IFEDD
THE INTERNATIONAL FEDERATION
OF EATING DISORDER DIETITIANS

Thank you for the opportunity to comment on the Requirements Related to the Mental Health Parity and Addiction Equity Act.

The International Federation of Eating Disorder Dietitians, known as "IFEDD," is a non-profit professional organization of 900+ Registered Dietitians who provide Medical Nutrition Therapy, commonly referred to as "nutrition counseling," to individuals with eating disorders at all levels of care. The majority of our members live and work in the United States, with some overseas working on military bases.

Our organization was founded in 2012 with the express mission of improving access to eating disorder care, so we are very appreciative of your efforts to do the same by ensuring compliance with MHPAEA.

The most significant issue reported by our members every single year since our founding, and the one that most threatens the health and wellbeing of our patients, is being unable to access eating disorder nutrition counseling/MNT on an outpatient basis. For individuals with Medicare and Medicaid, eating disorders are inexplicably not considered qualifying diagnoses. For individuals with private insurance, the inability to access care is more complex. Denials of nutrition counseling/MNT for eating disorders violate MHPAEA, of course, but there is no one reason. Explanations of benefits give different reasons even for the same patient at different times, and it is usually impossible to find an insurance representative who can explain the problem. What we know for certain is that improper denials affect patients and dietitians across the nation, in every state, and are perpetrated by every major insurance provider, both in fully- and self-funded policies.

As you noted on page 51554, the harm caused by insurance non-compliance with MHPAEA is "incalculable." The time, money, and emotional cost that individuals with eating disorders and their families and support partners face attempting to get coverage for their nutrition counseling/MNT – care they are entitled to and have paid for, care that has been illegally denied – is detrimental to eating disorder treatment and often to their mental health in general. As you know, appealing denied care requires hours and hours of back-and-forth communication, the ability to place and receive phone calls during the workday, familiarity with complex insurance jargon, and the immense amount of courage needed to press on undeterred when every message implies that the matter is closed.

In some cases, there is no one with the resources to pursue the necessary appeals, so the patient assumes they must drop out of care. This can lead to relapse, emergency department visits, or hospitalization – all significantly more costly in every sense than the outpatient nutrition counseling/MNT would have been. Hidden costs include the reinforcement of an individual's belief that they don't need care or don't deserve it, and at least one former patient has publicly stated that she considered suicide when she learned she could not access MNT upon discharge from the hospital, because she knew she could not survive without it.

Earlier this year some of our members began reporting an increase in improperly denied claims for eating disorder MNT. With the help of an attorney working on a pro bono basis, we created the IFEDD Access to Care project to provide assistance to these dietitians and their patients in preparing appeals

and complaints to regulatory agencies. We sent out one email asking for those who needed help to contact us. Within 72 hours, we had 182 separate patient cases of improper denials, and they continue to flow in. Many of these denials have been overturned and paid, but the hours, days and weeks our dietitians and volunteers have spent obtaining and reviewing policy documents, calling and emailing insurance companies to get each case reviewed individually, and in communication with federal and state regulators is unsustainable. There must be change at a higher level.

There are many benefits to the proposed rules outlined in this document, but they leave room for continued non-compliance. Knowing firsthand the many, many ways insurance fails our patients and based on reviewing hundreds of improperly denied claims, we have some suggestions to the proposed rules in order for them to have the desired compliance effects.

A. On page 51566, the proposed rule states "eating disorders, such as anorexia nervosa, bulimia nervosa, and binge-eating disorder, are mental health conditions under generally recognized independent standards of current medical practice."

While that statement is correct, it leaves the door open for insurance to reject claims for the other eating disorder diagnoses: "avoidant-restrictive food intake disorder," "rumination disorder;" "anorexia nervosa, subtype unspecified," "other specified eating disorder," which includes "purging disorder," "atypical anorexia nervosa," "bulimia nervosa of low frequency or limited duration," "binge-eating disorder of low frequency or limited duration," and "night eating syndrome;" and "unspecified eating disorder," which includes "orthorexia," "pica in adults," "psychogenic loss of appetite," "chewing and spitting," "rumination disorder in adults," and is also used in situations where a patient is unable to respond to questions about their eating disorder.

We understand that based on the current wording it may seem that all eating disorders are already covered, but this is not occurring in practice. Just as one example, peer-reviewed research has confirmed that atypical anorexia nervosa is equally life-threatening as anorexia nervosa, with the same consequences of starvation and malnutrition and the same needs for nutrition rehabilitation, yet our members report numerous denials of coverage related to this diagnosis.

