

# American Psychiatric Association

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June 1, 2011

Peter Q. Harris, M.D., Ph.D.  
Medical Director  
MHNet Behavioral Health  
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Austin, Texas 78720

Alan Wise  
Chairman and CEO  
Coventry Health Care, Inc.  
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Dear Dr. Harris and Mr. Wise:

We have received your letters dated March 3, 2011 and March 31, 2011 (the “MHNet Response”), in which MHNet Specialty Services, LLC (“MHNet”) responded to a letter from the American Psychiatric Association (the “APA”) and the Psychiatric Society of Virginia (the “Society”) (the APA and the Society are collectively referred to herein as the “Associations”), dated January 21, 2011 (the “Associations’ Inquiry”). As you know, in the Associations’ Inquiry, the Associations expressed concerns over certain policies and requirements of MHNet that seem to implicate the provisions of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (the “Parity Act”). For your convenience and ease of reference, we are attaching the Associations’ Inquiry and MHNet Response behind Tab 1.

Just by way of background, the Associations are medical specialty societies representing psychiatrists practicing in the Commonwealth of Virginia, who have contracted with MHNet to provide psychiatric services. Some of these psychiatrists have identified certain issues with MHNet and the ability of their patients to access mental health and substance use disorder benefits (“MHSUD Benefits”) from MHNet under Coventry Health Care, Inc. (“Coventry”) health plans. In this letter, we are not only addressing MHNet, but also Coventry, as we understand that Coventry is MHNet’s parent corporation. Since MHNet administers MHSUD Benefits on behalf of Coventry and

Coventry administers most other benefits (including medical/surgical benefits) under various health plans, Coventry would be helpful to MHNNet in coordinating the information relevant to questions of compliance with the Parity Act.

We appreciate MHNNet's efforts in formulating the MHNNet Response, as we know it takes time and effort to respond to such an inquiry. However, we must say that the MHNNet Response falls short of answering the questions posed in the Associations' Inquiry. Moreover, MHNNet has not provided some of the information requested by the Associations, which is most pertinent to the Associations' Inquiry. Our review of the MHNNet Response reveals a number of misunderstandings as to the questions posed in the Associations' Inquiry. With that said, we feel that it may be helpful for us to clarify our requests, including, in some cases, the purpose and basis for them, and hope that these clarifications will allow MHNNet and Coventry the opportunity to revise the MHNNet Response, so that the Associations can proceed with their analysis.

Set forth in detail below is the original requests, MHNNet's response to the requests, and the clarification or current information still outstanding.

#### 1. Clarification as to Coordination of Parity within Health Plans.

One key concern the Associations have with the MHNNet Response is that MHNNet feels it is not in a position to provide certain information, as it does not administer medical/surgical benefits. Specifically, in the MHNNet Response dated March 3, 2011, MHNNet states that it cannot provide the medical/surgical criteria requested by the Associations, because it does not administer medical/surgical benefits. Similarly, in the MHNNet Response dated March 31, 2011, MHNNet states that it contracts with payors to manage and/or administer mental health and substance abuse services only and not medical/surgical services (such as E&M codes).

As you know, the Parity Act specifies that health plans that provide mental health benefits shall ensure that:

- (ii) the treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage) and there are no separate treatment limitations that are applicable only with respect to mental health or substance abuse benefits.<sup>1</sup>

Furthermore, the Parity Act's definition of health plans includes health insurers and/or specialty vendors (commonly referred to as managed behavioral healthcare organizations, or MBHOs) they may contract with to manage to MHSUD Benefits.

Once a health plan offers MHSUD Benefits, it is bound by the Parity Act and the Parity Act's Interim Final Rule<sup>2</sup> (the "IFR"). The fact that the MHSUD Benefits are separately

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<sup>1</sup> 29 U.S.C. Section 1185a(a)(3)(A).

<sup>2</sup> 75 Fed. Reg. 5410.

managed or that claims are managed by a separate entity is not relevant and does not sever the health plan from its obligations under the Parity Act.<sup>3</sup>

While the Associations understand that MHNNet merely administers the MHSUD Benefits for health plans, is not a health plan itself, and does not administer medical/surgical benefits, the Associations assumed that MHNNet could obtain the information requested or had the information on hand, given its need to coordinate compliance of the Parity Act with Coventry. If this is not the case, we request this information at this time from Coventry, who is now addressed in this letter. We are attaching a summary of our requests hereto for MHNNet's and Coventry's convenience as Tab 2. We appreciate this joint effort in responding to these requests.

