Health plans have worked diligently and successfully to ensure compliance with requirements of the Mental Health Parity and Addiction Equity Act (MHPAEA).

Health plans have adopted a variety of medical management tools that are used across both medical/surgical and mental health/substance use disorder benefits to help promote access to safe, appropriate, and cost-effective health care.

The value of medical management, long recognized by health plans and employers in the private sector, has also been affirmed in federal regulations and guidance.
**Background**

Health plans have worked diligently to ensure compliance with requirements of the Mental Health Parity and Addiction Equity Act (MHPAEA). Health plans have worked with clinical and administrative personnel across medical and behavioral departments to promote understanding, implementation, and compliance with the protections established by the parity rules – and they have made great progress. A 2013 report prepared for the U.S. Department of Health and Human Services (HHS) found “employers and health plans have made substantial changes to their plan designs in order to comply with MHPAEA.”

While much of the focus has been on compliance with financial requirements and quantitative treatment limitations, an equally important aspect of parity relates to non-quantifiable treatment limitations (NQTLs), which includes medical management. Health plans use medical management for medical/surgical benefits, as well as for mental health/substance use disorder (MH/SUD) benefits to help promote access to safe, appropriate, and cost-effective health care.¹

**Quality, Safety, and Affordability Continue to Pose Challenges to Effective Care**

During the last decade, various landmark reports from the Institute of Medicine (IOM) and the Agency for Healthcare Research and Quality (AHRQ) have drawn attention to the significant gaps that exist between evidence-based best practices and the care actually being delivered to patients.²,³ Wide variation in provider performance and the little to no correlation between spending and health care quality have been well-documented by researchers and policy experts at Dartmouth, RAND, and the IOM, among others.⁴ Safety concerns also persist, particularly regarding new therapies without a proven track record, therapies prone to overuse, and treatments that may only be effective for specific conditions or populations. Underscoring the need for tools to support clinical decision-making and strategies to address these challenges, recent findings show beneficiaries in the traditional Medicare program receive a significant amount of “low-value” care – services that have little or no clinical benefit or where the risk of harm from the service outweighs the potential benefit.⁵

These problems are exacerbated for behavioral health care due to a quality measurement infrastructure that is less developed than that for medical/surgical care, and the resulting lack of readily available information on the quality of behavioral health clinicians and facilities.⁶ For example, while the National Quality Forum has identified more than 700 health quality measures overall, only 30 are directly linked to behavioral health care. Most MH/SUD quality measures are clinical process of care measures; only a few, such as depression remission, are outcome measures. Likewise, the lack of widespread adoption of certification/accreditation standards for behavioral health facilities adds to the difficulty in identifying effective facilities.

Appendix A highlights selected examples of inappropriate care, including overuse, underuse, and misuse, in MH/SUD and underscores the need for a more robust quality measurement infrastructure, as well as continued flexibility to implement medical management programs.
Health Plan Medical Management Activities Target Challenges and Help Improve Care

Health plans have adopted a variety of medical management tools that are used across both medical/surgical and MH/SUD. For instance, medical necessity reviews help ensure care ordered by a provider is consistent with evidence-based clinical standards of care. By leveraging their infrastructure and data analytics, health plans designate Centers of Excellence (COE) and implement preferred tiers of providers and prescription drugs to promote quality, affordability, and improve patient outcomes. Medical management techniques such as prior authorization typically target services prone to overuse or misuse, while tools like step therapy and dosing limits address safety and affordability concerns specific to select prescription drugs. These medical management tools, coupled with value-based benefit design and alternative payment models that incentivize quality outcomes over volume, promote access to safe, effective, and affordable medical and behavioral health care.

The Value of Medical Management is Affirmatively Recognized by Federal Programs

The value of medical management, which has long been recognized by health plans and employers in the private sector, has also been affirmatively recognized in some federal regulations and guidance. For example, federal regulations implementing essential health benefits requirements make clear that issuers may use reasonable medical management techniques. Similarly, federal regulations implementing preventive health services coverage requirements encourage the use of value-based insurance design (VBID) in connection with preventive health benefits and contraceptive services. This permits health plans to use reasonable medical management techniques to determine the frequency, method, treatment or setting for the required services. Likewise, a VBID model has been implemented in the Medicare Advantage program. Medical management techniques, including the use of evidence-based guidelines and prior authorization for radiology services, were included in the recently passed reforms of the traditional Medicare program, building on recommendations made in 2008 when a U.S. Government Accountability Office (GAO) study recommended CMS add more front-end approaches, such as prior authorization, to address the rapid growth in Medicare spending on imaging services. The Medicare Payment Advisory Commission (MedPAC) made similar recommendations in 2011 with respect to prior authorization for imaging services, and medication therapy management has been a part of the Medicare Part D program since 2003.