More specific wording is needed so that insurance benefits are clearly understood to include ALL eating disorders and to stop the practice of improper denial of claims for lesser-known eating disorders.

We propose the following wording as a replacement for "eating disorders, such as anorexia nervosa, bulimia nervosa, and binge-eating disorder, are mental health conditions under generally recognized independent standards of current medical practice":

> "All eating disorder types and subtypes within the International Classification of Diseases (ICD-10) section F (https://icd10cmtool.cdc.gov/) are mental health conditions under generally recognized independent standards of current medical practice.

> Note: Eating disorders labeled as 'other specified' and 'unspecified,' are recognized mental health conditions under generally recognized independent standards of current medical practice. Excluding eating disorders labeled as 'other specified' and 'unspecified' is an NQTL if a plan covers eating disorders, because it is limiting a recognized eating disorder category."

To further clarify that eating disorders treatment is a covered mental health benefit, weight discrimination must be addressed. Weight/BMI misuse by insurance reviewers as a means to deny care because the patient "is not underweight" occurs with all eating disorder diagnoses and is particularly problematic for individuals diagnosed with avoidant-restrictive food intake disorder, bulimia nervosa, binge-eating disorder, or "atypical" anorexia.

Using weight/BMI to diagnose eating disorder status is an outdated practice that – even when it was used in clinical practice – caused great harm to the many individuals experiencing eating disorders that were not underweight. It has been disproved as a method for determining severity of eating disorders and reflects a failure on the part of insurance to stay up to date with clinical practice or evidentiary standards of care.

It is evident to all that neither weight nor BMI reflect mental health status by the simply fact that no other mental health condition is subject to insurance denial of coverage based on body size. Malnutrition, electrolyte imbalances, heart damage and other dangerous medical conditions can be present in an individual of any weight or BMI. It is not clinically appropriate to use body weight/BMI to determine whether an eating disorder is present or whether eating disorder treatment is medically necessary.

Denials for coverage of eating disorder treatment based on weight are not only frequent and in violation of MHPAEA, they are harmful beyond just the denial of needed care. They add to the belief held by an individual that they are not "sick enough" or not deserving of treatment. Both factors – the inability to access care and the mental impact of the rejection – contribute to deterioration of the eating disorder condition, overall mental health, worsening physical state, and in some cases, disability or death.

We propose the following addition to the proposed rule:

> "Neither body weight nor body mass index/BMI is allowable as a criterion for denying coverage for eating disorder treatment. A plan that uses weight or BMI as a rationale to deny a claim for eating disorder treatment is not MHPAEA compliant."

B. Also on page 51566, the proposed rule states, "Therefore, benefits for treatment of eating disorders are mental health benefits for purposes of MHPAEA and may not be defined as medical/surgical benefits under a plan or coverage."

Although mental health benefits/services are provided by other disciplines credentialed by insurance as medical providers – primary care physicians, nurse practitioners, physician assistants, and others – the same standard is not applied to dietitians. Insurance does not credential dietitians as mental health providers, or as medical providers eligible to provide mental health services. This results in an improper denial when a dietitian credentialed with insurance as a medical provider submits a claim for a patient with an eating disorder diagnosis. The medical plan administrator will deny the claim on the basis that the eating disorder is a mental health diagnosis, and the behavioral plan administrator will deny the claim on the basis that dietitians are not credentialed with them as mental health providers.

We suggest clarifying that dietitians be credentialed using the same standard as other medical providers who treat mental health diagnoses, and that MNT claims for eating disorder diagnoses be processed using the same standard as other medical services for eating disorder diagnoses, so that there is no confusion in whether MNT provided by a dietitian for an eating disorder diagnosis is a covered benefit under mental health benefits. We believe this will be the simplest solution that will provide the desired compliance with MHPAEA. Alternately, here are three other options:

1. Apply the standard used for dually category claim codes such as Evaluation and Management (E&M) procedure codes and dually credential MNT CPT codes (97802, 97803 and 97804) so that they can be submitted as medical and mental health benefits depending on the associated diagnosis.
2. Clarify that behavioral health plan administrators credential dietitians as mental health providers for purposes of providing nutrition counseling (consistent within their scope of practice, i.e. only using CPT codes 97802-97804, not to provide psychotherapy) to individuals with mental health conditions (this would include individuals with other mental health diagnoses, not just individuals with eating disorders).
3. Clarify that behavioral health plan administrators credential dietitians as mental health providers for purposes of providing nutrition counseling (consistent within their scope of practice, i.e. only using CPT codes 97802-97804, not to provide psychotherapy) exclusively to individuals with eating disorder diagnoses.

