Date

Member: John Doe

Member DOB: [insert]

To Whom It May Concern:

This letter is in support of a *member appeal* for Mr. John Doe. Insurance Company[[1]](#footnote-1) has delegated the responsibility for adjudicating claims to Claims Administrator Company, Inc. (“Claims Administrator”).[[2]](#footnote-2) Pursuant to this delegation, Insurance Company approved Claims Administrator’s use of proprietary medical necessity criteria guidelines [insert Name of Guidelines in brackets] that do not comport with generally accepted standards of medical practice. Following a utilization review on [insert date], Claims Administrator denied coverage for Mr. Doe’s medically necessary residential mental health treatment using these substandard proprietary guidelines.

In its [insert date listed], written notification of the adverse benefit determination, Claims Administrator wrote:[[3]](#footnote-3)

“After reviewing the clinical information provided by your doctor/medical facility, your health plan, and the medical necessity criteria guidelines, we have determined the service requested is not medically necessary in your case. You entered treatment due to poor functioning and mood. You were thinking about harming yourself. You received therapy and medication at your residential treatment facility. Your mood is stable, and you can take care of your daily needs. You do not have moderately severe symptoms of a mental health disorder. The information we have does not show you are a danger to yourself or others. Therefore, the request is denied as not medically necessary. There may be other treatment options to help you, such as the partial hospitalization level of care.”[[4]](#footnote-4)

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.[[5]](#footnote-5) [[6]](#footnote-6)

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.[[7]](#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,[[8]](#footnote-7) among others, have coalesced around eight principles of effective treatment that reflect generally accepted standards of care.[[9]](#endnote-2) [[10]](#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.

Regrettably, the Claims Administrator denial of coverage here is grossly at odds with **seven of the eight**[[11]](#footnote-8)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.[[12]](#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,[[13]](#endnote-5) [[14]](#endnote-6) [[15]](#endnote-7) [[16]](#endnote-8) treatment of **co-occurring disorders** (including mental health, substance use and medical) in a coordinated manner that considers the interactions of the disorders,[[17]](#endnote-9) [[18]](#endnote-10) [[19]](#endnote-11) treatment of **underlying** **conditions** (e.g., early adversity, trauma, chronicity) **that is** **not limited to alleviation of the individual’s current symptoms**,[[20]](#endnote-12) [[21]](#endnote-13) and consideration of the **individual needs of the patient without arbitrary limits on the duration of such treatment**.[[22]](#endnote-14) [[23]](#endnote-15) [[24]](#endnote-16) [[25]](#endnote-17)

In this case, Claims Administrator failed to meet these standards by relying on the overly restrictive (proprietary) Name of Guidelines that focus too narrowly on current symptomatology and acute care needs and safety (e.g., “The information we have does not show you are a danger to yourself or others. Therefore, the request is denied as not medically necessary”). 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.[[26]](#endnote-18)

The Claims Administrator denial of coverage here clearly reflects a failure to consider the diagnostic complexity of Mr. Doe’s treatment-refractory depression and anxiety; debilitating functional impairments; suicidality; co-morbid alcohol use disorder and vulnerability to relapse; and the impact of early adversity and trauma on Mr. Doe’s emotional development, symptom severity and chronicity, disruptions in his support systems, difficulty forming and maintaining trusting treatment alliances, and need for consistent immersion in a treatment environment with 24-hour nursing and other therapeutic supports.

Furthermore, Mr. Doe’s co-occurring alcohol use disorder represents an aggravating factor that necessitates a comprehensive, coordinated approach to treat any of his conditions effectively. Thus, Mr. Doe requires more structure and support than can be provided through even the most rigorous outpatient program. Mr. Doe’s considerable needs were communicated to Claims Administrator representatives during several utilization reviews and directly to Dr. Insurance during the peer-to-peer review on [insert date].

