Date

Member: Jane Doe

Member DOB: [insert]

To Whom It May Concern:

This letter is in support of a *member appeal* for Ms. Jane Doe. On [insert date], Insurance Company[[1]](#footnote-1) conducted this utilization review using the Level of Care Utilization System for Psychiatric and Addiction Services [LOCUS, Adult Version 20]. Regrettably, the Insurance Company LOCUS scores failed to reflect the severity of Ms. Doe’s psychiatric symptoms and level of care needs as outlined in the clinical information provided, resulting in a denial of coverage for her medically necessary residential mental health treatment.

In its [insert date listed], written notification of the adverse benefit determination, Insurance Company wrote:[[2]](#footnote-2)

“Your request for continued residential services was received. We have reviewed your request. This review showed that you are taking medications. Your mood has improved. You do not feel like harming yourself anymore. You are active in your treatment. You are motivated for treatment. Where you live provides the support you need to continue treatment. Your care could continue in the Mental Health Partial Hospitalization Program setting. Please discuss this option with your provider. It may help your provider to know that we used the Level of Care Utilization System (LOCUS) Adult Version 20.”[[3]](#footnote-3)

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (the “Federal Parity Act”) is an insurance nondiscrimination law designed to protect patients who seek treatment for mental health and substance use disorders. Insurance Company and their contracted third-party plan administrators are bound by federal and state antidiscrimination laws that protect patients with mental health and substance use conditions and provide for their access to needed medical care. The Final Rules under the Federal Parity Act, issued in 2013 and effective in 2014, expressly forbids insurers from impeding access to medically necessary and contractually obligated mental health services. As I am sure you are aware, this includes access to intermediate levels of care such as residential treatment.[[4]](#footnote-4) [[5]](#footnote-5)

In all areas of medicine, there is no single source of generally accepted standards of care. Rather, generally accepted standards of care are derived from multiple sources such as practice guidelines from professional organizations, guidelines and materials distributed by government agencies, and evidence-based peer-reviewed studies in academic journals.[[6]](#endnote-1) Behavioral health experts and leading medical specialty groups such as the American Medical Association, the American Psychiatric Association, and the National Council for Mental Wellbeing,[[7]](#footnote-6) among others, have coalesced around eight principles of effective treatment that reflect generally accepted standards of care.[[8]](#endnote-2) [[9]](#endnote-3) These standards are consistent with non-profit professional sources of accepted standards, such as the Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS) and the American Society for Addiction Medicine Treatment Criteria for Addictive, Substance Related and Co-Occurring Conditions (ASAM Criteria) that evaluate medical necessity for treatment throughout the continuum of care.

Unfortunately, the Insurance Company denial of coverage here is grossly at odds with **six of the eight**[[10]](#footnote-7)generally accepted standards of clinical practice as recognized by the behavioral health and psychiatric medical community. Following these standards is seen as best medical practice. The failure to follow best medical practice puts your company at risk for violating parity law.

Psychiatric conditions are best understood through a holistic biopsychosocial approach that considers the complex interplay of multiple determinants.[[11]](#endnote-4) Based on generally accepted standards, effective clinical care must include a **multidimensional assessment** that accounts for a wide variety of information about the patient,[[12]](#endnote-5) [[13]](#endnote-6) [[14]](#endnote-7) [[15]](#endnote-8) treatment of **underlying conditions** (e.g., early adversity, trauma, chronicity) **that is** **not limited to alleviation of the individual’s current symptoms**,[[16]](#endnote-9) [[17]](#endnote-10) and consideration of the **individual needs of the patient without arbitrary limits on the duration of such treatment**.[[18]](#endnote-11) [[19]](#endnote-12) [[20]](#endnote-13) [[21]](#endnote-14)

In this case, Insurance Company violated these standards through flawed scoring and application of the LOCUS guidelines which failed to consider the diagnostic complexity of Ms. Doe’s health conditions including her treatment-refractory mood disturbance, history of childhood adversity, debilitating functional impairments, longstanding difficulties with emotion management, difficulty forming and sustaining trusting treatment alliances, and disruptions in her support systems and recovery environment due to poor functioning, interpersonal struggles, and family conflict. Ms. Doe’s clinical needs were clearly articulated to Insurance Company during several utilization reviews and to Dr. Insurance during the peer review. Moreover, even if it were true that, “Where [Ms. Doe] live[s] provides the support [she] need[s] to continue treatment,” generally accepted standards of medical practice do not limit coverage for residential treatment based on the presence of recovery-undermining environmental factors.

