August 11, 2023

Benefits Advisor James Doll

U.S.Department of Labor

Doll.James.W@dol.gov

RE:

Complaint: UMR's denial of medically necessary Eating Disorder Medical Nutrition Therapy "MNT[1]" violates the Mental Health Parity and Addiction Equity Act "MHPAEA" and the Employee Retirement Income Security Act of 1974 "ERISA"

Therefore I request that UMR

- **Forward my entire complaint document to the Plan Administrator and UMR's General Counsel or Regulatory Affairs Department**
- **Agree in writing to cover my full billed charges for Eating Disorder MNT billed under 92802 and 92803 with an eating disorder diagnosis code, in accordance with my Plan benefits, starting on the first date of service, and for as long as it is medically necessary.**
- **Respond to my MHPAEA Document Request in Appendix A.**
- **Respond to the DOL's requests in particular to the plan rules "for nutritional counseling in other contexts, such as diabetes, and what/how many visits are covered for that type of care?"**

Dear Benefit Advisor Doll and UMR:

This letter is in response to UMR's reply to omplaint. As previously stated, this is a complaint for the denial of Eating Disorder[2] Medical Nutrition Therapy "MNT.[3]" Eating Disorders are mental health conditions and Eating Disorder MNT is a mental health benefit. Since Eating Disorder MNT is a mental

[1] "Eating Disorder MNT" and the Plan's term, ""Nutritional Counseling if Medically Necessary"" may be used interchangeably.

[2] ICD-10 F50.x Eating Disorder codes

[3] CPT 97802, 97803, 97804

health benefit, any limitations must comply with the Mental Health Parity and Addiction Equity Act "MHPAEA."

The current 4 visit limit for Eating Disorder MNT violates MHPAEA because the process to determine coverage for this outpatient benefit is not in parity with the process to determine coverage for any other Medical/Surgical outpatient services. Additionally, nutritional counseling is covered for other physical health conditions with no limit. The 4 visit limit is not compliant with the terms of Services, LLC. Plan Document. The Plan Document shows coverage with no limits for "Nutritional Counseling if Medically Necessary." Eating Disorder MNT meets this condition.The TPA may argue that the Plan has a 4 visit limit on "Nutritional Counseling if Medically Necessary" and is compliant with MHPAEA. However, the Plan language is so vague that a reasonable person would assume there was no limit on medically necessary Eating Disorder MNT. At the very least, the TPA should cover Eating Disorder MNT services as a courtesy until a new Plan Document is drafted indicating a 4 visit limit also applies to "Nutritional Counseling if Medically Necessary."

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. **is making a formal_request for MHPAEA compliance documents or plan instruments (see Appendix A) .**

UMR's June 13,2023 Appeal Denial and August 8, 2023 Complaint Response highlights that UMR is not only unfamiliar with the Plan and their fiduciary responsibilities but also in the rules and requirements of MHPAEA. It is also deeply disturbing that UMR did not provide a single document which was responsive to the Department of Labor "DOL''s request. We will directly comment on their responses and also provide a more in depth argument to support omplaint.

Thank you for your cooperation in appropriately resolving this issue. uffers from a serious eating disorder with comorbid physical complications . She has dramatically reduced necessary treatment due to UMR's unreasonable refusal to pay these covered benefits . Parity is meant to ensure equal treatment of mental health conditions-. This type of process would never be used to determine limits on something like cancer and UMR is not just administering the terms of A person is assumingly

reading this letter. When you are done, ask yourself if a reasonable person would think Eating Disorder MNT is covered without a 4 visit limit. The continued disregard of MHPAEA and reliance on a vague interpretation of the Plan Documents to deny her otherwise covered care is cruel.

Respectfully,
Domna Antoniadis, Esq.

UMR's June 13, 2023 Appeal Denial

Findings:

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.

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[4]. Eating disorders are mental health conditions and thus the treatment of an eating disorder, including Eating Disorder MNT, is a mental health benefit.

UMR continuously states they relied on the Plan Documents to reach their adverse benefit determination. **As required under ERISA, please furnish a complete copy of the GBA Corporate Services,LLC Plan Document.**

UMR's August 8,2023 Complaint Response

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.

