# Federal Mental Health Parity and Addiction Equity Filing

## Table 5: Non-Quantitative Treatment Limitations

***[redacted] and [redacted] (collectively "[redacted] have delegated behavioral health benefit and network management to [redacted]. As part of this delegation, [redacted] is responsible for criteria development and dissemination as well as utilization review for all levels of care related to mental health/substance use disorder. This NQTL analysis was completed for the fully-insured commercial plans offered by [redacted] on a holistic basis; accordingly, a single report is provided for the three [redacted] companies licensed in Connecticut.***

| | | |
|---|---|---|
| A. Plan Name: [redacted] and [redacted] | | B. Date: March 5, 2021 |
| C. Contact Name: [redacted] | D. Telephone Number: [redacted] | E. Email: [redacted]com |
| F. Line of Business (HMO, EPO, POS, PPO): HMO, EPO, POS and PPO | | |
| G. Contract Type (large group, small group, individual): large group, small group, individual | | |
| H. Benefit Plan Effective Date: January 1, 2020 | | I. Benefit Plan Design(s) Identifier(s):[1] |

| Area | Medical/Surgical (M/S) Benefits | Mental Health/Substance Use Disorder (MH/SUD) Benefits | Explanation |
|---|---|---|---|
| | Summarize the plan's applicable NQTLs, including any variations by benefit. | Summarize the plan's applicable NQTLs, including any variations by benefit. | Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4). |
| **A. Definition of Medical Necessity**<br><br>What is the definition of medical necessity? | **MEDICALLY NECESSARY OR MEDICAL NECESSITY:**<br>Health Services that a health care practitioner, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its | **MEDICALLY NECESSARY OR MEDICAL NECESSITY:**<br>Health Services that a health care practitioner, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its | **Explanation:**<br>The same definition for **Medically Necessary or Medical Necessity** applies to both M/S and MH/SUD benefits, as defined by [redacted] plan documents. There is no other, separately applicable, definition of "Medically Necessary" |

| Area | Medical/Surgical (M/S) Benefits | Mental Health/Substance Use Disorder (MH/SUD) Benefits | Explanation |
|---|---|---|---|
| | symptoms, and that are:<br><br>1. In accordance with generally accepted standards of medical practice.<br>2. Clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease.<br>3. Not primarily for the convenience of the patient, physician or other health care provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.<br><br>For the purposes of this definition, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community or otherwise consistent with the standards set forth in policy issues involving clinical judgment. | symptoms, and that are:<br><br>1. In accordance with generally accepted standards of medical practice.<br>2. Clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease.<br>3. Not primarily for the convenience of the patient, physician or other health care provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.<br><br>For the purposes of this definition, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community or otherwise consistent with the standards set forth in policy issues involving clinical judgment. | or “Medical Necessity.” |
| **B. Prior-authorization Review Process**<br><br>Include all services for which prior-authorization is required. Describe any step- therapy or “fail first” requirements and requirements for submission of treatment request forms or treatment plans. | | | |
| Prior Authorization - Inpatient, In-Network: | **Prior Authorization - Inpatient, In-Network:**<br>**Services:**<br>All elective inpatient admissions require prior authorization. | **Prior Authorization - Inpatient, In-Network:**<br>**Services:**<br>All elective (planned) inpatient admissions require prior authorization. | **Explanation:**<br>Parity compliance is evident by the use of the same processes, standards, factors and appropriately comparable clinical evidentiary standards. This is exhibited in writing and in operation within the body of |