Of note, the adverse determination letter failed to provide LOCUS scores and a sufficiently detailed explanation of the clinical reason(s) for the denial, specific to these medical necessity criteria and as relevant to Ms. Doe’s clinical status. As a result, it is impossible to discern whether Insurance Company considered the clinical information required to accurately assess Ms. Doe’s current treatment needs. The fact that Ms. Doe’s “mood has improved” and that she is “active in [her] treatment,” “motivated for treatment,” “taking medications,” and “do[es] not feel like harming [her]self anymore” has little bearing on the complex and chronic mental health conditions that warrant treatment at a residential level of care. In fact, these gains were achieved within the supportive structure of this residential setting. As outlined herein, this excessive emphasis on symptom acuity and crisis stabilization is inconsistent with professional standards of care that recognize the chronicity of many mental health and substance use conditions and the need to treat more than just the acute symptoms (i.e., subacute and chronic symptoms that drive recurrent acute illness) to promote long-term stabilization and clinical recovery.[[22]](#endnote-15)

Under generally accepted standards of care, effective treatment should occur at the **least intensive and restrictive level of care that is both safe and effective**,[[23]](#endnote-16) [[24]](#endnote-17) [[25]](#endnote-18) and include services needed to **improve functioning, maintain day-to-day functioning, and to prevent deterioration**.[[26]](#endnote-19) [[27]](#endnote-20) [[28]](#endnote-21) However, placement in a less restrictive and intensive setting is appropriate only if it is likely to be safe and *just as effective* as treatment at a higher level of care in addressing a patient’s overall condition. Generally accepted standards of care instruct that if a patient’s condition(s) can be treated more effectively at a higher level of care, the higher level of care should be authorized, regardless of whether the patient can be maintained safely at a lower level of care.[[29]](#endnote-22) [[30]](#endnote-23) [[31]](#endnote-24)

During the past three years, Ms. Doe has cycled through intensive outpatient, residential, and inpatient hospitalization programs with failed attempts to sustain functioning within a lower level of care. Given the chronicity and severity of Ms. Doe’s conditions, Ms. Doe, her family, and her outpatient providers recognized her need for more intensive sustained care, and she entered treatment at [insert Name of the Treatment Center].

Residential treatment at the [insert Name of the Treatment Center] is specifically designed to address problems underlying recurrent acute symptoms with the goal of interrupting cycles of ineffective treatments and poor adjustment in the community. Within the supportive structure of this residential setting, Ms. Doe is working to identify and address the painful feelings and experiences that underlie her chronic mood instability, interpersonal struggles, and functional impairments. Individuals who have experienced significant early adversity, such as Ms. Doe, often require real-time psychosocial interventions within a therapeutic milieu to feel safe enough to learn from the psychotherapy and other treatment offerings.[[32]](#endnote-25) Though challenging, Ms. Doe has been able to build trusting and collaborative relationships with her treatment providers which has historically represented a barrier to meaningful utilization of outpatient services.

We are collaboratively working with Ms. Doe to assess her ability to engage in treatment safely and effectively at a lower level of care. However, Insurance Company failed to consider what service would truly be the most effective and prevent deterioration and gave little credence to the professional recommendations and concerns of Ms. Doe’s treatment team. This denial of coverage risks prematurely truncating a course of residential mental health treatment that is effectively addressing Ms. Doe’s current symptoms as well as her underlying vulnerabilities to repeated episodes of acute illness.

