

I have worked in the field of psychotherapy for more than thirty years. In the state of Texas, I am a licensed clinical psychologist (#2-3583), licensed professional counselor, and a licensed marriage and family therapist. I am certified as a sex therapist, addiction therapist, and certified to do Neurofeedback (EEG biofeedback) and Quantitative EEG. I have been on the board of the international organization of Neurofeedback (International Society for Neurofeedback and Research – ISNR) for a total of five years since its inception. I was the President of this organization (2007-2008) and am serving as the Past President currently.

I have provided Neurofeedback (EEG biofeedback) treatment to individuals for more than twenty years. I have successfully treated persons with Attention Deficit Hyperactivity Disorder, Mood Disorders, substance abuse, Autism, PTSD, traumatic brain injury (TBI), and other disorders. Many of these were treatment failures with traditional medical procedures. Neurofeedback (EEG biofeedback) is safe and non-invasive, and is an empirically validated and widely recognized effective non medication treatment for many conditions. There is an ample evidence base in over thirty years of clinical practice and hundreds of published studies. A recent review of this literature concluded “EEG biofeedback meets the American Academy of Child and Adolescent Psychiatry criteria for” Clinical Guidelines “for treatment of ADHD.” This means that Neurofeedback (EEG biofeedback) meets the same criteria as to medication for treating ADHD, and that EEG biofeedback “should always be considered as an intervention for this disorder by the clinician”.

This service has been denied by Aetna, United Behavioral Health, Blue Cross, Cigna, Humana, Value Options, Amerigroup, and others. This is limitation of an effective and validated treatment for mental health problems. The reasons given by the insurance companies for this denial fell into two categories: 1) our company does not cover biofeedback for Mental Health problems or 2) there is not yet sufficient evidence for the efficacy of Neurofeedback (EEG biofeedback). As such, they are using evidence-based criteria that are far more restrictive for mental health services than the criteria which are used for medical/surgical services. There are many routine medical and surgical procedures which have far fewer controlled studies about their efficacy than does Neurofeedback. Neurofeedback research includes randomized controlled studies as well as non-randomized, open trials and case studies. Medical and surgical procedures are generally not limited because of concerns about how many controlled studies have been performed about them. It is also noted that about 60% of prescriptions are in fact "off label" and the insurers say nothing to any physician about their use - as they see fit - of any medication for whatever purpose they choose. Further, medications are routinely prescribed for children that have had no safety or efficacy research.

I believe that the parity regulations, based on legal reviews of the parity statute should require that employers and plans pay for the same range and scope of services for Behavioral Treatments as they do for Medical/Surgical benefits. Today plans are being more restrictive in how they review evidenced based Mental Health and Substance Abuse Treatments when compared to Medical/Surgical treatments. This violates both the intent and letter of the parity statute and we hope that the regulations will clarify this and that it won't continue.

It is of note that in 2001 the State of Texas Legislature mandated (HB 1626) that EEG biofeedback (neurofeedback) must be covered by insurance companies in the treatment of acquired brain injury and its sequelae, including mental health effects such as depression, anxiety, and cognitive deficits. Recently

(April 2009), Blue Cross of Texas declared that biofeedback and EEG biofeedback (neurofeedback) were “experimental” and “not medically necessary” for all conditions (that they had previously covered) EXCEPT acquired brain injury. (See the end of this letter for a copy of the bill.)

As already reported, a review of the research on the efficacy of EEG biofeedback was published in 2005 in *Child and Adolescent Psychiatric Clinics of North America*, a well respected psychiatric journal. This review employed criteria for judging the degree of scientific evidence of treatment efficacy that were employed by the American Academy of Child and Adolescent Psychiatry, the child psychiatry professional organization, for developing practice guidelines for the treatment of ADHD. These criteria specified four levels:

- “Minimal Standards” [MS] are recommendations that are based on substantial empirical evidence (such as well-controlled, double-blind trials) or overwhelming clinical consensus. Minimal standards are expected to apply more than 95% of the time. i.e., in almost all cases. When the practitioner does not follow this standard in a particular case, the medical record should indicate the reason.
- “Clinical Guidelines” [CG] are recommendations that are based on limited empirical evidence (such as open trials, case studies) and/or strong clinical consensus. Clinical guidelines apply approximately 75% of the time. These practices should always be considered by the clinician, but there are exceptions to their applications.
- “Options” [OP] are practices that are acceptable but not required. There may be insufficient empirical evidence to support recommending these practices as minimal standards or clinical guidelines. In some cases they may be appropriate, but in other causes they should be avoided. If possible, the practice parameter will explain the pros and cons of these options.
- “Not Endorsed” [NE] refers to practices that are known to be ineffective or contraindicated. Based on these scientific review criteria, as advanced by the chief child psychiatry professional organization, EEG biofeedback was considered to be meet the review criteria as a “clinical guideline for treatment of ADHD, seizure disorders, anxiety (eg, obsessive-compulsive disorder, GAD, posttraumatic stress disorder, phobias), depression, reading disabilities, and addictive disorders. This finding suggests that EBF always should be considered as an intervention for these disorders by the clinician. “

This review was published in 2005; many additional studies demonstrating the efficacy of EEG biofeedback have been published since that time. It is without question that there is a substantial research evidence base of documenting the effectiveness of this very safe and widely available treatment in a range of very difficult to treat mental and behavioral health disorders.

Perhaps more importantly, EEG biofeedback shows substantial efficacy in many conditions that are quite resistant to treatment by other means. For example, seven studies have been completed evaluating the efficacy of EEG biofeedback for autism spectrum disorders. All have shown substantial benefit in social, emotional, and executive function, in several studies after only 20 sessions, or ten weeks of treatment. Neurofeedback more consistently attains positive results in less time than any other form of intervention I know. The same is true for the use of Neurofeedback in the treatment of PTSD. It is a very dynamic intervention for many acquired brain Injury patients that the medical establishment has given up on.

Indeed, using the scientific review criteria that predominate in medical/surgical field, Neurofeedback meets the predominant criteria for treatment of the following disorders:

- ADHD
- Autism spectrum disorders
- Substance abuse/addictions
- Generalized anxiety disorder
- Obsessive compulsive disorder
- PTSD
- Phobias
- Panic disorder
- Major depression
- Bipolar disorder
- Conduct disorder
- Traumatic brain injury
- Reading disabilities
- Reactive attachment disorder
- Schizophrenia

Texas House Bill HB 1626:

1-1 AN ACT

1-2 relating to health benefit plan coverage for certain benefits

1-3 related to brain injury.

1-4 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

1-5 SECTION 1. Subchapter E, Chapter 21, Insurance Code, is
1-6 amended by adding Article 21.53Q to read as follows:

1-7 Art. 21.53Q. HEALTH BENEFIT PLAN COVERAGE FOR CERTAIN
1-8 BENEFITS RELATED TO BRAIN INJURY

1-9 Sec. 1. APPLICABILITY OF ARTICLE. (a) This article
1-10 applies only to a health benefit plan that provides benefits for
1-11 medical or surgical expenses incurred as a result of a health
1-12 condition, accident, or sickness, including an individual, group,
1-13 blanket, or franchise insurance policy or insurance agreement, a
1-14 group hospital service contract, or an individual or group evidence
1-15 of coverage or similar coverage document that is offered by:

1-16 (1) an insurance company;

1-17 (2) a group hospital service corporation operating
1-18 under Chapter 20 of this code;

1-19 (3) a fraternal benefit society operating under
1-20 Chapter 10 of this code;

1-21 (4) a stipulated premium insurance company operating
1-22 under Chapter 22 of this code;

1-23 (5) a reciprocal exchange operating under Chapter 19
1-24 of this code;

2-1 (6) a Lloyd's plan operating under Chapter 18 of this
2-2 code;
2-3 (7) a health maintenance organization operating under
2-4 the Texas Health Maintenance Organization Act (Chapter 20A,
2-5 Vernon's Texas Insurance Code);
2-6 (8) a multiple employer welfare arrangement that holds
2-7 a certificate of authority under Article 3.95-2 of this code; or
2-8 (9) an approved nonprofit health corporation that
2-9 holds a certificate of authority under Article 21.52F of this code.
2-10 (b) This article applies to a small employer health benefit
2-11 plan written under Chapter 26 of this code.
2-12 (c) This article does not apply to:
2-13 (1) a plan that provides coverage:
2-14 (A) only for benefits for a specified disease or
2-15 for another limited benefit other than an accident policy;
2-16 (B) only for accidental death or dismemberment;
2-17 (C) for wages or payments in lieu of wages for a
2-18 period during which an employee is absent from work because of
2-19 sickness or injury;
2-20 (D) as a supplement to a liability insurance
2-21 policy;
2-22 (E) for credit insurance;
2-23 (F) only for dental or vision care;
2-24 (G) only for hospital expenses; or
2-25 (H) only for indemnity for hospital confinement;
2-26 (2) a Medicare supplemental policy as defined by
2-27 Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss),
3-1 as amended;
3-2 (3) a workers' compensation insurance policy;
3-3 (4) medical payment insurance coverage provided under
3-4 a motor vehicle insurance policy; or
3-5 (5) a long-term care insurance policy, including a
3-6 nursing home fixed indemnity policy, unless the commissioner
3-7 determines that the policy provides benefit coverage so
3-8 comprehensive that the policy is a health benefit plan as described
3-9 by Subsection (a) of this section.

