A COMPELLING ARGUMENT FOR FACILITATING THE EQUITABLE USE OF GENERALLY ACCEPTED STANDARDS OF CARE:

STRATEGIES FOR MENTAL HEALTH AND SUBSTANCE USE DISORDER PROVIDERS

NATIONAL COUNCIL
FOR BEHAVIORAL HEALTH

A TOOLKIT

Acknowledgements

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Addressing Overly Restrictive Standards of Care Guidelines as a Parity Violation

Though some advances have been made since the enactment of a series of federal laws to enforce equal insurance coverage for the treatment of mental and substance use disorders (M/SUDs) and medical and surgical care, **inequities persist**.

According to America's Mental Health 2018 study, 42 percent of the U.S. population considered cost and poor insurance coverage top barriers for accessing mental health care and 25 percent reported having to choose between getting mental health treatment and paying for daily necessities.[1] The result of this inequity is that people, including the nation's youth, are being denied access to medically necessary and effective care. A recent court ruling in the Wit v. United Behavioral Health case (hereafter referred to as the Wit case) highlights the ongoing issues around insufficient access to care and insurance coverage for M/SUD treatment. The court found that United Behavioral Health (UBH) denied patients coverage for M/SUD services because the guidelines they were using to make care determinations were more restrictive than generally accepted standards of care. This landmark case provides powerful justification for mental health and substance use disorder (MH/SUD) organizations as they pursue appeals for overly restrictive insurance utilization decisions.

[1] Cohen Veterans Network and National Council for Behavioral Health (2018). America's Mental Health 2018: Attitudes & Access to Care. Retrieved from https://www.cohenveteransnetwork.org/wp-content/uploads/2018/10/Research-Summary-10-10-2018.pdf.

Call to Action

Claim Responsibility for Applying Generally Accepted Standards of Care

Claim your role as the expert authority on generally accepted standards of care. As clinicians and behavioral health professionals, you have a professional and moral obligation to ensure your patients receive medically necessary and effective care. You also have valuable expertise in generally accepted standards of care and experience assessing clinical need based on these standards. It can feel discouraging to routinely encounter situations where care decisions are made based on criteria that are misaligned with your expert opinion and the widely accepted sources of appropriate standards. Luckily, the shifting legal landscape has provided a unique opportunity for payers and providers to bridge this gap in how generally accepted standards are understood and applied. This toolkit provides a roadmap for MH/SUD professionals and organizations as they claim their expert authority and partner with payers to facilitate appropriate access to care.

Use This Toolkit

Intended audience. This toolkit is intended for MH/SUD organizations, particularly administrators, clinicians and staff who process claim denial appeals and prior authorizations. MH/SUD organizations should use the recommended strategies and resources within the toolkit to ensure their patients are receiving access to medically necessary services as determined by appropriately applying generally accepted standards of care.

Toolkit contents. Toolkit contents. This toolkit 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. This groundbreaking ruling established a clear set of generally accepted standards of care that is consistent with widely accepted professional sources of standards (including the Level of Care Utilization System for Psychiatric and Addiction Services Standards [LOCUS][2], Child and Adolescent Level of Care Utilization System (CALOCUS)[3] and the American Society for Addiction Medicine Treatment Criteria for Addictive, Substance Related and Co-Occurring Conditions [ASAM Criteria][4]).

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[2] American Association of Community Psychiatrists (2016). Level of Care Utilization Standards for Psychiatric and Addiction Services. Retrieved from https://sites.google.com/view/aacp123/resources/locus.
[3] American Association of Community Psychiatrists (2010). Child and Adolescent Level of Care Utilization System. Retrieved from https://cchealth.org/mentalhealth/pdf/CALOCUS.pdf.
[4] American Society of Addiction Medicine (2019). The ASAM Criteria. Retrieved from https://www.asam.org/resources/the-asam-criteria/about.

One critical implication of the Wit case ruling for MH/SUD organizations is that the framework stipulated by the court may be applied to all payers. The reason for this is that virtually all insurance coverage, including Medicaid managed care plans, require the requested treatment to be consistent with generally accepted standards of care. Another major implication is that the case alerts MH/SUD organizations to insurers' potential propensity to overemphasize crisis stabilization and acute care needs; they do so by disregarding a multidimensional assessment that accounts for patients' co-occurring disorders, underlying conditions, developmental stage, care history and other critical information.

Learnings from the court case and general guidance on appeal strategies are distilled here to provide MH/SUD organizations with an implementation guide that addresses the top 11 concepts of effective appeals. It also includes appeal letter templates for providers and patients and talking points for behavioral health staff who participate in utilization reviews over the phone. These resources include critical language from the Wit case ruling and draw the connection between generally accepted standards of care and parity issues. This toolkit does not provide legal advice, nor does it provide a comprehensive step-by-step appeal process guide, though it includes complimentary appeal strategy resources; rather it provides actionable guidance to enhance the appeal approach.

Wit Case Summary

LANDMARK RULING

On March 5, 2019, Chief Magistrate Judge Joseph C. Spero of the U.S. District Court for the Northern District of California delivered a groundbreaking ruling in the Wit case (Case No. 14-cv-02346-JCS)[5]. The court found that UBH wrongfully denied plaintiffs coverage for mental health and substance use service benefits because UBH's Level of Care Guidelines and Coverage Determination Guidelines were more restrictive than generally accepted behavioral health standards of care. As part of its determination, the court enunciated eight principles of accepted standards of care. These principles align with generally accepted standards that behavioral health service providers use when recommending treatment (e.g. LOCUS/CALOCUS, ASAM Criteria). This powerful declaration of accepted standards of care now serves as legal leverage for those seeking appropriate care and those advocating on behalf of others.

[5] United States District Court, Northern District of California (2019). David Wit et al., Plaintiffs v. United Behavioral Health, Defendant: Findings of Fact and Conclusions of Law. Retrieved from: https://www.cand.uscourts.gov/filelibrary/3631/C14-2346-JCS_Redacted-FF-and-CL.pdf.