## 2. Clarifications on Prior Authorization Requirements Inquiry.

In the Associations' Inquiry, the Associations stated that it was their understanding that MHNNet had established a prior authorization requirement for individuals to receive services from a psychiatrist to treat mental health conditions and substance use disorders, except for an initial assessment and medication management. It is also the Associations' understanding that Coventry does not impose such a requirement for the majority of its medical services or for access to primary care practitioners for medical or surgical services in connection with a mental health conditions or substance use disorders. Therefore, in the Associations' opinion, there appears to be a difference between how MHNNet treats psychiatrists providing mental health or substance use services and how Coventry treats other physicians providing medical/surgical services, as well as other physicians providing mental health and substance use services. It is the Associations' concern that this difference could violate the Parity Act.

It was acknowledged in the Associations' Inquiry that MHNNet had had conversations with the Society and understood that MHNNet had two key reasons justifying its compliance with the Parity Act. The first reason is due to MHNNet's interpretation of the Parity Act and the IFR. The Associations took issue with the interpretation,<sup>4</sup> but left this issue open for another discussion and forum.

The second reason MHNNet provided for its prior authorization requirement for MHSUD Benefits was that it has "recognized clinically appropriate standards of care" that permits

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<sup>3</sup> The IFR discusses how health plans cannot separate benefits to avoid compliance with the Parity Act. See 75 Fed. Reg. 5413. Specifically, the Parity Act prohibits a plan from creating separate classifications that apply treatment limitations or financial requirements only to MHSUD Benefits within the classification. A plan could also not move MHSUD Benefits into a newly created class and argue that no parity requirements apply to MHSUD Benefits.

<sup>4</sup> The Associations do not agree with MHNNet that the IFR has established a separate test for non-quantitative treatment limitations ("NQTLs") that is exclusive of the predominant and substantially all test set forth in the quantitative treatment limitations ("QTLs"). We would be happy to spend some time discussing our position with you.

a difference in treatment between the medical/surgical benefits administered by Coventry and the MHSUD Benefits it administers. This is critical, in our view, because the only recognized exception to the NQTL general rule, as a matter of policy, is when there is a recognized clinically appropriate standard. Hence, MHNet is averring that the general NQTL rule requirement of “comparability” is not applicable and, therefore, it is not germane at all as to how Coventry manages the medical/surgical benefit. The Associations know of no such standards, which would justify such a differential management protocol. Therefore, the Associations requested certain information in order to better understand MHNet’s position. The information requested is as follows:

- 1) Details specifying the clinically appropriate evidentiary standard, which justifies the prior authorization requirement for mental health care and not for other medical services, which are part of the health plan.
- 2) The clinically appropriate evidentiary standard that justified the prior authorization for mental health care rendered by a psychiatrist but not for mental health care provided by a primary care physician.
- 3) The published research studies that provide the evidentiary standard that psychiatrists need preauthorization as opposed to primary care physicians.
- 4) Experts in the field of psychiatric practice that recommend differential protocols for services provided by psychiatrists. We would also be interested in their, if any, pecuniary relationship to MHNet.
- 5) The national medical organizations that have endorsed this policy.
- 6) The criteria used for review of both medical/surgical benefits and MHSUD Benefits.<sup>5</sup>

Despite this request, the MHNet Response did not answer any of the questions posed, nor did MHNet provide any of the documentation requested. In its March 3, 2011 letter, the MHNet Response stated that the prior authorization criteria is “applied equally by MHNet, regardless if the services are rendered by an MHNet contracted psychiatrist, or other MHNet contracted mental health professional, such as a psychologist or licensed clinical social worker” [emphasis added]. MHNet concluded that since MHNet does not differentiate between psychiatrists and other mental health professionals, the documents requested do not exist.

As you can see, there seems to be a misunderstanding between the Associations’ Inquiry and the MHNet Response. In the Associations’ Inquiry, the Associations are requesting information which helps them to analyze whether MHNet’s prior authorization requirement for MHSUD Benefits complies with the Parity Act. Since the Society has been told that the reason that MHSUD Benefits require prior authorization is because

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<sup>5</sup> The statutory basis for this request is set forth below in Section 3 of this letter.

