NATIONAL COUNCIL
FOR BEHAVIORAL HEALTH

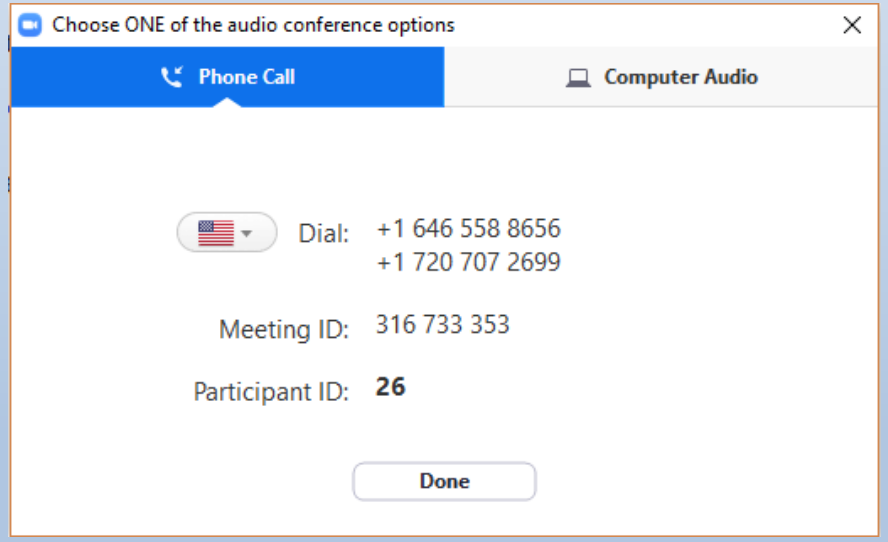
Medical Director Institute Presents:

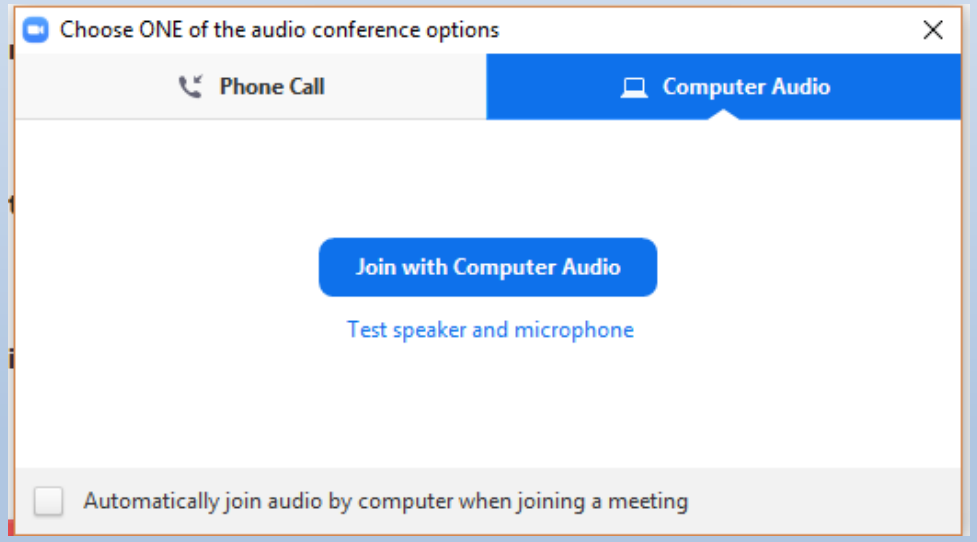
Upholding Generally Accepted Standards of Care: Strategies Informed by the Wit Case

Thursday, March 5, 2020
1:30-3:00pm ET

Webinar Logistics: Audio

- Call in **on your telephone**, or use your **computer audio option**
- **If you are on the phone, remember to enter your Audio PIN** so others can hear you
- **Please mute your line** when you are not speaking since we will have lines open throughout the call





Webinar Logistics: How to Ask a Question

Prefer to write?

Type in the chat box or use the Q&A function. Both are located at the bottom of your screen. You can choose who to send a chat or question to.

Prefer to talk?

"Raise your hand" and we will unmute you to ask your question to the group.

Speakers

Joseph Parks, MD
Vice President, Practice Improvement
National Council for Behavioral Health

Eric Plakun, MD
Medical Director & CEO
Austen Riggs Center

Lindsi DeSorrento, MPH
Director, Healthcare Transformation
National Council for Behavioral Health

Objectives

1. Identify systemic factors that influence care denials

2. Hear directly from a service provider who has incorporated learning from the Wit case into level of care determination and appeal process

3. Learn how to use the toolkit and apply learning from the Wit case to ensure care decisions are based on generally accepted standards of care

4. Discuss implications for your organization: Q&A

Poll #1: What best describes your role?