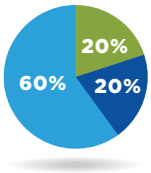
Plaintiffs

Eleven plaintiffs (representing 10 beneficiaries of UBH health plans) brought charges against UBH, though because it is a class action suit, the ruling applies to over 50,000 similarly insured individuals. Plaintiffs include children and adults who were seeking residential, intensive outpatient and outpatient services for M/SUDs. Sixty percent of the beneficiaries were denied residential treatment and half of the beneficiaries were children 18 years old or younger, a population that is particularly vulnerable due to their developmental stage. Lastly, half of beneficiaries sought treatment for a SUD, while the other half sought treatment for a mental disorder, indicating that restrictive guidelines were exercised in both sectors of behavioral health service claims.

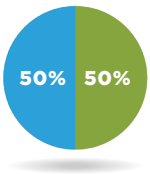
Linda Tillett filed on behalf of her son Maxwell, who was a UBH beneficiary. The Tilletts requested coverage under the plan for Max's residential treatment in Owatonna, M.N. In July 2015, Max was denied further coverage for residential treatment; just months later, he died of a drug overdose.[6]

WIT CASE PLAINTIFFS

Adults and Children:
50% children 18 or younger;
50% adults



Treatment Type:
60% residential
20% IOP
20% Outpatient



Disorder Type:
50% SUD
50% MH

Claims

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 were more restrictive than generally accepted standards of care.

[6] Snowbeck, C. (2019). Minnesota family's loss shows stakes in health plan fight. *Star Tribune*, May 18, 2019. Retrieved from http://www.startribune.com/minnesota-family-s-loss-shows-stakes-in-health-plan-fight/510119802/.

Court Rationale

The court made several conclusions that served as a framework for its findings. It stipulated that:

- UBH guidelines are clinical, not administrative decisions and therefore are not terms of the plan.
- There is no single source of generally accepted standards of care; rather there are multiple sources, including peer-reviewed studies in academic journals, consensus guidelines from professional organizations and materials distributed by government agencies.
- There are eight principles of generally accepted standards of care, as outlined in Figure 1.

Credible Standard of Care Sources According to the Court

American Society of Addiction Medicine (ASAM) Criteria[7]

Level of Care Utilization System (LOCUS)/Child and Adolescent LOCUS (CALOCUS)[8]

Child and Adolescent Service Intensity Instrument (CASII)[9]

Medicare Benefit Policy Manual[10]

Practice Guidelines for the Treatment of Patients with Substance Use Disorders[11]

Practice Guidelines for the Treatment of Patients with Major Depressive Disorder[12]

Principles of Care for Treatment of Children and Adolescents with Mental Illnesses in Residential Treatment Centers[13]

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[7] American Society of Addiction Medicine (2019). The ASAM Criteria. Retrieved from https://www.asam.org/resources/the-asam-criteria/about.
[8] American Association of Community Psychiatrists (2016). Level of Care Utilization Standards for Psychiatric and Addiction Services. Retrieved from https://sites.google.com/view/aacp123/resources/locus.
[9] American Academy of Child & Adolescent Psychiatry (no date). Child and Adolescent Service Intensity Instrument. Retrieved from https://www.aacap.org/Shared_Content/Shop/Categories/CASII.aspx.
[10] Centers for Medicare & Medicaid Services (no date). Medicare Benefit Policy Manual. Retrieved from https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS012673.
[11] American Psychiatric Association (2006). Practice Guideline for the Treatment of Patients with Substance Use Disorders: Second Edition. Retrieved from https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/substanceuse.pdf.
[12] American Psychiatric Association (2006). Practice Guideline for the Treatment of Patients with Major Depressive Disorder: Third Edition. Retrieved from https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/mdd.pdf.
[13] American Academy of Child and Adolescent Psychiatry (2010). Principles of Care for Treatment of Children and Adolescents with Mental Illnesses in Residential Treatment Centers. Retrieved from https://www.aacap.org/App_Themes/AACAP/docs/clinical_practice_center/principles_of_care_for_children_in_residential_treatment_centers.pdf.

Figure 1. Principles of Accepted Standards of Care as Outlined in the Wit Case

Effective treatment requires treatment of the individual's **underlying condition** and is not limited to alleviation of the individual's current symptoms.
Effective treatment requires treatment of **co-occurring mental health and substance use disorders** and/or medical conditions in a coordinated manner that considers the interactions of the disorders when determining the appropriate level of care.
Patients should receive treatment for mental health and substance use disorders at the **least intensive and restrictive level of care that is safe and effective**.
When there is ambiguity as to the appropriate level of care, the practitioner should **err on the side of caution** by placing the patient in a higher level of care.
Effective treatment of mental health and substance use disorders includes services needed to **maintain functioning or prevent deterioration**.
The appropriate duration of treatment for mental health and substance use disorders is based on the individual needs of the patient; **there is no specific limit on the duration of such treatment**.
The **unique needs of children and adolescents** must be taken into account when making decisions regarding the level of care involving their treatment for mental health or substance use disorders.
The determination of the appropriate level of care for patients with mental health and/or substance use disorders should be made on the basis of a **multidimensional assessment** that takes into account a wide variety of information about the patient.

Court Findings

The court ruled in favor of the plaintiffs, finding that UBH had breached its duty as fiduciary and that they were liable with respect to the denial of benefits claim. The court also found UBH in violation of state laws in those states that mandate the use of specific level of care guidelines (Illinois, Connecticut, Rhode Island and Texas). The court concurred with the assertion that UBH's guidelines were more restrictive than generally accepted standards of care, citing 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. The ruling also highlighted UBH's omission of special guideline considerations for children and 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."