Examples of Medical Management in Behavioral Health

Health plans, employer-sponsored plans, and government-sponsored health care programs have long utilized medical necessity review for medical and surgical procedures to ensure patients receive optimal care based on well-established evidence of efficacy and safety, while providing benefit to the individual patient. Medical necessity review is generally done when
there is a lack of or conflicting evidence supporting a particular therapy or drug; safety concerns especially for specific populations; questions pertaining to a therapy’s effectiveness for a specific population; licensure requirements for the clinician or facility providing the care; and questions regarding benefit design. Because there is less information on the quality of behavioral-related providers, facilities, and outcomes, and more gaps in evidence than for medical/surgical care, medical necessity review is an important tool to promote safe, appropriate behavioral health care. For instance, the evidence for use of atypical antipsychotic medications in younger children is limited and medical necessity reviews can help make sure these medications are not routinely prescribed in the absence of approved or evidence-supported indications. Medical necessity reviews can also make sure the provider recommending the treatment is licensed and qualified to provide the service and, for example, can help ensure recommended psychiatric testing of a patient is conducted by a clinician who holds a license as a psychologist or above.

**Prior authorization** is an important tool within medical necessity review for both medical/surgical and behavioral health conditions. As medical evidence usually links efficacy of drugs and services to a specific population or subpopulation, it is important that a prescribed therapy is safe and effective for the patient’s specific condition, provides the greatest value, and is a covered benefit. Particularly with respect to services prone to overuse or misuse, prior authorization can be used to ensure care takes place in the most appropriate setting, at the most appropriate frequency, and is delivered by the most appropriate provider. Prior authorization can also be used to make sure drugs and devices are not used for clinical indications other than those approved by the Food and Drug Administration (FDA). Often off-label drug use requires the prescriber to confirm the use for which the drug was prescribed off-label and the rationale for its use over other recommended drugs for that condition. This process helps ensure the patient is not placed at risk and allows for monitoring of the drug’s use. In addition, prior authorization can help ensure prescribing select medications is limited to specific physician specialists, such as those with a high level of expertise in prescribing and monitoring the treatment. In fact, prior authorization is a tool used by many state Medicaid programs with respect to the prescribing of the addiction recovery drug Suboxone (buprenorphine-naloxone) as a way to reduce the risk of misuse, further addiction, and diversion of the medication, which is classified by the Drug Enforcement Agency (DEA) as a controlled substance. As an additional example, given the FDA’s black box warning regarding the use of antidepressants in the pediatric population and the increased risk of suicidal thinking, prior authorization can help ensure an appropriate psychiatric evaluation is conducted by a provider certified in pediatric mental health.

**Step therapy** may be used for prescription drugs used to treat both medical and behavioral conditions. Step therapy involves prescribing a recognized safe and cost-effective drug before approval of a more complex, costlier or riskier drug or drug combination. For example, there is limited evidence on the safety and efficacy of using two or more antipsychotic medications concurrently, yet the prescribing of multiple antipsychotic drugs occurs in as much as 35
percent of outpatients and 50 percent of inpatients. The professional society of psychiatrists advises clinicians that use of multiple antipsychotic medications concurrently not be tried until at least three attempts using a single antipsychotic medication have failed.\(^{14}\)

Health plan step therapy policies can help reinforce this professional society recommendation.

**Quantity or dosing limits** may be used for prescription drugs used to treat both medical and behavioral conditions. Quantity or dosing limits help make sure that consumers get a safe amount of the drug being prescribed. For instance, given the national crisis on opioid prescribing and addiction, some health plans have implemented quantity limits for initial prescriptions, maximum daily dosages, limits to short-acting opioids, and/or maximum refills to promote access to appropriate pain care while reducing the risk of addiction and diversion of opioids. In fact, the 2016 Centers for Disease Control (CDC) Guideline for Prescribing Opioids for Chronic Pain recommends limiting quantities when initiating opioids for acute pain.\(^{15}\)

Particularly with respect to pain medications like buprenorphine, ongoing monitoring is critical to ensure appropriate dosages and duration in light of concerns that some clinicians may be prescribing higher than recommended dosages and patients may be taking the medications for longer than necessary, raising the risk of addiction. Patients with cancer or who are terminally ill are excluded from these limits and, for other patients, clinicians can request authorization for additional prescriptions or higher dosages if clinically appropriate.

