systematic approach raises concerns about the legal and compliance implications of BCBSNC’s practices.

RE: Mental Health Parity Violation for Eating Disorder Medical Nutrition Therapy "MNT"

This is a complaint for the 6 visit limit and subsequent denial of Eating Disorder[1] Medical Nutrition Therapy (MNT[2]). Eating Disorders are mental health conditions and Eating Disorder MNT is a mental health benefit. Since Eating Disorder MNT is a mental health benefit, any limitations must comply with the Mental Health Parity and Addiction Equity Act (MHPAEA).

The current coverage limitation violates MHPAEA because the process to determine coverage for this mental health/substance abuse disorder, (MH/SUD) outpatient, office based, in-network benefit is not in parity with the process to determine coverage for any other medical/surgical (M/S) outpatient, office based, in-network benefit.

The Visit Limit Process Fails The Quantitative Treatment Limitation (QTL) Test[3].

1. Classification: The benefit is classified as outpatient, office based, in-network.

2. Visit Limits: The Plan imposes a limit of 6 visits per year for Eating Disorder MNT, a MH/SUD benefit.

3. Substantially All Test: A visit limit does not apply to at least two-thirds (2/3) of the M/S benefits for outpatient, office based, in-network benefits.

4. Predominant Test: If substantially all outpatient, office based, in-network benefits M/S benefits have a visit limit, the most common (predominant) is unlikely to be 6 visits or less per year.

5. Comparison and Parity Requirement: The visit limits for MH/SUD benefits is more

[1] ICD-10 F50.x Eating Disorder codes
[2] CPT 97802, 97803, 97804
[3] (29 U.S.C. § 1185a and 45 C.F.R. § 146.136)

restrictive than the predominant visit limit applied to M/S benefits within the same classification.

The Visit Limit Process Fails The Non-Quantitative Treatment Limit "Nqtl" Test.

- The Plan discriminates against eating disorder MNT- a MH/SUD benefit- and does not use the medically necessary standard which is used for all other M/S benefits.
- The Plan uses reasonable medical management techniques to determine coverage limitations for M/S benefits but DOES NOT use reasonable medical management techniques for Eating Disorder MNT- .
- The Plan covers other MNT treatments for MS/S beyond 6 visits (i.e. Type 1 Diabetes).
- Despite covering eating disorders, the Plan excludes a standard of care treatment and fails to provide meaningful benefits to treat this condition.
- The Plan is discriminating against the provider who otherwise meets the definition of a qualifying practitioner.
- The Plan restricts coverage based on service location.

SUMMARY OF EVENTS

Initial Diagnosis and Coverage Denial

I was diagnosed with an eating disorder in January 2020. Since then, I have participated in an intensive outpatient program at Veritas Collaborative, a Partial Hospitalization Program at the Eating Recovery Center, and another intensive outpatient program at Carolina House. A

critical, standard of care and medically necessary part of stepping down from these programs is securing an outpatient therapist and dietitian to work with after discharge.

Starting in June 2023, I have been denied coverage for my Eating Disorder MNT appointments, except for the first six appointments. A dietitian is integral to my outpatient team. Duke's arbitrary visit limit is not based on any reasonable medical standards. Despite my diagnosed eating disorder and a letter of medical necessity from my dietitian, I was told that they only cover six dietitian appointments a year.

Due to Duke's and BCBSNC's arbitrary restriction for my Eating Disorder MNT appointments, I am forced to pay out of pocket and reduce the frequency and length of appointments. **This reduction in care goes against my treatment team's medical recommendations. I am at immediate risk of physical and psychological harm.** The refusal of this care is preventing me from obtaining adequate treatment, and is harming my health.

Efforts to Resolve Issues

I called BCBSNC and Duke University several times to get my Eating Disorder MNT appointments covered. In January 2024, I reached out to Duke's Plan manager, to request coverage for my Eating Disorder MNT appointments beyond the six visit limit. I explained that the policy was discriminatory and violating MHPAEA. In February 2024, the Plan manager contacted BCBSNC and asked if the six visit limit complied with the law. BCBSNC told her that visit limits were compliant. I was also told that Duke is not required to offer a "nutrition" benefit.

I informed Duke that Eating Disorder MNT is not " healthy eating or general wellness." It meets the Plan's definition of an outpatient mental health benefit, offered by a qualified provider and is medically necessary for the treatment of a diagnosed eating disorder. I appealed the denial and my appeal was denied in March 2024.

In support of my claim, I pointed out that Duke's Student Plan recently removed their visit limit for mental health MNT appointments. The justification given for the inconsistency was that the student Plan is fully insured and managed separately from the self-insured Plan.

Duke is responsible for MHPAEA Violation Even if Relied on BCBS Interpretation

I pointed out that BCBSNC is not liable if a self-funded Plan fails to comply with MHPAEA. However, BCBSNC is legally accountable for ensuring their fully insured Plans comply with MHPAEA. In fact, BCBSNC removed the visit limits from all of their fully insured Plans soon after the DOL published the proposed new rules for MHPAEA.

BCBSNC Fully insured language now states:

"Nutritional Counseling 30 visits. Visit limits do not apply to MENTAL ILLNESS diagnosis."

Duke self-funded language states:

"Nutritional Counseling Six visits. Visit limits do apply to MENTAL ILLNESS diagnoses."

Please have Duke's General Counsel review my concerns. The Plan's limitations on Eating Disorder MNT have no lawful basis and should be immediately stopped. This is a medically necessary treatment by a qualified practitioner and in an outpatient setting. My Health Plan covers outpatient mental health benefits that are medically necessary. Trying to get these appointments covered has taken hours of my time advocating to Duke, BCBSNC, and the Department of Labor. I am simply requesting that the medically necessary care I require as someone with an eating disorder be covered in my insurance Plan so that I am able to preserve my health and live a life in recovery.

I request that:

- The Plan covers Eating Disorder MNT (billed under an eating disorder diagnosis code) so long as it is medically necessary.
- The Plan covers Eating Disorder MNT billed under my eating disorder diagnosis code in writing AND in operation.
- The Plan retroactively reimburse denied claims, reimburses claims going forward and

extends any deadlines for claim submission.

- **The Agency forward my entire complaint immediately to the Duke.**
- **The Plan forward the complaint to their general counsel.**
- The Plan complies with 21st Century Cures Act and responds within 30 days to my MHPAEA Comparative Analysis Request in Appendix A.

Thank you for your cooperation in this matter.

Sincerely,

Cecilia Marquez

Mental Health Parity and Addiction Equity Act "MHPAEA."

The Plan is limiting a core component of Eating Disorder treatment and the process used is not comparable to any used for medical/ surgical benefits. MHPAEA, as amended by the Patient Protection and Affordable Care Act "ACA", generally requires that Health Plans offering group or individual health insurance coverage ensure that the financial requirements and treatment limitations on mental health or substance use disorder MH/SUD benefits they provide are no more restrictive than those on medical or surgical benefits. This is commonly referred to as providing MH/SUD benefits in parity with medical/surgical benefits.

Specifically, MHPAEA prohibits health Plans from:

(i) imposing financial requirements (such as deductibles, copayments, co-insurance, and out-of-pocket expenses) on mental health or substance use disorder (MH/SUD) benefits that are more restrictive than the predominant level of financial requirements applied to substantially all medical/surgical benefits;

[4] 29 U.S.C. § 1185a; 42 U.S.C. § 300gg-26; 45 C.F.R. § 146.136(c)(4)(i).

(ii) imposing treatment limitations (such as limits on the frequency of treatment, number of visits, and other limits on the scope or duration of treatment) on mental health or substance use disorder treatment that are more restrictive than the predominant treatment limitations applied to substantially all medical/surgical benefits, or applicable only with respect to mental health or substance use disorder benefits; and

(iii) conducting medical necessity review for mental health or substance use disorder benefits using processes, strategies or standards that are not comparable to, or are applied more stringently than, those applied to medical necessity review for medical/surgical benefits. [4]

Summary of Terms

For purposes of this complaint, "Eating Disorder MNT " will be used to describe the mental health benefit - medically necessary outpatient MNT by a Registered Dietitian " RD" or "RDN" to treat an individual with an eating disorder diagnosis. "Wellness Nutrition" will be used to describe nutrition services which promote healthy lifestyles , weight management or general information on special diets . "Nutrition Services" will be used to describe any service billed under CPT 97802, 97803, 97804 and includes Wellness Nutrition, Eating Disorder MNT and any other MNT service . "Limitation" will be used to identify the various restrictions applied on Eating Disorder MNT (being told not covered, being told it is covered then denied, exclusions, visit limits on some diagnosis but not others, etc.)