MHNet has clinically appropriate standards of care that justifies differential treatment under the law, the Associations would like to determine what the clinically appropriate standards of care are. The questions asked and material requested in the Associations' Inquiry would enable the Associations to do so.

The Associations are not looking to determine whether MHNet treats psychiatrists and other mental health care providers differentially. This issue is not an issue that relates to the Associations' Inquiry. In fact, we would like to point out that, in some cases, differential management protocols for psychiatrists and other mental health providers may be appropriate. Psychiatrists are physicians (i.e., they are educated as medical doctors and licensed by the Commonwealth of Virginia to provide medical care to patients) and provide different services than non-medical practitioners.

If MHNet has data which would show a recognized clinically appropriate standard of care that would justify a difference so that a prior authorization requirement for mental health and substance use services is appropriate, while a prior authorization requirement for medical or surgical services is not, we would be interested to see it and understand MHNet's position. As it stands now, a patient covered under a Coventry health plan can obtain mental health and substance use services through his/her primary care physician without obtaining prior authorization, but cannot obtain mental health and substance use services from a psychiatrist without prior authorization. This would appear to be inconsistent with the Parity Act.

Therefore, we respectfully resubmit this request to MHNet and Coventry to provide the information set forth in the list above.

### 3. Clarification on Request for Medical Necessity Criteria.

In the MHNet Response dated March 3, 2011, MHNet states that MHNet has no responsibility under the IFR to provide copies of its medical necessity criteria. Furthermore, it states that it cannot provide medical/surgical criteria, because MHNet does not administer the medical/surgical benefits.

Our request for the medical necessity criteria is consistent with 42 C.F.R. 146.136(d)(1), which outlines the legal obligation regarding the disclosure of medical necessity criteria as follows:

Availability of plan information - (1) Criteria for medical necessity determinations. The criteria for medical necessity determinations made under a group health plan with respect to mental health or substance use disorder benefits (or health insurance coverage offered in connection with the plan with respect to such benefits) must be made available by the plan administrator (or the health insurance issuer offering such coverage) to any current or potential participant, beneficiary, or contracting provider upon request.

Medical necessity criteria is an NQTL per the IFR.<sup>6</sup> As you know, the IFR provides the following:

(4) Nonquantitative treatment limitations – (i) General rule. A group health plan (or health insurance coverage) may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification, except to the extent that recognized clinically appropriate standards of care permit a difference. (29 CFR Part 146.136(c)(4)(i))

The reason for our request for medical necessity criteria is, because independent of prior authorization requirements, the criteria used to render medical necessity decisions are still subject to the standards set forth in the IFR. We would welcome the opportunity to review the medical necessity criteria for medical/surgical benefits in conjunction with the criteria for MHSUD Benefits available on MHNet’s web site in the context of the NQTL general rule. Accordingly, we respectfully request copies of Coventry’s medical necessity criteria.

#### 4. Clarification on Fail First Criteria.

In the Associations’ Inquiry, the Associations noted the presence of fail-first criteria as part of MHNet’s admission standards for adult rehabilitation units for substance use disorders and asked MHNet how such fail-first criteria complied with the Parity Act.<sup>7</sup> In the MHNet Response dated March 3, 2011, MHNet responded that it does not use fail-first criteria in its medical necessity criteria.

We believe that it would be helpful for us to provide MHNet with the exact reference to the criteria it finds questionable, so that MHNet can specifically address the criteria. In MHNet’s Utilization Improvement Manual for Adult Rehabilitation Unit for Substance-Related Disorders, a “Global Indicator” to determine if admission is appropriate is that “alternate levels and locations of care, such as partial hospitalization, have been attempted and relapse has occurred within 6 months of the patient’s active participation in such a program.” This specific Global Indicator means that a patient must have been treated at a lower level of care and relapsed (or failed such level of care) before the patient can be treated in a rehabilitation unit, even if care in a rehabilitation unit is determined by their psychiatrist to be the appropriate and medically necessary level of care for the patient. This criteria is a fail-first policy.

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<sup>6</sup> 29 CFR Part 146.136(c)(4)(ii).

<sup>7</sup> Fail first criteria are regarded by the IFR as NQTLs, inasmuch as they affect the scope and duration of benefits under a health plan.

We respectfully request that MHNNet explain how this fail-first policy complies with the Parity Act. In addition, given this specific reference, we would be interested in examples of similar fail-first policies that apply to medical/surgical benefits. We would appreciate it if MHNNet and Coventry could provide such examples to us.

