Executive Summary **The Coalition for Psychotherapy Parity:**
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Clinical Necessity Guidelines for Psychotherapy, Insurance Medical Necessity and Utilization Review Protocols and Mental Health Parity

Most patients who seek mental health treatment have chronic and recurring symptoms that require the ongoing availability of treatment. Clinical experience and extensive research demonstrate that psychotherapy is effective, cost-effective and often provides a cost-offset in decreased overall medical expenses, morbidity, mortality and disability. The standard for other medical conditions reimbursed by insurance is the continuation of effective treatment until meaningful recovery and is therefore the standard required by the Mental Health Parity and Addictions Equity Act (MHPAEA) for mental health care. However, insurance companies evade the legal requirement to cover treatment of mental illness at parity with other medical conditions by applying inaccurate proprietary definitions of medical necessity and by imposing utilization review procedures that block access to ongoing care.

Support for Psychotherapy

- Clinical expertise and psychotherapy research identify significant populations of psychiatric patients who need ongoing availability of open-ended psychotherapy**.** [1,2]
- Insurance companies prefer to authorize only brief treatments which do not meet the clinical needs of these patients**.** [3,6]
- Insurance companies block access to psychotherapy of adequate duration and frequency for the large group of more chronic patients who need more than brief therapy to ameliorate ongoing vulnerability and decrease disability, morbidity, mortality, relapse and expenses in other medical care**.** [4,5]
- Patients with a single diagnosis (no co-morbidities) are highly atypical of real-world clinical populations. Research trials based on these atypical populations are therefore uninformative with respect to duration and frequency of treatment required by most patients. However, health insurers cite these trials as justification for authorizing only brief treatment for *all* patients. Moreover, even in the highly selected and atypical populations generally studied in controlled trials, relapse rates are high even in patients initially considered treatment successes. [6]
- Large patient groups with recurrent and chronic illness (e.g. chronic complex disorders such as severe ongoing anxiety and depression, multiple chronic psychiatric disorders, personality disorders) improve substantially with ongoing access to psychotherapy. Longer duration and higher frequency of psychotherapy have independent and additive effects. They lead to the most positive outcomes, sustained improvement, decreased disability, and often "cost-offset" savings in other medical and social costs. The non-psychiatric medical costs of psychiatric patients far exceed those of patients without mental disorders. [1,5,7]
- Optimal psychotherapy without arbitrary limitations yields outcomes in sustained improvement in patients' emotional well-being, work and interpersonal functioning, and decreases morbidity, mortality and overall medical costs. [7]
- Even when fully reimbursed, only a small percentage of insurance subscribers access psychotherapy and most do not pursue extended treatment. When the cost burden for psychotherapy is increased beyond that for other medical care patients who need more care forego adequate treatment. [8]

Clinical necessity guidelines should support access to psychotherapy as prescribed by the clinician without arbitrary limitations in duration or frequency.

Medical Necessity and Utilization Review

- MHPAEA requires health insurance coverage of mental health care to be comparable to and no more stringent than that of other medical conditions.[9] The Affordable Care Act defines mental health care as an essential health benefit, including psychotherapy.
- **Medical necessity** criteria assess a treatment's eligibility for reimbursement. The Institute of Medicine (IOM) and the American Medical Association (AMA) define *medical necessity* as health care services in accordance with generally accepted standards of medical practice, clinically appropriate in type, frequency, extent, site and duration, and not primarily for the economic benefit of health plans. The AMA opposes medical necessity standards that emphasize cost and resource utilization above quality and clinical effectiveness and prevent patients from getting needed medical care. Yet insurers discriminate against mental health coverage compared to coverage for other medical conditions for which more deference is given to provider expertise in prescribing care.[10,11,12]
- Insurers' mental health medical necessity guidelines cover treatment to resolve acute symptoms to restore the baseline condition prior to symptom onset. Treatment of chronic, subacute illness with ongoing vulnerability to more acute illness is frequently not covered – a practice comparable to reducing a fever without treating or diagnosing its underlying cause. Insurers' proprietary guidelines often deviate from their own cited primary sources and disregard empirical literature supporting intensive and ongoing treatment.[13,14]
- A cost-saving but care-minimizing insurance company practice is a requirement that patients first access and fail to benefit from abbreviated care ("fail first" protocols) prior to approval of a provider's treatment recommendations of greater frequency and/or duration. "Fail first" protocols put patients at risk by delaying more appropriate and definitive treatment[15] and demoralizing patients who are made to feel untreatable rather than inadequately treated.
- **Utilization review** is an insurance company's monitoring process to pre-authorize reimbursement for recommended treatment and to assess ongoing treatments ("clinical reviews") for continuing eligibility for reimbursement. In violation of mental health parity, utilization review is used more restrictively for mental health treatment than for other medical care for both pre-authorization of new care and "clinical review" of ongoing treatment. Clinical review protocols often close down a course of mental health treatment when acute symptoms have improved to a patient's baseline condition without resolving chronic underlying vulnerabilities to repeated episodes of acute illness.[16,17,14,13]
- Utilization review has been found to lack reliability and validity, to impose a needless administrative burden, and to cause a "sentinel effect" in which providers experience a distortion in their practice style from the expectation of intrusive insurance company review. Very brief psychotherapy is often authorized for a broad spectrum of diagnoses regardless of severity.[18,19]
- Medical necessity and utilization review protocols are too often designed to conserve insurance company costs in the short term without consideration of the sequelae from undertreated illness -- its increased associated costs in other medical services, in increased morbidity and mortality and the enormous costs to society in increased disability.[20,21]