The use of **Centers of Excellence and/or tiering** is one component of a larger, value-based insurance design effort to create financial incentives to encourage the utilization of higher-value, evidence-based treatments and lower utilization of unnecessary treatments and services. For example, certain medical or surgical services are frequently only covered if performed at a recognized and contracted Center of Excellence. These facilities have a proven track record of offering high-quality care with minimal complications and utilize experienced, qualified clinicians. Tiering is most often used with physicians, hospitals, and prescription drugs and establishes groupings of health care providers and facilities based on specified performance metrics, including measures of quality and cost efficiency. Copayments are lower for consumers who seek care from those providers and facilities that fall into a higher-performing tier and are higher for those providers and facilities that fall into a lower-performing tier. A similar framework is typically used for prescription drugs, with separate tiers and cost-sharing levels for generic drugs, preferred brand drugs, and non-preferred brand drugs.

Like prior authorization, **concurrent review** is an important medical necessity review tool that is used primarily with inpatient stays to make sure that the length of stay is consistent with evidence-based guidelines. Concurrent review also gives health plans an opportunity for dialogue with the provider about discharge planning, referral to case management, and opportunities for quality improvement.

**Policy Implications**

Medical management activities work to ensure everyday clinical practice is consistent with safe, evidence based care. Tools assessing safety and
medical appropriateness – as well as formulary and provider network designs that tier prescription drugs and providers based on performance and value – are integral to promoting access to quality and affordable medical/surgical and MH/SUD benefits. Recent emphasis on parity and access to behavioral health care have raised awareness about the use of NQTLs such as medical management and the impact they may have on access to care. Promoting parity between medical and behavioral health benefits is an ongoing, enterprise-wide endeavor to which health plans are strongly committed. Essential to the successful implementation of parity is health plans’ ability to use reasonable medical management to enable them to ensure that members receive safe and appropriate evidence-based treatments from qualified providers. With a number of federal regulations and guidance affirmatively recognizing the value of medical management, and the persistent challenges to safety, quality, and affordability, it is important to promote a greater understanding of the role medical management plays, as well as the fact that these medical management techniques are used across both medical/surgical and MH/SUD.

Lastly, providers and patients should be aware that processes are in place to address circumstances where an individual’s attending provider can request an exception to the application of medical management if clinically appropriate. These safeguards are far preferable to the widespread dismantling of tools and activities that are effective in addressing the long-standing challenges to safe and affordable evidence-based health care.
Inappropriate Behavioral Health Care Summary of Selected Examples

The examples summarized below show inappropriate care, including overuse, underuse, and misuse, in behavioral health and underscore the need for a more robust quality measurement infrastructure and continued flexibility to implement medical management programs.

**Settings of Care**

**Growth of Residential Treatment Centers Despite Uneven Quality, Gaps in Oversight.** There is a great deal of ambiguity and wide variation in the quality and regulatory oversight within the current landscape of residential treatment centers. As a result, loose definitions (e.g., residential facilities may include wilderness therapy programs, ranches, and boot camps, etc.), an undefined scope of service, and often very long duration treatment options that can isolate the patient from family support and involvement in treatment plans, create challenges for improved outcomes, continuity and coordination of care, and patient satisfaction. (“Position Statement 44: Residential Treatment for Children and Adolescents with Serious Mental Health and Substance Use Conditions.” Mental Health America, June 3, 2015; “Marketing Residential Treatment Programs for Eating Disorders: A Call for Transparency.” Attia, E., et al. Psychiatric Services 67:6, March 2016. See also “Residential Facilities: Improved Data and Enhanced Oversight Would Help Safeguard the Well-Being of Youth with Behavioral and Emotional Challenges.” GAO-08-346, May, 2008).16

**Overuse of Psychiatric Hospitalization Despite More Effective Care Settings.** A study by the Minnesota Hospital Association found that nearly one in five days that mental health patients spend admitted to inpatient community hospital psychiatric units is avoidable. The study found that patients would have been better served if treated in a different care setting. Of the 32,560 total mental health bed days in 20 participating hospitals, 6,052 (19 percent) were identified as potentially avoidable. (“Reasons for Delays in Hospital Discharges of Behavioral Health Patients.” Results from the Minnesota Hospital Association Mental and Behavioral Health Data Collection Pilot, July 2016.)17