UMR acknowledges that the plan is governed by "ERISA" and processed based on GBA's Plan Document. However, UMR's response to her complaint indicates they do not understand their fiduciary responsibilities as a Third Party Administrator "TPM" nor the contents of GBA's Plan Document.

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

The Plan maximum visits for nutritional and wellness coaching per calendar year is four maximum visits… .Therefore, the appeal was upheld correctly as it was over the plan's maximum benefits.

Correct. The Plan has a 4 visit maximum for "Nutritional and Wellness Coaching" per calendar year. However, as stated in both the appeal and complaint, is not requesting "Nutritional and Wellness Coaching," she is requesting coverage for medically necessary Eating Disorder MNT.The Plan explicitly covers "Nutritional Counseling if Medically Necessary." This is NOT the same as "Nutritional and Wellness Coaching."The difference between the two services is confirmed by the Plan documents. The Section of Covered Benefits, shows coverage for "Nutritional and Wellness Coaching" AND just below has " Nutritional Counseling if Medically Necessary." (See Attachment B).

The Plan does not state there is a maximum of four visits for "Nutritional Counseling if Medically Necessary." The visit limit only applies to "Nutritional and Wellness Coaching." This was confirmed by who called UMR on at least 2 separate occasions asking for clarification. In call reference #2308120000282, vas informed there is no visit limit on nutritional counseling CPT 978031 for diabetes or if medically necessary. She was also informed that these services have a $15 copay. In call reference #23081800003471, *ν*as informed there is no visit limit on nutritional counseling CPT 978031 for diabetes or if medically necessary. She was also told that this is a different benefit from "Nutritional and Wellness Coaching."

The Plan documents further support the difference between these two services given that the copay amounts are different. "Nutritional and Wellness Coaching" has a $20 copay. As per conversations with UMR, the copay for "Nutritional Counseling if Medically Necessary" is $15. The copay amount also demonstrates that "Nutritional Counseling if Medically Necessary" is not meant to include preventative care coverage for nutritional counseling. According to the Affordable Care Act "ACA," a Plan must cover certain preventative care services (which includes nutritional counseling for some conditions) with no copay. Indeed, the Plan documents have a specific section which outlines coverage for nutrition counseling as a preventative benefit. In addition the TPA cannot argue that "Nutritional Counseling if Medically Necessary" only applies to preventative benefits because most preventative benefits do not meet the definition of medically necessary.

Non-Responsiveness to DOL Request

It is unlikely that UMR, "the largest largest third-party administrator in the U.S," does not know their responsibilities under ERISA's Claim Procedure Rules. Their response to the following document requests indicated indifference to their duties as a TPA and to DOL's authority.

The DOL Requested:	**UMR Response**	**Response**
Plan Document in effect during Plan Years 2022-2023 Summary Plan Description in effect during Plan Years 2022-2023	"I have only included the 2022 plan document as there is not a new plan document for 2023." UMR then included a table titled "PPO SCHEDULE OF BENEFITS"	UMR claimed to include the 2022 plan document but this is nowhere to be seen. UMR did not provide the Summary Plan Description as requested by Mr. Doll. The table provided is not even the Summary of Coverage and Benefits. It appears that UMR copied the first 3 lines of the Summary of Coverage and Benefits and then the line regarding "Nutritional and Wellness".
Drug Formulary during Plan Years 2022-2023	"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."	A beneficiary is entitled to a copy of their Plan's Drug Formulary or information on how to access it. UMR's response is inconsistent with this requirement.
Clinicians' notes associated with the DOS listed above Protocols,Medical guidelines or criteria, Expert advice, Internal policies or other		submitted clinical medical records to support her appeal. UMR has these documents on file so it is unclear as to why they refuse to provide them. UMR's claim that they can not "provide the

[5] https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/benefit-claims-procedure-regulation

Evidence used to process the claims at issue;		internal policies as it is considered proprietary information" is in direct violation of ERISA. Under 29 CFR § 2560.503-1 *if an internal rule, guideline, protocol, or similar criterion was relied upon in making an adverse benefit determination, the notification of the adverse benefit determination must either set forth the rule, guideline, protocol, or criterion or indicate that such was relied upon and will be provided free of charge to the claimant upon request.*[5]

Plan Document

The TPA grossly misinterprets the terms of Plan. The relevant sections which support her complaint are:

Nutritional And Wellness Coaching: • Co-pay Per Visit • Maximum Visits Per Calendar Year • Paid By Plan After Deductible	$20 100% (Deductible Waived)	Not Applicable 4 Visits 50%

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This benefit shows a $20 copay which indicates that it is not the same as nutritional counseling preventive benefits.

