

May 28, 2009

Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attention: CMS-4137-NC  
P.O. Box 8017  
Baltimore, MD 21244-8010

**Re: Request for Information Regarding the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008**

Dear Sir or Madam:

I am writing on behalf of the New York State Psychiatric Association, the statewide medical specialty society which represents 4,500 psychiatrists practicing in the state ("NYSPA"). I am pleased to provide comments in connection with the Request for Information Regarding the Paul Wellstone and Pete Domenici Mental Health and Addiction Equity Act of 2008 (the "Act") issued in the Federal Register on April 28, 2009.

Our comments will focus on two issues of priority to our members: (i) the expansion of state mental health and substance use disorder mandates under the Act; and (ii) application of the Act to eliminate disparate treatment between the processing of evaluation and management claims submitted by psychiatrists and the processing of evaluation and management claims submitted by other physicians.

I. Expansion of State Mental Health and Substance Use Disorder Mandates under the Act

Section 512 of the Act states:

**FINANCIAL REQUIREMENTS AND TREATMENT LIMITATIONS.—**

“(A) IN GENERAL.—In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that—

“(i) the financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits; and

“(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 use disorder benefits.

...

**OUT-OF-NETWORK PROVIDERS.**—In the case of a plan or coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits, if the plan or coverage provides coverage for medical or surgical benefits provided by out-of-network providers, the plan or coverage shall provide coverage for mental health or substance use disorder benefits provided by out-of-network providers in a manner that is consistent with the requirements of this section.’’

The language of the Act requires covered health plans that cover mental health or substance use disorder benefits to provide comparable coverage with other medical and surgical benefits, with respect to financial requirements, treatment limitations and out-of-network coverage. As stated in the Act, treatment limitations applied to mental health and substance use disorder benefits must be no more restrictive than treatment limitations applied to other benefits. The Act defines the term “treatment limitations” to include limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.

This clear statutory mandate for parity in limits imposed on the frequency and scope of medical treatment should require health plans subject to the Act, after the effective date of the Act, to expand their current mental health offerings, making them equivalent to all other benefits provided under their plans. Over 40 states have enacted legislation establishes varying mandates for coverage of inpatient and outpatient treatment of mental illness. These state mandates typically take the form of minimum hospital days and minimum outpatient visits or a requirement for full parity for a designated set of mental illnesses (e.g., full parity for designated “biologically based mental illnesses”).

The unequivocal federal requirement for equal treatment among benefits results in the amplification and expansion of existing state mental health mandates into full parity coverage for mental illnesses and substance use disorders. Furthermore, this amplification and expansion should apply to both state laws that require parity with respect to treatment limitations as well as state laws that require coverage of specific mental health diagnoses.

NYSPA urges the Department to make crystal clear in its implementing regulations that the Act, once in effect, will work to expand and enhance existing state mental health mandate statutes as described above. If a health plan offers unlimited visits per plan year to a participant's primary care physician, the Act’s mandate for parity in treatment limitations requires the health plan to also offer unlimited visits per plan year for mental health treatment.

By way of illustration, New York State’s mental health parity law, Timothy’s Law, requires all group health plans to provide coverage for at least 30 inpatient days of treatment and 20 outpatient days of treatment for all mental illnesses. The provisions of the federal law requiring parity in treatment limitations should, for all new plan years starting on or after October 3, 2009, require health plans in New York to replace the 30 inpatient/20 outpatient benefit limit for

mental health services with the same inpatient and outpatient benefit available for all other medical services.

Following this line of reasoning, it would appear that a state mental health mandate of only one mental health visit per year would be legally sufficient to require full parity under the Act. Similarly, a state mandate for a limited set of “biologically based mental illnesses” should similarly provide the basis for expansion to full parity under the Act.

In addition, a separate New York state law requires health plans to provide at least 60 days of outpatient treatment for alcoholism and substance use disorders. Using the above analysis, if a health plan offers both outpatient and inpatient benefits for medical and surgical services, under the Act, those plans should also be required to provide substance use disorder benefits on an outpatient and inpatient basis as well. Therefore, the Act would also work to “expand” the state substance use disorder mandate for outpatient care into a federal mandate for both outpatient and inpatient care.

## II. Parity in Claims Processing for Evaluation and Management Codes Submitted by Psychiatrists

The provisions of the Act delineated above requiring parity in coverage for mental health benefits and substance use disorder benefits also require parity in processing of claims submitted by mental health professionals. We wish to bring to your attention that many private insurance carriers do not currently accept claims for evaluation and management services provided by psychiatric physicians for office-based services and restrict psychiatrists to the CPT codes for office psychotherapy. Evaluation and management (“E/M”) codes are the CPT codes (99xxx) that most physicians use, both inpatient and outpatient, when evaluating and treating the medical condition of new and existing patients. Evaluation and management includes medical history, medical examination and medical decision-making. Although psychiatrists frequently provide E/M outpatient services to their patients, many insurance carriers will only accept claims from psychiatrists that fall into the category of psychotherapy (e.g., CPT codes 90804-90807).

The Act’s requirements for parity mandate equal treatment in coverage of E/M services provided by psychiatrists with the same E/M services provided by other medical specialties. For example, if a health plan covers E/M codes for office visits (CPT codes 99201-99205 for new patients and 99210-99215 for established patients), then health plans must accept and process claims submitted by psychiatrists for these same codes. We urge the Department to issue regulations stating that while a health plan is not required to provide coverage for every E/M code listed in CPT, to the extent that it covers specific E/M codes when provided by non-psychiatrist physicians, health plans subject to the Act must accept, process and pay claims for those E/M codes submitted by psychiatrists.

Thank you for the opportunity to provide comment and we appreciate your consideration.

Sincerely,  
Seth P. Stein, Esq.  
Executive Director and General Counsel  
New York State Psychiatric Association