- Medical Director
- Insurer
- Administrator/Leadership
- Process appeals and/or obtain PA
- Community Stakeholder
- Other (specify in chat box)

Setting the Stage: Problem Summary

- There is a disconnect between how treating clinicians assess what care is needed and how the insurance utilization review clinician assesses what care is needed.
  - Treating clinician focuses on **recovery, a treatment goal within generally accepted standards of care**
  - Utilization review clinician focuses on **crisis stabilization, which is too restrictive**

THIS LEADS TO WRONGFUL CARE DENIALS

Setting the Stage: Shared Responsibility

Mental Health & Substance Use Disorder (MH/SUD) Organizations

- Know generally accepted standards of care
- Determine patients' level of care needs and apply generally accepted standard of care appropriately
- Clearly communicate with insurers about how to appropriately apply generally accepted standards of care when there is a disconnect

Insurers

- Know generally accepted standards of care
- Uphold fiduciary duty by authorizing care that is consistent with generally accepted standards.
- Apply generally accepted standards of care appropriately and systematically to complete utilization reviews
- Allow reasonable timeframes and opportunities for patient information exchange that lends itself to a multidimensional assessment

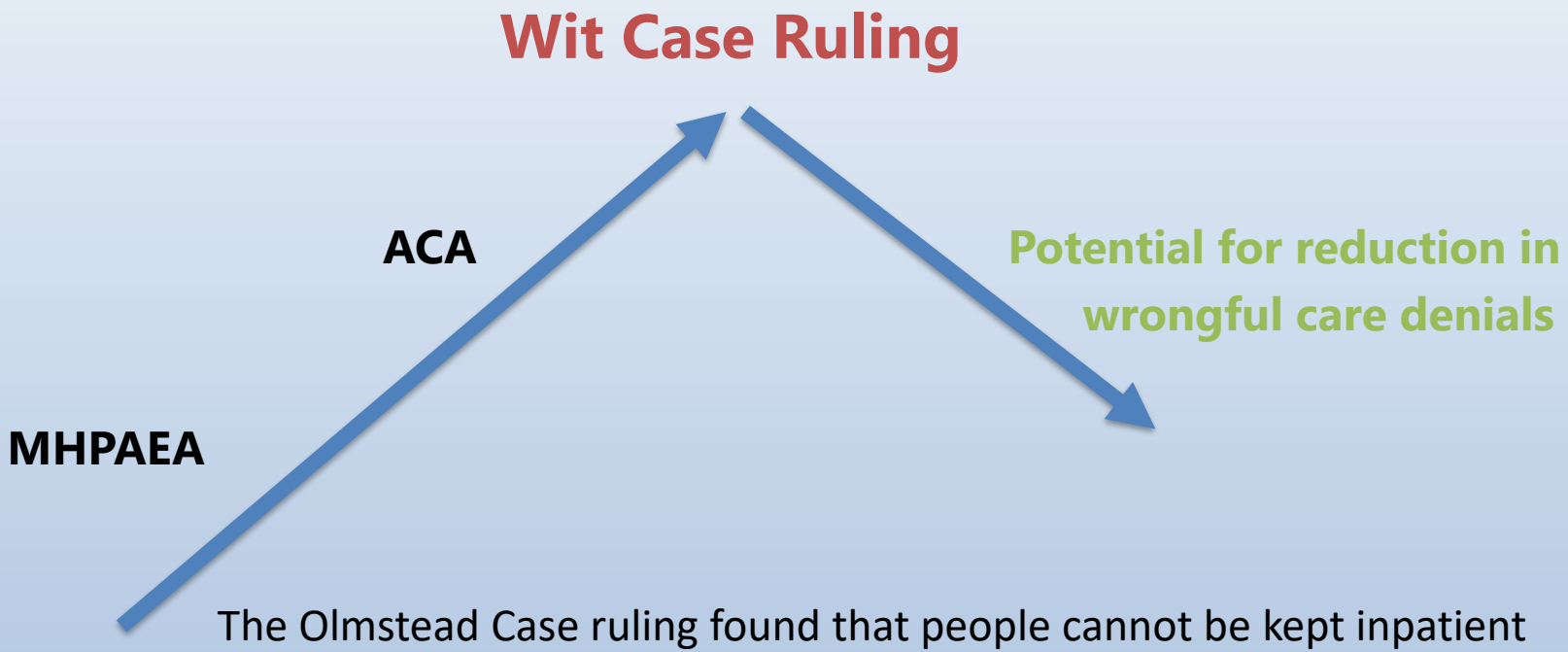
How did we get here?
Regulatory Environment

Lack of regulation meant that insurance companies were free to limit treatment to crisis stabilization

Steps in the right direction:

- 2008 Mental Health Parity and Addiction Equity Act (MHPAEA)
- Affordable Care Act

The Tipping Point: Wit Case



The Olmstead Case ruling found that people cannot be kept inpatient without providing standard of care treatment. The Wit Case ruling finds that outpatients must also be provided with standard of care treatment. https://en.wikipedia.org/wiki/Olmstead_v._L.C.

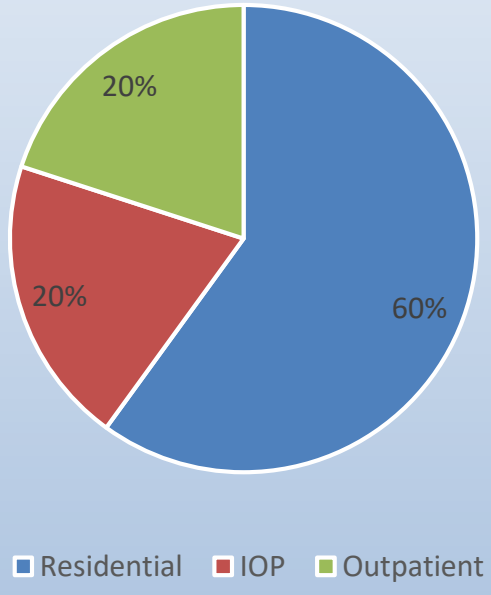
Wit Case Overview: Plaintiffs

Eleven plaintiffs asserted UBH failed to uphold its statutory obligation as a fiduciary by making benefits decisions based on its own financial interests rather than the healthcare needs of its beneficiaries. Their claims were based on the position that in all cases, UBH's guidelines for making coverage determinations for access to outpatient, intensive outpatient and residential treatment were more restrictive than generally accepted standards of care.