— **Wit case ruling**

UBH has subsequently announced that they will no longer use the guidelines in question in the Wit case, and will instead use the LOCUS.

For more information on how this case relates to the Mental Health Parity and Addiction Equality Act (MHPAEA), the Employee Retirement Income Security Act (ERISA) and the fight for parity, see the article, Holding Insurers Accountable for Parity in Coverage of Mental Health Treatment.[14]

Implications for Mental Health and Substance Use Disorder Organizations

The Wit case ruling provides a concrete framework for medical necessity decisions using nationally recognized standards of care and is a critical piece of evidence for individuals and organizations seeking to appeal overly restrictive claims decisions. The court proceedings brought to light several issues that MH/SUD organizations should keep in mind.

1. Though this case pertains specifically to UBH, the framework stipulated by the court may be applied to ALL payers, both public and private, where one condition of coverage is that the requested treatment must be consistent with generally accepted standards of care. If a managed care organization or insurer uses their own guidelines to evaluate claims, it is possible that those guidelines could deviate from generally accepted standards of care.

2. If you are operating in a state that mandates the use of medical society guidelines, insurers must evaluate claims in accordance with those guidelines to uphold its fiduciary

[14] Applebaum, P.S., Parks, J. (2019). Holding insurers accountable for parity in coverage of mental health treatment. *Law and Psychiatry*. doi: https://doi.org/10.1176/appi.ps.201900513.

duties. If an insurer's guidelines are more restrictive than the medical society guidelines, they could be violating state law.

3. Insurance standards of care may overemphasize crisis stabilization and treatment of acute symptoms and underemphasize longer-term, comprehensive care that considers co-occurring disorders, underlying conditions and individual needs. This approach may be accomplished in a variety of explicit and implicit ways. Many common reasons for denial are deemed inconsistent with generally accepted standards of care.

4. Insurance standards may overemphasize safety as determining the appropriate level of care and not give adequate weight to a higher level of care providing more effective treatment than a lower level of care.

5. Children and adolescents may be especially vulnerable to overly restrictive claims denials if insurers fail to account for the unique and developmentally appropriate needs of this population.

6. Residential care (especially longer-term levels of residential care) may be particularly at risk for unlawful denial, since these services are inherently aimed at providing an environment for improvement and maintenance of functioning beyond the crisis stabilization phase. This is consistent with the idea that insurers often erroneously characterize these intermediate levels of care as supporting acute management and crisis stabilization and serving as an alternative to inpatient care.[15]

7. MH/SUD organizations are influential stakeholders in advocating for the lawful execution of claims evaluation based on the court's generally accepted standards of care framework. Work with your staff and clients to leverage language from this court case to facilitate appropriate access to care.

These implications inform the following appeal strategy by providing an overview of the changing legal landscape within which insurers and providers are operating.

Appeal Strategy

Now that the Wit case has provided a robust, real-world legal standard for level of care authorization guidelines, MH/SUD organizations have a responsibility to leverage their expertise in this realm and remain vigilant in promulgating generally accepted standards of care. One way to do this is through a comprehensive appeals strategy.

[15] Plakun, E.M. (2018). Clinical and Insurance Perspectives on Intermediate Levels of Care in Psychiatry. *Journal of Psychiatric Practice*, 24(2), 111 – 116.

Strengthen Your Case with Federal Court Findings

There are a number of patient and provider guides for navigating the appeals process that contain complimentary guidance, much of which aligns with the considerations below. The following proposed appeals strategy builds on current guidance by offering language and approaches for incorporating Wit case findings as a motivating factor for insurers to reconsider care denial decisions.

Complimentary Appeal Guidance

Dr. Plakun's 4 Tools to Maximize Appeal Success (Austen Riggs Center)[16]

Appealing Treatment and Reimbursement Denials (American Psychiatric Association)[17]

A Patient's Guide to Navigating the Insurance Appeals Process (Patient Advocate Foundation)[18]

What to Do if You're Denied Care by Your Insurance (National Alliance on Mental Illness)[19]

Appeal Strategy Concepts

Apply the following strategies when preparing for and responding to excessively restrictive claims denials.

✓ **Examine your organization's claims denial data** to identify where insurers' reasons for denials are at odds with one or more of the eight principles stipulated by the court in the Wit case and how often appeals are granted or denied. This analysis will enable you to execute an appeal strategy that is informed by the challenges your patient population faces and provides a mechanism for continuous quality improvement. Pay close attention to trends in populations such as children, adolescents, young adults, pregnant/postpartum women and those with co-occurring or underlying conditions, as these groups may be at increased risk for denial of necessary care. If you are not currently analyzing this type of data, it should not prevent you from implementing the rest of the appeal strategies; however, you may consider denial and appeal data analysis as a longer-term goal for your organization.

✓ **Understand each of your common insurer's utilization review criteria**. As noted previously, although the findings in the Wit case only involved one insurer, the standard of care concepts should be applied broadly across all behavioral health insurers. Keep in mind that even if the guidelines are compliant on paper, they must also be compliant as applied in operations.

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[16] Plakun, E.M. (2019). Dr. Plakun's 4 Tools to Maximize Appeal Success. *Austen Riggs Center*. Retrieved from https://www.austenriggs.org/sites/default/files/DenialofCare_flyer_2019.pdf.
[17] American Psychiatric Association (no date). Appealing Treatment Denials. Retrieved from https://www.psychiatry.org/psychiatrists/practice/helping-patients-access-care/appealing-treatment-denials.
[18] Patient Advocate Foundation (no date). A Patient's Guide to Navigating the Insurance Appeals Process. Retrieved from https://www.patientadvocate.org/wp-content/uploads/NavigatingInsuranceAppeals.pdf.
[19] National Alliance on Mental Illness (no date). What to Do If You're Denied Care by Your Insurance. Retrieved from https://www.nami.org/Find-Support/Living-with-a-Mental-Health-Condition/Understanding-Health-Insurance/What-to-Do-If-You-re-Denied-Care-By-Your-Insurance.

