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Docket: IRS-2009-0008
Request for Information for Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

Comment On: IRS-2009-0008-0001
Request for Information Regarding the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

Document: IRS-2009-0008-0067
Comment on FR Doc # E9-09629

Submitter Information

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Organization: Allied Psychophysiology, PLLC

General Comment

1. Effective rules are needed to address and incorporate the growing recognition within the medical community that health promotion is integrally linked to psychophysiology.

2. Coverage and authorization of treatment should be based on medical need (as based on provider judgment not an insurance clerk or panel) and provider licensure and certification, not some arbitrary rules concocted by the insurance companies.

3. Co-pays for mental health should be the same as for primary care office visits.

4. Effective implementation of Mental Health Parity will save healthcare costs as the administrative costs in navigating coverage differences should be reduced.

5. The insurance companies need to provide parity to mental health providers by allowing them to provide the covered services legally within their scope of practice. Medical / surgical providers are not restricted as to what covered procedures they can perform if it is within their legal scope of practice.

6. The health insurance industry needs to eliminate the bias against mental health oriented procedures and recognize biofeedback and neurofeedback therapy (CPT 90901) as a clinically effective intervention for those illnesses that that have a track

record of effective use and study through scientific peer review (not an insurance panel review).

7. Labeling a mental health procedure such as biofeedback as "alternative" should not allow insurance companies to make it immune to mental health parity regulation.

Attachments

IRS-2009-0008-0067.1 Comment on FR Doc # E9-09629

Federal Register / Vol. 74, No. 80 / Tuesday, April 28, 2009 / Proposed Rules

DEPARTMENT OF THE TREASURY
Internal Revenue Service
26 CFR Part 54
RIN 1545-BI70

DEPARTMENT OF LABOR
Employee Benefits Security Administration
29 CFR Part 2590
RIN 1210-AB30

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
45 CFR Parts 144 and 146
[CMS-4140-NC]
RIN 0938-AP65

Request for Information Regarding the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

page 19157, II B specific areas 1, 2 and 4

I am the Medical Practice Administrator for a private healthcare practice in North Carolina that provides assessments, treatment and care of psychophysiological and neuropsychiatric disorders. The owner of the practice is an advanced practice nurse, licensed and nationally board certified as a nurse practitioner (to provide primary medical care) and is also a licensed and nationally board certified advance practice nurse clinical specialist in psychiatry and mental health. The owner is nationally certified (BCIA) in biofeedback and EEG-neurofeedback. Our practice is a unique clinical resource to the SE coastal region of North Carolina that enables our clients to obtain treatment and care for functional medical and neuropsychiatric disorders that they would otherwise need to travel 100+ miles to Duke or UNC Chapel Hill Medical Centers to receive.

I provide all of the insurance and managed care support for the practice, and I have done so for the last 3+ years. I have a Master's of Science degree in systems management (which is a blending of applied mathematics - operations research - and management science), and I also have 10+ years experience as a former federal regulator. I was retained by the practice to enable them to survive financially in the increasingly complex and poorly reimbursed fields of primary care and mental health. After three years of severe cost cutting and making tough choices about which insurance plans to maintain active in-network contracts, the practice is still not profitable and the owner has continued to self-finance and underwrite the practice and has not drawn any income to date. Our continued survival to offer this much needed service to our community is in question. Much of this is due to disparity in reimbursement for mental health related disorders, confusion and lack of clear accountability in insurance policies over the "cross-over diagnoses that are psychophysiological - those which have both mental health and medical components to the claims", denials in coverage and refusal of payment by insurers, disparity in payment to advanced practice nurses, and lack of recognition by insurers of the efficacy of biofeedback and EEG neurofeedback (which is based on a bias against mental health procedures). Given my expertise and experience on the "frontlines" of working with providers and insurance companies for both medical and mental health services, I believe I am exceptionally well qualified to comment on considerations for this advanced rule.

First of all, **effective rules are needed to address and incorporate the growing recognition within the medical community that health promotion is integrally linked to psychophysiology.** Psychophysiology is the science of the inter-relationship between mental activity and physical functions - in other words, how mental activity affects the body, and how physiological activity affects the mind.

Applied psychophysiology is the healthcare specialty which uses this information to enable individuals to learn to recognize and control mental processes and physiological functions which may be causing health problems. Applied psychophysiological interventions have helped many medical specialties, for example, many of our referrals are from cardiology practices to help patients control the medical consequences of chronic stress related illnesses. The problem with the viability of our practice is not a lack of demand for services, but rather if and how much the services will be reimbursed.

When I contact a prospective, referred patient, I help them navigate their insurance coverage. This seems to be "all over the map". Many plans offer the exact inverse coverage of other plans yet both may justify their inclusion and exclusion criteria based on some "current medical review".

Coverage and authorization of treatment should be based on medical need (as based on provider judgment not an insurance clerk or panel) and provider licensure and certification, not some arbitrary rules concocted by the insurance companies. This level of examining claims and establishing guidelines for medical need, based on my experience, is far more disproportionate on the mental health side rather than the medical and is the current insurance industry loophole to avoid payment of legitimate claims.