Issue 1: Duke's Current Limitation Violates the Proposed New MHPAEA Rules

In August 2023, the federal government published proposed new MHPAEA rules, which will take effect in January 2025. There are two key provisions which are relevant to Duke's MNT limitation. The proposed rule reiterates that failure to provide sufficient coverage for MNT is a violation of MHPAEA.[5]

[5] https://www.federalregister.gov/d/2023-15945/p-361

Under proposed Example 6, a Plan generally covers diagnosis and treatment for eating disorders, a mental health condition, but specifically excludes coverage for nutrition counseling to treat eating disorders, including in the outpatient, in-network classification. Nutrition counseling is one of the primary treatments for eating disorders. The Plan generally provides benefits for the primary treatments for medical conditions and surgical procedures in the outpatient, in-network classification. In this proposed example, the exclusion of coverage for nutrition counseling for eating disorders results in the Plan failing to provide meaningful benefits for the treatment of eating disorders in the outpatient, in-network classification, as determined in comparison to the benefits provided for medical/surgical conditions in the classification. Therefore, the Plan violates the proposed rules in 26 CFR 54.9812-1(c)(2)(ii), 29 CFR 2590.712(c)(2)(ii), and 45 CFR 146.136(c)(2)(ii). The Departments note that, if the Plan covers medical/surgical benefits for nutritional counseling, this Plan would also violate the proposed rules in 26 CFR 54.9812-1(c)(4)(vi), 29 CFR 2590.712(c)(4)(vi), and 45 CFR 146.136 (c)(4)(vi) prohibiting separate NQTLs applicable only to mental health or substance use disorder benefits.

The 2013 final regulations set forth the only classifications of benefits that may be used in applying the parity rules for financial requirements and treatment limitations, and listed specific instances when a Plan or issuer may divide benefits into sub-classifications beyond the six classifications permitted in paragraph (c)(2)(ii)(A) of the 2013 final regulations. Specifically, a Plan (or health insurance coverage) may apply different levels of financial requirements to different tiers of prescription drug benefits based on reasonable factors determined in accordance with the rules in 26 CFR 54.9812-1(c)(4), 29 CFR 2590.712(c)(4), and 45 CFR 146.136(c)(4) and without regard to whether a drug is generally prescribed with respect to medical/surgical benefits or with respect to mental health or substance use

disorder benefits. Additionally, if a Plan or issuer provides benefits through multiple tiers of in-network providers (such as an in-network tier of other preferred providers with more generous cost-sharing than a separate in-network tier of participating providers), the Plan may divide its benefits furnished on an in-network basis into sub-classifications that reflect network tiers, if the tiering is based on reasonable factors determined in accordance with the rules in 26 CFR 54.9812-1(c)(4), 29 CFR 2590.712(c)(4), and 45 CFR 146.136(c)(4) (such as quality, performance, and market standards) and without regard to whether a provider provides services with respect to medical/surgical benefits or mental health or substance use disorder benefits.[147] A Plan or issuer is also permitted to divide its benefits furnished on an outpatient basis into two sub-classifications: (1) office visits (such as physician visits), and (2) all other outpatient items and services (such as outpatient surgery, facility charges for day treatment centers, laboratory charges, or other medical items).[148] These proposed rules at 26 CFR 54.9812-1(c)(2)(ii)(A), 29 CFR 2590.712(c)(2)(ii)(A), and 45 CFR 146.136(c)(2)(ii)(A) would clarify that Plans and issuers may use the permissible sub-classifications under the 2013 final regulations when applying all of the rules for financial requirements and treatment limitations, including NQTLs.

After any of these permissible sub-classifications are established, a Plan or issuer may not impose any financial requirement or quantitative treatment limitation on mental health or substance use disorder benefits in any sub-classification that is more restrictive than the predominant financial requirement or quantitative treatment limitation that applies to substantially all medical/surgical benefits in the sub-classification. These proposed rules would clarify at 26 CFR 54.9812-1(c)(3)(iii), 29 CFR 2590.712(c)(3)(iii), and 45 CFR 146.136(c)(3)(iii) that Plans and issuers are not permitted to divide benefits into any sub-classifications other than

> those specifically permitted under this paragraph. While this proposed amendment would not make any substantive changes to the existing rule, the Departments are proposing to make these regulatory amendments to further reiterate that Plans and issuers are not permitted to sub-divide the classifications other than as described in paragraph (c)(3)(iii).

While a proposed rule is not necessarily reflective of the final rule, the executive agencies are required to consider all submitted comments. The proposed new rule had 9,502 comments, only 4 specifically disagreed with the meaningful benefit component of the proposed rule as applied to Eating Disorder MNT. In contrast, 234 comments explicitly supported the clarification that failure to provide meaningful benefits as seen in the Example 6-MNT for eating disorders- is an MHPAEA violation. Based on this feedback, it is almost certain that this provision will remain in the final proposed rule.

The proposed rule specifically reinforces that Plan Sponsors (Duke), not TPAs (BCBSNC), are responsible for MHPAEA Compliance. [6]

> The Departments are aware that Plans and issuers contract with managed behavioral health organizations (MBHOs), third-party administrators (TPAs), or other service providers to provide or administer mental health or substance use disorder benefits.152 The preamble to the 2013 final regulations notes that the fact that an employer or issuer contracts with one or more entities to provide or administer mental health or substance use disorder benefits or other benefits does not relieve the employer, issuer, or both of their obligations under MHPAEA.152 78 FR 68239, 68250 (Nov. 13, 2013).

The proposed rule requires Plan Sponsors to include a certification by a fiduciary stating that the comparative analysis is in compliance with the content

---

[6] https://www.federalregister.gov/d/2023-15945/p-375

requirements indicated below. Duke, not BCBSNC, will be liable if the comparative analysis fails to comply with required content requirements. [7]

> Finally, for Plans subject to ERISA, the comparative analysis would be required to include a certification by one or more named fiduciaries who have reviewed the analysis, stating whether they found the comparative analysis to be in compliance with the content requirements of these proposed rules. This requirement, along with the requirement that the Plan provide named fiduciaries with a written list of all NQTLs and a general description of any existing documentation relied on by the Plan or issuer in preparing the comparative analysis for each NQTL, would help ensure that Plan fiduciaries meet their obligations under ERISA to review the comparative analyses and properly monitor their Plans for compliance with MHPAEA.
>
> The Departments emphasize that the proposed requirement to include this information on the factors, evidentiary standards, and sources used to design or apply the NQTL is crucial to understanding whether the NQTL complies with MHPAEA's requirements. Plans and issuers must disclose information as required by MHPAEA to participants and beneficiaries, as well as the Departments, regardless of whether such information is "proprietary" and/ or has "commercial value."] Similarly, if finalized, Plans and issuers must include all information required in the comparative analyses.

Issue 2: The Plan is using a vaguely defined limitation for a complimentary benefit (Wellness Nutrition) to restrict an otherwise covered essential mental health benefit (Eating Disorder MNT).

Medically Necessary Eating Disorder MNT Is Clinically Different from Wellness Nutrition

A limitation on Wellness Nutrition should not apply to Eating Disorder MNT. There appears to be bonafide confusion as to the definition of Eating Disorder MNT. As a result, the

[7] https://www.federalregister.gov/d/2023-15945/p-419

Plan is incorrectly interpreting the Plan Documents to restrict Eating Disorder MNT even when medically necessary. A clarification of appropriate terminology, and benefit designation, is essential before even applying a MHPAEA analysis. The limited choice of CPT codes for any service provided by a Registered Dietitian exacerbates the confusion regarding nutrition services to **prevent** disease and nutrition services to **treat** a disease.