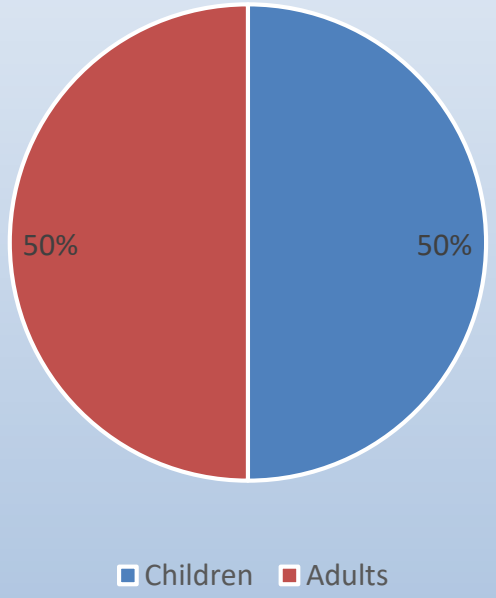
Because it is a class action suit, the ruling applies to over **50,000** similarly insured individuals.

Wit Case Overview: Plaintiff Characteristics

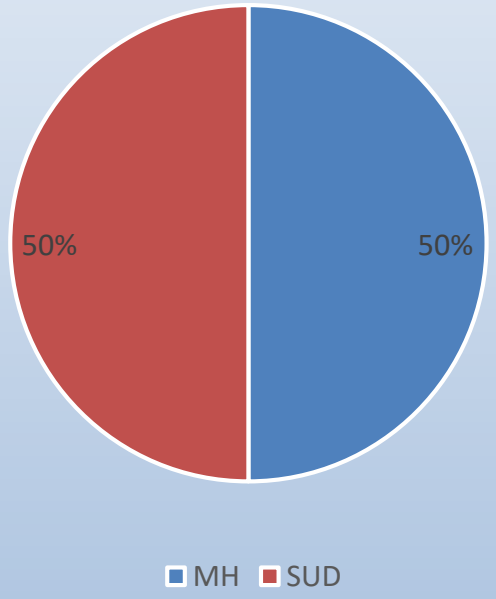
Treatment Type



Age

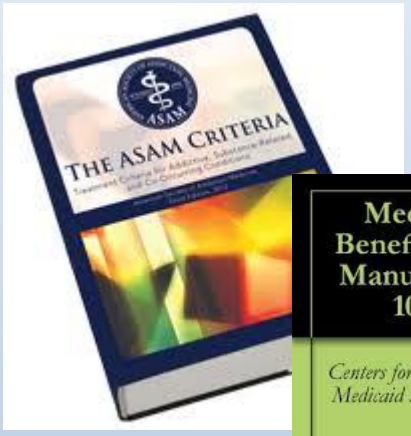


Disorder Type



Wit Case Overview: Court Findings

There is no single source of generally accepted standards of care; rather there are multiple sources, including:



Medicare Benefit Policy Manual IOM 100-2

Centers for Medicare and Medicaid Services CMS

PRACTICE GUIDELINE FOR THE
Treatment of Patients With Major Depressive Disorder
Third Edition

LOCUS

LEVEL OF CARE UTILIZATION SYSTEM
FOR
PSYCHIATRIC AND ADDICTION SERVICES

Adult Version 2010

AMERICAN ASSOCIATION COMMUNITY PSYCHIATRISTS

March 20, 2009

CASII
CHILD & ADOLESCENT SERVICE INTENSITY INSTRUMENT

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY
WWW.AACAP.ORG

Principles of Care for Treatment of Children and Adolescents with Mental Illnesses in Residential Treatment Centers

June 2010

PRACTICE GUIDELINE FOR THE
Treatment of Patients With Substance Use Disorders
Second Edition

Wit Case Overview: Court Findings
Eight Generally Accepted Standards of Care

- Treats underlying problems and not just the current presenting problem
- Treats co-occurring conditions
- Uses a multidimensional assessment to determine level of care (e.g., LOCUS, ASAM criteria)
- Duration is individualized and without arbitrary limits
- Treatment may be to maintain functional capacity or prevent deterioration
- Treatment approach should be both Safe and Effective. [Cannot sacrifice effectiveness because a treatment is equally safe.]
- Addresses special needs of children and adolescents when making level of care decisions
- Errs on the side of caution by using a higher level of care when there is ambiguity

Wit Case Overview: Court Ruling

- UBH **breached its duty as fiduciary** and were liable with respect to the denial of benefits claim.
- UBH **violated state laws** in those states that mandate the use of specific level of care guidelines (Illinois, Connecticut, Rhode Island and Texas).
- UBH's guidelines were **more restrictive than generally accepted standards of care.** There was an overemphasis on moving patients to a less restrictive setting and creating a system focused on treating acute symptoms rather than facilitating long-term improvement or maintenance of existing function and treatment of underlying conditions.
- UBH's guidelines were "fundamentally flawed because [the process] is **tainted by UBH's financial interests**."