Preventive / Routine Counseling For Alcohol Or Substance Use Disorder, Tobacco Use, Obesity, Diet, And Nutrition: • Paid By Plan After Deductible	100% (Deductible Waived)	50%

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The Preventive Benefits have a $0 copay, uses the term nutrition **counseling** and has no visit limit and is not the same as "Nutritional and Wellness Coaching."

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

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This section covers nutritional counseling for diabetes. It uses the term counseling, not coaching. These benefits are separate from preventive diabetes nutritional counseling. Preventive nutritional counseling coverage for diabetes only applies to Type 2 diabetes. This section does not limit coverage to Type 2.

34. **Hospice Care Services:** Treatment given at a Hospice Care Facility must be in place of a stay in a Hospital or Extended Care Facility, and may include:

- **Assessment,** which includes an assessment of the medical and social needs of the Terminally Ill person and a description of the care required to meet those needs.
- **Inpatient Care** in a facility when needed for pain control and other acute and chronic symptom management, psychological and dietary counseling, physical or occupational therapy, and part-time Home Health Care services.
- **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.

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This section covers nutritional counseling for Terminal Illness. This category uses the term counseling, not coaching.

45. **Morbid Obesity Treatment** includes only the following treatments if those treatments are determined to be Medically Necessary and be appropriate for an individual's Morbid Obesity condition. Refer to the Glossary of Terms for a definition of Morbid Obesity.

- Physician-supervised weight loss programs at a medical facility.
- Nutritional counseling by registered dieticians or other Qualified Providers.

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This section covers nutritional counseling for Morbid Obesity if medically necessary. This category uses the term counseling, not coaching. These benefits are separate from preventive obesity nutritional counseling. Preventive nutritional counseling coverage for obesity applies to individuals with a BMI over 30. This section applies to those with a BMI over 40 and if medically necessary.

47. **Nutritional and Wellness Coaching.**

48. **Nutritional Counseling** if Medically Necessary.

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In covered services, the Plan has separate categories for "Nutritional and Wellness Coaching" and "Nutritional Counseling if Medically Necessary." If these were the same benefit then they would not be separate benefit categories.

59. **Preventive / Routine Care** as listed under the Schedule of Benefits.

The Plan pays benefits for Preventive Care services provided on an Outpatient basis at a Physician's office, an Alternate Facility, or a Hospital that encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes, and include the following as required under the applicable law:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;

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The Plan pays benefits for Preventive Care services - which include preventive nutritional counseling benefits-"if they are effective in either the early detection of disease or the prevention of disease." This coverage category does not meet the Plan's definition of medically necessary and thus must be a different category from "Nutritional Counseling if Medically Necessary."

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

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The Mental Health Benefits Section confirms that Outpatient therapy services are covered if provided by a Qualified Provider. Eating Disorder Medical Nutrition THERAPY meets this definition since it is outpatient therapy provided by the Plan's definition of a Qualified Provider.

Essential Health Benefit means any medical expense that falls under the following categories, as defined under the Patient Protection and Affordable Care Act; ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; Prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and Pediatric Services, including oral and vision care, if applicable.

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This section confirms the Plan uses the ACA's definition of mental health services. Under the ACA, these are services provided to treat a mental health condition. Eating Disorder MNT meets this definition.

Medically Necessary / Medical Necessity means health care services provided for the purpose of preventing, evaluating, diagnosing, or treating an Illness, Injury, mental illness, substance use disorder, condition, or disease or its symptoms, generally meet the following criteria as determined by us or our designee, within our sole discretion:

- In accordance with *Generally Accepted Standards of Medical Practice*; and
- Clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for Your Illness, Injury, mental illness, substance use disorder, or disease or its symptoms; and
- Not mainly for Your convenience or that of Your doctor or other health care provider; and
- Is the most appropriate care, supply, or drug that can be safely provided to the member and is at least as likely as an alternative service or sequence of services to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's Illness, Injury, disease, or symptoms; and

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Ms. Blanchard's request for coverage of Eating Disorder MNT meets the Plan's definition of "Nutritional Counseling if Medically Necessary." The 4 visit limit should not apply to this service because it is different from "Nutritional and Wellness Coaching" and no part of the Plan mentions a visit limit for this service.