**Depression**

**Use of Antidepressants in Children and Adolescents May Cause Increased Risk of Suicidal Thinking.** Clinicians have been cautioned about prescribing Selective Serotonin Reuptake Inhibitors (SSRIs) for children and adolescents; the FDA’s black box warning notes that use of these anti-depressants in the pediatric population can lead to an increased risk of suicidal thinking, (“Antidepressant Use in Children, Adolescents, and Adults.” U.S. Food and Drug Administration, May 2, 2007.)18

**Prescribing Antidepressants in Children Without Sufficient Rationale and/or Evidence.** The Director of Mental Health at the World Health Organization, Dr. Shekhar Saxena, has raised questions about antidepressant use in young people – namely, that young people are prescribed antidepressants without sufficient reason and that some off-label prescriptions have not been tested on children. (“Anti-
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depressants: WHO concern over use by children.” Griffith, H. BBC News, March 8, 2016.)

Treatment for Depression Often Unrelated to Screening for Condition. A 2016 study analyzed treatment data for 46,417 adults who screened positively for depression. The results found that of the approximately 8.4 percent of adults who screened positive for depression, only 28.7 percent received any treatment for the condition. Additionally, among a broader population of adults treated for depression, only 29.9 percent had screened positively for depression and 21.8 percent had serious psychological distress. The study showed that most adults who screened positively for depression did not receive depression treatment, while most treated for depression did not screen positively. (“Treatment of Adult Depression in the United States.” Olfson, M., et al. JAMA Internal Medicine 176:10, August 2016.)

Behavioral Therapy Just as Effective and Fewer Side Effects Than Antidepressant Medications for Patients with Major Depressive Disorder. A systematic review of the literature by AHRQ found that cognitive behavioral therapy is as effective as second-generation antidepressants in relieving symptoms of mild to severe major depressive disorder in adults. Moreover, second-generation antidepressants generally lead to a higher risk of adverse events (including nausea, vomiting, diarrhea, fatigue, headache, insomnia and weight gain) when compared with behavioral therapy. (“Nonpharmacological Versus Pharmacological Treatment for Patients With Major Depressive Disorder: Current State of the Evidence.” Agency for Healthcare Research and Quality, December 8, 2015.)

Lithium Underused Despite Indications of Effectiveness in Suicide Prevention, Bipolar Disorder. In this study, authors analyzed 48 randomized controlled trials involving 6,700 patients to determine the effectiveness of lithium as an agent to reduce the number of suicides among patients with depression and bipolar disorder. Lithium was found to reduce the risk of suicide by more than 60 percent in comparison to placebo. (“Lithium in the Prevention of Suicide in Mood Disorders: Updated Systematic Review and Meta-Analysis.” Cipriani, A. et al. BMJ 2013:346, June 27, 2013 and “Lithium Lowers Suicide Risk in Mood Disorders.” Boyles, S. MedPage Today, June 30, 2013.)

Lithium Underused for Bipolar Disorder. In a paper detailing the history of lithium, the author notes that mood stabilizers and antidepressants are given to bipolar patients more often than lithium in the United States, despite evidence of its effectiveness. (“The History of Lithium.” Shorter, E. Bipolar Disorder 11(0 2), June 2009.)

Anti-Psychotic Medications

Clozapine Underused for Treatment-Resistant Schizophrenia Despite Evidence of Effectiveness. While clozapine has proven to be the “gold standard of therapy” for treatment-resistant schizophrenia, its underuse has been well-documented. Clozapine has proven to be more effective than chlorpromazine, quetiapine, and risperidone in head-to-head comparisons, and the drug has shown positive effects on reducing mortality rates when compared to other antipsychotic medications. Yet, an analysis of prescribing trends showed that clozapine only represented 5 percent of second-generation antipsychotic prescriptions in 2002 in the United States. (“Clozapine: A Review of Clinical Practice Guidelines and Prescribing Trends.” Warnez, S., et al. BMC Psychiatry 2014:14, April 7, 2014.)
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Clozapine Underused for Schizophrenia in Medicaid Population. Despite the fact that up to 30 percent of people with schizophrenia are potential candidates for clozapine due to non-response to previous medications, only 2 percent to 3 percent of people are prescribed the drug. The study looked at a sample of 7,035 Medicaid recipients and found that 98 percent of patients received a prescription for an antipsychotic other than clozapine. (“Factors Associated with the Initiation on Clozapine and on Other Antipsychotics Among Medicaid Enrollees.” Manuel, J., et al. Psychiatric Services 63:11, November 2012.)