There could be underlying and implicit processes that contribute to overly restrictive care decisions. Consequently, behavioral health professionals should ultimately rely on expert opinion and consideration of unique patient needs when deciding whether or not to appeal. Most insurers are required to make their guidelines public. If you do not have access, contact the insurer for a copy.

✓ **Consider systematically using the ASAM Criteria, LOCUS and CALOCUS as medical necessity criteria in your organization**. Federal court has determined that these level of care guidelines represent the current standard of care; adopting them can strengthen your position when negotiating disagreements with insurers that are using guidelines that have not been found to represent the current standard of care by a federal court.

✓ **Educate staff** on the Wit case ruling, important language and how to incorporate the findings into the appeal process. Ensure there are efficient workflows in place to facilitate the appeal process. This means creating a system for how appeals resources such as this toolkit are stored and accessed; outlining the steps (including timeline, staff responsible and actions necessary) of the appeals process; and training staff on their role. Organizations can monitor the effectiveness of their appeal workflow by collecting data on processes, outcomes and staff attitudes. For example, an organization may track the amount of time it takes to submit an appeal letter and identify specific steps that are slowing the process; track the percentage of appeals that are successful; and survey staff to solicit ideas for continuous quality improvement. (**See Appendix A** for an educational infographic highlighting powerful quotes from the Wit case that can be shared with staff.)

✓ **Modify appeal request language and routinize sending appeal letters** that:

- **Provide enough detail** to make the connection between the patient's condition and the requested level of care, while still remaining concise. Letters allow providers to fully explain the needs of the patient and serve as clear documentation. Incorporate details such as changes in diagnosis or condition; co-occurring disorders; special treatments and/or testing; medications; next steps in treatment; and recommended alternative treatments, if applicable.[20]
- **Cite rationale** from the Wit case ruling to strengthen your position by offering evidence of medical necessity and the insurer's failure to recognize generally accepted standards of care. Figure 2 outlines several elements MH/SUD professionals and organizations may include when requesting an appeal; these elements are paired with supporting language from the Wit case. Although you might not use all of these exact quotes in your letters, the table demonstrates how the court findings are generalized to make your case. **Appendices B-D** provide templates and examples for how to apply these guidelines (including a provider appeal letter template, patient appeal letter template and sample provider appeal letter).

[20] American Psychiatric Association (no date). Appealing Treatment and Reimbursement Denials. Retrieved from https://www.psychiatry.org/psychiatrists/practice/helping-patients-access-care/appealing-treatment-denials.

Figure 2. Wit Case Language

ELEMENTS OF APPEAL LETTER BASED ON THE WIT CASE	SUPPORTING LANGUAGE FROM WIT CASE
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."
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." The Wit case specifically mentioned the LOCUS/CALOCUS, ASAM Criteria, the Child and Adolescent Service Intensity Instrument (CASII) and the Centers for Medicare and Medicaid Services Manual.
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."
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. Example 1: When applicable, assert that effective care accounts for the unique needs of children/adolescents. Example 2: When applicable, assert that effective care is at the least intensive and restrictive level of care that is safe and effective.	**See Figure 1**. Example 1: "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." Example 2: "The fact that a lower level of care is less restrictive or intensive does not justify selecting that level if it is also expected to be less effective. Placement in a less restrictive environment 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, including underlying and co-occurring conditions."
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.	This is one of the eight generally accepted standards of care articulated by the court. **See Figure 1**.

- ✓ **Be prepared with talking points** that cite language from the Wit case ruling if you must speak with insurance utilization reviewers over the phone (**see Appendix E** for talking points). Utilization reviewers often do not ask the types of questions that uncover the details necessary to provide a multidimensional view of the patient, so be prepared to offer this information rather than waiting for the reviewer to dictate the parameters of the conversation. Your first-hand knowledge of the nuances of your patients' needs is valid, valuable and critical to communicate. Follow up the phone call by sending a written appeal letter that documents your conversation and reiterates your rationale.

- ✓ **Make the case for immersive residential treatment**, when applicable. Residential treatment services are particularly vulnerable to denials, as evidenced by the makeup of the Wit case plaintiffs (60 percent were denied residential treatment care). A primary reason for this disparity is the stark contrast between how clinicians understand and how a large number of insurers understand the generally accepted standard for intermediate levels of care.[21] According to America's Health Insurance Plans (AHIP), the national trade association for the health insurance company, intermediate levels of care "support acute management of patients with mental health and substance use disorders. They often serve as alternatives to inpatient care and are intended to have the ability to address acute symptoms or provide crisis stabilization."[22] This view of residential care overemphasizes crisis stabilization, while clinicians, on the other hand, understand that intermediate levels of care address issues far beyond acute needs. Highlight the insurer's erroneous conclusion and support the clinical perspective which aligns with professional sources of standards of care (e.g., LOCUS). Examples of rationale for this level of care include but are not limited to: they lack the capacity to effectively use outpatient sessions to make gains or maintain functioning; they lack the capacity to function adequately between outpatient sessions; they are stuck in a cycle of crisis admissions and discharges and residential services can interrupt this; they would benefit from engaging underlying issues in

[21] Plakun, E.M. (2018). Clinical and Insurance Perspectives on Intermediate Levels of Care in Psychiatry. *Journal of Psychiatric Practice*, 24(2), 111 – 116.
[22] Yohanan M. Senior Physician Editor, subject matter expert in behavioral health. MCG Health website. Retrieved from www.ahip.org/wp-content/uploads/2017/06/MCG-White-Paper-Mental-Health-Parity.pdf.

their overall treatment plan; they are a young adult who is struggling to navigate the transition from child to adult.