Since the date of denial, Mr. Doe’s symptom profile has included persistent depressed mood, anxiety, suicidal ideation, sleep and appetite disturbances, poor motivation, feelings of hopelessness, helplessness, shame, and guilt, self-critical ruminations, unstable interpersonal relationships, social isolation, struggles around trust, and cravings for alcohol and other mood-altering substances. Because of these symptoms, Mr. Doe has been unable to complete college, sustain gainful employment, meet his basic material needs independently, fulfill social responsibilities, engage effectively with outpatient providers, or consistently maintain sobriety and complete activities of daily living without intensive care and support.

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**,[[27]](#endnote-19) [[28]](#endnote-20) [[29]](#endnote-21) and include services needed to **improve functioning, maintain day-to-day functioning, and to prevent deterioration**.[[30]](#endnote-22) [[31]](#endnote-23) [[32]](#endnote-24) 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.[[33]](#endnote-25) [[34]](#endnote-26) [[35]](#endnote-27) In this case, Claims Administrator failed to consider what service would truly be the most effective and prevent deterioration.

Mr. Doe has a history of two inpatient psychiatric hospitalizations, and he has been unable to achieve more than intermittent and partial benefit from outpatient treatment, including multiple partial hospitalization and day treatment programs. While Mr. Doe’s mental health and substance use conditions are longstanding, he has experienced a progressive and serious psychiatric decompensation over the past year in the context of numerous stressors (e.g., family discord, difficulty transitioning to college, experiences of racism). Given the precariousness of his sobriety and suicidal vulnerabilities, Mr. Doe, his family, and his outpatient treaters recognized his need for more intensive sustained care, and he entered treatment at the Name of the Treatment Center.

Residential treatment at the 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, Mr. Doe is working to identify and address the painful feelings and experiences that underlie his chronic mood instability, anxiety, dangerous suicidality, severe alcohol dependence, interpersonal struggles, and functional impairments. He is working to use intra- and interpersonal supports to directly face and manage intense feelings instead of exclusively relying upon ineffective and, at times, life-threatening strategies such as social isolation, emotional suppression, suicidal thinking and behavior, and alcohol use. Unfortunately, this Claims Administrator denial of coverage threatens to prematurely close a course of residential mental health treatment that is effectively addressing Mr. Doe’s current symptoms as well as his underlying vulnerabilities to repeated episodes of acute illness.

I trust you are committed to upholding your legal responsibility as Mr. Doe’s fiduciary. As such, I respectfully suggest that you reconsider your decision to deny Mr. Doe’s request for residential mental health treatment using access to care criteria that are consistent with generally accepted standards of care as widely recognized by the behavioral health and psychiatric medical community, such as the LOCUS, which I used to determine Mr. Doe’s treatment needs. The LOCUS is a nationally used third-party guide developed by the American Association of Community Psychiatrists that assesses service needs over six dimensions and six defined levels of resource intensity.

Based on the following LOCUS scores, Mr. Doe meets criteria for **Level Five - Medically Monitored Residential Services**, which he is receiving at the Name of the Treatment Center. Here are his 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]

As outlined in this appeal, I believe a reasonable person would conclude that the Name of Guidelines used to make this coverage determination are far more restrictive than those that are generally accepted, even though Mr. Doe’s health insurance plan provides for coverage of treatment that is consistent with generally accepted standards of care. I also believe a reasonable person would conclude that this denial was arbitrary and capricious. Mr. Doe suffers from serious and destabilizing mental health and substance use conditions and was denied coverage for residential care after only *two weeks* of treatment purportedly due to lack of “medical necessity.”