Prescribing Multiple Antipsychotic Medications for Schizophrenia Continues Contrary to Treatment Guidelines. Despite the lack of empirical evidence that antipsychotic polypharmacy produces superior outcomes to antipsychotic monotherapy, clinicians continue to prescribe multiple antipsychotic medications for patients diagnosed with schizophrenia. Treatment guidelines for schizophrenia recommend against the use of antipsychotic polypharmacy or only endorse it as a last resort after unsuccessful trials of monotherapy. There is also clear evidence that antipsychotic polypharmacy presents complications for patients. (“Antipsychotic Medication Prescribing Practices Among Adult Patients Discharged From State Psychiatric Inpatient Hospitals.” Ortiz, G., et al. Journal of Psychiatric Practice 22:4, July 2016.)

Off-Label Prescribing of Antipsychotic Medications for Insomnia Despite Increased Risk of Death. In a 2015 report issued through a joint working group of the Canadian Psychiatric Association, the Canadian Academy of Child and Adolescent Psychiatry, and the Canadian Academy of Geriatric Psychiatry, Choosing Wisely Canada noted that while second-generation antipsychotics are often prescribed off-label for insomnia, the potential side effects are significant, including an increased risk of cerebrovascular event and increased risk of death among dementia patients. (“Thirteen Things Physicians and Patients Should Question.” Choosing Wisely Canada, June 2, 2015.)

Insufficient Evidence for Off-Label Use of Antipsychotic Medications. Researchers found limited evidence to support the use of eight antipsychotic medications for the treatment of off-label conditions. While antipsychotic medications are approved by the FDA for the treatment of schizophrenia, they are also used off-label for anxiety, ADHD, depression, insomnia, and post-traumatic stress disorder – all conditions for which they have not been approved. Especially among children, possible side effects can include substantial weight gain, elevated cholesterol and triglyceride levels, uncontrollable movements and tremors, and an increased risk of type 2 diabetes. The drugs evaluated in this research were Abilify, Saphris, Fenapt, Zyprexa, Zyprexa Zydis, Invega, Seroquel, Seroquel XR, Risperdal, and Geodon. (“Use of Antipsychotic Medications ‘Off-Label’ to Treat: Anxiety, ADHD, Depression, Insomnia, and PTSD – Evaluating Safety and Effectiveness.” Consumer Reports Best Buy Drugs, November 2013)

Antipsychotic Medications Used Without Diagnosed Mental Illness. An analysis of antipsychotic prescribing patterns found that most young people treated with antipsychotics do not have a diagnosed mental illness. And of those being treated with antipsychotics for a diagnosed mental health disorder, only a minority receive psychotherapy – despite evidence of the effectiveness of psychotherapy for disruptive behaviors, depression and anxiety in young people. Additionally, young children treated with antipsychotics commonly receive their prescriptions exclusively from non-psychiatrist physicians, raising additional safety concerns. (“Treatment of Young People with Antipsychotic Medications in the United States.” Olfson, M., et al. JAMA Psychiatry 72:9, September 2015.)
Opioids

Prescribing Opioids in Combination with Benzodiazepines Increasing Despite Adverse Patient Outcomes, Including Death. The number of patients receiving opioids and benzodiazepines increased by 8 percent and 31 percent, respectively, from 2002 to 2014. During this period, the annual proportion of opioid recipients dispensed a benzodiazepine concomitantly increased from 6.8 percent to 9.6 percent, a relative increase of 41 percent. Approximately half of these patients received both prescriptions from the same prescriber on the same day. Concomitancy was more common in patients receiving opioids for >= 90 days, women, and the elderly. Concomitant prescribing of opioids and benzodiazepines is increasing despite adverse patient outcomes related to these medications, including overdose deaths and ED visits. ("Trends in the Concomitant Prescribing of Opioids and Benzodiazepines, 2002–2014." Hwang, C., et al. American Journal of Preventive Medicine 51:2, August 2016.)