✓ **Enlist the help of the patient/guardian and extended support networks**. Get your patient's permission to appeal on their behalf and support them in sending a complimentary appeal letter on their own behalf (**see Appendix C** for a patient appeal letter template). In some cases, it may also be appropriate to recommend the patient request assistance from their human resources department if they are insured through an employer plan. An appeal can only be strengthened by submitting multiple requests.

✓ **Advocate for a peer review**. A peer review is a conversation between a physician at the insurance company and the attending clinician. This allows for a robust exchange of information that can help make the case for a particular level of care. However, an insurer may offer limited opportunities for scheduling a peer review (e.g. short timeframe for scheduling or offering only one time slot). In the absence of a peer review the insurer's physician conducts a chart review, which means they are deciding based on the information in the patient's medical records. The chart review is more likely to result in denial because it lacks the persuasive element of the peer review conversation. Request that the insurer allow you a reasonable opportunity to schedule a peer review to make the case for the appropriate level of care. If your requests are unsuccessful, encourage the patient to file a complaint with the insurer.

✓ **Maintain documentation** of all efforts to appeal denials, including letters sent, calls made, dates, hold times, names of insurance personnel you communicate with, their credentials and the nature of the correspondence. This detailed documentation will assist with holding insurers accountable for upholding not only generally accepted standards of care, but also the appropriate utilization review process. For example, denials of psychiatrists' services should be made only by psychiatrists; so, if the reviewer's credentials do not meet this requirement, file a complaint. Request written notification of the reasons for denial if not already in your possession.

✓ **If at first you don't succeed, try, try again**. Many insurers offer multiple levels of appeals. Take advantage of these opportunities to demonstrate that you have the knowledge, resources and conviction to advocate for appropriate care decisions.

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[23] American Psychiatric Association (no date). Appealing Treatment and Reimbursement Denials. Retrieved from https://www.psychiatry.org/psychiatrists/practice/helping-patients-access-care/appealing-treatment-denials.

✓ Refer to the American Psychiatric Association's Appealing Treatment and Reimbursement Denials[23] resource for additional tips about utilization review timelines, special cases and requests you can make throughout the appeal process.

As behavioral health service providers, you have a tremendous responsibility to deliver quality care to your patients, often while navigating complex operational challenges. It is difficult work; and yet, a difference can be made, patient by patient. Focus on training staff on the outcome and significance of the Wit case ruling and using the provided appeal letter templates and talking points as a framework for applying the recommended appeal strategies.

National Council for Behavioral Health

The National Council is the unifying voice of America's healthcare organizations that deliver mental health and substance use disorder treatment and services. Together with our 3,400 member organizations serving more than 10 million adults, children and families living with mental illnesses and substance use disorders, the National Council is committed to all Americans having access to comprehensive, high-quality care that affords every opportunity for recovery. The National Council's professional staff stays current on the insurance landscape and encourages you to reach out if you have any questions about this resource or the appeals process. To learn more, contact LindsiL@TheNationalCouncil.org.

[23] American Psychiatric Association (no date). Appealing Treatment and Reimbursement Denials. Retrieved from https://www.psychiatry.org/psychiatrists/practice/helping-patients-access-care/appealing-treatment-denials.

Appendices

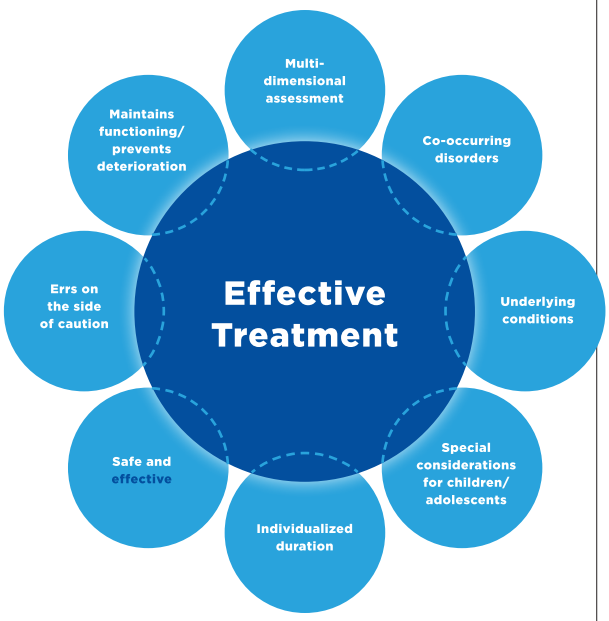
Appendix A — Wit Case Infographic

WIT CASE: FACILITATING THE APPLICATION OF GENERALLY ACCEPTED STANDARDS OF CARE

A court ruling in the *Wit v. United Behavioral Health* (UBH) case highlights the ongoing issues around insufficient access to care and insurance coverage for mental and substance use disorder (M/SUD) treatment. The court found that UBH denied patients coverage for M/SUD services because the guidelines they were using to make care determinations were more restrictive than generally accepted standards of care.

The court recognized **eight generally accepted standards of care** that are consistent with widely accepted sources for standards (including the LOCUS and ASAM Criteria) and **consider a number of critical factors beyond current symptomology and acute care needs**.

This landmark case provides powerful justification for mental health and substance use disorder organizations as they pursue appeals for overly restrictive insurance utilization decisions. Here are just some of the **implications of the Wit decision**:



RESTRICTIVE GUIDELINES

Insurance standards of care may overemphasize crisis stabilization and treatment of acute symptoms and underemphasize longer-term, comprehensive care that considers co-occurring disorders, underlying conditions and individual needs.

SAFETY VS. EFFECTIVENESS

Insurance standards may overemphasize safety and underemphasize treatment effectiveness.

RESIDENTIAL CARE

Longer-term levels of residential care may be particularly at risk for overly restrictive claims denials, since these services are aimed at providing support for improvement and maintenance of functioning beyond crisis stabilization.

IMPLICATIONS OF FEDERAL COURT RULING

CHILDREN AND ADOLESCENTS

Children and adolescents may be especially vulnerable to overly restrictive claims denials if insurers fail to account for the unique and developmentally appropriate needs of this population.