Given appropriate medical necessity guidelines at parity with other medical care, consistent with provider expertise and a broad range of psychotherapy research, there would be no need or place for utilization review protocols.

Provision of Psychotherapy: Critique of Psychiatric Diagnosis and How Psychotherapy is Studied and Reimbursed

Summary Statement and Recommendations:

Psychotherapy should be available as prescribed by the clinician without arbitrary limits on frequency or duration. Most psychiatric patients have chronic and recurrent illnesses for many of which psychotherapy is effective, cost-effective, and often leads to significant "cost-offset" savings in other medical costs. These patients need more than the availability of brief treatment and yet lack access to the full treatment that they need without which they incur increased costs in other medical care as well as increased morbidity and mortality. Empirically supported studies of psychotherapy and current psychiatric nosology do not reflect either the true nature of psychiatric illness or the actual need for an ongoing availability of effective treatments including psychotherapy. Stigma about psychiatric illness and treatments persists despite the research finding that even when psychotherapy is fully covered, only a small percentage of insurance subscribers access it and most of these attend only a few sessions. On the other hand, when the cost burden for psychiatric patients is increased beyond that for other medical care, significantly ill psychiatric patients simply forego treatment.

Current prevailing views on nosology and evidence supported psychotherapy are based on research findings and psychiatric diagnosis since DSM 3 in 1980. **(3)** In sum, brief, highly-scripted forms of psychotherapy, studied in randomized controlled trials (the perceived "gold standard") with subjects bearing a single DSM diagnosis without co-morbidities yield statistically significant effects. These brief, pre-scripted therapies are then promoted as the approaches of choice for the diagnoses studied.

(6) **T**his type of research does *not* identify efficacious therapies for the overwhelming majority of patients seeking mental health care. Such research conclusions lack relevance for most patients because 1) the vast majority of patients seeking mental health care present with conditions more complex than those who meet artificial inclusion and exclusion criteria of academic research studies. In real-world clinical populations, psychiatric "co-morbidity" (or co-occurrence of multiple DSM-defined psychiatric diagnoses) is the norm. Clinical guidelines and insurance reimbursement protocols derived from this approach to psychotherapy research do not reflect the realities of real-world patient populations and are simply not generalizable to the vast majority of patients who seek mental health treatment.

(6) Additionally, 2) "statistical significance," which has been the primary focus of academic research studies, does not speak to the question of whether or not patients improve in clinically meaningful ways. A "statistically significant" difference between a treatment and control group does not mean that the patients get well. There is thus a profound mismatch between the

questions addressed by academic research studies versus the information actually needed by patients, providers, and health care policy makers.

The Majority of Psychiatric Patients Need the Availability of Ongoing Effective Treatment

(6) Most psychiatric patients have chronic and recurrent illnesses underlying their acute symptoms that may lead them to episodes of treatment. To be treated successfully and more definitively with psychotherapy, most will need more than brief treatment focused primarily on the acute presenting problem. Current "wisdom" (or accepted myth) is that Empirically Supported Treatments (ESTs) are Randomized Controlled Trials (RCTs) that test treatments with subjects who have one diagnosis. By virtue of excluding most real-life psychiatric patients who are in fact co-morbid, their study design renders outcomes that are not truly generalizable. For example, one Star*D study found that 78% of one sample group of depressed patients were disqualified from randomized trials due to comorbid conditions or suicidal ideation and had poorer treatment response than those accepted into the studies (Wisnieski et al, 2009.) In another randomized trial of treatments for social phobia, out of a total of 840 potential subjects, only 27% were deemed eligible, the major exclusion for the study being comorbid depression, followed by having a different diagnosis as primary, with a total of 58% excluded for comorbidity (Huppert, Franklin, Foa et al, 2002.) These high exclusion rates are unsurprising, since for example, from an epidemiological perspective with respect to major depression (MDD), we know that 78.5% of cases (12-month prevalence) have additional psychiatric comorbidity, "with MDD only rarely primary" (Kessler et al., 2003).

