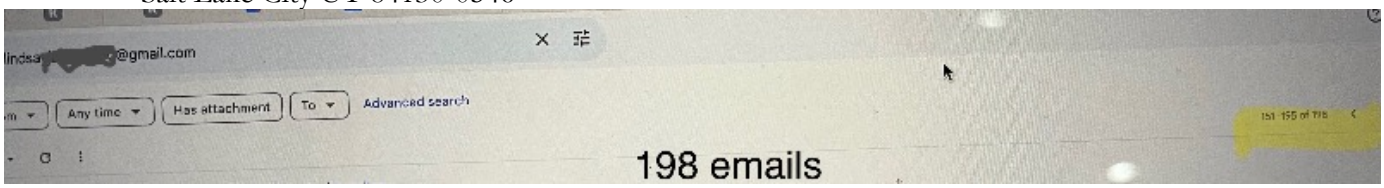
PO Box 30546
Salt Lake City UT 84130-0546




November 1, 2023

**It took over one year, 2 appeals, 3 complaints and 100s of emails for UMR to fix their $420.00 error. It took this long to review the intent of the Plan but still they failed to provide prompt pay interest,**
**still failed to provide comparative anaysis and still has NQTL for requiring more stringent medical review for continued use of this outpatient claim.**

**I wonder how much this all cost the Plan Sponsor?**

Member ID:
Complainant:
Member Name:

Dear James Doll:

I am writing in response to the above complaint that was submitted to your office regarding our denial of plan benefits on claims for services provided to on October 31, 2022, November 21, 2022, December 12, 2022, January 9, 2023, and March 27, 2023 by

UMR provides claims administrative services to employers who maintain self-funded health and welfare benefit plans. In this instance, we administer a non- grandfathered, self-funded plan established, designed and maintained by situated in the state of Kansas. The plan is governed by the Employee Retirement Income Security Act of 1974 (ERISA). Claims are processed based on plan provisions defined in the Plan Document.

**Background Information:**
Claim for dates of service October 31, 2022, November 21, 2022, December 12, 2022, January 9, 2023, and March 27, 2023 denied as maximum number of visits met for this benefit period.

**Determination:**
Based on additional review of the claims for dates of service October 31, 2022, November 21, 2022, December 12, 2022, January 9, 2023, and March 27, 2023. I am pleased to inform you that the denial of these claims has been reversed. After further review of these claims

and the plans intent we have concluded that these claims should have been allowed under the Nutritional Counseling benefit, and not under the Nutritional Coaching & Wellness. The claims will be adjusted and allowed. Future visits will be covered based off medical necessity. The provider will have to submit medical records to verify medical necessity for future visits.

The reprocessed EOB (Explanation of Benefits) for dates of service October 31, 2022, November 21, 2022, December 12, 2022, January 9, 2023, and March 27, 2023 have been attached for your review.

If you should have any questions regarding this complaint, please feel free to contact our office by calling 1-800-826-9781.

Sincerely,

Allison G.
Senior Appeal Auditor
Claim Appeals

Attachment

PO BOX 30541 SALT LAKE CITY UT 84130-0541
1-866-868-8249 • www.umr.com

Patient:

| Service(s) you received | Reason code | Service date(s) | Amount billed by provider | Your discount - | Not allowed - | Amount due to provider* | PLAN PAYS % | PLAN PAYS Plan Paid - | YOU PAY Co-pay + | YOU PAY Applied to deductible + | YOU PAY Co-insurance + | YOU PAY Not covered + | YOU PAY Total you may owe** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| MEDICAL SERVICE | | 10/31/22 | $105.00 | $0.00 | $0.00 | $85.00 | 100 | $85.00 | $20.00 | $0.00 | $0.00 | $0.00 | $20.00 |
| **Totals** | | | $105.00 | $0.00 | $0.00 | $85.00 | | $85.00 | $20.00 | $0.00 | $0.00 | $0.00 | **$20.00** |

*This amount does not include any co-pay or deductible you may owe.
**This total may not reflect any payments/co-pays you made at the time of service. Please wait for a provider bill before making a payment.
(+) Indicates any payment you may owe. (–) Indicates any discount or plan payment that will reduce what you owe.