According to the Academy of Nutrition and Dietetics:

Medical Nutrition Therapy "MNT"	nutritional diagnostic, therapy, and counseling services for the purpose of disease management which are furnished by a registered dietitian or nutrition professional.
Nutrition Intervention	purposefully Planned action intended to positively change a nutrition-related behavior, environmental condition, or aspect of health status for an individual (and his/her family or caregivers), target group, or the community at large.
Nutrition Counseling	supportive process, characterized by a collaborative counselor– patient/client relationship. Counseling integrates information obtained from nutrition assessment and diagnostic processes to establish food, nutrition and physical activity priorities, goals, and action Plans and empowers individuals and groups to take responsibility for self-care to treat an existing disease and/or condition and promote health.
Nutrition education	The formal process to instruct or train

	patient(s)/client(s) in a skill or to impart knowledge to help patient(s)/client(s) voluntarily manage or modify food choices and eating behavior to maintain or improve health.

In this situation, there are clear distinctions between Wellness Nutrition and Eating Disorder MNT.

Wellness Nutrition	**Eating Disorder Medical Nutrition Therapy**
Is a medical/surgical benefit because it is used to address a physical health condition	Is a mental health benefit because it is used to treat a mental health condition
Patient may not have a medical or mental health diagnosis	Patient is diagnosed with an eating disorder and/or one or more medical or mental health diagnoses
Is NOT a treatment for a covered condition	Is treatment for a covered condition
Often does NOT meet the definition of medically necessary	Does meet the definition of medically necessary
Often used to prevent disease	Is used when a person already has the condition
Is NOT an essential or standard of care treatment for a covered health condition	Is an essential and standard of care treatment for a covered health condition
Is more consistent with the definition of “wellness coaching” or “nutrition education” - “Reinforcement of basic or essential nutrition-related knowledge”	Is NOT nutrition education and is a nutritional diagnostic, therapy, and counseling services for the purpose of **disease management**

Is a general health promoting or complimentary benefit to beneficiaries	Is specifically tailored to address the individual's unique circumstances and psychological barriers
Often does NOT include psychological processes	Often incorporates psychological processes like Cognitive Behavioral Therapy.
Follow up sessions are often monthly or less	Follow up sessions are often weekly
Follow up sessions are generally 15-30 minutes, or CPT 97803 x1, or CPT 97803 x2	Follow up sessions are more in line with traditional therapy, approximately 45 minutes, or CPT 97803 x 3
Does NOT have a naturally occurring end point	Naturally stops when the treatment is no longer medically necessary
Is NOT a required component of accreditation for disease management at higher levels of care	Is a required component of accreditation for eating disorder treatment at higher levels of care

Plans (and regulators) often use the terms “nutrition therapy” or “nutritional counseling” without providing further clarification as to the term’s formal definition. Clinically appropriate terminology is not being utilized. In many circumstances, the terms “nutritional counseling,” “nutrition for weight management” or even “MNT” are used incorrectly to describe “Wellness Nutrition”services. This sloppy use of language contributes to unlawful limitations on medically necessary Eating Disorder MNT

Eating Disorder MNT Qualifies as an Essential Health Benefit Under the ACA

Wellness Nutrition does not meet the definition of an Essential Benefit, but Eating Disorder MNT does. The Affordable Care Act “ ACA” has identified 10 categories of essential benefits which must be included in a non-grandfathered Health Plan. Mental health services are one of the essential benefit categories under the “ ACA.”MHPAEA defines “mental health

benefits" as benefits with respect to items or services for mental health conditions, as defined under the terms of the Plan or health insurance coverage and in accordance with applicable Federal and State law, which must be defined to be consistent with generally recognized independent standards of current medical practice[8].

Eating disorders are mental health conditions and thus the treatment of an eating disorder(including Eating Disorder MNT) is a mental health service. On the other hand while some Wellness Nutrition may qualify as a mandated Preventive Care benefit, it does not meet the definition of an essential benefit.

Eating Disorder MNT Meets the Plan's Definition for a Covered Mental Health Benefit and Wellness Nutrition Often Does Not

A Plan generally does not need to cover a specific outpatient service unless it is an essential service, meets the definition of an outpatient service by a qualified practitioner, and is recommended for treatment for a covered health condition that is medically necessary.

Eating Disorder MNT is consistent with the Plan's definition of a covered benefit because:

- The Plan covers the ACA essential benefits, which includes mental health benefits.
- Eating disorders are mental health conditions and therefore treatment of an eating disorder is a "mental health benefit" within the meaning of that term as defined by MHPAEA.
- Eating Disorder MNT is a service utilized to treat this mental health condition and therefore is a mental health benefit.
- The Plan does not exclude coverage for Eating Disorders.
- Eating Disorder MNT meets the Plan's definition for outpatient visit . As an outpatient mental health benefit, it also meets the definition of a covered benefit because the Plan explicitly includes coverage for outpatient mental health services.

[8] https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQ-Part-38.pdf)

- The practitioner, a registered dietician, meets the Plan's definition of qualified practitioner
- Eating Disorder MNT is recommended to treat this covered health condition.
- Eating Disorder MNT meets the Plan's definition of medically necessary.
- On the contrary, Wellness Nutrition is generally seen as a health promoting service. Since it may not always fall under a Plan's definition of a covered benefit, many Plans- including this one- have elected to offer it to beneficiaries. The Plan is disregarding the very distinct differences between these two types of nutrition based services.

Eating Disorder MNT is medically necessary[9]

In this case, Eating Disorder MNT meets the Plan's requirements as medically necessary. It is incorrect to state that Eating Disorder MNT is not a covered benefit because it is not listed specifically in the policy.[10]. Eating Disorder MNT is medically necessary because it is clinically appropriate and required for the management of the condition. The health of the insured would be adversely affected if the service was not provided. Failure to obtain appropriate Eating Disorder MNT can result in continued eating disorder behaviors that can cause severe cardiac, metabolic, skeletal, pulmonary, digestive and other acute and chronic injuries that can become life-threatening and cause death.

The service is being provided in accordance with generally-accepted standards of medical practice. Eating Disorder MNT by Registered Dietitians is evidence-based and

---

[9] The National Association for Insurance Commissioners "NAIC" provides a general definition for "medical necessity." These are services that are:

- provided for the diagnosis, treatment, cure, or relief of a health condition, illness,injury, or disease; and except for clinical trials that are described within the policy, not for experimental, investigational, or cosmetic purposes;
- necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease or its symptoms;
- within the generally accepted standards of medical care in the community; and/or not solely for the convenience of the insured, the insured's family or the provider.

[10] The policy does not list every type of service which is covered for every single medical condition. For example, the Plan does not state that immunotherapy is a covered benefit for the treatment of cancer, or that a consultation with a gastroenterologist for diverticulitis is a covered benefit. These services are simply included in coverage when they are medically necessary, consistent with standard of care treatment, in the appropriate setting and provided by a qualified provider.

recommended by the Academy of Nutrition and Dietetics, the American Psychiatric Association, the American Psychological Association, the International Association of Eating Disorder Professionals, and other professional organizations as appropriate and necessary for the treatment of eating disorders.

This treatment is not for patients' convenience, and there are no other less costly alternatives. Outpatient office visits are the least intensive form of Eating Disorder MNT. Given this information, medically necessary outpatient Eating Disorder MNT by a Registered Dietitian in an office setting unequivocally fits the definition of a covered service

MNT is Standard of Care Treatment for Eating Disorders

Evidence-based medical guidelines confirm the important role of Medical Nutrition Therapy provided by a Registered Dietitian in the treatment of eating disorders.

The American Psychiatric Association's (APA) Practice Guideline for the Treatment of Patients with Eating Disorders: Medical Nutrition Therapy provided by a Registered Dietitian is an empirically supported component of effective treatment.
Academy of Nutrition and Dietetics: Medical Nutrition Therapy provided by a Registered Dietitian is an essential component of team treatment of patients with anorexia nervosa, bulimia nervosa, and other eating disorders (EDs) during assessment and treatment across the continuum of care. Registered Dietitians are integral and uniquely qualified to provide Medical Nutrition Therapy for the treatment of eating disorders, normalization of eating patterns and nutritional status.
The International Association of Eating Disorders Professionals: Individuals with eating disorders being treated in the outpatient setting are recommended to see a

[11] See Attachment for references and additional support

Registered Dietitian for Medical Nutrition Therapy at least once per week. “As the patient improves, the frequency of the sessions will vary.”