#### 5. Clarification on E&M Codes.

In the Associations Inquiry, the Associations' identified that MHNNet did not pay psychiatrists for medical evaluation and management ("E/M") codes for new and/or established patients (i.e., the 992xx series codes). In the MHNNet Response dated March 31, 2011, MHNNet said that it has decided that it will cover any appropriate use of 992xx and 993xx codes by psychiatrists to the extent the service is covered under a member's benefit plan. We assume that virtually all health plans to which MHNNet is a party provide coverage with the 992xx and 993xx codes for medical/surgical benefits.

The Associations would like to thank MHNNet for addressing this issue. A remaining concern we have with respect to E/M codes is the rate at which psychiatrists will be reimbursed for the use of 992xx and 993xx series codes. It is not clear from your correspondence whether the rates for psychiatrists are identical to the medical/surgical rates for the same codes. The psychiatrists' rates and other physicians' rates for the same E/M codes must be identical to maintain parity under the Parity Act.

While we understand that you contract with providers and your contract sets forth the rates at which providers are reimbursed, we know that most (if not all) provider contracts have a provision that the contracts must comply with law. We believe that to pay psychiatrists a rate less than what other physicians are paid for these codes would not be consistent with the Parity Act. We also know that some provider contracts may allow MHNNet to unilaterally modify the reimbursement rates for physicians (including psychiatrists) without the physicians' consent. If the contracted rates for 992xx and 993xx series codes for services provided by psychiatrists are different from other physicians' 992xx and 993xx codes under the same health plan, the contracts will no longer comply with law and may be void or terminable, depending on the terms of the contract.

We would appreciate it if you would please provide clarification of the actual rate that MHNNet will reimburse psychiatrists for 992xx and 993xx series codes and the rates that Coventry reimburses other physicians for 992xx and 993xx series codes.

#### 6. Conclusion.

We thank you in advance for taking the time to understand our positions and requests regarding these issues. We look forward to your response. If you believe it would be productive, we would welcome an in-person meeting to discuss the Parity Act, the IFR, and the issues raised in our correspondence. We believe it would be extremely helpful to discuss the issues face-to-face.

In the meantime, if you have any questions, please contact Sam Muszynski, J.D., Director of the APA's Office of Systems and Financing at [imus@psych.org](mailto:imus@psych.org) or 703-907-8594.

Sincerely,

A handwritten signature in black ink, appearing to read "James H. Scully, Jr.", with a stylized flourish at the end.

James H. Scully, Jr., M.D.  
Medical Director and CEO  
American Psychiatric Association

Adam T. Kaul, M.D., DFAPA  
President  
Psychiatric Society of Virginia

John P.D. Shermo, M.D., DFAPA  
Assembly Representative, Chairman Managed Care Liaison Committee  
Psychiatric Society of Virginia

cc. Amy Turner, DOL/Office of Health Plan Standards and Compliance Assistance  
Jim Mayhew, HHS/Office of Consumer Information and Oversight  
John O'Brien, HHS/SAMHSA  
Jacqueline K. Cunningham, Virginia Commissioner of Insurance  
Andrew Mann, Executive Director, Psychiatric Society of Virginia  
Sam Muszynski, J.D., Director, American Psychiatric Association

**TAB 1**  
**ASSOCIATIONS' INQUIRY / MHNET RESPONSE**

1. Associations' Inquiry
  2. MHNet Response March 3, 2011
  3. MNHet Response March 31, 2011
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# American Psychiatric Association

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January 21, 2011

Peter Q. Harris, M.D., Ph.D.  
Corporate Medical Director  
MHNet Behavioral Health  
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Austin, Texas 78720

Dear Doctor Harris:

We are writing on behalf of the American Psychiatric Association and the Psychiatric Society of Virginia as a follow-up to the correspondence among you, Dr. John Shemo, and Allen Wise. The matter at hand concerns the requirements of the federal parity law and MHNet/Coventry's (MHNet's) prior authorization (PA) requirements for medical services provided by psychiatrists to health plan participants, and the prohibition on psychiatrists using the general evaluation and management codes, i.e. the 992xx series.

In reviewing the relevant materials to prepare this letter, an additional matter has come to our attention that needs to be addressed. This concerns the medical necessity criteria utilized by MHNet that codify fail-first criteria necessary for approval of care in certain treatment settings.