Appendix B — Provider or Guardian Appeal Letter Template

Providers and patient guardians should use this template as a starting point for writing an appeal letter. Complete the letter by including relevant details for each unique patient.

[Date]

[Provider Name]
[Street Address]
[City, State ZIP]

Re: [Patient Name]
[Type of Coverage]
[Group number/Policy number]

To Whom It May Concern:

Introductory paragraph applies to all standard of care violation types.
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 [patient name] [service type requested] violates [number] of the eight standards. 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 [**Insert applicable sources based on mental health or substance use service requests, i.e.**, Level of Care Utilization Standards for Psychiatric and Addiction Services Standards (LOCUS) Child and Adolescent Level of Care Utilization System (CALOCUS) or American Society for Addiction Medicine Treatment Criteria For Addictive, Substance Related and Co-Occurring Conditions (ASAM Criteria)].

Insert this paragraph for any insurer other than UBH.
As you are likely aware, the UBH care utilization standards were found to violate the law and represent a breach of fiduciary duty to the patients served. In the written opinion, Judge Spero stated that "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." The court affirmed that there are eight generally accepted standard of care, which are consistent with professional sources of accepted standards, such as the LOCUS and ASAM. Unless your conditions of coverage do not require that requested treatment be consistent with the generally accepted standard of care, the eight principles enunciated by the court in the Wit case apply to [patient name].

Insert this paragraph if UBH is the insurer.
As you are likely aware, the UBH standards by which you determined [patient name]'s ineligibility for [service type] were found to violate the law and represent a breach of fiduciary duty to the patients served. In the written opinion, Judge Spero stated that "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." The court affirmed that there are eight generally accepted standard of care, which are consistent with professional sources of accepted standards, such as the LOCUS and ASAM.

Please note that UBH has announced that they will no longer use the guidelines in question in the Wit case, and will instead use the LOCUS. However, if you believe their decision to be inconsistent with the LOCUS, use this language.

Insert all paragraphs that apply, according to which standards of care you believe the insurer has violated.
The court stipulated, among other standards, that effective treatment…

…requires treatment of the individual's **co-occurring disorders and underlying conditions** and is not limited to alleviation of the individual's current symptoms. In this case, the reviewer violated these two standards by focusing too narrowly on current symptomatology and acute care needs and failed to consider [patient name]'s [diagnoses] and ongoing struggles with [**Insert underlying conditions, e.g.** processing trauma, navigating a major life change, processing grief, financial instability, etc.].

…should be at the **least intensive and restrictive level of care that is also both safe and most effective; maintains functioning or prevents deterioration; and errs on the side of caution and places the patient in the higher level of care when there is ambiguity**. These standards go further than assuring safety by stipulating that patients who can be treated more effectively at a higher level of care should be authorized for that higher level of care even if they can be maintained safely at a lower level of care. In this case, the reviewer violated these three standards by focusing too narrowly on current symptomatology, acute care needs and safety, and failed to consider what service would truly be the most effective and prevent deterioration. [patient name] has a history of crisis services admission and discharge, supporting the idea that a longer-term intermediate level of care is needed to break this ineffective acute care treatment cycle. Denial of this level of care puts [patient name] at risk for [**Insert risks, e.g.**, decompensation, inability to perform daily responsibilities].

…**does not have a specific time limit**, since duration is based on the individual needs of the patient. In this case, the reviewer violated this standard by focusing too narrowly on current

symptomatology and acute care needs and failed to consider what duration of treatment would best suit [patient's name]'s ongoing needs.

…accounts for the **unique needs of children and adolescents**. In this case, the reviewer violated this standard by judging a child's needs based on adult standards and failed to account for [patient name]'s intensified need due to their developmental level. Care decisions should be made using [**Insert appropriate example, i.e.**, the Child and Adolescent LOCUS (CALOCUS) or Adolescent ASAM Criteria] which considers children's unique needs.

…is based on a **multidimensional assessment** that accounts for a wide variety of information about the patient. For the reasons already identified above, the reviewer violated this standard by focusing too narrowly on current symptomatology and acute care needs and failed to consider [patient name]'s [Insert violations stated above, e.g. co-occurring disorders, underlying conditions, consideration of the most effective treatment (beyond safety), services needed to maintain functioning or prevent deterioration, needs beyond acute care, developmental].

I have already demonstrated that there are good clinical reasons to believe that [service type] is medically necessary in [patient name]'s case. **[Insert a summary of the reasons their need maps to a particular level of care. This should include anything that was not already mentioned above, including changes in diagnosis or condition; implications of co-occurring and underlying conditions; special treatments and/or testing; medications; next steps in treatment; treatment history; and recommended alternative treatments].**

Closing paragraph applies to all standard of care violation types.
If you reassess [patient name]'s medical needs using guidelines that are consistent with the generally accepted standards of medical care which makes a multidimensional assessment of the patient's functioning and treatment needs and is not restrictively focused on crisis or symptom criteria (e.g., the LOCUS/ASAM), you will find, as we do, that [patient name] clearly has continued to meet criteria for medical necessity at a [service type] level of care. In my opinion, failure to consider their needs in this broader context ignores their actual medical needs, confuses symptom-reduction with clinical recovery, and represents a breach of the medical duty, reaffirmed by the court, that you have toward [patient name].

Regards,

[clinician name]

Appendix C — Patient Appeal Letter Template

Providers should share this template with patients to use as a starting point for writing a personal appeal letter. Patients should complete the letter by including relevant details unique to them.