Implications for MH/SUD Organizations

1. Framework stipulated by court is **widely applicable**
   - Any insurance coverage where there is a requirement either in statute, regulation or contract terms that the coverage be consistent with the generally accepted community standard of care
   - The proprietary guidelines used to make coverage decisions regarding behavioral health services by other insurance companies as applied in operation are also often in violation of the eight principles enunciated by the court
2. Potential **state law** violations
3. Potential overemphasis on crisis stabilization and treatment of acute symptoms and de-emphasis on **longer-term, comprehensive care**
4. Potential overemphasis on treatment that is safe and de-emphasis on treatment that is maximally **effective**

Implications Continued

5. **Children and adolescents** may be especially vulnerable

6. **Residential care** may be particularly at risk for denial

7. **MH/SUD professional organizations are influential stakeholders** in advocating for the proper use of generally accepted standards of care

Involvement in the Wit case: Why me?

- Plaintiffs' attorneys for Wit sought an expert in assessing need for outpatient, intensive outpatient and residential levels of care for mental disorders
- Several decades at Austen Riggs as Director of Admissions & Treatment Team Leader making level of care decisions and overseeing appeals to insurance companies
- Over 40 years practicing psychiatry and psychoanalysis
- Broad knowledge & experience in organized psychiatry (APA, GAP, ABPN, etc.)

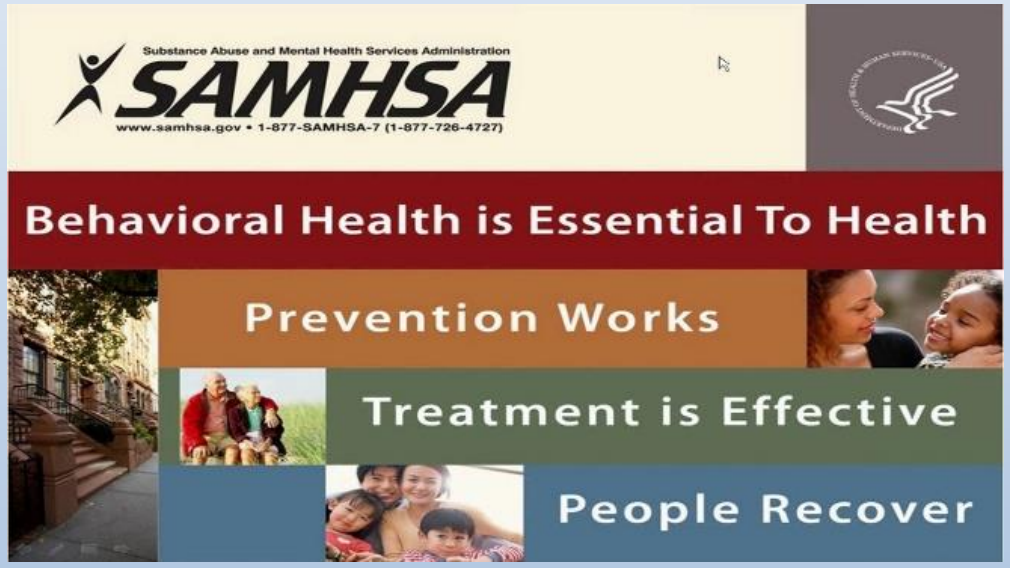
I had an open mind when I agreed to review UBH criteria. After all, managed care operates with the same moral imperative as the environmental movement

- We face a world of limited resources
- Whether this is the amount of greenhouse gas the earth can absorb without manmade climate change
- Or the costs of health insurance
- We must recognize the problem and manage limited **resources—while providing care within GAS**

Evaluating access to care criteria requires understanding the goal of M/SUD treatment

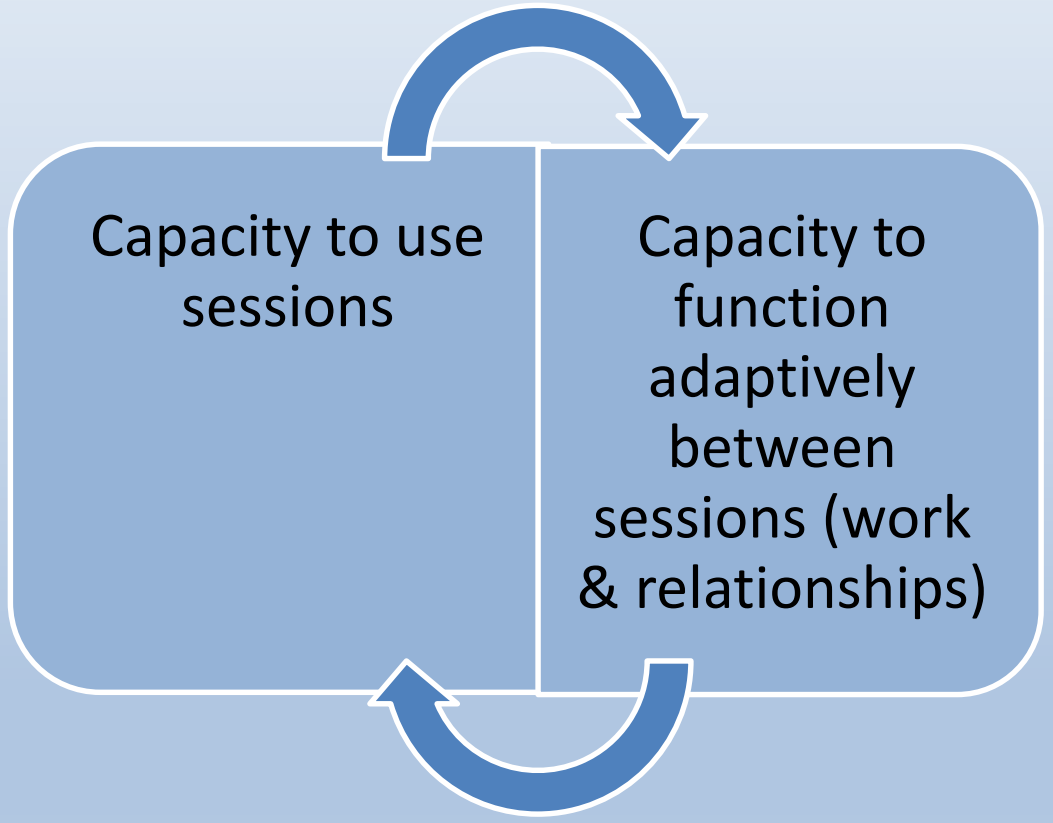
- Many pts struggle with:
- Chronic or recurrent disorders
- Comorbid disorders
- Early adversity or recent trauma
- EBTs work, but tested on single disorder "unicorn" pts
- Higher EBT failure rate with comorbidity, ACE
- Given this reality, the generally accepted goal of treatment is **improvement in functional status** to achieve:

SAMHSA definition of recovery from M/SUD aligns with generally accepted standards (GAS)



"A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential."

Outpatient treatment—the usual road to recovery in M/SUD treatment — requires two skills:



If one or both are impaired, we add services or move toward 24/7 immersion in treatment

Adding services

- Medications
- Therapy
- More frequent sessions
- Skills training
- Group and/or family Tx
- SUD or other treatment of comorbid disorders
- Eventually becomes IOP [~8/week] or PHP [~20/ week] as hours increase

24/7 Immersion services

- Inpatient setting if imminent risk of harm (Acute RTC?).
- Goal is "Crisis stabilization."
- RTC to grapple with underlying issues interfering with outpatient functioning, eg comorbidity, ACE, recent trauma.
- Goal is **improved functional status** to achieve **recovery**.

What I found was UBH criteria for M/SUD treatment differed from GAS familiar to clinicians

- Focus on “Crisis stabilization” and not “Recovery”
- Limiting access to care to current problem and then reducing or ending services
- Limiting intermediate levels of care (IOP, PHP, RTC) to crisis stabilization
- Doesn’t turn down the flame making the pot boil over!
- IOP and RTC became the canaries in the coal mine

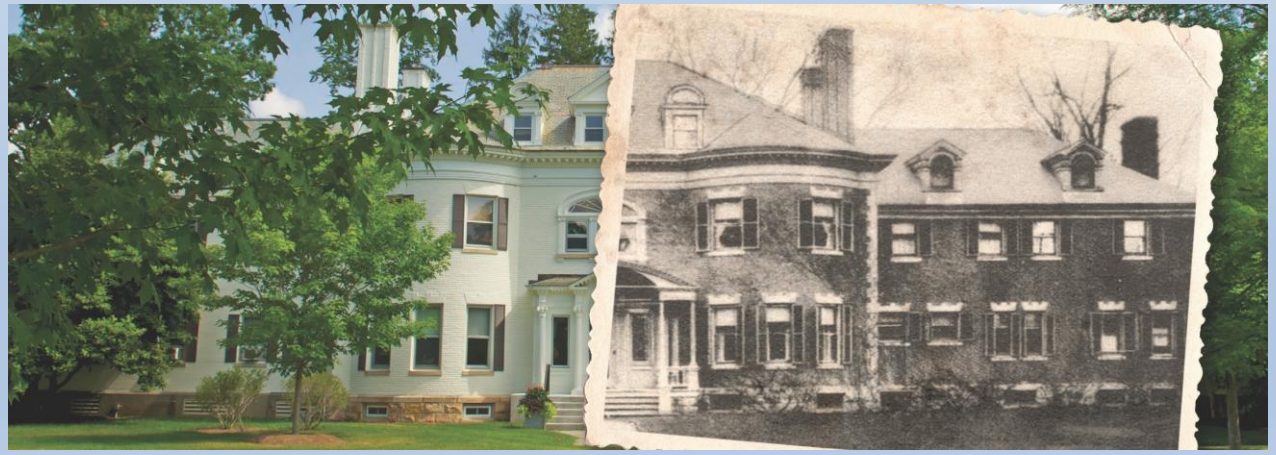
Recovery is a treatment goal that is within "generally accepted standards," but, when managed care expanded in the 1990s, insurance entities substituted the goal of crisis stabilization

- In the unregulated Wild West of that time, insurance entities were free to limit treatment to crisis stabilization
- Since then we have seen MHPAEA, ACA & Wit verdict that change things

Austen Riggs developed a systematic appeals strategy

Austen Riggs is a hospital-based continuum of care

- Most patients at RTC or IOP levels of care
- Followed by same team and in 4 times weekly therapy with same doctoral level therapist throughout all levels of care in a median 6-month length of stay.
- Fully open setting maximizing patient freedom and responsibility
- Riggs is: Where “treatment resistant” patients become people taking charge of their lives