(2) In addition, Westen and Morrison (2001) found that treatments are often considered "evidence based" due to a statistically significant reduction in measurable symptoms that were insignificant in the context of the patient's overall mental impairment or suffering. Furthermore, in an extensive review of manualized brief treatments for depressive and anxiety disorders, Westen et al (2004) found that treatment benefits were evanescent; over half of the patients in their sample sought treatment again within six to twelve months. An examination of the research literature on RCTs for anxiety and depression (Wampold et al, 2011) and on CBT for depression (Cuijpers, Smit et al, 2010) found that claims of efficacy were greatly exaggerated by study design flaws and publication bias.

(1) In notable contrast to those accepted into efficacy research cohorts, most patients in real-world clinical practice settings require more than a brief course of treatment. These individuals need ongoing psychotherapy or else are at risk of substance abuse, physical illness, and behavior that is destructive and costly, both to themselves and to society at large. Specifically, brief, " 'evidence-based' therapies are ineffective for most people most of the time" (Shedler, 2015, p. 48.) Shedler also quotes Driessen et al., (2013, p. 1047) re: a study of depressed

patients treated with brief CBT or psychodynamic therapy: “Our findings indicate that a substantial proportion of patients….require more than time-limited therapy to achieve remission.” In sum, 75% of patients did not get well.

How then should we identify and diagnose psychiatric patients more accurately in order to design more potentially valid efficacy research studies? With respect to patients with single DSM5/ICD10 diagnoses, the categories used are essentially superficial descriptions of symptoms, thus missing underlying more salient commonalities between them. In examining the patterns of comorbidity among common mental disorders, Krueger (1999) conceives of them not as “discrete, dichotomous entities, but rather as “extreme points on continua that span a range of emotional and behavioral functioning” (p. 922.) The superficial nosology accounts in no small measure for the frequent finding of “comorbidity.”

A more accurate and nuanced approach would be to identify and focus treatments on the actual underlying drivers of illness. Brown, Chorpita and Barlow (1998) noted that “the expansion of our nosologies has come at the expense of less empirical consideration of shared or overlapping features of emotional disorders that, relative to unique features of specific disorders, may have far greater significance in the understanding of the prevention, etiology, and course of disorders, and in predicting their response to treatment……Our classification systems have become overly precise to the point that they are now erroneously distinguishing symptoms and disorders that actually reflect inconsequential variations of broader, underlying syndromes” (p. 179.)

A number of researchers have focused on delineating these factors, identifying as common variables shared by certain diagnostic categories:

> ***Negative Affect,*** a construct based on intercorrelations between common psychological tests derived from studies of thousands of subjects measuring trait anxiety, depression, and neuroticism (Watson and Clark, 1984) **Negative affect** is also noted by Brown, Chorpita and Barlow (1998) as a common vulnerability in the development of both anxiety and depression, with anxious patients more prone to physiological hyperarousal and depressed patients lacking in positive affect.
>
> ***Neuroticism***, a construct derived from examining commonalities among anxiety and related disorders and their high rate of comorbidity (Barlow et al, 2014)
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> Krueger et al (2001) links dimensions of mental disorder with ***Dimensions of Personality***, with, for example, **internalization** (linked with higher negative emotionality) and **externalization** (linked with lower constraint) as “super-ordinate organizing axes of common psychopathological variation” (p.1254) and that “basic

dimensions of temperamental variation confer risk for a broad range of maladaptive outcomes." (p. 1256)

The assessment of the **Level of *Personality Organization, Quality of Mental Functioning, and Subjective Experience of Symptoms* (**PDM Task Force, 2006) is a comprehensive psychodynamic diagnostic tool that provides a detailed assessment of psychological strengths and vulnerabilities. The resultant profile yields a more nuanced and specific diagnosis of a patient's psychiatric illness than designations of superficial and observable symptoms.

Level and quality of ***Mentalization*** (Bateman and Fonagy, 2011), are assessed along a number of axes to examine the maturity of a patient's capacity to make sense of his/her own subjective states and mental processes as well as those of others. The maturity of a patient's mentalization is seen as a driving factor in psychiatric illness, is the focus of psychotherapy, and its improvement correlates with improvement in emotional health.