**Reason code explanations:**
This claim has been reprocessed.
Your Claim was processed at the In-Network Level of Benefits.

**Plan payment(s) made on this EOB:** **Payment to:** **Payment date:** 10-16-23 **Payment amount:** $85.00

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| | | | | | | | PLAN PAYS | | YOU PAY | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Service(s) you received | Reason code | Service date(s) | Amount billed by provider | Your discount - | Not allowed - | Amount due to provider* | % | Plan Paid - | Co-pay + | Applied to deductible + | Co-insurance + | Not covered + | Total you may owe** |
| MEDICAL SERVICE | | 11/21/22 | $105.00 | $0.00 | $0.00 | $85.00 | 100 | $85.00 | $20.00 | $0.00 | $0.00 | $0.00 | $20.00 |
| **Totals** | | | $105.00 | $0.00 | $0.00 | $85.00 | | $85.00 | $20.00 | $0.00 | $0.00 | $0.00 | **$20.00** |

*This amount does not include any co-pay or deductible you may owe.
**This total may not reflect any payments/co-pays you made at the time of service. Please wait for a provider bill before making a payment.
(+) Indicates any payment you may owe. (–) Indicates any discount or plan payment that will reduce what you owe.

**Reason code explanations:**
This claim has been reprocessed.
Your Claim was processed at the In-Network Level of Benefits.

**Plan payment(s) made on this EOB:** **Payment to:** [redacted] **Payment date:** 10-16-23 **Payment amount:** $85.00

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| | | | | | | | PLAN PAYS | | YOU PAY | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Service(s) you received | Reason code | Service date(s) | Amount billed by provider | Your discount - | Not allowed - | Amount due to provider* | % | Plan Paid - | Co-pay + | Applied to deductible + | Co-insurance + | Not covered + | Total you may owe** |
| MEDICAL SERVICE | | 12/12/22 | $105.00 | $0.00 | $0.00 | $85.00 | 100 | $85.00 | $20.00 | $0.00 | $0.00 | $0.00 | $20.00 |
| **Totals** | | | $105.00 | $0.00 | $0.00 | $85.00 | | $85.00 | $20.00 | $0.00 | $0.00 | $0.00 | **$20.00** |

*This amount does not include any co-pay or deductible you may owe.
**This total may not reflect any payments/co-pays you made at the time of service. Please wait for a provider bill before making a payment.
(+) Indicates any payment you may owe. (–) Indicates any discount or plan payment that will reduce what you owe.

**Reason code explanations:**
This claim has been reprocessed.
Your Claim was processed at the In-Network Level of Benefits.

**Plan payment(s) made on this EOB:** **Payment to:** **Payment date:** 10-16-23 **Payment amount:** $85.00

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| | | | | | | | PLAN PAYS | | YOU PAY | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Service(s) you received | Reason code | Service date(s) | Amount billed by provider | Your discount - | Not allowed - | Amount due to provider* | % | Plan Paid - | Co-pay + | Applied to deductible + | Co-insurance + | Not covered + | Total you may owe** |
| MEDICAL SERVICE | 908 | 01/09/23 | $45.00 | $4.35 | $0.00 | $20.65 | 100 | $20.65 | $20.00 | $0.00 | $0.00 | $0.00 | $20.00 |
| **Totals** | | | $45.00 | $4.35 | $0.00 | $20.65 | | $20.65 | $20.00 | $0.00 | $0.00 | $0.00 | **$20.00** |

*This amount does not include any co-pay or deductible you may owe.
**This total may not reflect any payments/co-pays you made at the time of service. Please wait for a provider bill before making a payment.
(+) Indicates any payment you may owe. (–) Indicates any discount or plan payment that will reduce what you owe.

**Reason code explanations:**
908 Provider negotiated discount. You are not responsible for this amount.
Your Claim was processed at the In-Network Level of Benefits.