| Area | Medical/Surgical (M/S) Benefits | Mental Health/Substance Use Disorder (MH/SUD) Benefits | Explanation |
|---|---|---|---|
| | Emergency admissions do not require prior authorization, but notification of the admission by the facility and/or the member/representative is required. Once notified, [redacted] will conduct a medical necessity and appropriateness of level of care review.<br><br>**What Factors Does the Plan Use to Determine if a Benefit Requires Prior Authorization?**<br>The Plan uses the following Prior Authorization factors to accomplish the following goals:<br>• Monitor and prevent potential overutilization and underutilization;<br>• Manage high-cost and prolonged-duration services;<br>• Ensure enrollee safety;<br>• Determine the appropriate level of care; and<br>• Determine whether the service or item is medically necessary.<br><br>**The Criteria by Which the Prior Authorization Factors are Evaluated:**<br>• Material Variation in Outcome, Utilization, or Cost: A statistically significant deviation from a mean, when compared to other services within the same benefit classification.<br>• Utilization patterns suggest that evidence-based national clinical guidelines are not being followed consistently: Shown by Clinically unwarranted variation, defined as a trend of statistically significant departure from evidence-based criteria in the treatment of a particular condition.<br>• New Services: New and emerging technologies may have limited utilization data available for analysis, either due to new FDA or other approval to market a service or the lack of specific billing and coding guidance for claims submission. In such cases, the need for prior authorization is | For emergency-based admissions, prior authorization is not required. These admissions will be clinically reviewed, after admission, when the In-Network facility or Provider (per contract) submits information needed to perform clinical review.<br><br>**What Factors Does the Plan Use to Determine if a Benefit Requires Prior Authorization?**<br>The Plan uses the following Prior Authorization factors to accomplish the following goals:<br>• Monitor and prevent potential overutilization and underutilization;<br>• Manage high-cost and prolonged-duration services;<br>• Ensure enrollee safety;<br>• Determine the appropriate level of care; and<br>• Determine whether the service or item is medically necessary.<br><br>**The Criteria by Which the Prior Authorization Factors are Evaluated:**<br>• Material Variation in Outcome, Utilization, or Cost: A statistically significant deviation from a mean, when compared to other services within the same benefit classification.<br>• Utilization patterns suggest that evidence-based national clinical guidelines are not being followed consistently: Shown by Clinically unwarranted variation, defined as a trend of statistically significant departure from evidence-based criteria in the treatment of a particular condition.<br>• New Services: New and emerging technologies may have limited utilization data available for analysis, either due to new FDA or other approval to market a service or the lack of specific billing and coding guidance for claims | the M/S and MH/SUD columns. Additionally, MH/SUD exhibits less stringency in the lack of Inpatient fail first or step therapy requirements. |

| Area | Medical/Surgical (M/S) Benefits | Mental Health/Substance Use Disorder (MH/SUD) Benefits | Explanation |
|---|---|---|---|
| | determined based upon estimated costs and an evaluation of the clinical evidence for safety, efficacy, and emerging indications compared with established treatment alternatives.<br>• Value of Applying Prior Authorization Exceeds Administrative Burdens: Consider the value of using Prior Authorization for each item or service, recognizing that there may be instances when high administrative costs and operational or financial burden resulting from application of Prior Authorization outweigh the benefits of implementing Prior Authorization.<br><br>**Step Therapy / Fail First Requirements:**<br>Varying treatment modalities are used to serve as step therapy for various inpatient procedures.<br><br>**Requirements for submission:**<br>Prior Authorization can be submitted by phone, fax or mail.<br><br>**Admission Authorization must contain the following details regarding the admission:**<br>• Member name and Member ID number<br>• Facility name and TIN or NPI<br>• Admitting/attending physician name and TIN or NPI<br>• Description for admitting diagnosis or ICD (or its successor) diagnosis code<br>• Admission date<br>• Clinical information sufficient to determine medical necessity | submission. In such cases, the need for prior authorization is determined based upon estimated costs and an evaluation of the clinical evidence for safety, efficacy, and emerging indications compared with established treatment alternatives.<br>• Value of Applying Prior Authorization Exceeds Administrative Burdens: Consider the value of using Prior Authorization for each item or service, recognizing that there may be instances when high administrative costs and operational or financial burden resulting from application of Prior Authorization outweigh the benefits of implementing Prior Authorization.<br><br>**Step Therapy / Fail First Requirements:**<br>[redacted] does not require any Step Therapy or Fail First Requirements for Inpatient Services.<br><br>**Requirements for submission:**<br>Prior Authorization can be submitted online or by phone.<br><br>**Admission Authorization must contain the following details regarding the admission:**<br>• Customer name and Customer ID number<br>• Facility name and TIN or NPI<br>• Admitting/attending physician name and TIN or NPI<br>• Description for admitting diagnosis or ICD (or its successor) diagnosis code<br>• Admission date<br>• Clinical information sufficient to determine medical necessity | |