Here are the coverage oriented questions I must address in obtaining benefits determination for our patients:

1) Is the plan in-network? Some out of network plans absolutely refuse to pay any benefits to out of network providers offering mental health services (Cigna Behavioral). Some, like United Health, will reduce the reimbursement from 90% to 60% or less. This is policy-specific and not necessarily company or plan specific. By adding complexity and confusion to the plan types, it's hard to tease out which lowered reimbursement may be due to lack of mental health parity versus some other variable. Some companies, such as United Health, offer "gap" coverage for out of network providers that offer specialized medical services. For example, if we receive a referral for biofeedback, we are the only practice in the region that features a nationally certified biofeedback professional. This sometimes, but not consistently, gives us gap coverage to receive in-network reimbursement rates. When the patient diagnosis is medical, we consistently receive gap coverage. When the patient diagnosis is mental health, gap coverage is frequently denied.

2) How does the plan handle office visits for "mental health" versus "medical" diagnoses? One must check to determine differences between how the policy covers therapy (90806, 90807) and health and behavior services (96150-95152)? Are all mental health diagnoses handled the same? Some plans (State Employees Plan of NC - BCBS) provide 100% coverage, and impose no limits to type and number of visits based on medical need only, provided the primary diagnosis is medical; and we code the claim using the CPT Health and Behavior codes (96150-96155). However, the State Plan restricts number and type of mental health visits and has much higher co-pays for mental health office visits than medical visits. **Co-pays for mental health should be the same as for primary care.**

Some plans refuse payment unless there is a "medical diagnosis" and not a primary mental health diagnosis (Aetna has refused payment on health and behavior codes, and these have also been rejected by Cigna, Cigna Behavioral Health, United Behavioral Health, United, and others). Some plans get even more arcane: Some insurance companies provide reduced coverage for what they deem to be the "lesser" mental illnesses (anxiety spectrum disorders as opposed to schizophrenia, bipolar or major depression). Anthem and CareFirst Blue Cross checks *the type of mental health diagnosis* to determine level of reimbursement (major mental health disorders such as depression and bipolar get reimbursed at a higher level than the anxiety spectrum disorders including panic disorder and PTSD).

The permutations in coverage and handling of procedures for specific diagnoses are nearly endless, and occupy a huge administrative cost to a practice offering mental health services. Sometimes, more than four hours of administrative time is spent on determination of benefits to enable effective coding of a claim before the client is ever seen. This is a terrible use of healthcare dollars. **Effective**

implementation of Mental Health Parity will save healthcare costs as the administrative costs in navigating coverage differences should be reduced.

3) Is pre-authorization needed? Is it needed for all procedure codes and at what time in the care? Are there limitations on what type of licensed healthcare professional can deliver these services? Insurance policies vary on what is needed for prior authorization. For example, BCBS FEHB requires prior approval for office based mental health services, but not for office based medical services.

Mental health providers are often further restricted than medical providers and not allowed to perform a service (even if it is included in the coverage) if they are not the *type of provider* specified in the policy. For example, Magellan Behavioral and Cigna Behavioral generally require a psychologist or physician to perform all psychological or neuropsychological testing with prior authorization. This restriction is purely exclusionary. Scope of practice limits enables advance practice mental health nurses to perform psychological and neuropsychological testing) yet some insurance company refuse to reimburse advance practice nurses for any testing (regardless of licensure or training in the testing procedure). This is not the case with the medical/surgical policy, where the insurance companies rarely if ever dictate who can perform the service (as this is implicit on how the provider is licensed and his/ her scope of practice.) However, insurance companies dictate, on the mental health side, what type of provider can do what procedure, and this frequently conflicts with licensed practice limits. The most obvious case is with psychological and neuropsychological testing, incorporated under the legal scope of practice for a nurse clinical specialist in mental health and psychiatry, yet excluded for reimbursement by many insurance companies.

The insurance companies need to provide parity to mental health providers by allowing them to provide the covered services legally within their scope of practice. Medical / surgical providers are not restricted as to what covered procedures they can perform if it is within their legal scope of practice.

4) How many visits are allowed? Some insurance plans limit the number of visits - some even to the point of not allowing clinically tested treatment protocols to be completed. For example, BC BS of NC limits treatment of biofeedback to 14 visits per year, even though most standard scientifically peer reviewed protocols call for 15- 40 visits for treatment (depending on the intervention). In the NC State Employees Plan, medical visits are unlimited but mental health visits usually are capped at 20 per year or less. In the BC BS Federal Employees Plan, mental health visits require pre-authorization by Magellan (the mental health carve-out company), and then require a care plan submittal and review after 6 visits. This bureaucratic hurdle to treatment is not levied for medical interventions.

The health insurance industry needs to eliminate the bias against mental health oriented procedures and recognize biofeedback and neurofeedback therapy (CPT 90901) as a clinically effective intervention for those illnesses that that have a track record of effective use and study through scientific peer review (not an insurance panel review).