Outpatient

- Specific considerations for the RD’s role at this level of care:
- Communication with the previous care team. If this is the first point of contact, coordinate new treatment team with local professionals trained in ED treatment
- Well-coordinated transition of meal Plan, supplementation and nutritional goals if patient is stepping down from higher level of care.
- Adjustment of nutritional goals to meet level of supervision and medical management in present environment
- Assistance in recognizing potential vulnerabilities presented within this environment for the individual patient and Plans for relapse prevention
- **Continuous assessment for appropriateness of environment for patients needs**
- **Flexibility with nutrition intervention which may include multiple individual sessions weekly and close monitoring, but typically 1 to 2 sessions per week initially**
- Close collaboration with attending physician and therapist, altering nutritional intervention as needed
- Communication with the family/participation in family sessions as appropriate
- Attention to the individual patients in helping them focus on their recovery goals and expectations, with the eventual goal of normalized eating
- Weight and behavior monitoring of patient
- Routine, consistent communication with treatment team regarding patient progress
- Management of the patient’s case, since often the RD acts as a “health navigator” in the outpatient

setting, by making sure communications occur between team members, educating patients and families about next steps and treatment options, and ensuring patients have continuous access to necessary treatment. This case management task is an appropriate role for RDs considering their training in both physical/medical and behavioral realms.[11]

The Limitations Should Be Struck Under the Contra Proferentem Rule and Reasonable Expectations Doctrine

Any exclusion or limitation applied to Eating Disorder MNT should be struck as unenforceable because it is ambiguous. It should also be struck because a reasonable individual purchasing a policy which covers mental health treatment would expect that medically necessary Eating Disorder MNT is covered.

The contra proferentem rule provides that if there is an ambiguity in the language of an insurance contract, courts may strictly construe the language against the insurer. Here, the Plan is using an undefined term to encompass very different categories of benefits. It is extremely ambiguous as to what it actually pertains to especially since the context appears to relate to Wellness Nutrition.

The Reasonable Expectations Doctrine refers to the principle that an insurance policy should be interpreted in accordance with the terms the policyholder thought it was purchasing, even if that interpretation is contrary to the plain terms of the policy. Eating disorder treatment falls under the category of essential mental health benefit.Any reasonable person would assume that a Plan offering mental health benefits would appropriately cover the integral services used for Eating Disorder Treatment. A reasonable person would not expect the Plan to arbitrarily restrict outpatient Medical **Nutrition** Therapy Treatment for **Eating** Disorders. Indeed, the primary reason that Eating Disorders are so fatal ,and MNT is an essential component of treatment, is because of the complex dynamic with **nutrition.**.

Issue 3: The Plan is not complying with MHPAEA classification rules. They incorrectly claim that Eating Disorder MNT is not a mental health benefit and a limitation is parity compliant because it applies to all benefit

All Treatments for Eating Disorders Is Subject to MHPAEA Even If the Service Is Administered by a Plan's Medical/ Surgical Department

Eating disorders are mental health disorders conditions, and **treatment of an eating disorder is a mental health benefit** within the meaning of that term as defined by MHPAEA[12]. For example, Section 13007 of the Cures Act provides that if a Plan or an issuer provides coverage for eating disorders, including residential treatment, they must provide these benefits in accordance with the requirements under MHPAEA.

Medical/surgical benefits means benefits with respect to items or **services for medical conditions** or surgical procedures

Mental health benefits means benefits with respect to items or **services for mental health conditions**

There are numerous publications by the federal government which indicate that because Eating Disorder MNT is a mental health benefit, unreasonable limitations violate MHPAEA. *See Appendix B.*

In this situation, the Plan incorrectly states that Eating Disorder MNT is not a mental health benefit. A Plan's **choice** to administer benefits from different departments is irrelevant on how benefits **MUS**T be categorized for MHPAEA purposes. It is the Plan's responsibility to coordinate with their different departments and ensure that the administration of **ALL** mental health benefits are MHPAEA compliant.

MHPAEA Provides Acceptable Classification of Benefits[13]

[12] *See ACA Implementation FAQs Part 38, Q1, available at* https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-38.pdf.

A Plan cannot just create their own classification of benefits for MPHAEA analysis purposes and must designate Eating Disorder MNT to the appropriate category . Under MHPAEA regulations, the six classifications of benefits are:

1) inpatient, in-network;

2) inpatient, out-of-network;

3) outpatient, in-network;

4) outpatient, out-of-network;

5) emergency care; and

6) prescription drugs[14].

In determining the classification in which a particular benefit belongs, a group health Plan or group or individual market health insurance issuer must apply the same standards to medical/surgical benefits as to MH/SUD benefits.[15] A Plan or issuer must also comply with MHPAEA's nonquantitative treatment limitations (NQTL) rules in assigning any benefits to a particular classification. [16]

MNT Treatment Is Not an Appropriate Sub-classification and Must Be Designated as Either Office Visits; or All Other Outpatient Items and Services

The Plan cannot just decide that an acceptable category for comparison purposes is their undefined term which encompasses any service by an RD. For purposes of determining parity for outpatient benefits (in-network and out-of- network), a Plan or issuer may divide its benefits furnished on an outpatient basis into two sub-classifications: (1) office visits; and (2) all other outpatient items and services, for purposes of applying the financial requirement and treatment limitation rules. [17]

---

[13]https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/self-compliance-tool.pdf

[14] *See 26 CFR 54.9812-1(c)(2)(ii), 29 CFR 2590.712(c)(2)(ii), 45 CFR 146.136(c)(2)(ii).*

[15] See 26 CFR 54.9812-1(c)(2)(ii)(A), 29 CFR 2590.712(c)(2)(ii)(A), 45 CFR 146.136(c)(2)(ii)(A)

[16] See 26 CFR 54.9812-1(c)(4), 29 CFR 2590.712(c)(4), 45 CFR 146.136(c)(4).

[17] 26 CFR 54.9812-1(c)(3)(iii); 29 CFR 2590.712(c)(3)(iii) 45 CFR 146.136(c)(3)(iii).

After the sub-classifications are established, the Plan or issuer may not impose any financial requirement or QTL on MH/SUD benefits in any sub-classification (i.e., office visits or non-office visits) that is more restrictive than the predominant financial requirement or treatment limitation that applies to substantially all medical/surgical benefits in the sub-classification using the methodology set forth in the final rules. [18]

Other than as explicitly permitted under the final rules, sub-classifications are not permitted when applying the financial requirement and treatment limitation rules under MHPAEA. Accordingly, separate sub-classifications for generalists and specialists are not permitted**. The six classifications and the subclassifications outlined above, are the only classifications that may be used when determining the predominant financial requirements or QTLs that apply to substantially all medical/surgical benefits.** [19]

Issue 4: The Plan's visit limitation on Eating Disorder MNT fails MHPAEA's Quantitative Treatment Limit " QTL" Test.

Quantitative Treatment Limits

The Plan's Limitation on Eating Disorder MNT is a QTL since it restricts the number of visits a patient has coverage for. A Plan cannot have treatment limits on MH/SUD that are more restrictive than the predominant financial requirement or quantitative limit applied to substantially all medical benefits. Types of QTLs include annual,episode,and lifetime day and visit limits,for example, number of treatments, visits, or days of coverage. [20]

To determine compliance, each type of financial requirement or QTL within a coverage unit must be analyzed separately within each classification.[21] The Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA)[22] provides the following process for assessing QTLs:

---

[18] *See 26 CFR 54.9812-1(c)(3)(i), 29 CFR 2590.712(c)(3)(i), 45 CFR 146.136(c)(3)(i), and 45 CFR 146.136(c)(3)(iii).*

[19] See 26 CFR 54.9812-1(c)(2)(ii), 29 CFR 2590.712(c)(2)(ii), 45 CFR 146.136(c)(2)(ii)

[20] *See 26 CFR 54.9812-1(c)(1)(ii), 29 CFR 2590.712(c)(1)(ii), 45 CFR 146.136(c)(1)(ii).*

[21] *See 26 CFR 54.9812-1(c)(2)(i), 29 CFR 2590.712(c)(2)(i), 45 CFR 146.136(c)(2)(i)*

[22] https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/self-compliance-tool.pdf

Step One ("substantially all" test): First determine if a particular type of financial requirement or QTL applies to substantially all medical/surgical benefits in the relevant classification of benefits.
Step Two ("predominant" test): If the type of financial requirement or QTL applies to at least two-thirds of medical/surgical benefits in that classification, then determine the predominant level of that type of financial requirement or QTL that applies to the medical/surgical benefits that are subject to that type of financial requirement or QTL in that classification of benefits. (Note: If the type of financial requirement or QTL does not apply to at least two-thirds of medical/surgical benefits in that classification, it cannot apply to MH/SUD benefits in that classification.) [23]

A Limitation on Eating Disorder MNT Fails the QTL test

In order for a quantitative limitation to be permissible on a mental health benefit it would need to pass the 2 part QTL test. Step 1 indicates that the limit would need to apply to at least 2/3rd of all benefits in the same category on the medical/ surgical side. In this situation, a visit limit that applies universally to Nutrition Services for both M/S and MH/SUD does not pass the QTL test . Nutrition Services is not a permissible subcategory under MHPAEA. The only appropriate category for Nutrition Services is under the outpatient classification . In order to conduct Part 1 of the QTL test, we need to see if 2/3rds of all outpatient medical/surgical benefits also had a visit limit. One only needs to scan the Plan terms to realize the limitation would fail this test- there is no visit limit on 2/3rd of all outpatient medical/surgical benefits .