[Date]

[Patient Name]
[Street Address]
[City, State ZIP]

[Type of Coverage]
[Group number/Policy number]

To Whom It May Concern:

Introductory paragraph applies to all standard of care violation types.
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 my [service type requested] violates [number] of the eight standards. I trust that you are committed to upholding your legal responsibility as my 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 [**Insert applicable sources based on mental health or substance use service requests, i.e.**, Level of Care Utilization Standards for Psychiatric and Addiction Services Standards (LOCUS) Child and Adolescent Level of Care Utilization System (CALOCUS) or American Society for Addiction Medicine Treatment Criteria For Addictive, Substance Related and Co-Occurring Conditions (ASAM Criteria)].

Insert this paragraph for any insurer other than UBH.
As you are likely aware, the UBH care utilization standards were found to violate the law and represent a breach of fiduciary duty to the patients served. In the written opinion, Judge Joseph C. Spero stated that "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." The court affirmed that there are eight generally accepted standard of care, which are consistent with professional sources of accepted standards, such as the LOCUS and ASAM. Unless your conditions of coverage do not require that requested treatment be consistent with the generally accepted standard of care, the eight principles enunciated by the court in the Wit case apply to me.

Insert this paragraph if UBH is the insurer.
As you are likely aware, the UBH standards by which you determined my ineligibility for [service type] were found to violate the law and represent a breach of fiduciary duty to the patients served. In the written opinion, Judge Spero stated that "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." The court affirmed that there are eight generally accepted standard of care, which are consistent with professional sources of accepted standards, such as the LOCUS and ASAM.

Please note that UBH has announced that they will no longer use the guidelines in question in the Wit case, and will instead use the LOCUS. However, if you believe their decision to be inconsistent with the LOCUS, use this language.

Insert all paragraphs that apply, according to which standards of care you believe the insurer has violated.
The court stipulated, among other standards, that effective treatment…

…requires treatment of the individual's **co-occurring disorders and underlying conditions** and is not limited to alleviation of the individual's current symptoms. In this case, the reviewer violated these two standards by focusing too narrowly on current symptomatology and acute care needs, and failed to consider my [diagnoses] and ongoing struggles with [**Insert underlying conditions, e.g.**, processing trauma, navigating a major life change, processing grief, financial instability].

…should be at the **least intensive and restrictive level of care that is also both safe and most effective; maintains functioning or prevents deterioration; and errs on the side of caution and places the patient in the higher level of care when there is ambiguity**. These standards go further than assuring safety by stipulating that patients who can be treated more effectively at a higher level of care should be authorized for that higher level of care even if they can be maintained safely at a lower level of care. In this case, the reviewer violated these three standards by focusing too narrowly on current symptomatology, acute care needs, and safety, and failed to consider what service would truly be the most effective and prevent deterioration. I have a history of crisis services admission and discharge, supporting the idea that a longer-term intermediate level of care is needed to break this ineffective acute care treatment cycle. Denial of this level of care puts me at risk for [**Insert risks, e.g.**, decompensation, inability to perform daily responsibilities].

…**does not have a specific time limit**, since duration is based on the individual needs of the patient. In this case, the reviewer violated this standard by focusing too narrowly on current symptomatology and acute care needs, and failed to consider what duration of treatment would best suit my ongoing needs.

…accounts for the **unique needs of children and adolescents**. In this case, the reviewer violated this standard by judging a child's needs based on adult standards, and failed to account for [patient name] intensified need due to their developmental level. Care decisions should be made using [**Insert appropriate example, i.e.**, the Child and Adolescent LOCUS (CALOCUS) or Adolescent ASAM criteria] which considers children's unique needs.

…is based on a **multidimensional assessment** that accounts for a wide variety of information about the patient. For the reasons already identified above, the reviewer violated this standard by focusing too narrowly on current symptomatology and acute care needs, and failed to consider my [**Insert violations stated above, e.g.**, co-occurring disorders, underlying conditions, consideration of the most effective treatment (beyond safety), services needed to maintain functioning or prevent deterioration, needs beyond acute care, developmental].

I have already demonstrated that there are good reasons to believe that [service type] is medically necessary in my case. **[Insert a summary of the reasons their need maps to a particular level of care. This should include anything that was not already mentioned above, including changes in diagnosis or condition; implications of co-occurring and underlying conditions; special treatments and/or testing; medications; next steps in treatment; treatment history; and recommended alternative treatments].**

Closing paragraph applies to all standard of care violation types.

If you reassess my medical needs using guidelines that are consistent with the generally accepted standards of medical care which makes a multidimensional assessment of my functioning and treatment needs and is not restrictively focused on crisis or symptom criteria (e.g., the LOCUS/ASAM), you will find, as I and those treating me do, that I clearly have continued to meet criteria for medical necessity at a [service type] level of care. In my opinion, failure to consider their needs in this broader context ignores my actual medical needs, confuses symptom-reduction with clinical recovery and represents a breach of the medical duty, reaffirmed by the court, that you have toward me.

Regards,

[patient name]

Appendix D — Sample Provider Appeal Letter

This serves as a best practice example of how to fill out the template provided in Appendix B. Please note these clinical details will vary from patient to patient and serve only as an example of the detail and types of information you may consider including when making the case for a particular level of care.

December 2, 2019

Emerald City Health System
137 Yellow Brick Road
Emerald City, Land of Oz, 01939

Re: Dorothy Gale

To Whom It May Concern:

— TIP —
Concisely state the problem (the decision violates generally accepted standards of care) and the action you would like the insurer to take.

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).*

— TIP —
Cite sources of generally accepted standards of care.

— TIP —
Quote the Wit case ruling and invoke the parity law.

As you are likely aware, the UBH standards by which you determined Ms. Gale's ineligibility for residential services were found to violate the law and represent a breach of fiduciary duty to the patients served. In the written opinion, Judge Spero stated that "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." The court affirmed that there are eight

generally accepted standard of care, which are consistent with professional sources of accepted standards, such as the LOCUS and ASAM. The court's ruling set a precedent for generally accepted standards of care that applies broadly to all behavioral health service payers. 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.

— TIP —
Explain which standards of care have been violated.