Outpatient means medical care, treatment, services, or supplies in a facility in which a patient is not registered as a bed patient and for whom room and board charges are not Incurred.

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Eating Disorder MNT (CPT 97803) is an outpatient service.

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.

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'ietitian meets the definition of a qualified provider since she is registered dietitian and scope of practice includes Eating Disorder MNT. Her service meets the Plan's definition for Mental Health Outpatient Benefits.

SUPPORTING DOCUMENTATION

The following documents detail the TPA 's violations. It provides an in-depth analysis and legal support for my complaints disputing the TPA 's unlawful policies.

Mental Health Parity and Addiction Equity Act “MHPAEA”
Summary of Terms
Complaints and Remedy Requested
Complaint 1: The TPA is using a vaguely defined limitation for Wellness Nutrition to restrict an otherwise covered essential mental health benefit (Eating Disorder MNT).
Complaint 2: The TPA is not complying with MHPAEA classification rules. They incorrectly claim that a) Eating Disorder MNT is not a mental health benefit, and b) that their Limitation is parity compliant because it applies to all Nutrition Services.
Complaint 3: The TPA 's visit limitation on Eating Disorder MNT fails MHPAEA’s Quantitative Treatment Limit “QTL” Test.
Complaint 4: The TPA 's restrictions on Eating Disorder MNT fails MHPAEA’s Nonquantitative Treatment Limit “NQTL” Test.
Appendix A Request For MHPAEA Compliance Documents or Plan Instruments
Appendix B Standard of Care Guidance on Eating Disorder MNT
Appendix C Miscellaneous and documents supporting Medical Necessity
Appendix D Government Guidance on Eating Disorder MNT
Appendix E GBA’s 2023 Summary Plan Description

Mental Health Parity and Addiction Equity Act "MHPAEA"

The TPA is limiting a core company 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;
> (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. [6]

Summary of Terms

For purposes of this complaint, "Eating Disorder MNT'' will be used to describe the mental health benefit of Medically Necessary Outpatient MNT by a Registered Dietitian "RD" or "RDN" to treat an individual with an eating disorder. UMR's term "Nutritional Counseling if Medically Necessary will fall under this term. "Wellness Nutrition '' will be used to describe nutrition services which promote healthy lifestyles for a person

[6] 29 U.S.C. § 1185a; 42 U.S.C. § 300gg-26; 45 C.F.R. § 146.136(c)(4)(i).

without a medical or mental health condition and not necessarily provided by a Registered Dietitian. UMR's term "Nutritional and Wellness Coaching '' will fall under this definition. "MNT '' and "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 diagnoses but not others, etc.)

Complaints

1. The TPA is using a vaguely defined limitation for a supplementary benefit (Wellness Nutrition) to restrict an otherwise covered essential mental health benefit (Eating Disorder MNT).
2. The TPA is not complying with MHPAEA classification rules. They incorrectly claim that a) Eating Disorder MNT is not a mental health benefit, and b) that their limitation on number of sessions is parity compliant because it applies to all benefits.
3. The TPA 's visit limitation on Eating Disorder MNT fails MHPAEA's Quantitative Treatment Limit "QTL" Test.
4. The TPA 's restrictions on Eating Disorder MNT fails MHPAEA's Nonquantitative Treatment Limit "NQTL" Test.

Issue 1: The TPA is using a vaguely defined limitation for a supplementary or optional benefit (Wellness Nutrition) to restrict an otherwise covered medically necessary and essential mental health benefit (Eating Disorder MNT).