Issue 5: The Plan's restrictions on Eating Disorder MNT fails MHPAEA's Nonquantitative Treatment Limit " NQTL '' Test.

Non-Quantitative Treatment Limits "NQTL"

Numerous NQTL's are being used in restricting Eating Disorder MNT. Every one of these restrictions violate MHPAEA in writing and in operation. An NQTL is generally a limitation on the

[23] See 26 CFR 9812-1(c)(3)(i)(A), 29 CFR 2590.712(c)(3)(i)(A), 45 CFR

scope or duration of benefits for treatment. The MHPAEA regulations prohibits a Plan from imposing NQTLs on MH/SUD benefits in any classification unless, under the terms of the Plan or coverage as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits in a classification are comparable to, and are applied no more stringently than, those used in applying the limitation with respect to medical/surgical benefits in the same classification. [24]

A 6-Step test[25] has been identified as a guide to help determine parity in the creation of an NQTL. If these factors are utilized, they must be applied comparably to MH/SUD and medical/surgical benefits.

● Provide the specific Plan language regarding the NQTL and describe all services to which it applies in each respective benefits classification.
● Identify the factors and the source for each factor used to determine that it is appropriate to apply this NQTL to MH/SUD benefits. Some examples include, ● Excessive utilization; ● Recent medical cost escalation; ● Provider discretion in determining diagnosis; ● Lack of clinical efficiency of treatment or service; ● High variability in cost per episode of care; ● High levels of variation in length of stay; ● Lack Of Adherence To Quality Standards; ● Claim types with high percentage of fraud;

[24] *See 26 CFR 54.9812-1*(*c)(4)(i), 29 CFR 2590.712(c)(4)(i), 45 CFR 146.136(c)(4)(i).*

[25]https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/rules-and-regulations/public-comments/faq-38/00018.pdf

- Identify and provide the source for the evidentiary standard for each of the factors identified in Step 2 and any other evidence relied upon to design and apply the NQTL. *Examples of sources of factors include, but are not limited to:*
  - Internal claims analysis;
  - Medical expert reviews;
  - State and Federal requirements;
  - National accreditation standards;
  - Evidentiary standards, including any published standards as well as internal Plan or issuer standards, relied upon to define the factors triggering the application of an NQTL to benefits.

- Provide the comparative analyses used to conclude that the NQTL is comparable to and no more stringently applied, as written.

- Provide the comparative analyses used to conclude that the NQTL is comparable to and no more stringently applied, in operation.

- Detailed summary explanation of how the analyses of all of the specific underlying processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits and to medical/surgical benefits have led the Plan to conclude compliance with MHPAEA.

Appendix A of this letter is a formal MHPAEA Document Request asking for the Plan's process and support in applying the following NQTLs to Eating Disorder MNT.

- medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;

The Plan's medical management standards uniquely Limit Eating Disorder MNT. This is a standard of care treatment for a covered health condition. It should just be seen as any other outpatient office visit by a qualified practitioner. However, the Plan has decided that Eating Disorder MNT for some reason should be treated differently.

Even if it was permissible to have a Limitation on Nutrition Services, the standards used are not applied in parity for Eating Disorder MNT . While the Plan's Limitation may be consistent with standard of care recommendations for certain physical health conditions, it most certainly is not consistent with guidance for eating disorders. It is a parity violation to use standard of care guidance to establish a visit limit on a physical health benefit but not also use standard of care guidance in establishing a mental health visit limit. For example, a visit limit or exclusion for psychotherapy (even if applied to medical / surgical) would clearly be seen as a violation if it was only based on physical health standard of care guidelines but not mental health.

Here the Plan's treatment of Eating Disorder MNT is at complete odds with any professional recommendation. The Plan will not be able to identify any other standard of care treatment on the M/S side where clinical recommendations are disregarded to this same extent.

- Exclusions of specific treatments for certain conditions

The exclusion of Eating Disorder MNT violates MHPAEA because the processes used to Limit this component of Eating Disorder treatment are not in parity with processes used to Limit treatments on M/S side.

The Plan covers mental health conditions and does not explicitly exclude Eating Disorders. Health Plans can exclude all treatments and services related to a particular MH/SUD condition. But if a Plan covers a MH/SUD condition in any classifications, it must provide coverage in all of

the classifications in which M/S benefits are available. In determining what services a Plan will ultimately cover in each classification , the same standards and procedures must apply to treatments for MH/SUD conditions and M/S conditions.

In this case, the Plan covers mental health conditions and covers all levels of care including outpatient. However, they chose to arbitrarily Limit Eating Disorder MNT- an essential, cost efficient and undisputed component of Eating Disorder treatment.

In most circumstances if a Plan questions the efficiency of a service which otherwise fits the terms of the Plan (outpatient office visit by qualified practitioner for a covered benefit) they deny the claim as experimental. These denials give a beneficiary the opportunity to submit evidence or request an external review. By simply excluding this service/ having a hard visit limit, individuals have no real appeal rights or review. They are unable to request an external review since an exclusion is not deemed a medical decision. As a result they have limited administrative remedies. This policy is uniquely applied to Eating Disorder MNT . There are no other standard of care outpatient office visits for a covered health condition listed in the exclusions/that have clinically inappropriate visit limits.

The exclusion/ limitation for Eating Disorder MNT also violates MHPAEA because the Plan covers Nutrition Services for Preventative Care and Diabetes using reasonable medical management techniques to determine any coverage limitations . The Plan may claim that these services are unique because under Section 2713 of the ACA, private health Plans must provide coverage for a range of recommended preventive services. This is not a sufficient justification. The text of Section 2713 does not mention , yet along mandate Nutrition Services. Instead it requires coverage without cost sharing for certain evidence based services , or screenings. The required preventive services come from recommendations issued by four expert medical and scientific bodies.

It states in part that a Plan is required to cover:

Evidenced-based items or services that have in effect a rating of “A” or “B” in the current recommendations

[26] See 26 CFR 54.9815-2713T(a)(4), 29 CFR 2590.715-2713(a)(4), 45 CFR 147.130(a)(4)(7)

of the United States Preventive Services Task Force (USPSTF) with respect to the individual involved;

…

When the manner a recommendation or guideline does not specify the frequency, method, treatment, or setting for the provision of that service, the Plan or issuer can use reasonable medical management techniques to determine any coverage limitations[26].

Compliance with Section 2713 is no different than compliance with MHPAEA. In both circumstances, the government is directing a Plan to cover services that are clinically recommended. Section 2713 is directing the Plan on how to determine coverage for preventative benefits and MHPAEA is directing the Plan on how to determine coverage for mental health benefits.

- The Plan has restrictions on applicable provider billing codes and on, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the Plan or coverage.

The Plan's Limitation on outpatient Eating Disorder MNT is an NQTL violation because the Plan will cover the treatment at a higher level of care. The Plan explicitly covers inpatient and outpatient mental health care services, including but not limited to residential, partial hospitalization program services and intensive outpatient program services, relating to the diagnosis and treatment of mental, nervous and emotional disorders.

For eating disorders, residential, partial hospitalization and intensive outpatient programs universally include meal support and medical nutritional therapy. In fact, the Joint Commission requires the inclusion of these services in order for a facility to be accredited.[27]

There is no circumstance on the medical/ surgical side where a covered treatment at a higher level of care would not be covered if it can be provided effectively at a lower level. This is an NQTL restriction on facility type that limits scope or duration of benefits for services.