3-10 **Sec. 2. EXCLUSION OF COVERAGE PROHIBITED. (a) A health**
3-11 **benefit plan may not exclude coverage for cognitive rehabilitation**
3-12 **therapy, cognitive communication therapy, neurocognitive therapy**
3-13 **and rehabilitation, neurobehavioral, neurophysiological,**
3-14 **neuropsychological, and psychophysiological testing or treatment,**
3-15 **neurofeedback therapy, remediation, post-acute transition services,**

3-16 or community reintegration services necessary as a result of and
3-17 related to an acquired brain injury.

3-18 (b) Coverage required under this article may be subject to
3-19 deductibles, copayments, coinsurance, or annual or maximum payment
3-20 limits that are consistent with deductibles, copayments,
3-21 coinsurance, and annual or maximum payment limits applicable to
3-22 other similar coverage under the plan.

3-23 (c) The commissioner shall adopt rules as necessary to
3-24 implement this section.

3-25 Sec. 3. TRAINING FOR CERTAIN PERSONNEL REQUIRED. (a) In
3-26 this section, "preauthorization" means the provision of a reliable
3-27 representation to a physician or health care provider of whether
4-1 the issuer of a health benefit plan will pay the physician or
4-2 provider for proposed medical or health care services if the
4-3 physician or provider renders those services to the patient for
4-4 whom the services are proposed. The term includes
4-5 precertification, certification, recertification, or any other
4-6 activity that involves providing a reliable representation by the
4-7 issuer of a health benefit plan to a physician or health care
4-8 provider.

4-9 (b) The commissioner by rule shall require the issuer of a
4-10 health benefit plan to provide adequate training to personnel
4-11 responsible for preauthorization of coverage or utilization review
4-12 under the plan to prevent wrongful denial of coverage required
4-13 under this article and to avoid confusion of medical benefits with
4-14 mental health benefits.

4-15 SECTION 2. (a) On or before September 1, 2006, the Sunset
4-16 Advisory Commission shall conduct a study to determine:

4-17 (1) to what extent the health benefit plan coverage
4-18 required by Article 21.53Q, Insurance Code, as added by this Act,
4-19 is being used by enrollees in health benefit plans to which that
4-20 article applies; and

4-21 (2) the impact of the required coverage on the cost of
4-22 those health benefit plans.

4-23 (b) The Sunset Advisory Commission shall report its findings
4-24 under this section to the legislature on or before January 1, 2007.

4-25 (c) The Texas Department of Insurance and any other state
4-26 agency shall cooperate with the Sunset Advisory Commission as
4-27 necessary to implement this section.

5-1 (d) This section expires September 1, 2007.

5-2 SECTION 3. This Act takes effect September 1, 2001, and
5-3 applies only to a health benefit plan delivered, issued for

5-4 delivery, or renewed on or after January 1, 2002. A health benefit
5-5 plan delivered, issued for delivery, or renewed before January 1,
5-6 2002, is governed by the law in effect immediately before the
5-7 effective date of this Act, and that law is continued in effect for
5-8 that purpose.

President of the Senate Speaker of the House

I certify that H.B. No. 1676 was passed by the House on April
30, 2001, by a non-record vote.

Chief Clerk of the House

I certify that H.B. No. 1676 was passed by the Senate on May
22, 2001, by a viva-voce vote.

Secretary of the Senate

APPROVED: _____

I strongly urge that you write and enforce regulations that require health insurers to use the same scientific review criteria for mental health services such as Neurofeedback that they use for most medical procedures. If they do so, then I am confident Neurofeedback will be covered and this safe and effective treatment will be available to the very large number of people in our country for whom more traditional treatment approaches were not enough.

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