The Failure of Brief Treatments

(1) Longer and more intensive courses of psychotherapy yield better outcomes for many diagnostic groups of patients including those with personality disorders, chronic anxiety, chronic depression, and chronic complex disorders. (Berghout, Zevalkink et al, 2001a, 2001b, Beutel, Rasting et al, 2004, DeMaat, deJonge et al, 2009, DeMaat, Philipszoon et al, 2007, Huber, 2012, Leichsenring and Rabung, 2008, 2011, Seligman 1995, Shedler, 2010, 2015) For those who require an extended course of psychotherapy due to their mental illness, both longer duration and higher frequency of psychotherapy have independent positive effects. Together, these factors are associated with the most positive treatment outcomes (Grande et al., 2006; Rudolf, Manz, & Ori, 1994; Sandell et al., 2000.)

(4) Despite the demonstrated need for certain patient groups, most insurance company medical necessity guidelines put up a stiff resistance to authorizing more than brief courses of psychotherapy lest it impact their bottom lines. According to the U.S. Department of Labor Bureau of Labor Statistics 2016 report, the median number of years that wage and salary workers had been with their current employer was 4.2 years in January 2016, down from 4.6 years in January 2014. Accordingly subscribers who obtain their insurance through their employment change their insurance providers every few years. The cost savings by under-reimbursing mental health care is of greater interest to an insurer; a cost offset in overall medical expenses down the line by virtue of the adequate coverage of mental health services would not be a consideration to a current insurer focused on its own immediate expenses.

(8) Insurers also perpetuate stigma against psychotherapy in their concern that readily available outpatient psychotherapy would be overused. However, a RAND study demonstrated that when weekly outpatient psychotherapy is fully covered, only 4.3% of the insured population uses it and the average length of treatment is 11 sessions (Manning et al. 1986.) With respect to those patients who do in fact need more, higher copayments for mental health services reduce both initial access to and treatment intensity of mental health visits, and this reduction of care affects patients at all levels of clinical need (Landerman et al. 1994; Simon et al. 1996.) A more recent Dutch study found that increasing costs to patients for mental health care leads to a substantial and significant decrease in new mental health visits in equal measure for both severe and mild disorders and a larger decrease in low compared to high-income neighborhoods. Furthermore the costs of an associated increase in involuntary commitment and acute mental health care exceed the cost savings from the decline in new mental health visits. Increasing costs to patients reduces access to mental health care and increases costs and morbidity particularly among high-need, vulnerable populations. (Ravesteijn, Schachar, Beekman, et al 2017; Druss 2017) Poor and very ill psychiatric patients are disproportionately affected by discriminatory copayments and financial disincentives designed to screen out a hypothetical group of patients who it is thought would capriciously abuse covered mental health services (Lazar, 2010.)

(7) To consider in greater detail a particularly nuanced study of psychotherapy for patients with depressive and anxiety disorders: Knekt et al (2008) found different outcomes for short versus long-term psychotherapy, depending on the length of follow-up and patients' personality functioning. One finding was a faster recovery at one year from depressive and anxiety symptoms after short term dynamic therapy and from depressive symptoms after solution focused therapy compared to those treated with long term dynamic therapy. While the brief treatment cohorts sustained their improvement at three years, at this point those treated with longer therapy had a stronger treatment effect. On five-year follow-up Knekt et al (2011) found a reduction in symptoms, improvement in work ability and functional capacity in all treatment groups with the short-term therapies more effective during the first year, long-term psychodynamic psychotherapy most effective at three-year follow-up and psychoanalysis emerging as the most effective at five-year follow-up. Knekt, Lindfors et al (2016) found that patients with a poor level of personality organization improve more in symptoms, work capacity and remission with long term compared to brief dynamic psychotherapy and that on longer follow-ups, long-term psychodynamic psychotherapy emerges as more effective for patients with both low and higher level personality organization. Although at 10 year follow-up, Knekt, Virtala et al (2016) found only a small difference in outcome between the study treatments with no remaining significant difference in personality functioning, there was a significant difference in remission, symptom improvement and work ability conferred by long term treatment in addition to a significantly greater use of psychotropic medication and auxiliary psychotherapeutic treatments in the short term therapy groups.

These studies illustrate the impact on outcomes both of (a) patients' strength of personality and (b) greater length of follow-up, variables often missing and therefore not measured in typical efficacy of psychotherapy research protocols.

(2) With respect to the epidemiology of the patients who need more treatment, Depression is common and affects one fifth of Americans at some point in their lifetime (Kessler,Berglund, et al 2005.) It is a leading cause of world disability (World Health Organization, 2008.) Anxiety Disorders are the most common mental health problem affecting 18.1% of adults yearly (Kessler, Chiu et al, 2005.) The lifetime prevalence of Personality Disorders is between 10% and13.5% (Casey & Tyrer, 1986, Lennzenweger, 2008; Maier, Lichtermann, Klingler, Heun, & Hallmayer, 1992; Reich, Nduaguba, & Yates, 1988; Zimmerman & Coryell, 1990), affecting at least 30 million Americans of all social classes, races, and ethnicities. Borderline Personality Disorder in the U.S. has a point prevalence of 1.6%, a lifetime prevalence of 5.9%, is seen in 6.4 percent of urban primary care patients, 9.3 percent of psychiatric outpatients, and approximately 20 percent of psychiatric inpatients (Skodol, 2017.)