| Area | Medical/Surgical (M/S) Benefits | Mental Health/Substance Use Disorder (MH/SUD) Benefits | Explanation |
|---|---|---|---|
| | **For Emergency Admissions:** when a Member is not capable of providing benefit plan information, the facility should notify as soon as the information is known and communicate the extenuating circumstances.<br><br>**Authorization Responsibility**: For In-Network facilities and providers, the In-Network facility/provider is responsible for authorization. Failure to seek authorization before claim submission may result in facility/claim denial or reduced payment, with facility/provider liability. Appeal rights will be provided.<br><br>**Timeframe to respond:** M/S follows all applicable state and federal or accreditation (NCQA) timeframe requirements.<br><br>**Staff Qualifications:** M/S is staffed by clinical, non-clinical and administrative personnel. All clinical reviews are performed by appropriate clinical staff and a licensed physician reviews any determination of medical necessity that is the basis of a potential adverse determination and makes the adverse determination.<br><br>[redacted] offers the opportunity for practitioners to discuss coverage determinations and confer with [redacted] Peer Reviewers before a grievance or appeal is submitted. This peer to peer discussion is not considered part of a grievance or appeal process.<br><br>**Clinical Criteria:** M/S clinical staff make determinations using Milliman Care Guidelines | **For Emergency Admissions:** when a Member is not capable of providing benefit plan information, the facility should notify as soon as the information is known and communicate the extenuating circumstances.<br><br>**Authorization Responsibility**: For In-Network facilities and providers, the In-Network facility/provider is responsible for authorization. Failure to seek authorization before claim submission may result in facility/claim denial or reduced payment, with facility/provider liability. Appeal rights will be provided.<br><br>**Timeframe to respond:** MH/SUD follows all applicable state and federal or accreditation (NCQA) timeframe requirements.<br><br>**Staff Qualifications:** MH/SUD is staffed by clinical, non-clinical and administrative personnel. All clinical reviews are performed by appropriate clinical staff (e.g., RN, LPC, LCSW) and all clinical adverse determinations are made by Board Certified Medical Directors or PhDs.<br><br>[redacted] offers the opportunity for practitioners to discuss coverage determinations and confer with [redacted] Peer Reviewers (Board Certified Clinicians with expertise in child or adolescent MH/SUD as applicable, or Adult MH/SUD as applicable), before a grievance or appeal is submitted. This peer to peer discussion is not considered part of a grievance or appeal process.<br><br>**Clinical Criteria:** MH/SUD clinical staff make determinations using nationally recognized clinical | |

| Area | Medical/Surgical (M/S) Benefits | Mental Health/Substance Use Disorder (MH/SUD) Benefits | Explanation |
|---|---|---|---|
| | (MCG). Internally developed criteria are also used which are created utilizing references and/or guidelines from applicable physician specialty organizations and participating practitioners in the appropriate specialty. Development of criteria also incorporates a review of guidelines from national organizations. | guidelines and criteria: LOCUS (Level of Care Utilization System), CASII (Child and Adolescent Service Intensity Instrument), ECSII (Early Childhood Service Intensity Instrument) for MH, and ASAM (American Society of Addiction Medicine) for SUD. | |
| Prior Authorization -Outpatient, In-Network: | **Prior Authorization - Outpatient, In-Network:**<br><br>**Services:** Authorization is required for the following outpatient services:<br>• Land or air ambulance/medical transport that is not due to an Emergency<br>• Durable Medical Equipment (DME): for the following items (if a covered benefit): customized wheelchairs and scooters, osteogenic stimulators (including spinal, non-spinal and ultrasound)<br>• Clinical trials<br>• Cardiac monitoring with Mobile Cardiac Outpatient Telemetry or continuous computerized daily monitoring with auto-detection<br>• Craniofacial treatment<br>• Gastric bypass surgery, including laparoscopic (if a covered benefit)<br>• Genetic testing<br>• Hospital clinics, non-contracted or out of the Service Area<br>• Interventional Pain Management Services for Chronic Back pain<br>• Neuropsychological Testing<br>• Oncotype DX breast cancer test<br>• Oral appliances for the treatment of Obstructive Sleep Apnea<br>• Oral surgery (if a covered benefit)<br>• Reconstructive surgery<br>• Varicose vein surgery (if a covered benefit)<br>• Ventricular Assist Devices | **Prior Authorization - Outpatient, In-Network:**<br><br>**Services:** Authorization is required for the following outpatient services:<br>• Applied Behavioral Analysis (ABA) for the treatment of Autism Spectrum Disorder (ASD) (if a covered benefit)<br>• Neuropsychological Testing when ordered by a behavioral health provider<br>• Outpatient Electro-Convulsive Treatment (ECT)<br>• Extended Outpatient Psychotherapy (Greater than 60 minutes)<br>• Psychological Testing Over 5 Hours (1 to 5 hours requires notification only)<br>• Transcranial Magnetic Stimulation (TMS)<br>• Intensive Outpatient Programs (IOP)<br>• Partial Hospitalization Programs (PHP)<br><br>. | **Explanation:**<br>Parity compliance is evident by the use of the same processes, standards, factors and appropriately comparable clinical evidentiary standards. This is exhibited in writing and in operation, as summarized above and described within the body of the M/S and MH/SUD columns. Additionally, MH/SUD exhibits less stringency in the application of outpatient fail first or step therapy requirements. |