As you know, MHNet has basically established a prior authorization requirement for individuals to receive services from a psychiatrist to treat mental health conditions, excepting initial assessment and medication management service codes. Our review of MHNet's parent health plan provisions and provider manuals does not indicate that any such requirement applies as a general condition for: 1) access to the majority of medical services for non-mental health conditions; or 2) access to a primary care practitioner for medical services in connection with a mental health condition.

Regardless, MHNet asserts compliance with the parity requirements on the following basis:

- 1) The parity regulations establish a separate test for NQTLs as opposed to QTLs;
- 2) The regulatory test provides as follows:



(4) Nonquantitative treatment limitations – (i) General rule. A group health plan (or health insurance coverage) may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification, except to the extent that recognized clinically appropriate standards of care permit a difference. [Emphasis added]

- 3) MHNet is in compliance with the regulatory standard via the ‘exception’ language because its PA requirements are supported by “clinically appropriate evidentiary standards.”

First, we disagree that the Interim Final Rule (IFR) has established a separate test for nonquantitative treatment limitations (NQTLs) that is exclusive of the predominant and substantially all test set forth for quantitative treatment limitations (QTLs). Whether or not the test for NQTLs is additive to the test for QTLs is not a fully clarified matter. The final regulations will clarify this. In addition, the IFR is explicit that an NQTL has to be comparable to and no more stringent than those for medical/surgical benefits, so any application of a more restrictive NQTL will need to show that there is some degree of parity in application, and applying an NQTL to a small proportion of the medical benefit but to the majority of the MHSUD benefit will likely be ruled noncompliant. Regardless of how the IFR should be applied to NQTLs, this is not the primary focus of the issue here because it is unlikely we would agree on the appropriate application.

Moreover, the invocation of the exception language by MHNet as the justification for compliance with the parity regulations is an admission that there is, in fact, nothing of substance that is comparable for medical/surgical benefits to be found within relevant Coventry health plan provisions that would justify the PA requirements for mental health services.

Given MHNet’s regulatory citation as the basis for parity compliance we have the following questions:

- 1) Can you provide detail specifying which clinically appropriate evidentiary standard of care justifies the PA requirement for mental health care and not for other medical surgical services?
- 2) What is the clinically appropriate evidentiary standard that justifies PA for mental health care rendered by a psychiatrist but not for mental health care rendered by a primary care physician?
- 3) What published research studies provide an “evidentiary standard” that psychiatrists need preauthorization as opposed to non-psychiatrists?
- 4) Can you identify which experts in the field of psychiatric practice recommend a differential protocol? Please note if these experts are external to MHNet and if any of them have a pecuniary relationship with MHNet, including which of them are in MHNet’s network.



- 5) What national mental health organizations have endorsed your policy that more restrictive access to care by psychiatrists as opposed to non-psychiatrists is a “clinically appropriate ... standard”?
- 6) Could you provide us with a copy of the criteria used for both medical/surgical and MH as required by MHPAEA?

Answers to the foregoing questions are necessary for us to finalize our understanding of your position and complete our analysis of this issue in order to determine what, if any, additional actions we need to pursue to resolve this.

Another concern we have is that while MHNNet reimburses psychiatrists for those codes in the 908xx services that bundle medical evaluation and management with psychotherapy (e.g., 90805 and 90807) after PA, MHNNet refuses to pay psychiatrists for the medical evaluation and management codes for new and/or established patients; i.e., the 992xx series codes.

First, the 992xx E/M codes and the 908xx codes with E/M are not equivalent services. The 992xx codes embody basic medical evaluation and management including counseling and coordination of care. These codes are used by all physicians for basic care and/or management of disease conditions, e.g., diabetes. Medical evaluation and management and counseling and coordination of care (but not psychotherapy) for individuals with psychiatric disorders are often essential. Depression, as an example, is a condition like diabetes, among others, that requires ongoing medical evaluation and management and counseling and coordination of care (especially when there are medical comorbidities).

In contrast, the psychotherapy codes with E/M in the CPT 908xx series contemplate limited medical E/M, but psychotherapy as a medical procedure (not counseling and coordination of care) is the primary treatment modality.

Given that these are nonequivalent services, and all are relevant for the care and treatment of individuals with psychiatric disorders, denial of plan participant access to medical E/M services by a psychiatrist is a separate treatment limitation. As you know, the parity requirements prohibit separate treatment limitations on mental health services. We are requesting that this policy of denying payment to psychiatrists who provide E/M services be reversed and brought into compliance with the parity requirements that specifically prohibit separate treatment limitations.