**Plan payment(s) made on this EOB:** **Payment** [redacted] **Payment date:** 10-30-23 **Payment amount:** $20.65

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| | | | | | | | PLAN PAYS | | YOU PAY | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Service(s) you received | Reason code | Service date(s) | Amount billed by provider | Your discount - | Not allowed - | Amount due to provider* | % | Plan Paid - | Co-pay + | Applied to deductible + | Co-insurance + | Not covered + | Total you may owe** |
| MEDICAL SERVICE | 908 | 03/27/23 | $45.00 | $4.35 | $0.00 | $20.65 | 100 | $20.65 | $20.00 | $0.00 | $0.00 | $0.00 | $20.00 |
| **Totals** | | | $45.00 | $4.35 | $0.00 | $20.65 | | $20.65 | $20.00 | $0.00 | $0.00 | $0.00 | **$20.00** |

*This amount does not include any co-pay or deductible you may owe.
**This total may not reflect any payments/co-pays you made at the time of service. Please wait for a provider bill before making a payment.
(+) Indicates any payment you may owe. (–) Indicates any discount or plan payment that will reduce what you owe.

**Reason code explanations:**

This claim has been reprocessed.
908 Provider negotiated discount. You are not responsible for this amount.
Your Claim was processed at the In-N[illegible] Benefits

**Plan payment(s) made on this EOB:** **Payment to:** SUNRI[illegible]RTION CONSU[illegible] **Payment date:** 10-16-23 **Payment amount:** $20.65

PO Box 30546
Salt Lake City UT 84130-0546

Appeal response completely disregards appeal documents and is clearly autogenerated.

June 13, 2023

UMR's responds to LB's complaint and the DOL's request for comparative analysis by saying that they DO NOT need to provide this.

d more

I am writing in response to your appeal of the adverse bene rvices provided September 15, 2022, through March 27, 2023, by

**Background Information:**
You filed an appeal to our denials of your post-service claims; your appeal was received on May 23, 2023. This claim was for medical nutrition counseling, which was denied as benefit maximum has been met u LLC health plan.

**Final Adverse Benefit Determination:**
Your adverse benefit determination has been upheld. In making this determination we reviewed the following information: your letter of appeal and the plan language.

**Findings:**
We received the information provided and determined that all benefits accurately reflect the maximum allowances and guidelines for the services performed. Based on a review of the plan language, it has been determined that the nutritional counseling is not billed as an outpatient mental health therapy service which would be covered under your mental health benefits. For the type of service billed by the provider, your plan allows four (4) visits per calendar year.

**Your Plan has the Following:**

## PPO SCHEDULE OF BENEFITS

## MEDICAL BENEFITS

**Benefit Plan(s) PPO Plan**

**All health benefits shown on this Schedule of Benefits are subject to the following: Deductibles, Co-pays, Plan Participation rates, and out-of-pocket maximums**. Refer to the Out-of-Pocket Expenses and Maximums section of this SPD for more details.

Benefits are subject to all provisions of this Plan including any benefit determination based on an evaluation of medical facts and covered benefits. Refer to the Covered Medical Benefits and General Exclusions sections of this SPD for more details.

If a benefit maximum is listed in the middle of a column on the Schedule of Benefits, it is a combined Maximum Benefit for services that the Covered Person receives from all in-network and out-of-network providers and facilities.

| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Annual Deductible Per Calendar Year:** | | |
| • Per Person | $1,000 | $2,000 |
| • Per Family | $3,000 | $6,000 |
| **Plan Participation Rate, Unless Otherwise Stated Below:** | | |
| • Paid By Plan After Satisfaction Of Deductible | 80% | 50% |
| **Annual Total Out-Of-Pocket Maximum:**<br><br>***Note: Medical And Pharmacy Expenses Are Subject To The Same Out-Of-Pocket Maximum.*** | | |
| • Per Person | $6,000 | $12,000 |
| • Per Family | $12,000 | $24,000 |
| **Nutritional And Wellness Coaching:** | | |
| • Co-pay Per Visit | $20 | Not Applicable |
| • Maximum Visits Per Calendar Year | 4 Visits | |
| • Paid By Plan After Deductible | 100% (Deductible Waived) | 50% |

**Member Rights:**
You are entitled to receive, upon written request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to this claim.