Generally accepted standards of medical practice do not place artificial time limits on residential mental health treatment, especially for patients like Mr. Doe, whose behavioral health conditions are chronic and refractory.[[36]](#endnote-28) It is my professional opinion that Mr. Doe’s condition will further deteriorate if his treatment services are prematurely withdrawn. 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**.[[37]](#endnote-29)

You should be aware that this denial of coverage has likely imposed a substantially greater burden and expense upon Mr. Doe than if he had sought comparable non-psychiatric medical services. Both the American Medical Association and the American Psychiatric Association oppose medical necessity criteria that prioritize cost and resource utilization above quality and clinical effectiveness and prevent patients’ access to needed medical care.[[38]](#endnote-30) [[39]](#endnote-31) 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.”[[40]](#endnote-32) The decision to deny residential treatment through use of aberrant proprietary medical necessity guidelines that are not recognized by practitioners and non-profit medical specialty groups could be interpreted as an effort to evade compliance with this federal law and therefore discriminatory practice and a breach of the terms of Mr. Doe’s health Plan.

If you reassess Mr. Doe’s medical needs using guidelines that are consistent with generally accepted standards of medical care (e.g., the LOCUS, which makes a multidimensional assessment of the patient’s functioning and treatment needs not restrictively focused on crisis- or symptom-criteria), you will find, as I do, that Mr. Doe clearly meets criteria for medical necessity at a residential level of care. In my opinion, failure to consider his needs in this broader context ignores his actual medical needs, confuses symptom-reduction/crisis stabilization with clinical recovery, and represents a breach of the medical duty that you have toward Mr. 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 Mr. Doe will expect you to respond in a way that honors the terms of his 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 the name of the claims administrator in place of “Claims Administrator” throughout the document. This information can be found in the adverse determination (denial) letter.

Note: If the insurer did not utilize a third-party plan administrator, use the name of the insurance company throughout the document. [↑](#footnote-ref-2)
3. 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-3)
4. Hypothetical case for illustrative purposes. [↑](#footnote-ref-4)
5. 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-5)
6. 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-6)
7. 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)
8. On May 6, 2021, The National Council for Behavioral Health changed its name to the National Council for Mental Wellbeing  [↑](#footnote-ref-7)
9. *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)
10. 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)
11. See “Eight Principles of Effective Treatment That Reflect Generally Accepted Standards of Care” [insert link here] [↑](#footnote-ref-8)
12. 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)
13. 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)
14. 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)
15. 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)
16. 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)
17. Druss, B.G. & Reisinger-Walker, E. (2011). *Mental disorders and medical comorbidity* [Research Synthesis Policy Brief No. 21]. Robert Wood Johnson Foundation, Princeton. http://www.rwjf.org/files/research/ 71883.mentalhealth.report.pdf [↑](#endnote-ref-9)
18. Dennis, M. & Scott, C.K. (2007). Managing addiction as a chronic condition. *Addiction Science & Clinical Practice, 4*, 45-55. doi:10.1151/ascp074145 [↑](#endnote-ref-10)
19. LOCUS, *supra* note 5. [↑](#endnote-ref-11)
20. 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-12)
21. 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-13)
22. 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-14)
23. 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-15)
24. APA, *supra* note 8. [↑](#endnote-ref-16)
25. APA, *supra* note 13. [↑](#endnote-ref-17)
26. APA, *supra* note 13 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-18)
27. 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-19)
28. ASAM, *supra* note 7. [↑](#endnote-ref-20)
29. Lazar, *supra* note 15. [↑](#endnote-ref-21)
30. CMS, *supra* note 14. [↑](#endnote-ref-22)
31. SAMHSA, *supra* note 12. [↑](#endnote-ref-23)
32. LOCUS, *supra* note 5. [↑](#endnote-ref-24)
33. ASAM, *supra* note 7. [↑](#endnote-ref-25)
34. Lazar, *supra* note 15. [↑](#endnote-ref-26)
35. Plakun, *supra* note 19. [↑](#endnote-ref-27)
36. CMS, *supra* note 14. [↑](#endnote-ref-28)
37. 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-29)
38. 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-30)
39. 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-31)
40. Lazar, *supra* note 15. [↑](#endnote-ref-32)