Finally, as noted earlier we reviewed MHNNet’s Medical Necessity criteria as part of our review of plan documents. We noted the presence of fail-first criteria as part of MHNNet’s admission standards for adult rehabilitation units for substance use disorders. We did not thoroughly review all the medical necessity criteria for all other settings/levels of care respecting fail-first criteria so we cannot speak to their exact extent. As you know, such criteria are regarded by the interim final parity regulations as NQTLs inasmuch as they affect the scope or duration of benefits under a health plan. Please advise how fail-first policies embedded in MHNNet’s medical necessity criteria comply with the standard set by the parity regulation for NQTLs.

We respectfully request a prompt reply since the new plan year has commenced and the IFR provisions governing NQTLs are in force. Plan participants are fully entitled to plan policies and protocols that are



in full compliance with the IFR. We (or our designee) would be happy to discuss these issues by telephone or in person if that is your preference.

Sincerely,



James H. Scully, Jr., M.D.  
Medical Director and CEO  
American Psychiatric Association



Cheryl Jones, MD, DFAPA  
President  
Psychiatric Society of Virginia



John P. D. Shemo MD, DFAPA,  
Assembly Representative, Chairman Managed Care Liaison Committee  
Psychiatric Society of Virginia

cc: Allen Wise, CEO, Coventry  
Amy Turner, DOL/Office of Health Plan Standards and Compliance Assistance  
Jim Mayhew, HHS/Office of Consumer Information and Oversight  
John O'Brien, HHS/SAMHSA  
Jacqueline K. Cunningham, Virginia Commissioner of Insurance  
Andrew Mann, Executive Director, Psychiatric Society of Virginia Inc.



March 3, 2011

**VIA OVERNIGHT DELIVERY**

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Re: MHNet

Dear Drs. Jones, Shemo and Scully:

This is in response to your letter dated January 21, 2011, regarding MHNet Specialty Services, LLC's ("MHNet") compliance with the interim final regulations ("Parity Regulations") issued pursuant to the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. A description of your general concern is noted in bold text below, followed by MHNet's response.

**APA Assertion: MHNet prohibits psychiatrists from using the general evaluation and management codes (992xx codes).**

**MHNet Response:** Given that this necessitates a review of MHNet's prior authorization, provider contracting and claims processing policies and procedures and systems regarding the use of the 992xx codes, MHNet needs additional time to review and respond to this issue. We will provide a response on this issue by April 1, 2011.

**APA Assertion: MHNet applies different prior authorization requirements for outpatient therapy services for psychiatrists than other MHNet contracted mental health professionals.**

As described in my letter dated August 26, 2010, MHNet's prior authorization criteria and standards with respect to outpatient therapy are in compliance with the Parity Regulations and were developed pursuant to the standards set forth

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***The Total Behavioral Health Solution***

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in the Parity Regulations applicable to nonquantitative treatment limitations. In addition, the prior authorization criteria and standards are applied equally by MHNet, regardless if the services are rendered by an MHNet contracted psychiatrist, or other MHNet contracted mental health professional, such as a psychologist or licensed clinical social worker. Given that MHNet's prior authorization criteria and standards for outpatient therapy do not differentiate between psychiatrists and other licensed mental health professionals, the documents you requested regarding different standards in MHNet's criteria for psychiatrists versus other licensed mental health professionals do not exist.

**APA Assertion: MHNet must, in accordance with the Parity Regulations, provide a copy of all of its medical/surgical and MHSA medical necessity criteria.**

We disagree with your assertion that MHNet must provide the requested information pursuant to the Parity Regulations. However, as a matter of practice, MHNet's medical necessity criteria are available on the web at:

<http://www.mhnet.com/Providers/ProviderResources/MNC/tabid/141/Default.aspx>.

With respect to your request for MHNet's medical/surgical criteria, MHNet does not administer medical/surgical benefits and therefore, cannot provide such criteria.

**APA Assertion: MHNet's medical necessity criteria for admissions to adult rehabilitation units for substance use disorders contain fail-first criteria which is prohibited by the Parity Regulations.**

MHNet's medical necessity criteria do not contain fail-first criteria. MHNet's criteria, similar to many medical and MHSA services criteria, often look at, among other things, a member's treatment history to determine the appropriate level of treatment for a particular member. However, MHNet does not require every member to fail a particular treatment before a more intense level of care will be authorized. All coverage determinations are based on the individual member's current condition and symptoms, history and treatment plan.