**Right to second level Appeal:**

We realize you may still have concerns about this decision. You may further request a voluntary second appeal by submitting a written request within 60 days to the following address:

Appeals Department
PO Box 30546
Salt Lake City UT 84130-0546

When requesting a review, you should state the reasons you believe the denial was improper and submit any additional information, material or comments which you consider appropriate. The Plan Administrator will review your appeal and send you a written notice of the Plan Administrator's decision. The determination notice will include the specific reasons for the decision as well as specific references to the pertinent Plan provisions on which the decision is based.

You may have the right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act (ERISA) once all mandatory levels of appeal have been completed. The amount of time you have to file the civil action may be limited. Please refer to your Summary Plan Description (SPD).

If you need assistance understanding this notice or our decision to deny your appeal, or if you need diagnosis or treatment code information for this claim, please contact us by using the phone number on the back of your member ID card.

**Right to External Review:**
Following completion of the internal appeals process, you may be eligible to submit a request for external review, which will be conducted by an independent physician external review group. Your request for external review will have no effect on other benefits available under your plan. If you wish to pursue an external review, please send a written request to the following address:

External Review
Appeal Unit
PO Box 8048
Wausau, WI 54402-8048

Your written request should include: 1) your specific request for an external review; 2) the employee's name, address, and member ID number; 3) your designated representative's name and address, when applicable; 4) the service that was denied; and 5) any new, relevant information that was not provided during the internal appeal. Your written request must be received within four (4) months after the date you receive the final benefit determination on the second level of appeal. You will be provided more information about the external review process at the time we receive your request.

**Other Resources:**
In addition, there may be other resources available to help you understand the appeals process. For questions about your ERISA rights, this notice, or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272). Additionally, a consumer assistance program may be able to assist you at:

UMR

Kansas Insurance Department
1300 SW Arrowhead Rd
Topeka, KS  66604
Toll-free telephone: 1-800-432-2484 (In Kansas only)
(785)296-3071 (All others)
Web site: http://www.ksinsurance.org
E-mail: kid.commissioner@ks.gov

Sincerely,

Rachel T.
Appeals Auditor

UMR

**U.S. Department of Labor**

Employee Benefits Security Administration
2300 Main Street, Suite 11093
Kansas City, MO 64108-2415
Phone: (816) 285-1800
Fax: (816) 285-1888

July 17, 2023

UMR
Attention: Claims & Appeals
PO Box 30546
Salt Lake City, UT 84130 – 0546
UMR-Appeals@umr.com

*Sent via First Class Mail and Electronic Mail*

Re: Memb
Memb
Patien
Patien
Provid
Claim
Claim
Date o

Dear UMR – Claim Appeals,

The U.S. Department of Labor, Employee Benefits Security Administration (EBSA) has responsibility for the administration and enforcement of Title I of the Employee Retirement Income Security Act of 1974 (ERISA). Title I establishes standards governing the operation of employee benefit plans such as the GBA Companies Corporate Services, LLC Employee Welfare Benefit Plan (Plan).

In general, EBSA's responsibility is to administer the fiduciary, reporting and disclosure provisions of Title I of ERISA. As such, the Department has the discretion to make informal inquiries with a plan, plan sponsor or third-party administrator on a participant's or beneficiary's behalf in order to obtain information that may be useful in clarifying eligibility for benefits from an employee benefit plan or to resolve disputes between a plan and its participants.

This letter concerns Plan participant, Garrett Blanchard, who, along with patier reached out to our office again on June 27th, 2023, for assistance regarding health claims and clarification after receiving a response to their appeal. This inquiry for clarification is separate from any appeals they may be filling in the process of exhausting any internal and/or external appeal rights they may have, as applicable, though the appeal process. We are requesting clarification as to why the claims were denied in relation to the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).