A. 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 bona fide confusion as to the definition of Eating Disorder MNT. As a result, the TPA 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, MNT is defined as follows:

Medical Nutrition Therapy "MNT"	Nutritional diagnostic, therapy, and counseling

	services for the purpose of disease management which are furnished by a Registered Dietitian.
Nutrition Intervention	A feature of MNT defined as a purposefully-planned action intended to positively change a nutrition-related behavior, environmental condition, or aspect of health status for an individual and their caregivers, if applicable.
Nutrition Counseling	A feature of MNT defined as a supportive process, characterized by a collaborative dietitian-patient/client relationship. Nutrition 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	A feature of MNT defined as the formal process to instruct or train a patient/client (and caregivers, if applicable) in a skill, or to impart knowledge to help patient(s)/client(s) (and caregivers, if applicable) 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 either a medical/surgical benefit because it is used to address either a physical health condition OR a supplemental/optional benefit because it is used as a preventive measure	Is a mental health benefit because it is used to treat a mental health condition
Patient may not have any medical or mental health diagnosis OR any diagnoses are not related to a mental health condition	Patient is diagnosed with an eating disorder and/or one or more related or unrelated medical or mental health diagnoses
May or may not be treatment for a covered	Is treatment for a covered condition

condition	
May not meet the definition of medically necessary	Does meet the definition of medically necessary
May be used to prevent a disease or condition	Is used when a person already has the condition
May not be 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 general health education for the public	Is THERAPEUTIC INTERVENTION requiring ongoing nutritional assessment and diagnosis for the purpose of specific DISEASE MANAGEMENT, individualized and tailored to address the patient's unique circumstances and disorder
Is performed by a variety of licensed or unlicensed providers or para-professionals	Is provided by a Registered Dietitian with eating disorder expertise
Is a general health-promoting or supplemental benefit	Is an essential benefit
May not include care coordination with mental health providers for insight into psychological processes affecting nutrition	Includes care coordination with mental health providers for insight into psychological processes affecting nutrition
Does not require weekly sessions	Requires weekly sessions to maintain progress
Follow up sessions are generally 15-30 minutes, or CPT 97803 x1 or x2	Follow up sessions are similar to psychotherapy, approximately 45-60 minutes, or CPT 97803 x3 or x4
May not have a naturally occurring end point as it was not initiated to a specific condition	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.

B. 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 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**[7].

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.

C. 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:

1. The Plan covers the ACA essential benefits, which includes mental health benefits.
2. 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.
3. Eating Disorder MNT is a service utilized to treat this mental health condition and therefore is a mental health benefit.
4. The Plan does not exclude coverage for Eating Disorders.
5. 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.
6. The practitioner, a Registered Dietitian, meets the Plan's definition of qualified practitioner.

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

7. Eating Disorder MNT is not only recommended to treat this covered health condition, it is **considered essential by generally recognized independent standards of current medical practice**.
8. 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 TPA is disregarding the very distinct differences between these two types of nutrition based services.

D. Eating Disorder MNT is medically necessary[8]

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.[9] 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 severe, life-threatening, and expensive to treat cardiac, metabolic, skeletal, pulmonary, digestive and other acute and chronic injuries that can cause disability, suffering and 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 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

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[8] 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.

[9] 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.

necessary outpatient Eating Disorder MNT by a Registered Dietitian in an office setting unequivocally fits the definition of a covered service.

E. 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.

1. 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.
2. 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 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.
3. The International Association of Eating Disorders Professionals: Individuals with eating disorders being treated in the outpatient setting are recommended to see a Registered Dietitian for Medical Nutrition Therapy at least once per week. "As the patient improves, the frequency of the sessions will vary." Specifics of Outpatient MNT for Eating Disorders: - Communication with 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

[10] See Attachment for references and additional support

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.[10]

F. 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 TPA 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 TPA 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 2: The TPA 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 benefits.

A. 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, and **treatment of an eating disorder is a mental health benefit** within the meaning of that term as defined by MHPAEA[11]. 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 TPA incorrectly states that Eating Disorder MNT is not a mental health benefit. A TPA 's **choice** to administer benefits from different departments is irrelevant on how benefits **MUS**T be categorized for MHPAEA purposes. It is the TPA 's responsibility to coordinate with their different departments and ensure that the administration of **ALL** mental health benefits are MHPAEA compliant.

B. MHPAEA Provides Acceptable Classification of Benefits[12]

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[11] *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 TPA 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[13].

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.[14] A plan or issuer must also comply with MHPAEA's nonquantitative treatment limitations (NQTL) rules in assigning any benefits to a particular classification. [15]

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

The TPA 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. [16]

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

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

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

[14] 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)

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

[16] 26 CFR 54.9812-1(c)(3)(iii); 29 CFR 2590.712(c)(3)(iii) 45 CFR 146.136(c)(3)(iii).

substantially all medical/surgical benefits in the sub-classification using the methodology set forth in the final rules. [17]

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.** [18]

Issue 3: The TPA 's visit limitation on Eating Disorder MNT fails MHPAEA's Quantitative Treatment Limit "QTL" Test.