| Area | Medical/Surgical (M/S) Benefits | Mental Health/Substance Use Disorder (MH/SUD) Benefits | Explanation |
|---|---|---|---|
| | • Home Health Care: Home health services and Hospice care<br>• Infertility Services<br>• Outpatient Radiological Services: Radiation Therapy for Cancer, Stereotactic Radiosurgery and Stereotactic Body Radiation Therapy for all diagnosis<br>• Bone mineral density exams ordered more frequently than every 23 months; CT scans (all diagnostic exams); MRI/MRA (all examinations); Nuclear cardiology; PET scans; Stress echocardiograms<br>• Outpatient Rehabilitative Services: Pediatric only: Occupational therapy, Physical therapy, Speech therapy (including specialty Hospitals, acute care Hospitals and providers of rehabilitation services)<br><br>**What Factors Does the Plan Use to Determine if a Benefit Requires Prior Authorization?**<br>The same Factors are used, as described above for Inpatient, In-Network.<br><br>**The Criteria by Which the Prior Authorization Factors are Evaluated:**<br>The same Criteria are used, as described above for Inpatient, In-Network.<br><br>**Step Therapy / Fail First Requirements:**<br>[redacted] applies step therapy to various outpatient services (e.g., MRIs, echocardiograms).<br><br>**Requirements for submission:**<br>Prior Authorization can be submitted by phone, fax or mail.<br><br>**Authorization requests must contain the following details:** | **What Factors Does the Plan Use to Determine if a Benefit Requires Prior Authorization?**<br>The same Factors are used, as described above for Inpatient, In-Network.<br><br>**The Criteria by Which the Prior Authorization Factors are Evaluated:**<br>The same Criteria are used, as described above for Inpatient, In-Network.<br><br>**Step Therapy / Fail First Requirements:**<br>[redacted] applies step therapy to Transcranial Magnetic Stimulation (TMS).<br><br>**Requirements for submission:**<br>Prior Authorization can be submitted online or by phone.<br><br>**Authorization requests must contain the following details:** | |

| Area | Medical/Surgical (M/S) Benefits | Mental Health/Substance Use Disorder (MH/SUD) Benefits | Explanation |
|---|---|---|---|
| | • Member name and Member ID number<br>• Facility name and TIN or NPI<br>• Admitting/attending physician name and TIN or NPI<br>• Description for admitting diagnosis or ICD (or its successor) diagnosis code<br>• Admission date<br>• Clinical information sufficient to determine medical necessity<br><br>**Authorization Responsibility**: For In-Network facilities and providers, the In-Network facility/provider is responsible for authorization. Failure to seek authorization before claim submission may result in facility/claim denial or reduced payment with facility/provider liability. Appeal rights will be provided.<br><br>**Timeframe to respond:** M/S follows all applicable state and federal or accreditation (NCQA) timeframe requirements.<br><br>**Staff Qualifications:** M/S is staffed by clinical, non-clinical and administrative personnel. All clinical reviews are performed by appropriate clinical staff and a licensed physician reviews any determination of medical necessity that is the basis of a potential adverse determination and makes the adverse determination.<br><br>[redacted] offers the opportunity for practitioners to discuss coverage determinations and confer with [redacted] Peer Reviewers before a grievance or appeal is submitted. This peer to peer discussion is not considered part of a grievance or appeal process. | • Customer name and Customer ID number<br>• Facility name and TIN or NPI<br>• Admitting/attending physician name and TIN or NPI<br>• Description for admitting diagnosis or ICD (or its successor) diagnosis code<br>• Admission date<br>• Clinical information sufficient to determine medical necessity<br><br>**Authorization Responsibility**: For In-Network facilities and providers, the In-Network facility/provider is responsible for authorization. Failure to seek authorization, before claim submission may result in facility/claim denial or reduced payment with facility/provider liability. Appeal rights will be provided.<br><br>**Timeframe to respond:** MH/SUD follows all applicable state, federal and accreditation timeframe requirements.<br><br>**Staff Qualifications:** MH/SUD is staffed by clinical, non-clinical and administrative personnel. All clinical reviews are performed by appropriate clinical staff (e.g., RN, LPC, LCSW) and all adverse determinations are made by Board Certified Medical Directors or PhDs.<br><br>[redacted] offers the opportunity for practitioners to discuss coverage determinations and confer with [redacted] Peer Reviewers (Board Certified Clinicians with expertise in child or adolescent MH/SUD as applicable, or Adult MH/SUD as applicable), before a grievance or appeal is submitted. This peer to peer discussion is not considered part of a grievance or appeal process. | |