(5) Compared to patients without psychiatric illness, the increased medical expenses of the psychiatrically ill extend above and beyond the costs of their psychiatric care. They have more primary care visits, higher outpatient charges, and longer hospital stays (Melek and Norris, 2008, Luber, Hollenberg et al, 2000, Deykin, Keane, et al, 2001.) A high percentage of the psychiatrically ill are never diagnosed and a majority of those who are receive inadequate treatment (Wang, Berglund et al, 2005, Wang, Lane et al, 2005), their ongoing psychiatric illnesses continuing to drive higher overall medical costs as well as losses from disability and suicide. The prevalence and costs of untreated and insufficiently treated psychiatric illness require more precision in diagnosis and thoroughness of treatment.

(1) The collaborative longitudinal personality disorders study (clps) found that personality disorder comorbidity seriously compromises remission from depressive illness and adversely affects the course of the illness. Clearly, both the personality psychopathology and depression need to be treated (Skodol, Grilo, et al, 2005, Markowitz, Skodol et al, 2007.) Borderline personality disorder (BPD) is the most robust predictor of chronicity of depression, accounting for 57% of chronic cases (Grilo, Stout, Markowitz, et al, 2010; Skodol, Grilo, Keyes, et al, 2011.) Multiple studies document the need for more than a brief course of psychotherapy to treat BPD (Howard, Kopta, et al, 1986, Kopta, Howard et al, 1994, NICE guidelines, 2009.) Psychotherapy is the treatment of choice for personality disorders as well as for patients with chronic major depression with a history of childhood trauma (Nemeroff, 2003.) Depressed patients with residual symptoms after treatment are at risk for recurring illness and need more than a brief treatment (Fava, Ruini, et al, 2007.) In addition, perfectionistic depressed patients do poorly in all brief treatments and fare better in intensive, extended psychodynamic psychotherapy than in less intensive long-term therapies (Blatt, 1992, Blatt, Quinlan et al, 1995.)

(7) Long term dialectical behavior therapy is cost-effective and cost-saving in decreased emergency room visits and hospitalization for patients with borderline personality disorder (Linehan and Heard, 1999, Linehan et al, 1991, Matusiewicz, Hopwood, Banducci et al 2010.) Mentalization Based Therapy and Transference Focused Psychotherapy are also cost-effective for borderline personality patients (Stoffers-Winterling, Vollm, Rucker, et al, 2012) A more recent review and meta-analysis of 33 randomized controlled trials with 2256 participants found both dialectical behavior and psychodynamic psychotherapy to be significantly more effective than control interventions for these patients. (Cristea, Gentili, Cotet, et al, 2017**)**

(7) In several publications Leichsenring and Rabung (2008) and in an updated meta-analysis of ten prospective controlled trials including 971 patients with chronic complex disorders in psychotherapy for at least a year or 50 sessions, Leichsenring and Rabung (2011) found that long-term psychodynamic psychotherapy is significantly more effective and provides greater improvements in symptoms and personality functioning compared to briefer treatments for such patients. Long term therapy was superior to less intensive forms of psychotherapy and outcome and duration of psychotherapy were positively correlated. The factors that contribute to the cost-effectiveness of extended intensive psychotherapy include savings from decreased sick leave, decreased medical costs and decreased hospital costs (Bateman & Fonagy, 1999; Bateman & Fonagy, 2003; Bateman & Fonagy, 2008; Clarkin et al., 2001; Clarkin, Levy, Lenzenweger, & Kernberg, 2007; Dossmann, Kutter, Heinzel, & Wurmser, 1997; Duehrssen, 1962; Duehrssen & Jorswiek, 1965; Hall, Caleo, Stevenson, & Meares, 2001; Heinzel, Breyer, & Klein, 1996; Keller, Westhoff, Dilg, Rohner, & Studt, 1998; Levy et al., 2006; Meares, Stevenson, & Comerford, 1999; Stevenson & Meares, 1992; Stevenson & Meares, 1999; Teufel & Volk, 1988; van Asselt, Dirksen, Arntz et al., 2008.)

Critique of Medical Necessity and Utilization Review

Summary Statement and Recommendations:

Medical Necessity is a tool of managed care used to adjudicate reimbursement based on explicit standards of medical need for each condition. In deviation from the American Medical Association's recommendation that medical necessity be determined "in accordance with generally accepted standards of medical practice…….not primarily for the economic benefit of the health plans," proprietary medical necessity standards of insurance companies are extremely compromised by cost and profit-saving financial goals.