With the exception of the use 992xx codes as applied to MHNet's administration of MHSA benefits, we believe this letter responds to your request. As indicated above, I will follow-up with a response to the 992xx codes issue after a review of MHNet's various policies, procedures and systems.

Sincerely,

*PP Denise Meredeth  
on behalf of Dr. Peter Harris*

Peter Q. Harris, M.D., Ph.D.  
Medical Director

Ken Burdick, MHNet  
Tom Zielinski, CHC

March 31, 2011

**VIA OVERNIGHT DELIVERY**

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Re: MHNet

Dear Drs. Jones, Shemo and Scully:

This is in follow-up to my letter of March 3, 2011 regarding MHNet Specialty Services, LLC's ("MHNet") compliance with the interim final regulations ("Parity Regulations") issued pursuant to the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. In that letter, I stated that MHNet was reviewing your concerns regarding MHNet's policies and procedures for the use and payment of general evaluation and management codes (992xx codes) ("E&M Codes") by psychiatrists. As a result of our review, which is described in further detail below, MHNet will no longer require prior authorization for the use of E&M Codes by psychiatrists.

First, contrary to your letter, MHNet has never prohibited providers, including psychiatrists, from performing services that are within the scope of their license. Given that MHNet contracts with payors to manage and/or administer mental health and substance abuse ("MHSA") services, historically MHNet has not contracted with providers to render non-MHSA services, such as E&M codes. Thus, while a psychiatrist may be licensed to provide E&M services, it was not a service for which MHNet had contracted with the psychiatrist to provide to health plan/MHNet members.

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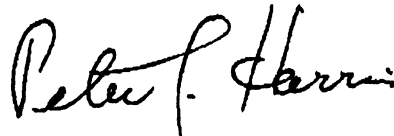
***The Total Behavioral Health Solution***

**Stonebridge Plaza I • 9606 N. Mopac Expressway • Suite 600 • Austin, TX 78759  
(512) 347-7900 • FAX (724) 741-4552**

After reviewing our procedures, MHNet has decided that it will cover any appropriate use of 992xx and 993xx CPT codes by psychiatrists, without prior authorization, to the extent the service is covered under the member's benefit plan. By covering these codes without prior authorization, I believe we have addressed the concerns raised by Dr. Shemo and The Psychiatric Society of Virginia. Their patients with a complex medical/psychiatric history requiring a greater intensity of service than can be covered by 90862 should be covered by 99212 and 99213 for outpatient services. In the event a patient requires a detailed/comprehensive history, a detailed/comprehensive physical exam and moderate/complex medical decision making, codes 99214 and 99215 are available. MHNet will pay the services based on rates in the applicable provider's contract for comparable services, as determined by MHNet. **Our system will be updated with these changes during the next two months.**

We believe this responds to the issues raised in your letter.

Sincerely,

A handwritten signature in black ink that reads "Peter Q. Harris". The signature is written in a cursive style with a large initial "P" and "H".

Peter Q. Harris, M.D., Ph.D.  
Medical Director

cc: Ken Burdick, MHNet  
Tom Zielinski, CHC

**TAB 2**  
**SUMMARY OF INFORMATION REQUESTED BY THE ASSOCIATIONS**

1. Details specifying the clinically appropriate evidentiary standard, which justifies the prior authorization requirement for mental health care and not for other medical services, which are part of the health plan.
  2. The clinically appropriate evidentiary standard that justified the prior authorization for mental health care rendered by a psychiatrist but not for mental health care provided by a primary care physician.
  3. The published research studies that provide the evidentiary standard that psychiatrists need preauthorization as opposed to primary care physicians.
  4. Experts in the field of psychiatric practice that recommend differential protocols for services provided by psychiatrists. We would also be interested in their, if any, pecuniary relationships with MHNet.
  5. The national medical organizations that have endorsed the preauthorization policy.
  6. The criteria used for review of both medical/surgical benefits and MHSUD Benefits.
  7. Copies of Coventry's medical necessity criteria.
  8. Examples of fail-first policies that apply to medical/surgical benefits.
  9. Coventry's rates for 992xx and 993xx series codes.
  10. MHNet's new rates for 992xx and 993xx series codes.
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