| Area | Medical/Surgical (M/S) Benefits | Mental Health/Substance Use Disorder (MH/SUD) Benefits | Explanation |
|---|---|---|---|
| | **Clinical Criteria:** M/S clinical staff make determinations using Milliman Care Guidelines (MCG). Internally developed criteria are also used which are created utilizing references and/or guidelines from applicable physician specialty organizations and participating practitioners in the appropriate specialty. Development of criteria also incorporates a review of guidelines from national organizations. | **Clinical Criteria:** MH/SUD clinical staff make determinations using nationally recognized clinical guidelines and criteria: LOCUS, CASII, ECSII for MH and ASAM for SUD, as well as Behavioral Clinical Policies for services that are not covered by the National Policies. | |
| Prior Authorization - Inpatient, Out-of-Network: | **Prior Authorization - Inpatient, Out-of-Network:**<br><br>**Services:** All elective inpatient admissions require prior authorization.<br><br>Emergency admissions do not require prior authorization, but notification of the admission by the facility and/or the member/representative is required. Once notified, [redacted] will conduct a medical necessity and appropriateness of level of care review.<br><br>**For members with an OON benefit plan:**<br>Prior Authorization is required for non-urgent services if the member is seeking the INN level of cost share, for OON care.<br><br>**For members without an OON benefit plan**:<br>Prior authorization is required for non-urgent services prior to the member obtaining services, or the services will not be covered.<br><br>**Determinations for authorization of non-emergency OON services are made in accordance with:**<br>• The member's benefit plan document.<br>• The need for a specific clinical expertise to treat the member's condition if not available from a facility/provider within the [redacted] network. | **Prior Authorization - Inpatient, Out-of-Network:**<br><br>**Services:** All elective (planned) inpatient admissions require prior authorization.<br><br>For emergency-based admissions, prior authorization is not required. These admissions will be clinically reviewed, after admission, when the member, representative, or facility/ Provider submits information needed to perform clinical review.<br><br>**For members with an OON benefit plan:**<br>Prior Authorization is required for non-urgent services if the member is seeking the INN level of cost share, for OON care.<br><br>**For members without an OON benefit plan:**<br>Prior authorization is required for non-urgent services prior to the member obtaining services, or the services will not be covered.<br><br>**Determinations for authorization of non-emergency OON services are made in accordance with:**<br>• The member's benefit plan document.<br>• The need for a specific clinical expertise to treat the member's condition if not available from an | **Explanation:**<br>Parity compliance is evident by the use of the same processes, standards, factors and appropriately comparable clinical evidentiary standards. This is exhibited in writing and in operation within the body of the M/S and MH/SUD columns. Additionally, MH/SUD exhibits less stringency in the lack of Inpatient fail first or step therapy requirements. |

| Area | Medical/Surgical (M/S) Benefits | Mental Health/Substance Use Disorder (MH/SUD) Benefits | Explanation |
|---|---|---|---|
| | • The identification of special circumstances and/or continuity of care issues related to the member's condition or health care needs which support OON authorization even when the services are available through the [redacted] contracted network of facilities/providers.<br><br>**The OON** factors/criteria, step therapy/fail first, requirements for submission, time frame to respond, staff qualifications and clinical criteria are the same as applied to Inpatient In-Network.<br>**The only difference is**: Out-of-network providers and facilities have no obligation to cooperate with requests for information, documents or discussions. Notwithstanding, M/S will seek the same types of clinical information from the out-of-network provider or facility | In-Network facility/provider.<br>• The identification of special circumstances and/or continuity of care issues related to the member's condition or health care needs which support OON authorization even when the services are available through the [redacted] contracted network of facilities/providers.<br><br>**The OON** factors/criteria, step therapy/fail first, requirements for submission, time frame to respond, staff qualifications and clinical criteria are the same as applied to Inpatient In-Network.<br>**The only difference is**: Out-of-network providers and facilities have no obligation to cooperate with requests for information, documents or discussions. Notwithstanding, MH/SUD will seek the same types of clinical information from the out-of-network provider or facility. | |
| Prior Authorization - Outpatient, Out-of-Network: | **Prior Authorization - Outpatient, Out-of-Network:**<br><br>**Services:** Authorization is required for the following outpatient services:<br>• Land or air ambulance/medical transport that is not due to an Emergency<br>• Durable Medical Equipment (DME): for the following items (if a covered benefit): customized wheelchairs and scooters, osteogenic stimulators (including spinal, non-spinal and ultrasound)<br>• Clinical trials<br>• Cardiac monitoring with Mobile Cardiac Outpatient Telemetry or continuous computerized daily monitoring with auto-detection<br>• Craniofacial treatment<br>• Gastric bypass surgery, including laparoscopic (if a covered benefit) | **Prior Authorization -Outpatient, Out-of-Network:**<br><br>**Services:** Authorization is required for the following outpatient services:<br>• Applied Behavioral Analysis (ABA) for the treatment of Autism Spectrum Disorder (ASD) (if a covered benefit)<br>• Neuropsychological Testing when ordered by a behavioral health provider<br>• Outpatient Electro-Convulsive Treatment (ECT)<br>• Extended Outpatient Psychotherapy (Greater than 60 minutes),<br>• Psychological Testing Over 5 Hours (1 to 5 hours requires notification only)<br>• Transcranial Magnetic Stimulation (TMS)<br>• Intensive Outpatient Programs (IOP) | **Explanation:**<br>Parity compliance is evident by the use of the same processes, standards, factors and appropriately comparable clinical evidentiary standards. This is exhibited in writing and in operation, as summarized above and described within the body of the M/S and MH/SUD columns. Additionally, MH/SUD exhibits less stringency in the application of outpatient fail first or step therapy requirements |