As we understand the facts osed with an eating disorder in 2021. Ms, lting by both her therapist and primary physician, after continued treatment for irritable bowel syndrome (IBS) and other digestive issues, from a gastrointestinal specialist with documentation including colonoscopies and endoscopies. he receives counseling, not wellness coaching. Though she is currently being held to 4 visits a year as if she was receiving coaching and not treatment for diagnosed mental and physical conditions.

In an effort to informally resolve this matter, we are requesting the bulleted items below. Please provide the following documents if used, relied upon and/or related to the denial (*or partial denial or processing of*) s with dates of service in question:

1. Plan Document in effect during Plan Years 2022-2023;
2. Summary Plan Description in effect during Plan Years 2022-2023;
3. Drug Formulary during Plan Years 2022-2023;
4. Clinician's notes associated with the DOS listed above;
5. Claims submission records associated with the DOS of listed above;
6. Protocols, Medical guidelines or criteria, Expert advice, Internal policies or other Evidence used to process the claims at issue;
7. Any other relevant documents or criteria;
8. Review of M tter including written clarification addressin l concerns, including but not limited to the following questions:
    a) Why is her medically necessary outpatient office visits are not being covered?
    b) What the plan rules are for nutritional counseling therapy in other contexts, such as diabetes, and what / how many visits are covered for that type of care?
9. If during the review, there is a determination that corrective actions are necessary and appropriate, we respectfully request a summary of the actions taken.

Please provide the requested documents and a complete response by 08/01/2023.

You m ia electronic mail or fax at ay also reach Benefits Advisor Don directly via phone at (810) 285-1847.

Thank you in advance for your prompt attention to this matter.

Sincerely,

Supervisory Benefits Advisor

PO Box 30546
Salt Lake City UT 84130-0546

August 8, 2023

Member ID: 24433114
Complainant:
Member Name:

Dear

I am writing in response to the above complaint that was submitted to your office regarding our denial of plan benefits on claims for services provided to
31, 2022, November 21, 2022, December 12, 2022, January 9, 2023, and March 27, 2023 by

UMR provides claims administrative services to employers who maintain self-funded health and welfare benefit plans. In this instance, we administer a non-grandfathered, self-funded plan established, designed and maintained by GBA Companies Corporate Services, LLC situated in the state of Kansas. The plan is governed by the Employee Retirement Income Security Act of 1974 (ERISA). Claims are processed based on plan provisions defined in the GBA Companies Corporate Services, LLC. Plan Document.

**Background Information:**
Claims for dates of service October 31, 2022, November 21, 2022, December 12, 2022, January 9, 2023, and March 27, 2023 denied as maximum number of visits met for this benefit period.

**Determination:**
The member filed an appeal received on May 23, 2023. The Plans maximum visits for nutritional and wellness coaching per calendar year is four maximum visits. The four visits that were used in 2022 are August 15, 2022, August 29, 2022, September 19, 2022 and

October 10, 2022. The four visits that were used in 2023 are January 2, 2023, January 16, 2023, February 13, 2023 and March 6, 2023. Therefore, the appeal was upheld correctly as it was over the plans maximum benefits.

Your requesting Drug Formulary during Plan Years 2022-2023. This information is not related to the claims in question and will not be included in the information sent. We do not have any clinical medical records, protocols, medical guidelines or criteria, expert advice on file for this request as this was not a clinical determination. We are unable to provide the internal policies as it is considered proprietary information that cannot be disclosed. I have only included the 2022 plan document as there is not a new plan document for 2023.

**Findings:**
**PPO SCHEDULE OF BENEFITS**

**MEDICAL BENEFITS**

**Benefit Plan(s) PPO Plan**

**All health benefits shown on this Schedule of Benefits are subject to the following: Deductibles, Co-pays, Plan Participation rates, and out-of-pocket maximums**. Refer to the Out-of-Pocket Expenses and Maximums section of this SPD for more details.