I trust you are committed to upholding your legal responsibility as Ms. Doe’s fiduciary. As such, I respectfully suggest that you re-consider your decision by evaluating Ms. Doe’s service needs in a manner that accurately reflects the complexity and severity of her overall clinical picture. Based on the following LOCUS scores, Ms. Doe meets criteria for **Level Five - Medically Monitored Residential Services**, which she is receiving at the [insert Name of the Treatment Center]. Here are her full scores which have remained consistent since the date of denial. Please note that I am certified by the American Association of Community Psychiatrists (AACP) to score the LOCUS and generated these scores via an electronic scoring algorithm [LOCUS Version 20] licensed by Deerfield Solutions, LLC., on behalf of the AACP.

Dimension I: Risk of Harm - Level [insert] – [insert] Risk of Harm: Meets criterion [insert]

Dimension Il: Functional Status - Level [insert] – [insert] Impairment: Meets criterion [insert]

Dimension III: Medical, Addictive, and Psychiatric Co-Morbidity - Level [insert] – [insert] Co-morbidity: Meets criterion [insert]

Dimension IV: Recovery Environment A) Level of Stress - Level [insert] – [insert] Stressful Environment: Meets criterion [insert]

Dimension IV: Recovery Environment B) Level of Support - Level [insert] – [insert] Support in Environment: Meets criterion [insert]

Dimension V: Treatment and Recovery History - Level [insert] – [insert] Response to Treatment and Recovery Management: Meets criterion [insert]

Dimension VI: Engagement - Level [insert] – [insert] Engagement and Recovery: Meets criterion [insert]

In closing, I believe a reasonable person would conclude that this Insurance Company denial of coverage was arbitrary and capricious. Insurance Company applied the LOCUS guidelines in a manner that was flawed and inconsistent with generally accepted standards of care, even though Ms. Doe’s health insurance plan provides forcoverage of treatment that is consistent with generally accepted standards of care. Generally accepted standards of medical practice do not place artificial time limits on residential mental health treatment, especially for patients like Ms. Doe, whose behavioral health conditions are chronic and refractory.[[33]](#endnote-26) At best, our disagreement could be representative of ambiguity about the appropriate level of care, in which case the generally accepted standard of care is to **err on the side of caution by placing the patient in the higher level of care**.[[34]](#endnote-27)

You should be aware that this denial of coverage has likely imposed a substantially greater burden and expense upon Ms. Doe than if she had sought comparable non-psychiatric medical services. Both the American Medical Association and the American Psychiatric Association oppose the application of medical necessity criteria that prioritize cost and resource utilization above quality and clinical effectiveness and prevent patients’ access to needed medical care.[[35]](#endnote-28) [[36]](#endnote-29) As clearly articulated by several leading experts in the field of psychiatry and behavioral health, “The standard for other medical conditions reimbursed by insurance is continuation of effective treatment until meaningful recovery, which is therefore the standard required by the Mental Health Parity and Addiction Equity Act for mental health care.”[[37]](#endnote-30) The decision to deny residential treatment through this flawed application of the LOCUS guidelines could be interpreted as an effort to evade compliance with federal and state parity laws and therefore discriminatory practice and a breach of the terms of Ms. Doe’s health Plan.

If you rescore the LOCUS in a manner that accurately reflects Ms. Doe’s psychiatric symptoms and level of care needs, you will find, as I do, that Ms. Doe clearly meets criteria for medical necessity at a residential level of care. In my opinion, failure to consider her needs in this broader context ignores her actual medical needs, confuses symptom-reduction/crisis stabilization with clinical recovery, and represents a breach of the medical duty that you have toward Ms. Doe.

I trust your review of this appeal and of the relevant laws and standards will lead you to the same conclusions. I am sure Ms. Doe will expect you to respond in a way that honors the terms of her Plan.

Should you have any questions, please do not hesitate to contact me.