| Area | Medical/Surgical (M/S) Benefits | Mental Health/Substance Use Disorder (MH/SUD) Benefits | Explanation |
|---|---|---|---|
| | • Genetic testing<br>• Hospital clinics, non-contracted or out of the Service Area<br>• Interventional Pain Management Services for Chronic Back pain<br>• Neuropsychological Testing<br>• Oncotype DX breast cancer test<br>• Oral appliances for the treatment of Obstructive Sleep Apnea<br>• Oral surgery (if a covered benefit)<br>• Reconstructive surgery<br>• Varicose vein surgery (if a covered benefit)<br>• Ventricular Assist Devices<br>• Home Health Care: Home health services and Hospice care<br>• Infertility Services<br>• Outpatient Radiological Services: Radiation Therapy for Cancer, Stereotactic Radiosurgery and Stereotactic Body Radiation Therapy for all diagnosis;<br>• Bone mineral density exams ordered more frequently than every 23 months; CT scans (all diagnostic exams); MRI/MRA (all examinations); Nuclear cardiology; PET scans; Stress echocardiograms<br>• Outpatient Rehabilitative Services: Pediatric only: Occupational therapy, Physical therapy, Speech therapy (including specialty Hospitals, acute care Hospitals and providers of rehabilitation services)<br><br>**Out-of-Network (OON) care is subject to medical necessity review.**<br><br>**<u>For members with an OON benefit plan:</u>**<br>Prior Authorization is required for non-urgent services if the member is seeking the INN level of cost share, for OON care. | • Partial Hospitalization Programs (PHP)<br><br>**Out-of-Network (OON) care is subject to medical necessity review.**<br><br>**<u>For members with an OON benefit plan:</u>**<br>Prior Authorization is required for non-urgent services if the member is seeking the INN level of cost share, for OON care. | |

| Area | Medical/Surgical (M/S) Benefits | Mental Health/Substance Use Disorder (MH/SUD) Benefits | Explanation |
|---|---|---|---|
| | **For members without an OON benefit plan**:<br>Prior authorization is required for non-urgent services prior to the member obtaining services, or the services will not be covered.<br><br>**Determinations for authorization of non-emergency OON services are made in accordance with:**<br>• The member's benefit plan document.<br>• The need for a specific clinical expertise to treat the member's condition if not available from a facility/provider within the [redacted] network.<br>• The identification of special circumstances and/or continuity of care issues related to the member's condition or health care needs which support OON authorization even when the services are available through the [redacted] contracted network of facilities/providers.<br><br>**The OON** factors/criteria, step therapy/fail first, requirements for submission, time frame to respond, staff qualifications and clinical criteria are the same as applied to Outpatient, In-Network.<br>**The only difference is:** Out-of-network providers and facilities have no obligation to cooperate with requests for information, documents or discussions. Notwithstanding, M/S will seek the same types of clinical information from the out-of-network provider or facility. | **For members without an OON benefit plan**:<br>Prior authorization is required for non-urgent services prior to the member obtaining services, or the services will not be covered.<br><br>**Determinations for authorization of non-emergency OON services are made in accordance with:**<br>• The member's benefit plan document.<br>• If a provider/facility type is not available within required standards for miles & minutes, or providers within the standard limits are not accepting new patients or are not able to see the patient within required timeframes.<br>• The identification of special circumstances such as: language barriers, continuity of care, or transition of care issues; related to the member's condition or health care needs which support OON authorization even when the services are available through the [redacted] contracted network of facilities/providers.<br><br>**The OON** factors/criteria, step therapy/fail first, requirements for submission, time frame to respond, staff qualifications and clinical criteria are the same as applied to Outpatient, In-Network.<br>**The only difference is:** Out-of-network providers and facilities have no obligation to cooperate with requests for information, documents or discussions. Notwithstanding, MH/SUD will seek the same types of clinical information from the out-of-network provider or facility. | |