C. On pages 51587, 51623, and 51655, proposed Example 6 repeatedly mentions “nutrition counseling” in the following contexts: “nutrition counseling to treat eating disorders,” “nutrition counseling for eating disorders,” and “Nutrition counseling is one of the primary treatments for eating disorders.”

While the phrase “nutrition counseling” is used in common practice to describe Medical Nutrition Therapy provided by a dietitian, in practice, “nutrition counseling” is not clear enough to be understood by insurance administrators. In practice, coverage for medically necessary, MHPAEA-required, Medical Nutrition Therapy provided by a dietitian for treatment of an eating disorder is often denied with the “explanation” that the plan excludes wellness coaching or that intravenous nutrient infusions are not a covered benefit.

Our request is to close this door by changing the terminology used through the entirety of the proposed rule, substituting one of the following phrases in the place of "nutrition counseling," depending on which is most appropriate to the context:

"Medical Nutrition Therapy"

"Medical Nutrition Therapy provided by a dietitian"

"Medical Nutrition Therapy provided by a dietitian (CPT codes 97802-97804)"

"Medical Nutrition Therapy provided by a dietitian for treatment of an eating disorder"

D. There is no reference in the proposed rule to improper limits on coverage related to number of eating disorder MNT services. We ask that you clarify that a plan is not MHPAEA compliant if it limits the number of MNT sessions for an eating disorder diagnosis using the standard for a medical diagnosis. For example if a plan limits MNT to 3 visits per year for a diagnosis of diabetes, the plan cannot limit MNT for eating disorders to 3 visits a year, since that would be applying a medical benefit limit to a mental health benefit.

E. There is no reference in the proposed rule to coverage for eating disorder MNT via telehealth. Outpatient telehealth has provided a noticeable increase in accessibility to care, especially among rural, disabled, medically compromised individuals, those who care for young children or elders, and those who are unable to travel to a physical appointment. We ask that you add clarification to the proposed rule that eating disorder MNT provided by a dietitian via telehealth is a covered mental health benefit for individuals who are unable to access in-person services for any reason and for individuals who prefer telehealth for any reason, and that there is no difference in reimbursement for telehealth services and office visits.

F. There is no reference in the proposed rule related to network adequacy of eating disorder dietitians. We ask that you add clarification to the proposed rule that a plan is not MHPAEA compliant if they credential other types of specialist providers (e.g. physicians) but have no eating disorder specialist dietitians and state that their network is closed and refuse to credential eating disorder specialist dietitians, or deny out of network access by claiming that a generalist dietitian is sufficient. We ask that you clarify that insurance networks that do not currently include eating disorder specialist dietitians provide expedited credentialing for eating disorder specialist dietitians and utilize in-network benefits to cover out of network eating disorder specialist dietitians.

G. There is no reference in the proposed rule to coverage for ongoing case management and treatment team coordination services regularly provided by dietitians for their patients with eating disorders. We ask that you add clarification that to be MHPAEA compliant, all services provided by dietitians for

the treatment of eating disorders using codes CPT codes 97802-97804 are covered mental health benefits, not just face-to-face patient care time.

H. There is no reference in the proposed rule to the appeals process when MNT for eating disorders is improperly denied. In practice, the appeals process for eating disorder MNT is circuitous to the point of uselessness. Insurance requirements that a physician - who may see a patient infrequently - to participate in a peer-to-peer review, rather than the dietitian who is seeing a patient weekly, causes needless delay and improper denials of treatment.

   We propose the following clarifications be added to the proposed rule:

   1. "To be MHPAEA compliant when medical necessity is in question, a plan must either:
      a. Provide an eating disorder specialist dietitian to perform a peer-to-peer review with a subscriber's dietitian, or
      b. Allow the subscriber's dietitian to participate with the insurance representative in a peer-to-peer review."
   2. "Once a denied claim for eating disorder MNT is overturned on appeal, future claims for the same patient for the same service for the same diagnosis must not be denied for the same reason that was overturned."
   3. "Once a subscriber or healthcare provider give evidence that an insurance determination or denial of care violated MHPAEA, the policy or guideline used to support the improper denial must be changed or removed system-wide for all plan subscribers, so that additional subscribers will not be denied care for the same reason."

Thank you for taking the time to review this letter, for the many individuals who contributed to this proposed rule, and to all those working to improve the lives of individuals with eating disorders. Although you may not see the effects of your work in practice, we can assure you that you are changing and saving lives. We look forward to your response to our comments.

Sincerely,

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