The refusal to cover Eating Disorder MNT (97802-97804) as a mental health benefit, or credentialing an RD as a mental health provider, is a restriction on provider specialty that limits scope or duration of benefits for services. The Plan is discriminating against this type of provider and service. According to the Academy of Nutrition and Dietetics, Medical nutrition therapy is a medical treatment. Like other medical treatments provided by non-physician practitioners, registered dietitian nutritionists generally can practice MNT because of licensure and certification laws which provide authority for RDNs to provide this medical service.

Psychiatrists- normally a MH/SUD provider- use Evaluation and Management "E/M" CPT codes which are also used for medical/ surgical services. Primary care physicians- normally a medical/ surgical provider - are permitted to bill for mental health codes (CPT 90832-90838). There is no evidence to support why the Plan will not administer MNT as both medical/ surgical AND MH/SUD services (since they allow this to occur with E/M codes). Or why an RD cannot be credentialed as both a medical/ surgical AND MH/SUD provider (as MDs are permitted).

Even if a Plan is compliant with parity in writing it fails the NQTL test if it is not compliant if IN OPERATION

CONCLUSION:

The Plan's inequitable restrictions on Eating Disorder MNT either reflects ignorance as to this treatment , or a complete indifference to the requirements under MHPAEA. There is no justification why medically necessary Eating Disorder MNT should be covered in a manner different from any other medically necessary treatment by a qualified practitioner . The denial of Eating Disorder MNT in this case is a clear violation of parity. Given that the claims are

[27] https://www.jointcommission.org/-/media/enterprise/tjc/imported-resource-assets/documents/approved_new_req_residential_outpatient_eating_disorderpdf.pdf?db=web&hash=3EA65359BD16E79B472F0F5BE8ECD35E

medically necessary and not subject to any lawful limitation from the policy, I respectfully respect that the denial be immediately reversed. Even if the service was excluded from the policy, it should be struck down as a violation of parity since MNT is covered for other health conditions using reasonable medical management techniques to determine any coverage limitations.

Appendix A

Request for MHPAEA Compliance Documents or Plan Instruments

Under ERISA section 104(b), participants and beneficiaries may request documents and Plan instruments regarding whether the Plan is providing benefits in accordance with MHPAEA and copies must be furnished within 30 days of request.

This may include documentation that illustrates how the health Plan has determined that any financial requirement, QTL, or NQTL is in compliance with MHPAEA. For example, participants and beneficiaries may ask for:

- An analysis showing that the Plan meets the predominant/substantially all tests. The Plan may need to provide information regarding the amount of medical/surgical claims subject to a certain type of QTL, such as a co-payment, in the prior year in a classification or its basis for calculating claims expected to be subject to a certain type of QTL in the current Plan year in a classification, for purposes of determining the Plan's compliance with the predominant/substantially all tests.

- Information regarding factors, such as cost or recommended standards of care, that are relied upon by a Plan for determining which medical/surgical or MH/SUD benefits are subject to a specific requirement or limitation. These might include references to specific related factors or guidelines, such as applicable utilization review criteria;

- A description of the applicable requirement or limitation that the Plan believes has been used in any given MH/SUD service adverse benefit determination (ABD) within the relevant classification;

This process is also available to individuals who are enrolled in coverage that is not through a private employer health Plan—for example, if they have individual health coverage or coverage sponsored by a public sector employer, like a city or state government.

I am requesting information concerning the Plan's treatment limitations related to coverage for:
Medically Necessary Medical Nutrition Therapy (97802, 97803,97804) for Eating Disorders by a RD

I was notified that a claim for coverage of treatment for my eating disorder was, or may be, denied or restricted because Medical Nutrition Therapy (97802, 97803) for eating disorders has a visit limit/ is not a covered benefit for my condition.

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

CLARIFICATION OF LIMIT

- **Provide the definitions of the terminology used in Plan documents and in operation to describe services by an RD.**
- **What evidence or guidance was used in creating these definitions?**
- **What evidence or guidance was used to support that this definition is clinically appropriate to describe MNT services as used to treat eating disorders?**
- **If it is determined this definition does not appropriately describe MNT treatment for eating disorders , what is the reason(and supporting evidence)that this service should be treated differently from any other medically necessary outpatient treatment by a qualified provider,**
- **Clarify if the exclusions/ limitations being applied in operation to Eating Disorder MNT were intended to exclude/limit them.**

General Request	**Clarification of Request as it Applies to Eating Disorder MNT**
	For outpatient in network office benefits:

1. Provide the specific Plan language regarding the limitation and identify all of the medical/surgical and mental health and substance use disorder benefits to which it applies in the relevant benefit classification;	● **Identify all of the medical/surgical and MH/SUD disorder benefits where medically necessary treatment for a covered health condition by a qualified provider in the lowest level of care is subject to a visit limit or is excluded**
2. Identify the factors used in the development of the limitation (examples of factors include, but are not limited to, excessive utilization, recent medical cost escalation, high variability in cost for each episode of care, and safety and effectiveness of treatment)	● **Identify the factors which led to your limitation on medically necessary Eating Disorder MNT.** ● **Identify the factors which led you to single out MNT treatment (97802/97803/97804) as a unique service and not an outpatient office visit by a qualified provider used to treat a covered mental health condition.** ● **Is there evidence that Eating Disorder MNT is not safe or appropriate ?** ● **Is there evidence that Eating Disorder MNT has a high likelihood for fraud?** ● **Is there evidence that supports why MNT for eating disorders should not be covered as an outpatient benefit when it is a required component of any higher level of care**

	treatment?
3. Identify the evidentiary standards used to evaluate the factors. Examples include, but are not limited to, the following: ● Excessive utilization as defined by two standard deviations above average utilization per episode of care; ● Recent medical cost escalation as defined by medical costs for certain services increasing 10% or more per year for 2 years; ● High variability in cost per episode of care as defined by episodes of outpatient care being 2 standard deviations higher in total costs than the average cost per episode 20% or more of the time in a 12-month period; and ● Safety and efficacy of treatment modality as defined by 2 random clinical trials required to establish a treatment is not experimental or investigational;	● **What supporting evidence justifies this unique treatment and limitation on medically necessary MNT treatment for an eating disorder.** ● **Please provide a description, credentials and selection of medical experts consulted in creating this benefit limit** ****Please note that the number of claims submitted, or appealed, with an eating disorder diagnosis code and MNT code is not an appropriate measure of clinical need. Restrictions often reduce the number of claims submitted.**
4. Identify the methods and analysis used in the development of the limitation;	● **Identify what evidence or methods was relied on to pick this specific number of visits / entirely exclude 97802/97803/97804 for eating disorders**
● 5. Provide any evidence and	

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

Appendix B.

Government Guidance on Eating Disorder MNT

U.S. Departments of Labor, Health and Human Services, Treasury issue 2022 Mental Health Parity and Addiction Equity Act Report to Congress ***Report shows failures to deliver parity in mental health, substance-use disorder benefits***	The report cites specific examples of health Plans and health insurance issuers failing to ensure parity. For example, a health insurance issuer covered nutritional counseling for medical conditions like diabetes, but not for mental health conditions such as anorexia nervosa, bulimia nervosa and binge-eating disorder.

2022 MHPAEA Report to Congress	Pg 13 " following is a list of the most common NQTLs for which EBSA requested a comparative analysis, listed in descending order of frequency… 10. Nutritional counseling limitations." Pg 19 These initial determination letters involved the following NQTLs that were not applied in parity for MH/SUD benefits: …exclusion of nutritional counseling for MH/SUD conditions."Pg 22 **Example #3 – Removal of Nutritional Counseling Exclusion for MH/SUD Conditions** Two large Plans using similar fully-insured products (an exclusive provider organization (EPO) product and a preferred provider organization (PPO) product) offered by the same health insurance issuer covered nutritional counseling for medical/surgical conditions like diabetes, but not for mental health conditions like anorexia nervosa, bulimia nervosa, and binge-eating disorder. EBSA's New York Regional Office requested comparative analyses for the nutritional counseling limitation from both Plans and directly from the issuer offering the fully-insured products used by the Plans. The responses received from the Plans and the issuer did not explain or demonstrate that the facially-discriminatory exclusion, which affected only MH benefits, was compliant with parity requirements. As a result, both Plans have amended their coverage documents to remove the exclusion, and the issuer is in the process of