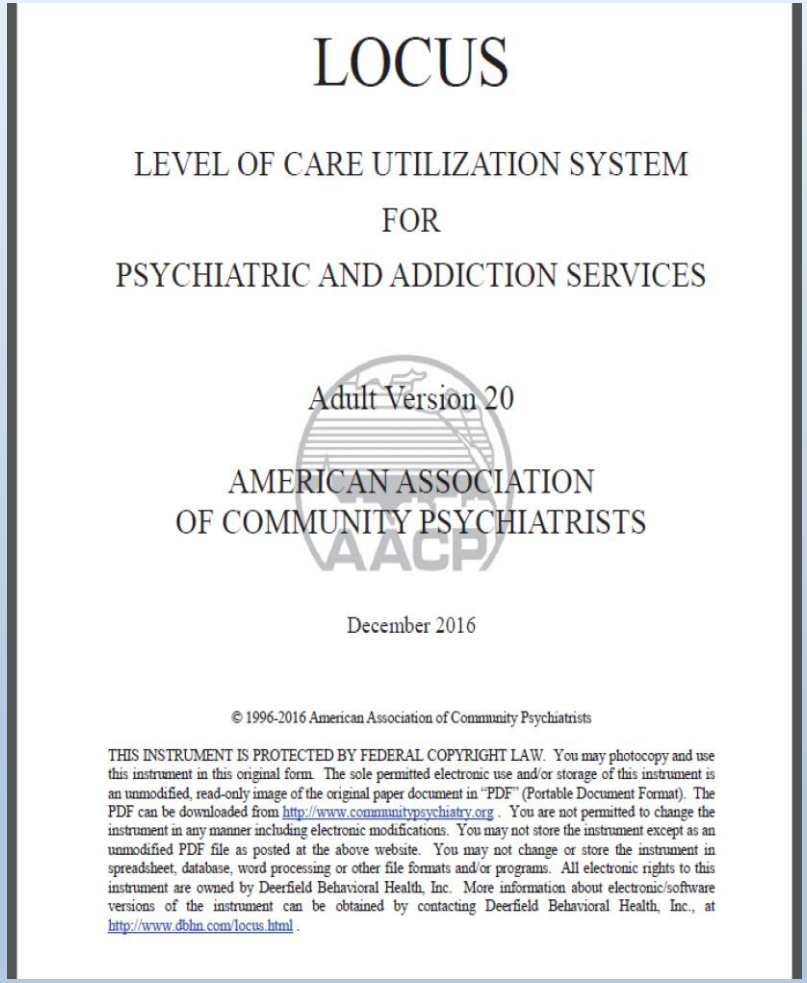


Consistent with our clinical mission, we developed an appeals process that

- Mobilizes the patient's voice as party to a legally binding contract
- Considers pros and cons of patient's use of an attorney
- Anchors appeals to third party resources (LOCUS, practice guidelines)
- Invokes the parity law
- Uses letter templates [shared with NCBH]
- After the Wit verdict, we added citation of elements of the verdict
- This is not about improving collections from insurers, but about holding insurance entities to generally accepted standards of care as required by top-down legislation and bottom-up litigation that "tame the wild west of managed care"

Level of Care Utilization System or LOCUS from American Association for Community Psychiatry (AACP)

- An example of professional society input creating GAS
- Widely used (26 states and several countries) to determine level of care
- Often cited as a source document for insurance UR standards for access to care



LOCUS

LEVEL OF CARE UTILIZATION SYSTEM
FOR
PSYCHIATRIC AND ADDICTION SERVICES

Adult Version 20

AMERICAN ASSOCIATION
OF COMMUNITY PSYCHIATRISTS

December 2016

3 Components of LOCUS: Looks beyond crisis stabilization to recovery

Defines 6 dimensions (safety, functional capacity, comorbidity, response to previous treatment, strengths, etc.) for assessing level of care needs

Describes levels of care from outpatient through inpatient hospitalization

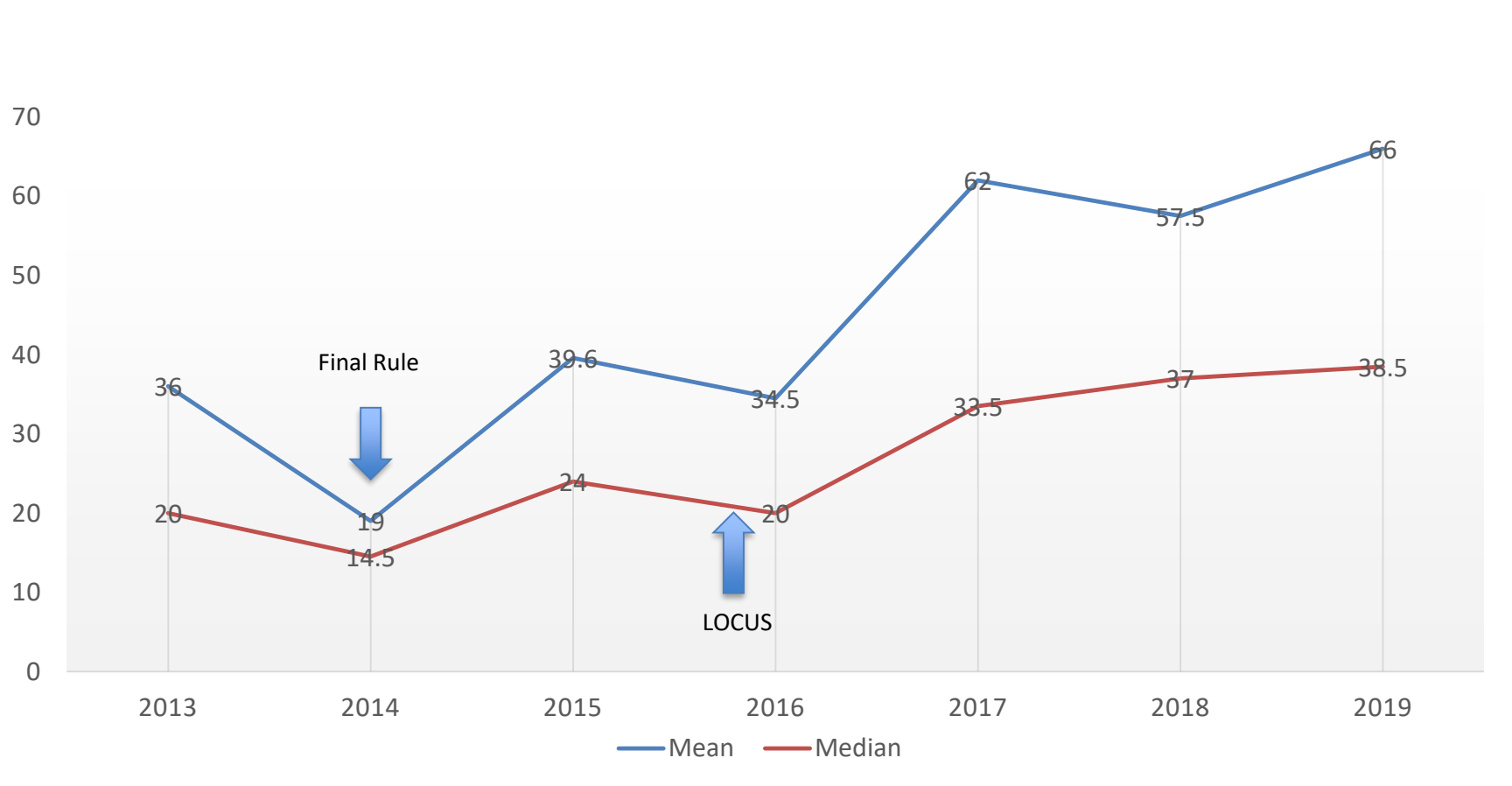
Offers quantitative methodology to rate appropriate level of care based on **total score** across all 6 dimensions or **override** scores