Utilization Review is another insurance company tool for pre-authorizing and reviewing ongoing medical treatment, ostensibly to ensure appropriate care, but in fact also serving to conserve costs and profits for these insurance entities. Medical necessity and utilization review standards constructed by insurance entities are defined even more narrowly for mental illness treatment compared to other medical care, in violation of the federal law mandating parity for mental health benefits. There should be no place for utilization reviews in an insurance plan with appropriate medical necessity standards as described by the American Medical Association.

Medical Necessity

(9) The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA -- "Mental Health Parity Act") requires health insurers to use equivalent standards to authorize care and to provide the same levels of insurance coverage for mental health conditions as they provide for other medical conditions ("parity"). **(12)** Nonetheless, health insurers routinely operationalize different and much more limited definitions of "medical necessity" for mental health treatment than for other medical care. **(10)** The concept of medical necessity is central to managed care and is used routinely by insurers to evaluate medical claims eligible for reimbursement (Knopeflmacher, 2016). **(20)** A 2003 report by the Substance Abuse and Mental Health Services Administration ("SAMHSA") found that medical necessity criteria are generally designed and controlled by insurers – not treating clinicians – and that medical necessity criteria are used to limit reimbursement for treatments deemed inconsistent with insurers' interpretations of relative cost and efficiency -- even when care is demonstrably consistent with professional standards. The SAMHSA report found that neither state nor federal regulatory processes universally controlled medical necessity standards promulgated by insurers (Rosenbaum, Kamoie, Mauery, et al, 2003).

While the Mental Health Parity Act did not alter insurers' provenance over definitions of and criteria for medical necessity, it did mandate public disclosure of clinical standards (Kessler, S, 2014). This was consistent with the recommendations of the 1989 Institute of Medicine ("IOM") report on private-sector utilization management and observations of the 1990 IOM Medicare quality assurance report. (Field and Lohr, 1990) **(11)** In 2011, subsequent to the passage of the Affordable Care Act ("ACA") and its mandate of essential health benefits, the American Medical Association ("AMA") issued a public statement to the IOM Committee on Determination of Essential Health Benefits. The AMA defined "medical necessity" as:

> Health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate in terms of type, frequency, extent, site and duration; and (c) not primarily for the economic benefit of the health plans and purchases or for the convenience of the patients, treating, physician, or other health care provider.

This AMA definition was endorsed in a 2015 Official Position Statement by the American Psychiatric Association. The "prudent physician" standard of medical necessity ensures that physicians are able to use their expertise and exercise discretion, consistent with good medical care, in evaluating the medical necessity of care for individual patients. As articulated in its public statement to the IOM, "the AMA has historically opposed definitions of medical necessity that emphasize cost and resource utilization above quality and clinical effectiveness. Such definitions of medical necessity interfere with the patient-physician relationship and prevent patients from getting the medical care they need." The AMA statement also reiterated the mandate for parity of coverage for all essential (mental) health benefits.

(13) While most insurance plans ostensibly incorporate these AMA and APA position statements on medical necessity, many managed behavioral healthcare organizations have operationalized medical necessity criteria that are grossly at odds with the AMA and APA's definitions. This disturbing and all too commonly overlooked practice often takes the form of proprietary medical necessity criteria touting consistency with generally accepted standards of medical practice but which in fact categorically fail to account for the chronicity and pervasiveness of mental illnesses and substance use disorders, and which apportion inadequate care based on the false premise that the generally accepted standard for treatment of behavioral health disorders is to focus on acute presenting symptoms in an episodic and time-limited way with treatment ending with improvement in the acute presenting symptoms. For example, a number of national managed behavioral healthcare organizations have recently used proprietary medical necessity criteria that expressly refer to outpatient treatment as "acute" or require acute symptoms to justify even outpatient services.

(15) Additionally, contrary to both generally accepted standards of medical practice and mental health parity laws, proprietary guidelines all too commonly shift evidentiary burdens onto patients, often requiring "objective" proof that their behavioral health conditions will deteriorate in the absence of proposed care or that less expensive, potentially inferior treatments have not or will not work. This evidentiary-shifting, "fail first" approach not only devalues the clinical judgment of treating providers, but imposes unacceptable risks on mental healthcare that are not tolerated in the medical/surgical context. As noted by the American Society of Addiction Medicine in *The ASAM Criteria* (Mee-Lee, Shulman et al, 2013), a "treatment failure" approach potentially puts the patient at risk because it delays a more appropriate level of treatment, and potentially increases health care costs, if restricting the appropriate level of treatment allows the addictive disorder to progress.