Sincerely,

[signature]

1. Insert the name of the patient’s insurance company in place of “Insurance Company” throughout the document. [↑](#footnote-ref-1)
2. Insert explanation provided in the letter. There is typically a paragraph or series of sentences that offer the name of the medical necessity criteria guidelines used, why the member does not meet these criteria, and the level of care recommended (e.g., outpatient services, partial hospitalization). This provides the reader with a useful visual and you may wish to quote and discuss pieces of what is listed (or not listed) here, in other sections of the appeal letter. [↑](#footnote-ref-2)
3. Hypothetical case for illustrative purposes. [↑](#footnote-ref-3)
4. You may elect to include a statement regarding any applicable laws pertaining to the state where the patient’s insurance policy was written. ParityTrack, which partners with the Kennedy Forum, among other groups, is a helpful resource: https://www.paritytrack.org/reports/ [↑](#footnote-ref-4)
5. You may wish to include the Plan’s definition of “medical necessity.” Many plans require medical necessity to be determined under “generally accepted standards of care.” Your patient can obtain this information by reviewing their full Policy (sometimes referred to as the *Subscriber Certificate and Riders* or *Certificate of Coverage*). [↑](#footnote-ref-5)
6. Some sources of generally accepted standards include:

   American Association for Community Psychiatrists Level of Care Utilization System (LOCUS); American Association for Community Psychiatrists Child and Adolescent Level of Care Utilization System (CALOCUS); American Society of Addiction Medicine (ASAM) Criteria; Principles of Care for Treatment of Children and Adolescents with Mental Illnesses in Residential Treatment Centers; Medicare benefit policy manual (CMS Publication No. 100-02); American Psychiatric Association Clinical Practice Guidelines [↑](#endnote-ref-1)
7. On May 6, 2021, The National Council for Behavioral Health changed its name to the National Council for Mental Wellbeing  [↑](#footnote-ref-6)
8. *Wit v. United Behavioral Health*. Brief amicus curiae of American Psychiatric Association, American Medical Association, California Medical Association, Southern California Psychiatric Society, Northern California Psychiatric Society, Orange County Psychiatric Society, Central California Psychiatric Society and San Diego Psychiatric Society. 5 May 2021. https://www.psychiatry.org/File%20Library/Psychiatrists/Directories/Library-and-Archive/amicus-briefs/amicus-2021-Wit-v-United-Behavioral-Health-Nos-20-17363-20-17364-21-15193021-15194.pdf. [↑](#endnote-ref-2)
9. The National Council for Behavioral Health. (2019). *Generally Accepted Standards of Care for Behavioral Health* [Position Statement]. https://www.thenationalcouncil.org/wp-content/uploads/2022/02/MDI-Wit-v-UBH-Position-Statement.pdf [↑](#endnote-ref-3)
10. See “Eight Principles of Effective Treatment That Reflect Generally Accepted Standards of Care” [insert link here] [↑](#footnote-ref-7)
11. See Melchert, T.P. (2015). *Biopsychosocial practice: A science-based framework for behavioral health care.* American Psychological Association. https://doi.org/10.1037/14441-000 [↑](#endnote-ref-4)
12. American Association for Community Psychiatry: LOCUS 20 (Level of Care Utilization System), 2016 Available at: https://sites.google.com/view/aacp123/resources/locus [↑](#endnote-ref-5)
13. American Association for Community Psychiatry: CALOCUS 20 (Child and Adolescent Level of Care Utilization System), 2019 Available at: https://sites.google.com/view/aacp123/resources/locus [↑](#endnote-ref-6)