A. Quantitative Treatment Limits

The TPA 's Limitation on Eating Disorder MNT is a QTL since it restricts the number of visits a patient has coverage for. A TPA 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, number of treatments, visits, or days of coverage. [19]

To determine compliance, each type of financial requirement or QTL within a coverage unit must be analyzed separately within each classification.[20] The Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA)[21] provides the following process for assessing QTLs:

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

[17] *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).*
[18] See 26 CFR 54.9812-1(c)(2)(ii), 29 CFR 2590.712(c)(2)(ii), 45 CFR 146.136(c)(2)(ii)
[19] *See 26 CFR 54.9812-1(c)(1)(ii), 29 CFR 2590.712(c)(1)(ii), 45 CFR 146.136(c)(1)(ii).*
[20] *See 26 CFR 54.9812-1(c)(2)(i), 29 CFR 2590.712(c)(2)(i), 45 CFR 146.136(c)(2)(i)*
[21] https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/self-compliance-tool.pdf
[22] See 26 CFR 9812-1(c)(3)(i)(A), 29 CFR 2590.712(c)(3)(i)(A), 45 CFR

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.) [22]

B. 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 4: The TPA 's restrictions on Eating Disorder MNT fails MHPAEA's Nonquantitative Treatment Limit "NQTL'' Test.

A. 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 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. [23]

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

A 6-Step test[24] 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.

1. Provide the specific plan language regarding the NQTL and describe all services to which it applies in each respective benefits classification.
2. 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.
3. 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.
4. Provide the comparative analyses used to conclude that the NQTL is comparable to and no more stringently applied, as written.
5. Provide the comparative analyses used to conclude that the NQTL is comparable to and no more stringently applied, in operation.
6. Detailed summary explanation of how the analyses of all 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.

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

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 TPA '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 TPA 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 TPA '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 TPA 's treatment of Eating Disorder MNT is at complete odds with any professional recommendation. The TPA 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

1. The exclusion of Eating Disorder MNT violates MHPAEA because the process used to Limit this component of Eating Disorder treatment are not in parity with process 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 TPA 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.

2. 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 TPA 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 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 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[25].

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

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 TPA'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 provided by a Registered Dietitian. In fact, the Joint Commission **requires** the inclusion of these services in order for a facility to be accredited.[26] 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 and refusal to credential a Registered Dietitian providing Eating Disorder MNT as a mental health provider are restrictions on provider specialty that limits scope or duration of benefits for services. The TPA is discriminating against this type of provider and service. According to the Academy of Nutrition and Dietetics, Medical Nutrition Therapy provided by a Registered Dietitian is a medical treatment. Like other medical treatments provided by non-physician practitioners, Registered Dietitians generally can practice MNT because of licensure and certification laws which provide authority for Registered Dietitians to provide this medical service.

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

For comparison, 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 TPA 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 IN OPERATION.

CONCLUSION

The TPA 'sinequitable restrictions on Eating Disorder MNT either reflect ignorance as to what this treatment is or a complete indifference to the requirements under MHPAEA. I have provided explanations to remedy both situations above, showing that 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 services represented by my denied claims are 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:

A. Provide the definitions of the terminology used in plan documents and in operation to describe services by an RD.

B. What evidence or guidance was used in creating these definitions?
C. What evidence or guidance was used to support that this definition is clinically appropriate to describe MNT services as used to treat eating disorders?
D. 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?
E. Clarify if the exclusions/limitations being applied in operation to Eating Disorder MNT were intended to exclude/limit them.