Benefits are subject to all provisions of this Plan including any benefit determination based on an evaluation of medical facts and covered benefits. Refer to the Covered Medical Benefits and General Exclusions sections of this SPD for more details.

| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Annual Deductible Per Calendar Year:** | | |
| • Per Person | $1,000 | $2,000 |
| • Per Family | $3,000 | $6,000 |
| **Plan Participation Rate, Unless Otherwise Stated Below:** | | |
| • Paid By Plan After Satisfaction Of Deductible | 80% | 50% |
| **Annual Total Out-Of-Pocket Maximum:** | | |
| ***Note: Medical And Pharmacy Expenses Are Subject To The Same Out-Of-Pocket Maximum.*** | | |
| • Per Person | $6,000 | $12,000 |
| • Per Family | $12,000 | $24,000 |
| Nutritional And Wellness Coaching: | | |
| • Co-pay Per Visit | $20 | Not Applicable |
| • Maximum Visits Per Calendar Year | 4 Visits | |

| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| • Paid By Plan After Deductible | 100%<br>(Deductible Waived) | 50% |

**Other Resources:**
The members first level appeal determination letter was mailed on June 13, 2023. The member can submit a 2nd level appeal within 60 days of the determination letter date.
**CLAIMS AND APPEAL PROCEDURES**

**Second Level of Appeal**: This is a **voluntary** appeal level. The Covered Person is not required to follow this internal procedure before taking outside legal action.

- A Covered Person who is not satisfied with the decision following the first appeal has the right to appeal the denial a second time.
- The Covered Person or his or her Personal Representative must submit a written request for a second review within 60 calendar days or 180 calendar days for Prescription benefits following the date he or she received the Plan's decision regarding the first appeal. The Plan will assume the Covered Person received the determination letter regarding the first appeal seven days after the Plan sent the determination letter.

Please find attached a copy of all relevant information and plan provisions.

If you should have any questions regarding this complaint, please feel free to contact our office by calling 1-800-826-9781.

Sincerely,

Attachments

**YOU DO NOT HAVE CONSENT TO CANCEL MY APPEAL**

April 27, 2023

**APPEAL OF DENIAL OF MEDICALLY NECESSARY NUTRITION COUNSELING FOR EATING DISORDER**

Medical Claim [redacted] (see paperwork submitted)
Sunrise Nutriti

To Whom It May Concern,

This is an appeal for the denial of medically necessary nutritional counseling for my eating disorder. My policy covers medically necessary treatment for mental health conditions.

Eating disorders are mental health conditions protected under Federal and State mental health parity laws (MHPAEA). Services provided for the treatment of a mental health condition are deemed mental health benefits and standards for coverage must be in parity with standards of coverage for medical/surgical conditions. Nutritional counseling is not a permissible subcategory under MHPAEA. It is classified as an outpatient office visit. The refusal to cover this service for eating disorders beyond 4 visits when it is covered for medical conditions and is a standard or care treatment is in violation with the law and appears to be both a quantitative treatment limit and NQTL.

In addition, the carrier is not complying with the terms of my policy which is an ERISA violation. My policy does not have a visit limit for medically necessary nutritional counseling therapy (CPT 97803) yet the carrier is limiting this medical treatment as if it was a wellness coaching session.

**Policy**

The following information from my plan supports that having a 4-visit limit for CPT 97803 is unlawful and goes against the terms of my plan and violates MHPAEA.

Pg 7
There is a 4 limit on nutritional and wellness coaching (this is NOT the same as 97803).

Pg 8

Preventative and routine services (including nutrition, obesity, diet nutrition) with no limits mentioned.

Pg 51

Diabetes Treatment: Charges Incurred for the treatment of diabetes and diabetic self-management education programs, diabetic shoes, and nutritional counseling.

Pg 53
Hospice
Outpatient Care, which provides or arranges for other services related to the Terminal Illness, including the services of a Physician or Qualified physical or occupational therapist or **nutrition counseling services provided by or under the supervision of a Qualified dietician.**

Pg 54
For morbid obesity • Nutritional counseling by registered dieticians or other Qualified Providers

Pg 55
Nutritional Counseling if Medically Necessary

Pg 61
Home Healthcare Benefits
Nutrition counseling provided by or under the supervision of a Qualified dietician or other Qualified Provider, if applicable.