In our system, therapists do doc to doc reviews or write appeal letters.

Tips from our experience:

- When seeking treatment beyond outpatient, speak about the patient's problems and overall need for treatment . . .
- But also make the case for their need for the specific level of care sought
- In appeals, focus letter or conversation on reasons for denial
- Nothing helps more than citing the LOCUS and the Wit verdict, as in:
  - "I understand you and I disagree about the need for X level of care, but the patient's LOCUS score aligns with my view, and it is the kind of multidimensional, independent, third party assessment, used in most states and other countries, that Judge Spero cited as essential in the Wit verdict"
- Document hold times, flawed numbers, different benefit explanations, and PERSIST

Riggs experience with RTC coverage 2013 to 2019 in those with OON RTC benefit
(Mean and median days covered per patient)



Going forward

Micro level:

Appeals and reviews

- At Riggs we will make NCBH toolkit available to our UR staff and clinicians

Macro level:

Taming the "Wild West"

- There has never been a better time for **clinicians** and our **professional organizations**
- To **reclaim our authority** over generally accepted standards
- For the good of those we serve
- **Judge Spero is a new sheriff in town. Let's help him bring in the rule of law to "Tame the Wild West"**

Toolkit Overview: What is it?

- **What need does this address?**

  Helps to bridge the gap between how generally accepted standards are understood and applied by payers and providers

- **Why is this especially relevant now?**

  2019 federal court case, Wit v. United Behavioral Health (UBH)

  Parity laws

- **What does the toolkit contain?**

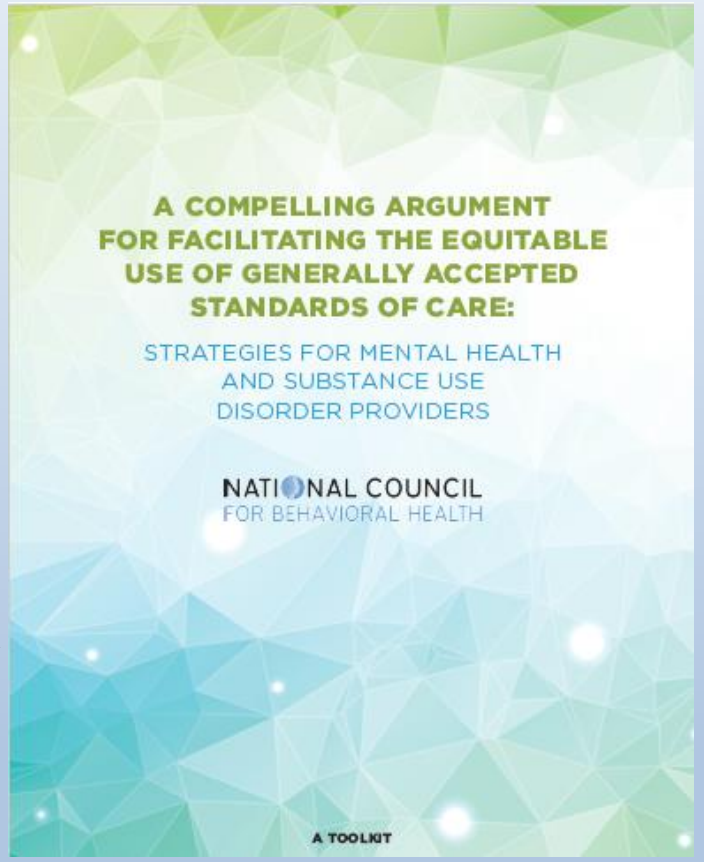
  Provides a compelling argument for upholding generally accepted standards of care and practical tools for implementing an effective appeal strategy. The recommended approach supplements general appeal guidance with important findings from the Wit case

  Does **not** contain legal advice

Toolkit Overview: How should it be used?