14. Mee-Lee, D., & Shulman, G. (2014). The ASAM criteria and matching patients to treatment. *The ASAM Principles of Addiction Medicine. 5th ed. China: Wolters Kluwer Health*. [↑](#endnote-ref-7)
15. American Psychiatric Association. (2020). *Level of Care Criteria for Acute Psychiatric Treatment* [Position Statement]. https://www.psychiatry.org/File%20Library/About-APA/Organization-Documents-Policies/Policies/Position-Continuing-Care-Criteria.pdf [↑](#endnote-ref-8)
16. SAMHSA. (2012). *SAMHSA’s Working Definition of Recovery: 10 Guiding Principles of Recovery* [Brochure]. https://store.samhsa.gov/sites/default/files/d7/priv/pep12-recdef.pdf [↑](#endnote-ref-9)
17. American Psychiatric Association. (2018). *Use of the Principles of Recovery* [Position Statement]. https://www.psychiatry.org/File%20Library/About-APA/Organization-Documents-Policies/Policies/Position-Use-of-the-Principles-of-Recovery.pdf [↑](#endnote-ref-10)
18. U.S. Centers for Medicare & Medicaid Services. (Revised 12/31/20). Medicare benefit policy manual chapter 6 - hospital services covered under Part B (CMS Publication No. 100-02). https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c06.pdf [↑](#endnote-ref-11)
19. Lazar, S.G., Bendat, M., Gabbard, G., Levy, K., McWilliams, N., Plakun, E.M., Shedler, J., & Yeomans, F. (2018). Clinical necessity guidelines for psychotherapy, insurance medical necessity and utilization review protocols, and mental health parity. *Journal of Psychiatric Practice*, *24*(3), 179-193. doi:10.1097/PRA.0000000000000309 [↑](#endnote-ref-12)
20. APA, *supra* note 8. [↑](#endnote-ref-13)
21. APA, *supra* note 10. [↑](#endnote-ref-14)
22. APA, *supra* note 10, at 1 (“Recovery requires a commitment to a broad range of necessary medical and mental health services. It should not be used to justify retraction of resources or reduction in access to skilled professionals and high-quality care. Recovery is predicated on the partnership between the individual, psychiatrist, and other practitioners in constructing and directing all services aimed at maximizing hope and quality of life.”) [↑](#endnote-ref-15)
23. Plakun, E.M. (2019). Psychotherapy and advocacy: Four freedoms as fundamental patient rights. *Journal of Psychiatric Practice,* *25*(2), 128-131. doi:10.1097/PRA.0000000000000366 [↑](#endnote-ref-16)
24. ASAM, *supra* note 7. [↑](#endnote-ref-17)
25. Lazar, *supra* note 12. [↑](#endnote-ref-18)
26. CMS, *supra* note 11. [↑](#endnote-ref-19)
27. SAMHSA, *supra* note 9. [↑](#endnote-ref-20)
28. LOCUS, *supra* note 5. [↑](#endnote-ref-21)
29. ASAM, *supra* note 7. [↑](#endnote-ref-22)
30. Lazar, *supra* note 12. [↑](#endnote-ref-23)
31. Plakun, *supra* note 16. [↑](#endnote-ref-24)
32. Fonagy, P., Luyten, P., & Allison, E. (2015). Epistemic petrification and the restoration of epistemic trust: A new conceptualization of borderline personality disorder and its psychosocial treatment. *Journal of Personality Disorders,* *29*, 575-609. doi.org/10.1521/pedi.2015.29.5.575. [↑](#endnote-ref-25)
33. CMS, *supra* note 11. [↑](#endnote-ref-26)
34. LOCUS, *supra* note 5, at 7 (“In most cases, the higher level of care should be selected, unless there is a clear and compelling rationale to do otherwise… to err on the side of caution and safety rather than risk and instability.”) [↑](#endnote-ref-27)
35. American Medical Association. (2016). *Definitions of "Screening" and "Medical Necessity"* [Policy H-320.953]. https://policysearch.amaassn.org/policyfinder/detail/H320.953?uri=%2FAMADoc%2FHOD.xml-0-2625.xml [↑](#endnote-ref-28)
36. American Psychiatric Association. (2020). *Medical Necessity* [Position Statement]. https://www.psychiatry.org/File%20Library/About-APA/Organization-Documents-Policies/Policies/Position-Medical-Necessity.pdf [↑](#endnote-ref-29)
37. Lazar, *supra* note 12. [↑](#endnote-ref-30)