(14) The recent proliferation of class action law suits challenging such aberrant criteria reveals disturbing deviations of proprietary guidelines from cited primary sources, the imposition of clinically insupportable requirements for care of chronic mental illness, and concurrent disregard of relevant clinical literature supporting ongoing and intensive treatments for a wide range of behavioral disorders. All this, however, should come as no surprise given that published critiques of proprietary guidelines entered the public health discourse as early as 2002. Wickizer and Lessler (2002) reported that with respect to the most widely used length of stay guidelines produced at the time by Milliman and Robertson (M&R), several analyses found a wide variance between actual length of stay data and M&R guidelines and raised questions about the generalizability of length of stay guidelines based on the performance of selected institutions, as well as their underlying validity. **(20)** To date, the most compelling warning issued by a non-profit, clinical specialty organization regarding substandard medical necessity criteria has come from American Society of Addiction Medicine in its 2009 Public Policy Statement on Managed Care, Addiction Medicine, and Parity: "When an MCO develops its own addiction treatment level of care admission and continuing stay guidelines for authorizing or denying requested treatment rather than adhering to nationally validated, reliable, and accepted guidelines, it may appear that decision-influencing factors such as cost considerations outweigh valid evidence based authorization requests for medically necessary treatment." (p. 3.)

Utilization Review: A History of the Practice

Impact on Access to Treatment

(20) By 2005 95% of privately insured persons were enrolled in managed care plans. Managed care, especially for mental health care, was seen to be moving increasingly toward limitations on access to treatment dictated by financial goals such as patient cost-sharing. (Merrick et al, 2009) In the national health plan survey examined in Merrick et al, 2009, 58% of health plans' managed care policies required prior authorization for outpatient mental health care in 2003 and policies contracting with managed behavioral health organizations were more likely to require prior authorization than those which did not. **(19)** The mean and median number of visits initially authorized was approximately eight for both substance abuse and mental health. Nearly ¾ of policies requiring pre-authorization for mental health used self-developed criteria to determine medical necessity.

(16) Utilization review (UR) is a monitoring process conducted by insurance companies to pre-authorize treatment and to examine and assess ongoing treatments for their continuing eligibility for insurance reimbursement. **(18)** Milstein (1997) defined utilization review as a process externally imposed upon the physician/patient treatment process directed at containing health care costs for payers. Wickizer and Lessler, (2002) found utililization review to be perhaps the most controversial and invasive feature of all utilization management techniques. In addition, a review of the literature on medical necessity criteria, including two of the most popular commercial for-profit guideline developers, Milliman and Robertson and InterQual, found numerous review instruments lacking in reliability and validity and problems in the application of the criteria. Another important impact lies in a hidden "sentinel effect," namely that physicians subject to utilization review can experience a distortion of their clinical

practice style knowing that their requests for treatment will be reviewed. Reductions in utilization associated with utilization review would reflect both the effect of denials and this sentinel effect. (Wickizer and Lessler, 2002.)

(17) Subsequent to a history of increasingly severe restrictions on mental health compared to other medical care, the savings in inpatient care by virtue of utilization review protocols are the greatest for mental health care accounting for only 5% of the patients but yielding 50% of total days saved (Wickizer and Lessler, 2002.) Wickizer and Lessler, 1996) also showed a pattern of a "a cookie-cutter approach" to the length of service authorizations in the utilization review of psychiatric cases for a population of patients with a wide variety of illnesses including schizophrenia, single-episode depression, recurrent depression, alcohol dependence, drug dependence, and adjustment reaction. Almost all were approved initially for six days of inpatient treatment. So perhaps it is not surprising that another outcome of UR protocols emerged in a study of three groups of patients (pediatric, cardiovascular and psychiatric) showing a reduction in requested length of stay resulting from utilization review leading to an increased risk of readmission within 60 days. (Wickizer and Lessler, 2002.)

(18) While one could hardly dispute that utilization review protocols should minimize administrative burdens on providers, they have in fact contributed to the now intolerable administrative burden on the American health care system. According to Wickizer and Lessler, 1998 and Wickizer et al, 1999, there is little justification for utilization review of all patients seeking inpatient or selected outpatient procedures and should rather be conducted on a case-by-case specifically targeted basis defined by physician utilization profiles, patient characteristics, diagnostic criteria or some combination of these. The goal should include monitoring diagnostic populations of patients to ensure they receive needed and appropriate preventive and acute care (Wickizer and Lessler, 2002.)