- **Who should use the toolkit?**
  MH/SUD organizations, particularly administrators, clinicians and staff who process claim denial appeals and prior authorizations

- **How should the toolkit be used?**
  Use the recommended strategies and resources within the toolkit to ensure patients are receiving access to medically necessary services as determined by appropriately applying generally accepted standards of care



Appeal Strategy: Data Analysis

Examine your organization's **claims denial data** to identify where insurers' reasons for denials are at odds with one or more of the eight standards of care principles

Appeal Strategy: Review Criteria Considerations

- Understand each of your common **insurer's utilization review criteria**
- Consider systematically using the **ASAM Criteria, LOCUS and CALOCUS** as medical necessity criteria in your organization

Appeal Strategy: Incorporate Wit Case Language

- **Educate staff** on the Wit case ruling, important language and how to incorporate the findings into the appeal process.

- Modify appeal request language and routinize sending appeal letters that **cite rationale from the Wit case ruling**

- **Be prepared with talking points** that cite language from the Wit case ruling if you must speak with insurance utilization reviewers over the phone, and **advocate for a peer review** rather than a chart review

Appeal Strategy: Thoroughness and Consistency

- Make the case for **immersive residential treatment**
  - Intermediate levels of care inherently address issues far beyond acute care needs, and are therefore more vulnerable to denial from an insurance company that overemphasizes crisis stabilization
- Maintain **documentation**
- Be **persistent**

Appeal Letters: Element #1

Explain that the ineligibility determination **violates generally accepted standards of care**.

"The Court finds, by a preponderance of the evidence, that UBH has breached its fiduciary duty by violating its duty of loyalty, its duty of due care and its duty to comply with plan terms by adopting Guidelines that are unreasonable and do not reflect generally accepted standards of care," and further, that "by a preponderance of the evidence, that UBH's Guidelines were unreasonable and an abuse of discretion because they were more restrictive than generally accepted standards of care."

Appeal Letters: Element #2

Reference professional or academic sources of generally accepted standards of care as supporting evidence of medical necessity.

"There is no single source of generally accepted standards of care. Rather, they can be gleaned from multiple sources, including peer-reviewed studies in academic journals, consensus guidelines from professional organizations and guidelines and materials distributed by government agencies."

Appeal Letters: Element #3

State that the decision is **noncompliant with MHPAEA** and explain why, when applicable. Draw the connection between overly restrictive guidelines and a violation of the parity law.

"The record is replete with evidence that UBH's guidelines were viewed as an important tool for meeting utilization management targets and mitigating the impact of the 2008 Parity Act."

Appeal Letters: Element #4

State the specific standard of care, as written in the court proceedings, that the insurer is violating. Provide rationale for why it constitutes a violation.

For example, when applicable, assert that effective care accounts for the unique needs of children/adolescents.

"One of the most troubling aspects of UBH's Guidelines is their failure to address in any meaningful way the different standards that apply to children and adolescents with respect to the treatment of mental health and substance use disorders."

Appeal Letters: Element #5

When there is disagreement between your staff and the insurer's utilization reviewers, close by reiterating that the disagreement is representative of ambiguity as to the appropriate level of care, in which case insurers and practitioners should **err on the side of caution** by placing the patient in a **higher level of care**.

Generally accepted standard of care stipulated by the court.

Appeal Letter Sample: Introductory Paragraph

Based on generally accepted standards of care set forth in the Wit v. United Behavioral Health (UBH) (No. 14-cv-02346-JCS) federal court ruling, I believe that your denial of Ms. Gale's residential services violates six of the eight generally accepted standards of care. I trust that you are committed to upholding your legal responsibility as your patient's fiduciary, and respectfully suggest that you reconsider your decision by applying standards that are consistent with sources of generally accepted standards of care, such as the Level of Care Utilization Standards (LOCUS).

Appeal Letter Sample: Explanation of Standard Violation

The court stipulated that effective treatment requires treatment of co-occurring disorders and underlying conditions (including mental health, substance use and medical) in a coordinated manner that considers the interactions of the disorders. In this case, the reviewer violated these two standards by focusing too narrowly on current symptomatology and acute care needs and failed to consider Ms. Gale's diagnostically complex conditions. She meets criteria for Major Depressive Disorder, Recurrent, Severe, with Anxious Distress and Unspecified Personality Disorder...etc.

Appeal Letter Sample: Conclusion Paragraph

Finally, at best, our disagreement about the appropriate level of care could be representative of ambiguity about the appropriate level care, in which case the court has found that the generally accepted standard of care is to err on the side of safety and authorize the higher level of care.

Peer Review Sample Script

- *I believe that a denial of [patient name]'s [service type requested] would violate [number] of the eight generally accepted standards of care. Following these standards is seen as best medical practice; a failure to do so puts your company at risk for violating parity law.*

- *One of the affirmed standards is that effective treatment must be based on a multidimensional assessment that accounts for many types of information. I'd like to provide you with that information so you can make a fair decision that is consistent with your legal fiduciary duty to [patient name].*

Access Toolkit & Contact Information

Please visit www.thenationalcouncil.org/standards-of-care/ to download a copy.

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Eric Plakun: Eric.Plakun@austenriggs.net
Lindsi DeSorrento: LindsiL@thenationalcouncil.org


Q
A

Upcoming Webinars and Events

- Refining Community Mental Health Settings: How Design Thinking can Improve Provider and Patient Satisfaction
  - **March 16th, 12-1pm ET**
  - Registration link: https://zoom.us/webinar/register/3215833621441/WN_he0vJ7yPS12T3ZOX2awPag

To register, visit https://www.eventscribe.com/2020/NatCon20/

Thank You

Questions?

Email Vidyaj@thenationalcouncil.org