Pg 75
Mental Health Benefits

**Outpatient Therapy Services are covered. The services must be provided by a Qualified Provider.**

Pg 122
Qualified Provider means a provider duly licensed, registered, and/or certified by the state in which he or she is practicing, whose scope of practice includes the particular service or treatment being provided that is payable under this Plan.

**NUTRITIONAL COUNSELING FOR EATING DISORDERS**

Data from the National Institute of Mental Health show that anorexia nervosa is the most fatal mental disorder, with an estimated mortality rate of approximately 10 percent. Evidence-based medical guidelines confirm the important role of nutritional counseling in the treatment of eating disorders. According to the American Psychiatric Association's Practice Guideline for the Treatment of Patients with Eating Disorders, nutritional counseling is "a useful part of treatment

and helps reduce food restriction, increase the variety of foods eaten, and promote healthy but not compulsive exercise patterns," and is an empirically supported component of effective treatment.[1]

Additionally, the National Eating Disorders Association has stated that nutritional counseling is a necessary component of treatment for eating disorders, because it incorporates education about nutritional needs, and helps plan for and monitor rational choices by patients.[2]

**RELEVANT LAW:**

The Federal Parity Act 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 benefits that are more restrictive than the predominant level of financial requirements applied to substantially all medical/surgical benefits; (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 8 of 18 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. 29 U.S.C. § 1185a; 42 U.S.C. § 300gg-26; 45 C.F.R. § 146.136(c)(4)(i).

The 21st Century Cures Act clarified that eating disorders and the treatment for eating disorders (including nutritional counseling) are considered mental health/ substance abuse benefits.

There are six classifications and the sub-classifications and are the only classifications that may be used when determining the predominant financial requirements or QTLs that apply to substantially all medical/surgical benefits.

Under the 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.

---

[1] NY Attorney General Assurance of Discontinuance against HealthNow New York (Aug. 2016),
[2] NY Attorney General Assurance of Discontinuance against HealthNow New York (Aug. 2016),

A plan or issuer may not use a separate sub-classification under these classifications for generalists and specialists. A plan cannot have treatment limits on BH that are more restrictive than the predominant financial requirement or quantitative limit applied to substantially all medical benefits.

**Government Guidance on Nutritional Counseling and Eating Disorders**

There have been numerous publications by the federal government which indicate that UHC's current practice of not covering nutrition for eating disorders is in violation with the law.

| | | |
|---|---|---|
| U.S. Departments of Labor, Health and Human Services, Treasury issue 2022 Mental Health Parity and Addiction Equity Act Report to Congress<br><br>***Report shows failures to deliver parity in mental health, substance-use disorder benefits*** | https://www.hhs.gov/about/news/2022/01/25/us-dol-hhs-treasury-issue-2022-mental-health-parity-addiction-equity-act-report-to-congress.html | 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 | https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/report-to-congress-2022-realizing-parity-reducing-stigma-and-raising-awareness.pdf | 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."<br><br>Pg 19 These initial determination letters involved the following NQTLs that were not applied in parity for MH/SUD benefits:<br><br>…exclusion of nutritional counseling for MH/SUD conditions."<br><br>Pg 22<br><br>**Example #3 – Removal of Nutritional Counseling Exclusion for MH/SUD** |

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| | | **Conditions**<br><br>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. Eating disorders are serious and often fatal illnesses associated with severe disturbances in people's eating behaviors and related thoughts and emotions.44 Eating disorders are among the deadliest MH/SUD conditions, and anorexia nervosa has the highest mortality rate of any mental health disorder.45<br><br>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 | https://www.apna.org/wp-content/uploads/2021/03/parity_toolkit_CMS.pdf | Pg 12<br><br>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* |

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| Medicaid and<br><br>Children's Health Insurance Programs | | *use disorders*).<br><br>*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. |

**CONCLUSION:**

Given that my claims are medically necessary and not subject to an exclusion from my 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 nutritional counseling is covered for other health conditions with no limit and is a cost-efficient standard of care office based outpatient treatment for a covered mental health condition.