| Area | Medical/Surgical (M/S) Benefits | Mental Health/Substance Use Disorder (MH/SUD) Benefits | Explanation |
|---|---|---|---|
| **C. Concurrent Review Process**, including frequency and penalties for all services. Describe any step-therapy or "fail first" requirements and requirements for submission of treatment request forms or treatment plans. | | | |
| Concurrent Review - Inpatient, In-Network: | **Concurrent Review - Inpatient, In-Network:**<br>1. Concurrent review may occur when [redacted] receives a request to extend a previous authorization and this is considered to be an urgent review.<br>**2.** Concurrent Review may also begin after notification of admission and receipt of clinical information, when not previously authorized, as an initial request for urgent review.<br><br>**Concurrent review is part of utilization management for the following reasons**:<br>• To detect and better manage over- and under-utilization.<br>• To determine whether continued services are covered under the medical benefit:<br>o consistent with the member's coverage<br>o medically appropriate, and<br>o consistent with evidence-based guidelines. | **Concurrent Review - Inpatient, In-Network:**<br>1. Concurrent review may occur when [redacted] receives a request to extend a previous authorization and this is considered to be an urgent review.<br>**2.** Concurrent Review may also begin after notification of admission and receipt of clinical information, when not previously authorized, as an initial request for urgent review.<br><br>**Concurrent review is part of utilization management for the following reasons**:<br>• To detect and better manage over- and under-utilization.<br>• To determine whether continued services are covered under the behavioral benefit:<br>o consistent with the member's coverage<br>o medically appropriate, and<br>o consistent with evidence-based guidelines. | **Explanation:**<br>Parity compliance is evident by the use of the same processes, standards, factors and appropriately comparable clinical evidentiary standards. This is exhibited in writing and in operation within the body of the M/S and MH/SUD columns. |

| Area | Medical/Surgical (M/S) Benefits | Mental Health/Substance Use Disorder (MH/SUD) Benefits | Explanation |
|---|---|---|---|
| | • To identify opportunities for quality improvement and cases that are appropriate for referral to case management programs.<br>• Assisting in scheduling follow-up appointments for the member when needed.<br><br>**Process for Concurrent Review:**<br>Concurrent review may occur when [redacted] receives a request to extend a previous authorization and this is considered to be an urgent review. Concurrent Review may also begin after notification of admission and receipt of clinical information, when not previously authorized, as an initial request for urgent review.<br>1) Reviews are conducted by the utilization manager either via fax, onsite, by accessing the Electronic Medical Records ("EMR") through the hospital portal or by telephone. Frequency of review is conducted at the utilization manager's (RN) discretion based on medical necessity and/or level of care. [redacted] staff or its delegate is available to hospital staff to support discharge or transition of care planning for members.<br>2) [redacted] posts on its Internet web site the clinical review criteria it uses, and links to any rule, guideline, protocol or other similar criterion it relies upon to make an adverse determination. [redacted] makes its clinical review criteria available upon request. | • To contribute to decisions about discharge planning, including "step-down" from Inpatient to IOP (Intensive Outpatient) or PHP (Partial Hospitalization).<br>• To identify opportunities for quality improvement and cases that are appropriate for referral to supportive case management, if applicable.<br>• Assisting in scheduling a follow-up appointment for the member when necessary, to promote members' recovery, resiliency, wellness and continued well-being.<br><br>**Process for Concurrent Review:**<br>Concurrent review may occur when [redacted] receives a request to extend a previous authorization and this is considered to be an urgent review. Concurrent Review may also begin after notification of admission and receipt of clinical information, when not previously authorized, as an initial request for urgent review.<br>• A concurrent review may be conducted by telephone, on-site, and when available, facilities can provide clinical information via access to Electronic Medical Records ("EMR").<br>• [redacted] posts clinical review criteria used, online through the Provider Express website. CT providers and members are able to access criteria, provided by information within their denial letter. They may also request additional information.<br>• If the reviewer (a mid- level clinician, such as a clinical social worker for MH/SUD benefits) believes that an admission or continued stay may not be covered, the facility will be asked for | |