	submitting forms to state regulators to remove the NQTL from the fully- insured products.
Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs	Pg 12 MH benefits are defined as benefits for items and services for *mental health conditions* (similarly, SUD benefits are defined as benefits for items and services for *substance use disorders*). *Example*: State Y has identified the DSM-V as the basis for defining benefits as MH/SUD and therefore defines anorexia as a mental health condition for purposes of parity compliance. Therefore, state Y must treat nutritional counseling as a mental health benefit when it is delivered for treatment of anorexia, regardless of the nature of the service or the provider delivering the service.
CMS Fact Sheet	21st Century Cures Act confirms that eating disorder treatment is considered a mental health benefit for parity analysis purpose
21st Century Cures Act	13007. CLARIFICATION OF EXISTING PARITY RULES. If a group health Plan or a health insurance issuer offering group or individual health insurance coverage provides coverage for eating disorder benefits, including residential treatment, such group health Plan or health insurance issuer shall provide such benefits consistent with the requirements of section 2726 of the Public Health Service Act (42 U.S.C. 300gg–26), section 712 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185a), and section 9812 of

	the Internal Revenue Code of 1986.
NY Attorney General Assurance of Discontinuance against Cigna (January 2014)	New York's attorney general on Wednesday announced a settlement with Cigna Corp. after investigating claims of disparate treatment. The insurer had limited coverage for mental health patients who received nutritional counseling when patients with other clinical maladies were not limited in receiving the same services.
Requirements Related to the Mental Health Parity and Addiction Equity Act EBSA-2023-0010-000	Pg 51588 Under proposed Example 6, a plan generally covers diagnosis and treatment for eating disorders, a mental health condition, but specifically excludes coverage for nutrition counseling to treat eating disorders, including in the outpatient, in-network classification. Nutrition counseling is one of the primary treatments for eating disorders. The plan generally provides benefits for the primary treatments for medical conditions and surgical procedures in the outpatient, in-network classification. In this proposed example, the exclusion of coverage for nutrition counseling for eating disorders results in the plan failing to provide meaningful benefits for the treatment of eating disorders in the outpatient, in-network classification, as determined in comparison to the benefits provided for medical/surgical conditions in the classification. Therefore, the plan violates the proposed rules in 26 CFR 54.9812-1(c)(2)(ii), 29 CFR 2590.712(c)(2)(ii), and 45 CFR 146.136(c)(2)(ii). The Departments note that, if the plan covers medical/surgical benefits for nutritional counseling, this plan would also

	violate the proposed rules in 26 CFR 54.9812-1(c)(4)(vi), 29 CFR 2590.712(c)(4)(vi), and 45 CFR 146.136 (c)(4)(vi) prohibiting separate NQTLs applicable only to mental health or substance use disorder benefits.

Appendix C

• **STANDARD OF CARE GUIDANCE & RECOMMENDATION FOR FREQUENCY, DURATION AND RD ROLE**	
CITATION	**EXCERPT**
• Herrin, M., & Larkin, M. (2012). Nutrition Counseling in the Treatment of Eating Disorders (2nd ed.) pg 54 Routledge. https://doi.org/10.4324/9780203870600	• Appointment Frequency'. They say: "Nutrition counseling is most effectively provided on a weekly basis for new-onset patients as well as for those patients with chronic ED diagnoses. Patients tend to not make behavioral progress with less frequent appointments unless they are highly motivated. Our experience has shown that more

	frequent visits at the beginning of treatment are more beneficial than meeting once monthly for a longer period of time. Bi-weekly and then monthly sessions are indicated as patients successfully meet and maintain treatment goals." ....
• Herrin, M., & Larkin, M. (2012). Nutrition Counseling in the Treatment of Eating Disorders (2nd ed.)pg 54 Routledge. https://doi.org/10.4324/9780203870600	• "Nutrition counseling is most effectively provided on a weekly basis for new-onset patients as well as those patients with chronic ED diagnoses. Patients tend not to make behavioral progress with less frequent appointments unless they are highly motivated.... Anorexic patients who require weight restoration may benefit from more frequent than once weekly sessions, especially if the patient is an adolescent or child.... From time to time patients inquire about the amount of time or the number of nutrition

	counseling sessions required for recovery. Although this seems like a fair question, it is difficult to predict a time frame for recovery. Much will depend on the patient's background, support system, and level of motivation. What we can tell the patient is that, ideally, the first three sessions are necessary to obtain background information, to gain an understanding of his or her situation,and to establish treatment goals. Additional sessions are required for implementation and monitoring of treatment goals."
• Crone C, Fochtmann LJ, Attia E, Boland R, Escobar J, Fornari V, Golden N, Guarda A, Jackson-Triche M, Manzo L, Mascolo M, Pierce K, Riddle M, Seritan A, Uniacke B, Zucker N, Yager J, Craig TJ, Hong SH, Medicus J. The American Psychiatric Association	• Medical Nutrition Therapy provided by a Registered Dietitians is an empirically supported component of effective treatment. • APA recommends (1C) that patients with an eating

Practice Guideline for the Treatment of Patients With Eating Disorders. Am J Psychiatry. 2023 Feb 1;180(2):167-171. doi: 10.1176/appi.ajp.23180001. PMID: 36722117.	disorder have a documented, comprehensive, culturally appropriate, and person-centered treatment Plan that incorporates medical, psychiatric, psychological, and nutritional expertise, commonly via a coordinated multidisciplinary team." ● … ● "Thus, for individuals treated in an outpatient setting, careful monitoring is essential and includes at least weekly weight determinations"
● International Association Eating Disorder Professionals (IAEDP) ● THE CEDRD [Certified Eating Disorder Registered Dietitian] IN EATING DISORDER CARE	● "When a patient steps down from more intense levels of treatment, it is recommended that the patient see the outpatient RD (CEDRD) at least once a week. As the patient improves, the frequency of the sessions will vary."

• International Association Eating Disorder Professionals (IAEDP) • THE CEDRD [Certified Eating Disorder Registered Dietitian] IN EATING DISORDER CARE • T*his document, created by the Association of Eating Disorder Nutrition Health Management Committee, is intended as a resource to promote recognition of the medical healthcare professional contributions to the eating disorder treatment team. It is not a comprehensive clinical guide for treatment. Every attempt was made to include current evidenced based references and clinical practice standards. Accordingly, the Committee has relied on peer- reviewed sources and clinical expertise that reflects evidence based approaches from a variety of eating disorder professionals and research conducted within the United States and internationally. Thus, the content of this document reflects*	• Outpatient... • Specific considerations for the RD's (CEDRD's) role at this level of care: • Communication with the previous care team. If this is the first point of contact, coordinate new treatment team with local professionals trained in ED treatment • Well-coordinated transition of meal Plan, supplementation and nutritional goals if patient is stepping down from higher level of care. • 18 • Adjustment of nutritional goals to meet level of supervision and medical management in present environment • Assistance in recognizing potential vulnerabilities presented within this

current knowledge and standards of eating disorders management.	environment for the individual patient and Plans for relapse prevention ● **Continuous assessment for appropriateness of environment for patients needs** ● **Flexibility with nutrition intervention which may include multiple individual sessions weekly and close monitoring, but typically 1 to 2 sessions per week initially** ● Close collaboration with attending physician and therapist, altering nutritional intervention as needed ● Communication with the family/participation in family sessions as appropriate ● Attention to the individual patients in helping them focus on their recovery goals and expectations, with the eventual goal of normalized eating

	• Weight and behavior monitoring of patient • Routine, consistent communication with • treatment team regarding patient progress • Management of the patient's case, since often the RD (CEDRD) acts as a "health navigator" in the outpatient setting, by making sure communications occur between team members, educating patients and families about next steps and treatment options, and ensuring patients have continuous access to necessary treatment. This case management task is an appropriate role for RDs (CEDRDs) considering their training in both physical/medical and behavioral realms.
• Setnick, Jessica. The Eating Disorders Clinical Pocket Guide,	• Outpatient Care • Description: Individual

2nd Edition. 2013	appointments with care providers in their offices. ● Time commitment: Varies, e.g. 1-2 hours per week with each provider”
● Setnick, Jessica. Academy of Nutrition & Dietetics Pocket Guide to Eating Disorders, Second Editiod. 2017	● Currently there is no standard of practice for the caseload of a registered dietitian nutritionist working with eating disorder patients. Eating disorders require a high level of acuity as well as significant nutrition intervention and frequent monitoring. It is commonly accepted in our profession that patients with eating disorders may require more of an RDN’s time than patients with other diagnoses, regardless of treatment setting or level of care.”
● Novaković B;Jovicić J;Pavlović LT;Grujicić M;Torović L;Balać D; (2010). Medical nutrition therapy Planning. Medicinski pregled.	● In addition to educating individuals on their nutritional decisions, MNT also helps people set goals,