I am requesting this specific information:

Information Legally Required to be Provided	**Clarification of Request as it Applies to Eating Disorder MNT**
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;	**For outpatient in network office benefits**: - **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.** - **Do you have evidence that Eating Disorder MNT is not safe or appropriate?** - **Do you have evidence that Eating Disorder MNT has a high likelihood for fraud?** - **Do you have 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 process 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, and incorrect information given by call center staff can result in incorrectly-coded claims.**
4. Identify the methods and analysis used in the development of the limitation;	- **Identify what evidence or methods were relied on to pick this specific number of visits/entirely exclude MNT for Eating Disorders by Registered Dietitians using codes 97802/97803/97804**
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

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	Appointment Frequency'. "Nutrition counseling is most effectively provided on a weekly basis for new-onset patients

Disorders (2nd ed.) pg 54 Routledge. https://doi.org/10.4324/9780203870600	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…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.... it is difficult to predict a time frame for recovery…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 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.	Medical Nutrition Therapy provided by a Registered Dietitians is an empirically supported component of effective treatment. APA recommends (1C) that patients with an eating 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."
Marzola, E., Nasser, J. A., Hashim, S. A.,	It is our clinical experience that the use of reason, insight, and

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.	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.
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 medicine, 31(5), 871-879.	CT (either alone, or in combination with nutritional therapy) remains the treatment of choice for bulimia nervosa
Novaković B;Jovicić J;Pavlović LT;Grujicić M;Torović L;Balać D; (2010). Medical nutrition therapy planning. Medicinski pregled. Retrieved November 29, 2021.	In addition to educating individuals on their nutritional decisions, MNT also helps people set goals, 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.
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*	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. 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

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 current knowledge and standards of eating disorders management.	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, 2nd Edition. 2013	Outpatient Care Description: Individual 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."
Ozier, A. D., & Henry, B. W. (2011). Position of the American Dietetic	It is the position of the American Dietetic Association that nutrition intervention, including nutritional counseling by a

Association: Nutrition Intervention in the Treatment of Eating Disorders. Eat Right	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.
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.
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 guidelines for the treatment of eating disorders. Aust. N. Z. J. Psychiatry. 2014;48:977–1008. doi: 10.1177/0004867414555814	A personalized treatment approach is required for all patients. The treatment intensity should be matched to the clinical presentation of 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,
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.

APPENDIX C:

GOVERNMENT GUIDANCE ON EATING DISORDER MNT

MHPAEA Comparative Analysis Report to Congress, July 2023	https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-parity/report-to-congress-2023-mhpaea-comparative-analysis	Pg 28" During the Reporting Period, EBSA expanded an initiative targeting service providers that administer many plans for possible impermissible exclusions." Examples include … and nutritional counseling to treat mental health conditions such as eating disorders. Pg 29 "In the current Reporting Period, EBSA is expanding this service provider approach by sending request letters or subpoenas to three more service providers, including some of the largest in the country. As it performed its investigative work, EBSA has encountered more total exclusions of key treatments for MH/SUD conditions than expected, such as ABA therapy to treat ASD, medication-assisted treatment (MAT)

		and medications for opioid use disorder (MOUD), and nutritional counseling for eating disorders. In response, the request letters will ask the service providers to specifically disclose whether they apply these exclusions or any other potentially impermissible exclusion. If they do, EBSA will seek the service provider's justification, if any, for why the exclusion is in parity and when appropriate, demand that they stop engaging in prohibited practices." 48 Types of NQTL "Exclusion of nutritional or dietary counseling for MH 2 "
FY 2022 MHPAEA ENFORCEMENT	https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-parity/mhpaea-enforcement-2022	pg 7 "obtained coverage for nutritional counseling. EBSA's Boston Regional Office investigated a self-insured single employer plan and discovered that the plan limited coverage of nutritional counseling to three visits per calendar year. The plan carved out an exception to this limitation for the treatment of diabetes (a medical/surgical condition) but included no carve out for any mental health or substance use disorder benefits. In response to the investigation, the plan was amended to state that the three-visit limitation did not apply to the treatment of any mental or behavioral health diagnoses (including eating disorders), and all 300 affected participants were notified of the change."
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***	https://www.hhs.gov/about/news/2022/01/25/us-dol-hhs-treasury-issue-2022-mental-health-parity-addiction-equity-	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.

deliver parity in mental health, substance-use disorder benefits	act-report-to-congress.html	
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." 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	https://www.apna.org/wp-content/uploads/2021/03/parity_toolkit_CMS.pdf	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	https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQ-Part-38.pdf	21st Century Cures Act confirms that eating disorder treatment is considered a mental health benefit for parity analysis purpose
21st Century Cures Act	https://www.congress.gov/114/plaws/publ255/PLAW-114publ255.pdf	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.