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 Personality Disorder NOS, with longstanding depression, hopelessness, anxiety, has difficulties with identity and interpersonal engagement and, most recently, suffered a collapse in her ability to function in the context of her upcoming transition out of college. The presence of multiple diagnoses and underlying conditions justifies immersive residential treatment.*

The court also stipulated that effective treatment should be at the ***least intensive and restrictive level of care that is also both safe and most effective; and maintains functioning or prevents deterioration; and errs on the side of caution and places the patient in the higher level of care when there is ambiguity****. In this case, the reviewer violated these three standards by focusing too narrowly on current symptomatology, acute care needs and safety, and failed to consider what service would truly be the most effective and prevent decompensation. Ms. Gale has a history of crisis services admission and discharge, supporting the idea that a longer-term intermediate level of care is needed to break this ineffective acute care treatment cycle. Denial of this level of care puts Ms. Gale at risk for being unable to perform daily responsibilities in a new college setting. Even if there was some doubt as to the level of care needed, the court stipulates that the practitioner should err on the side of caution and prescribe the higher level of care.*

Additionally, the court stipulated that effective treatment is based on a ***multidimensional assessment*** *that accounts for a wide variety of information about the patient. For the reasons already identified above, the reviewer violated this standard by focusing too narrowly on current symptomatology and acute care needs, and failed to consider Ms. Gale's multiple diagnoses, increased pressure of transitioning out of college and complex treatment history.*

I have already demonstrated that there are good clinical reasons to believe that residential treatment is medically necessary in Ms. Gale's case. She experienced the emergence of suicidal ideation with plan and intent in the months prior to coming to Emerald City Health System, for which she had several psychiatric emergency room visits and one inpatient admission.

— TIP —
Make the case for immersive residential treatment.

Additionally, within the safety of her treatment, Ms. Gale has begun opening up about perceptual disturbances (auditory and tactile hallucinations) that emerged in the months prior to her admission. This leads to important questions as to whether Ms. Gale's difficulties with mood, identity development and interpersonal engagement are severe enough as to cause perceptual disturbances, or whether Ms. Gale's difficulties are better explained as the result of an emerging psychotic process. Given Ms. Gale's age, long-standing sensitivities and interpersonal difficulties, she is at serious risk for further decompensation, should she not receive adequate care at this time. Additionally, Ms. Gale's psychological assessment suggested that her tendency towards overwhelm places her at high risk for self-destructive behavior, should she not receive adequate intervention at this time.

Concurrent with the urgency of Ms. Gale's clinical picture, her long history of living in an invalidating environment and fear of her own perceptual experiences make it very difficult for her to access care from providers. Ms. Gale has spent the last few years attempting to find an outpatient treatment that will work for her but has experienced patterns of becoming overwhelmed with her affective experience, feeling missed by providers and terminating treatment. Moreover, Ms. Gale's home environment has been a serious impediment to her treatment, as she experiences profound difficulty asserting herself amidst familial chaos and tends towards isolation and hopelessness. Given the severity and urgency of Ms. Gale's struggles, her interpersonal patterns that leave her with difficulties making use of treatment and the negative impact of her home environment on her attempts at stabilization, it is my professional opinion that Ms. Gale would greatly benefit from, and medically requires, continued residential treatment.

If you reassess Ms. Gale's medical needs using guidelines that are consistent with the generally accepted standards of medical care which makes a multidimensional assessment of the patient's functioning and treatment needs and is not restrictively focused on crisis or symptom criteria (e.g., the LOCUS/ASAM), you will find, as we do, that Ms. Gale clearly has continued to meet criteria for medical necessity at a the residential level of care. In my opinion, failure to consider her needs in this broader context ignores her actual medical needs, confuses symptom-reduction with clinical recovery and represents a breach of the medical duty, reaffirmed by the court, that you have toward Ms. Gale.

— TIP —
Reiterate the generally accepted standard of care to err on the side of caution.

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.

Regards,

Dr. G.A. Standard

Appendix E — Utilization Review Talking Points

Use these talking points when you speak to reviewers over the phone:

- *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.*

- *Eight standards of practice were affirmed by a federal court ruling of the Wit case which are consistent with professional sources of standards, such as the LOCUS and ASAM criteria.*

- *A denial of care would be more restrictive than the generally accepted standards of care for some of the same reasons UBH was found in the Wit case to violate its "duty of loyalty, its duty of due care and its duty to comply with plan terms" and was found to have adopted guidelines that "were unreasonable and an abuse of discretion."*

- *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]. Provide information on co-occurring disorders, underlying conditions, complex treatment history, developmental level, etc.*

- *Generally accepted standards of care say effective treatment (note the standards that apply):*

    - Requires treatment of the individual's **underlying condition** and is not limited to alleviation of the individual's current symptoms.

    - Requires treatment of **co-occurring mental health and substance use disorders** and/or medical conditions in a coordinated manner that considers the interactions of the disorders when determining the appropriate level of care.

    - Is the **least intensive and restrictive level of care that is also both safe and most *effective***.

    - **Errs on the side of caution**. When there is ambiguity as to the appropriate level of care, the practitioner should err on the side of caution by placing the patient in a higher level of care.

    - Includes services needed to **maintain functioning or prevent deterioration**.

- **Has no specific limit on the duration of such treatment**. The appropriate duration of treatment for mental health and substance use disorders is based on the individual needs of the patient.
- Accounts for the **unique needs of children and adolescents**.
- Is based on a **multidimensional assessment** that accounts for a wide variety of information about the patient.

- *If you assess [patient name]'s medical needs using guidelines that are consistent with the generally accepted standards of medical care which makes a multidimensional assessment of the patient's functioning and treatment needs and is not restrictively focused on crisis or symptom criteria (e.g., the LOCUS/ASAM), you will find, as we do, that [patient name] clearly has continued to meet criteria for medical necessity at a [service type] level of care.*

- *Any 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.*

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