Retrieved November 29, 2021.	deconstruct current behaviors, and build new habits. An added piece of MNT as an eating disorder treatment includes the psychodynamics of eating disorders. (2) A person with an eating disorder often has mental or emotional forces that encourage their relationship to food. To help someone with an eating disorder change their food-related behaviors, a dietitian will also understand the motivations behind a person's behavior.
● Ozier, A. D., & Henry, B. W. (2011). Position of the American Dietetic Association: Nutrition Intervention in the Treatment of Eating Disorders. Eat Right	● Abstract: It is the position of the American Dietetic Association that nutrition intervention, including nutritional counseling by a registered dietitian (RD), is an essential component of team treatment of patients with anorexia nervosa, bulimia nervosa, and other eating disorders (EDs) during assessment and treatment

	across the continuum of care. Diagnostic criteria for EDs provide important guidelines for identification and treatment. In addition, individuals may experience disordered eating that extends along a range from food restriction to partial conditions to diagnosed EDs. Understanding the roles and responsibilities of RDs is critical to the effective care of individuals with EDs. The complexities of EDs, such as epidemiologic factors, treatment guidelines, special populations, and emerging trends highlight the nature of EDs, which require a collaborative approach by an interdisciplinary team of mental health, nutrition, and medical specialists. RDs are integral members of treatment teams and are uniquely qualified to provide medical nutrition therapy for the normalization of eating

	patterns and nutritional status. However, this role requires understanding of the psychologic and neurobiologic aspects of EDs. Advanced training is needed to work effectively with this population. Further efforts with evidenced-based research must continue for improved treatment outcomes related to EDs, along with identification of effective primary and secondary interventions. This paper supports the “Practice Paper of the American Dietetic Association: Nutrition Intervention in the Treatment of Eating Disorders” published online at www.eatright.org/positions.
● Reiter, C. S., & Graves, L. (2010, April 22). Nutrition therapy for eating disorders. American Society for Parenteral and Enteral Nutrition. Retrieved November 29, 2021, from	● MNT is a vital component in treating eating disorders and is encouraged during a person's entire treatment.

• Whisenant, S. L., & Smith, B. A. (2003, May 8). Eating disorders: Current nutrition therapy and perceived needs in dietetics education and research. Journal of the American Dietetic Association.	• A dietitian is a critical part of a treatment team for someone with an eating disorder and is vital to a successful healing process. Dietitians working with individuals who live with eating disorders possess the specialized skills and knowledge base to promote behavioral changes in eating patterns. And through behavioral changes, people who have eating disorders can develop healthier eating habits. Research finds MNT to successfully change behaviors in those with anorexia and bulimia in inpatient and outpatient settings
• Reiter, C. S., & Graves, L. (2010). Nutrition therapy for eating disorders . Nutrition in Clinical Practice, 25(2), 122-136.	• Nutrition professionals are essential members of the multidisciplinary clinical team treating individuals with eating disorders. They possess knowledge and expertise that includes

	nutrition, physiology, and skills for promoting behavior change relative to the psycho-socio-cultural aspects of eating. This review provides an overview of the current state of the art in the practice of nutrition therapy for eating disorders, providing guidance in nutrition assessment, interventions, monitoring and interpretation of information and data, awareness of emerging roles for nutrition, and important considerations regarding professional boundaries practiced in the field of eating disorders. Training and experience in nutrition therapy specific to eating disorders promote a positive outcome in patients. Nutrition professionals are involved in all levels of care, including individual and group treatment in inpatient hospitalization or residential

	programs, partial hospitalization, and outpatient programs.
• Marzola, E., Nasser, J. A., Hashim, S. A., Shih, P. A. B., & Kaye, W. H. (2013). Nutritional rehabilitation in anorexia nervosa: review of the literature and implications for treatment. BMC psychiatry, 13, 1-13.	• It is our clinical experience that the use of reason, insight, and intuition are of limited efficacy in convincing an individual suffering from AN to eat. • In summary, we recommend that the restoration of both nutrient status and weight starts slowly and gradually accelerates as tolerated. There should be a continued focus on nutrient intake, as opposed to caloric intake, coupled with psychotherapy to encourage increasing both the amount and diversity in food selections with the eventual goal of weight and nutrition restoration in mind.
• Hay P., Chinn D., Forbes D., Madden S., Newton R., Sugenor L., Touyz S., Ward W. Royal Australian and New Zealand College of Psychiatrists clinical practice	• A personalized treatment approach is required for all patients. The treatment intensity should be matched to the clinical presentation of

guidelines for the treatment of eating disorders. Aust. N. Z. J. Psychiatry. 2014;48:977–1008. doi: 10.1177/0004867414555814	the patient allowing for stepping up and down in intensity of care as needed, rather than automatically starting patients at the lowest intensity option. Clinician firmness and empathy are needed to promote change. Session by session evaluation [29] collaboratively shared with the patient (and family as appropriate) is essential, not only for improving outcomes [30], but also for detecting lack of early change as this predicts poorer outcome across eating disorders and modalities of treatment ● Multidisciplinary care team (MDT). Treatment of eating disorders should be multidisciplinary, including a medical practitioner, mental health professional and a dietitian if accessible. Respective roles across the

	MDT should be clearly documented and understood, and a designated clinical lead identified. Processes of communication within the MDT need to be clearly outlined. All clinicians must practice within the scope of their profession and know when to refer to another clinician with focused eating disorder skills. However, all clinicians will need to have an interdisciplinary working knowledge of medical, mental health, nutritional and psychiatric aspects of eating disorders,
● Heruc, G., Hart, S., Stiles, G., Fleming, K., Casey, A., Sutherland, F., Jeffrey, S., Roberton, M., & Hurst, K. (2020). ANZAED practice and training standards for dietitians providing eating disorder treatment. Journal of eating disorders, 8(1), 77. https://doi.org/10.1186/s40337-020-00334-z	● The role of the dietitian in providing eating disorder treatment as part of the multidisciplinary team has been widely recognised [1–3]. Dietitians play a pivotal role in helping individuals with eating disorders and their families understand the interaction

	between food, nutrition and well-being, as well as supporting eating behaviors that align with their treatment and recovery goals. Eating disorders have high morbidity and mortality rates [4], and failure to provide early intervention is associated with a longer duration and severity of illness, serious physical health consequences and a higher risk of mortality including risk of suicide [5]. However, morbidity and mortality in individuals with an eating disorder can be improved with effective treatment [● Eating disorders present both psychiatric and medical risk which needs to be considered in Planning nutrition interventions. Given the dietary rigidity present in eating disorders, dietitians need to consider how their interventions either support

	or discourage eating flexibility and normalized eating patterns. In contrast to broad public healthy eating guidelines, nutrition interventions should be designed to minimize exclusion of any foods including those considered nutrient poor. Individuals with an eating disorder generally experience high levels of anxiety about eating, which may affect the individual's readiness for change and tolerance of uncertainty. Dietitians need to tailor their treatments to support individuals towards recovery while providing safe and ethical nutrition interventions. ● Monitoring and evaluation Throughout treatment, ongoing nutritional monitoring is required to evaluate outcomes of treatment and particularly change in eating disorder

	behavior. Due to the focus on nutritional recovery in eating disorder treatment, other members of the treatment team will also likely have a role in ongoing monitoring and evaluation. It is important that treatment outcomes are evaluated both qualitatively (e.g. change in the individual's perceived relationship with food) and quantitatively (e.g. change in nutritional intake). New and developing concerns need to be addressed with the individual and communicated to the rest of the treatment team as a lack of change in eating and eating disordered behavior may indicate a need to review treatment.
• Hsu, L. K. G., Rand, W., Sullivan, S., Liu, D. W., Mulliken, B., McDonagh, B., & Kaye, W. H. (2001). Cognitive therapy, nutritional therapy and their combination in the treatment of bulimia nervosa. Psychological	• CT (either alone, or in combination with nutritional therapy) remains the treatment of choice for bulimia nervosa

medicine, 31(5), 871-879.	