In theory, utilization review should promote higher quality health care, not merely cost containment. Its traditional focus has been to target the overuse of care which neglects identifying aspects of care that contribute to poor quality. According to the Institute of Medicine (Lohr, 1990), quality is "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge." Schuster et al. (2005) defines poor quality as too much care, too little care, or the wrong care. Ideally, utilization management should identify and correct poor quality for individual patients and for defined populations. Such procedures would target overuse, underuse and misuse of care. According to Wickizer and Lessler (2002), utilization management should monitor utilization patterns to ensure that efforts to reduce overuse do not lead to adverse health outcomes. Methods and criteria used should be transparent and support the responsibility of payers, health plans and providers toward the patient. However, utilization review programs have not secured the trust of patients or providers because their methods and criteria to manage care have historically often not been disclosed. **(21)** Furthermore, attention must be paid from a societal perspective to the least well understood impact of utilization review, namely its effect on overall societal medical and other costs in addition to the narrow focus on costs saved for the private payer (Wickizer and Lessler, 2002.)

(17) Bendat (2014) has described the continued disparity of insurance coverage for psychotherapy in the context of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and the Affordable Care Act (ACA) of 2010, both in terms of what these laws require as well as how they are circumvented and often fail to be enforced. "Parity" or equality for mental health benefits is mandated for insurance coverage for most medical insurance plans in both self-funded and fully-insured private employer plans if mental health benefits are offered and in both self-funded and fully-insured ACA plans with respect to essential mental health benefits with the exception of those "grandfathered" under the ACA. Parity has also been expanded to mental health benefits in managed Medicaid and CHIP programs. Parity is meant to apply both to "quantitative" (number of services) and "non-quantitative" (describing protocols) limitations on the scope and duration of treatment authorized for insurance coverage. "Non-quantitative treatment limitations" include medical management standards, standards for provider admission to insurance networks and reimbursement rates, methods for determining usual, customary and reasonable charges, and "fail-first policies" that require lower-cost therapies prior to authorizing coverage for more expensive treatments. While an incomplete list, these standards and a number of others are prohibited from being applied in a more restrictive manner for mental health services than for other medical care. Nonetheless, the mandate for parity is generally observed essentially in the breach. Managed behavioral healthcare organizations ration mental health care based on sub-standard and inappropriately restrictive medical necessity guidelines not developed by recognized mental health specialty groups and adjudicate benefits for other medical conditions based on more generally recognized standards. To authorize more than a set minimum of mental health services, other illegal practices include, for example, a more restrictive insistence on fail-first treatment protocols and on much more severe and immediately life-threatening conditions (e.g., ongoing risk of imminent suicide) by which to evaluate requests for nonhospital levels of care. And in lieu of the older annual visit limitations and higher co-pays for mental health services commonly used prior to MHPAEA (which the law has now proscribed) and in a hidden violation of the demand for parity in quantitative measures (number of services), insurers now use concealed algorithms to flag "outlier" patients who require more than a minimal, "normative" amount of treatment. These cases trigger the ostensibly "non-quantitative" protocol of managed care reviews masquerading as "quality control" or to uncover "fraud and abuse" with the ultimate aim of rationing care under the guise of "medical necessity" (Bendat, 2014).

To date, processes to provide avenues for insured patients' challenges to inappropriate denial of mental health benefits have been deeply flawed. Under Department of Labor rules, self-funded health plans (which cover nearly half of the country's health benefits) are permitted to contract (generally through managed behavioral health care organizations) with "independent" review organizations (IROs) to adjudicate such consumer appeals with respect to benefit denials. IROs, however, routinely overlook parity and due process violations and fail to reverse

benefit denials on these grounds since exercising actual independence and finding legal violations could compromise their contracts with the very managed care organizations that hire them. While the states have primary responsibility to enforce parity compliance of fully insured health plans, the states do not routinely examine denials with respect to parity requirements and also routinely employ the same IROs who service the self-funded insurance companies, leading essentially to the same result.

(17) In practice, insurance companies put up a strong resistance not only to covering the most expensive mental health benefits for hospitalization and residential treatment but also vigorously limit access to outpatient psychotherapy, particularly more than a brief course per year (Bendat, 2014). Aside from these obstacles inherent in the current system for appeals, in theory there always remains the potential remedy of litigation, however costly, financially and emotionally, for insurance subscribers faced with wrongful denial of coverage for mental health services. Individuals with employer-sponsored mental health benefits can exercise a private right to initiate legal action to enforce parity and due process remedies conferred by MHPAEA. However, even though the parity requirements apply also to individual and non-federal governmental health plans regulated by the states, these subscribers lack a right to private legal action to enforce their entitlement to mental health care parity, thus limiting recourse to approximately 30 million insured subscribers (Bendat, 2014). Among other measures, what is clearly needed are policy and regulatory revisions, the right of private legal action to all insurance subscribers, and establishment of true independence for "independent review organizations" adjudicating appeals of claim denials. (Lazar, 2016)

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