The situation in navigating the huge differences in patient insurance policies is very problematic for providing biofeedback, neurofeedback and related assessment services to clients. Biofeedback (CPT 90901), is a highly clinically effective intervention for many psychophysiological disorders, yet the payment policies are highly variable. A particularly ironic example of this problem is that Blue Cross Blue Shield of NC covers biofeedback therapy for some neuromuscular diagnoses (medical bias) but specially excludes coverage for biofeedback for any psychological diagnosis whereas Blue Cross Blue Shield of Nebraska will cover biofeedback therapy -- but only for psychological diagnoses. Both cite (outdated and non peer reviewed) articles to justify their coverage and exclusions. (I could provide a dozen or more examples of these conflicting definitions of coverage.) BCBS Federal Employee Plan excludes biofeedback under the heading "alternative treatment". Biofeedback is an alternative to pharmacological treatment, but it is not "alternative" to mainstream medicine. This is a false label and poor excuse for exclusion, and this should not be tolerated by the federal government for its employees. Does labeling something as "alternative" make it immune to mental health parity

regulation? In defense of the Blue Cross companies, at least they tend to publish their policy guidelines. United Health and United Behavioral Health refuse to do this, making the coding and claims process even more enigmatic and problematic.

Disorders that can be highly effectively treated using biofeedback or neurofeedback include: anxiety spectrum diagnoses (including Generalized Anxiety Disorder, somatoform illness, panic disorder, PTSD), AD/HD, high functioning autism and Asperger's, cognitive brain injury (TBI), depression and adjustment disorders, sleep disorders and insomnia, functional medical disorders such as irritable bowel syndrome and recurrent - spastic abdominal pain, functional breathing disorders, including hyperventilation syndrome, and stress related hypertension, migraine and tension headaches. Many of these disorders have a 30+ year of treatment study and use for biofeedback and neurofeedback, yet insurers continue to label them investigational to justify denial of coverage. Once again, there is no consensus among insurers as to which of these interventions for specific diagnoses really is investigational, as many of them contradict each other's policies. This determination is best left to the healthcare professionals and the professional societies which provide the ethical framework for intervention. In the case of biofeedback and neurofeedback, professional societies such as the ISNR and AAPB, and national independent certification entities such as BCIA provide excellent scientifically and peer-refereed forums for provider certification and procedure clinical efficacy evaluation. Once again, I find the bias against mental / behavioral health interventions is the fundamental underpinning that has limited coverage for biofeedback and neurofeedback.

Many insurance companies, including Medicare, NC Medicaid and TRICARE will not reimburse for biofeedback services for Mental Health problems as a matter of stated policy. This capriciously denies individuals access to a clinically effective intervention and encourages those same individuals to embark on other, more risky, less effective or costly interventions for their treatment. I estimate that 50% or more of our referred patients (who take the step of contacting us for treatment), decline following through with treatment because their insurance denies or limits reimbursement for biofeedback. Insurance companies also hide behind the label of "investigational" as a blanket means to deny coverage. Most all insurance companies refuse to reimburse for neurofeedback for AD/HD or TBI using the "investigational" trump card to deny. Many state in written policy that there is not yet sufficient evidence for the efficacy of biofeedback or neurofeedback. 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 biofeedback or neurofeedback. These medical and surgical procedures are generally not limited because of concerns about how many controlled studies have been performed about them. EEG biofeedback is an empirically validated and widely recognized effective non-medication treatment for AD/HD, TBI, as well as other conditions. For example, there are over 50 studies evaluating the effectiveness of EEG biofeedback in the treatment of AD/HD, TBI, Substance Use disorders and Autism. 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 EEG biofeedback meets the same criteria as 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 North Carolina Medicaid, United Behavioral Health, NC Blue Cross, Cigna and Cigna Behavioral Health, Magellan, among others.

Ironically, most clerks and representatives from the insurance industry that I interact with on a daily basis claim to have never heard of mental health parity or any laws concerning this. I routinely ask each company I deal with for their policies concerning mental health parity, and I have never received a single written statement from any. I can't count how many times the concept of this has been literally laughed at by the representatives from the insurance industry that I deal with. The federal government could set the example of leadership in this arena through reform of FEHB to remove restrictions to mental health services, including biofeedback, and through reform of Medicare policy (albeit out of the scope of this legislation), for inclusion of biofeedback and neurofeedback by TRICARE and the VA system (especially for treatment of PTSD and TBI).

The bottom line is that coverage and authorization of treatment should be based on provider determined medical need (not an insurance clerk or panel) and provider licensure and independent, accepted certification entities, not some arbitrary rules concocted by the insurance companies. Clinical efficacy guidelines for mental health services need to be on parity with medical guidelines.

I welcome the opportunity to provide input to you as you refine rules for implementation of this historic healthcare regulation, and only hope that practices such as ours survive in the interim until such clarity and common sense can be mandated.

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The bottom line is that coverage and authorization of treatment should be based on provider determined medical need (not an insurance clerk or panel) and provider licensure and independent, accepted certification entities, not some arbitrary rules concocted by the insurance companies. Clinical efficacy guidelines for mental health services need to be on parity with medical guidelines.

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