Black Box Warning on Prescribing Opioids with Benzodiazepines. On August 31, 2016, the FDA announced it will require almost 400 products to include the agency's strongest "black box" warning about the dangers of taking opioids and a class of anti-anxiety drugs known as benzodiazepines together. Both types of drugs depress the central nervous system and using them at the same time carries risks of extreme sleepiness, respiratory depression, coma, and death. The move was part of FDA's Opioids Action Plan and followed a review of the data that found overdose deaths involving both kinds of drugs nearly tripled from 2004 to 2011. The number of patients who were prescribed both drugs jumped by 41 percent from 2002 to 2014. "It is nothing short of a public health crisis when you see a substantial increase of avoidable overdose and death related to two widely used drug classes being taken together," FDA Commissioner Robert Califf said in a statement. ("FDA Requires Strong Warnings for Opioid Analgesics, Prescription Opioid Cough Products, and Benzodiazepine Labeling Related to Serious Risks and Death From Combined Use." U.S. Food and Drug Administration, August 31, 2016.)

Prescribing Opioids and Benzodiazepines Results in Higher Overdose Death Rate. This study showed that opioid analgesics were dispensed to 22.8 percent of residents in North Carolina. There were 629 overdose deaths, half of which had an opioid analgesic prescription active on the day of death. Mortality rates increased gradually across the range of average daily milligrams of morphine equivalents, and 80 percent of opioid patients also received benzodiazepines. The rate of overdose death among those co-dispensed opioids and benzodiazepines was 10 times higher than opioid analgesics alone (.7 per 10,000 per-years). ("Cohort Study of the Impact of High-Dose Opioid Analgesics on Overdose Mortality." Dasgupta, N., et al. Pain Medicine 17:1, January 14, 2016.)

Higher than Recommended Doses of Opiates, Benzodiazepines in Hospitalized Elderly. High risk medications, including opiates, benzodiazepines, and antipsychotics, were administered at higher than recommended doses to older adults who subsequently fall in the hospital. Specifically, of 328 falls, 62 percent occurred in individuals administered at least one high-risk medication within the 24 hours before the fall. Sixteen percent of the falls involved individuals receiving two high-risk medications and another 16 percent involved individuals receiving three or more high-risk medications within 24 hours before the fall. High-risk medications were often administered at higher-than-recommended geriatric daily doses, particularly benzodiazepines and benzodiazepine-receptor agonists (BRAs), for which the dose was higher than recommended in 57 percent of the cases. ("High-Risk Medications in Hospitalized Elderly Adults: Are We Making It Easy to Do the Wrong Thing?" Blackman, N., et al. Journal of the American Geriatrics Society. November 28, 2016.)
Other

Use of Psychostimulants in Children with ADHD Not Recommended. Through a joint working group of the Canadian Psychiatric Association, the Canadian Academy of Child and Adolescent Psychiatry, and the Canadian Academy of Geriatric Psychiatry, the Choosing Wisely Canada initiative recommended that psychostimulants not be used as a first-line intervention in preschool children with ADHD. The report notes that children of this age should be assessed for other neurodevelopmental disorders and the possibility of environmental stressors, such as neglect, abuse, or exposure to domestic violence. (“Thirteen Things Physicians and Patients Should Question.” Choosing Wisely Canada, June 2, 2015.)

Use of Hypnotics Associated with Increased Mortality. A 2012 study found that patients prescribed a hypnotic had substantially elevated hazards of death compared to those not prescribed. Those receiving the medication saw a nearly threefold increased hazard of death, even when prescribed fewer than 18 pills annually. The study concludes that the minimal benefits of hypnotics do not justify the substantial risk. (“Hypnotics’ Association with Mortality or Cancer: A Matched Cohort Study.” Kripke, D., et al. BMJ Open 2012:2, February 27, 2012.)

Related Topic

Medical Management: Promoting Access to Safe, Appropriate, Cost-Effective Care
Endnotes

1 NQTLs are permitted with regard to mental health and substance use provided that the “processes, strategies, evidentiary standards and other factors” used in applying the NQTL are comparable to medical/surgical benefits and not more stringent.


6 Institute of Medicine: Improving the Quality of Health Care for Mental and Substance-Use Conditions. Washington, DC, National Academies Press, 2006

7 45 CFR § 156.125(c).

8 45 CFR § 147.130(a)(4).


10 §218 of HR 4302. 


12 §218 of HR 4302.


14 Institute of Medicine: Improving the Quality of Health Care for Mental and Substance-Use Conditions. Washington, DC, National Academies Press, 2006


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