| Area | Medical/Surgical (M/S) Benefits | Mental Health/Substance Use Disorder (MH/SUD) Benefits | Explanation |
|---|---|---|---|
| | 3) When conducting reviews, the utilization manager will collect only the information necessary, including pertinent clinical information, to make the utilization review or benefit determination.<br>4) Potential denials will be reviewed by a physician who is an appropriate clinical peer and who will make the final decision considering all comments, documents, records and other information relevant to the request.<br>5) The requesting practitioner has the right to discuss an adverse determination with the clinical peer who made the decision. This discussion will not be considered as part of the appeal process.<br>6) Reviews may be conducted by a delegate under the terms of an active delegation agreement monitored by the Delegation Oversight Committee.<br><br>**Admission Notification Requirements:**<br>For unscheduled admissions, notification can be submitted via fax or the telephone number on the back of the member's ID card. Notification should occur as soon as reasonably possible.<br><br>**Responsibility**:<br>For In-Network facilities and providers, the In-Network facility/provider is responsible for cooperating with requests for information, or discussion per contract. Failure to respond or notify before claim submission may result in facility/claim denial or reduced reimbursement, with facility/provider liability. Appeal rights will be provided. | more information concerning the member's clinical condition, treatment and case management plan.<br>• The reviewer's assessment of whether an admission or continued stay is covered is based on whether the member's clinical condition meets criteria for continued coverage based on the application of nationally recognized clinical guidelines.<br>• When the admission or continued stay at the facility is determined to not be medically necessary, and therefore not covered, the member, facility and the physician will be notified consistent with state, federal or accreditation requirements. Applicable appeal rights are provided.<br>○ An alternate level of care may be offered, as clinically appropriate.<br>○ Supportive Case Management and referrals may be offered, as clinically appropriate.<br><br>**Admission Notification Requirements:**<br>For unscheduled admissions, notification can be submitted via online or the telephone number on the back of the member's ID card. Notification should occur as soon as reasonably possible.<br><br>**Responsibility**:<br>For In-Network facilities and providers, the In-Network facility/provider is responsible for cooperating with requests for information, or discussion per contract. Failure to respond or notify before claim submission may result in facility/claim denial or reduced reimbursement, with facility/provider liability. Appeal rights will be provided. | |

| Area | Medical/Surgical (M/S) Benefits | Mental Health/Substance Use Disorder (MH/SUD) Benefits | Explanation |
|---|---|---|---|
| | **Fail First Requirements:**<br>M/S does not apply Fail First Requirements to concurrent review for Inpatient Benefits.<br><br>**Timeframe to respond:** M/S follows all applicable state and federal or accreditation (NCQA) timeframe requirements.<br><br>**Staff Qualifications:** M/S is staffed by clinical, non-clinical and administrative personnel. All clinical reviews are performed by appropriate clinical staff and a licensed physician reviews any determination of medical necessity that is the basis of a potential adverse determination and makes the adverse determination.<br><br>As noted above, [redacted] offers the opportunity for practitioners to discuss coverage determinations and confer with [redacted] Peer Reviewers before a grievance or appeal is submitted. This peer to peer discussion is not considered part of a grievance or appeal process.<br><br>**Clinical Criteria:** For concurrent review of inpatient admissions or continued stays, M/S clinical staff make determinations using Milliman Care Guidelines (MCG). | **Fail First Requirements:**<br>MH/SUD does not apply Fail First Requirements to concurrent review for Inpatient Benefits.<br><br>**Timeframe to respond:** MH/SUD follows all applicable state and federal or accreditation timeframe requirements.<br><br>**Staff Qualifications:** MH/SUD is staffed by clinical, non-clinical and administrative personnel. All clinical reviews are performed by appropriate clinical staff (e.g., RN, LPC, LCSW) and all adverse determinations are made by Board Certified Medical Directors or PhDs.<br><br>[redacted] offers the opportunity for practitioners to discuss coverage determinations and confer with [redacted] Peer Reviewers (Board Certified Clinicians with expertise in child or adolescent MH/SUD as applicable, or Adult MH/SUD as applicable), before a grievance or appeal is submitted. This peer to peer discussion is not considered part of a grievance or appeal process.<br><br>**Clinical Criteria:** The reviewer's assessment of whether an admission or continued stay is covered, is based on whether the member's clinical condition meets criteria for continued coverage based on the application of nationally recognized clinical guidelines: (LOCUS, CASII, ESCII, ASAM). | |

| Area | Medical/Surgical (M/S) Benefits | Mental Health/Substance Use Disorder (MH/SUD) Benefits | Explanation |
|---|---|---|---|
| Concurrent Review- Outpatient, In-Network: | **Concurrent Review - Outpatient, In-Network:**<br><br>**Services Requiring Concurrent Review.**<br>Concurrent Review for in-network outpatient benefits begins when the Plan receives a request for coverage for a continuing course of outpatient treatment that was previously approved and is ending.<br><br>**Concurrent review is part of utilization management for the following reasons**:<br>• To detect and better manage over- and under-utilization.<br>• To determine whether continued services are covered under the behavioral benefit:<br>o consistent with the member's coverage<br>o medically appropriate, and<br>o consistent with evidence-based guidelines.<br>• To identify opportunities for quality improvement and cases that are appropriate for referral to supportive case management, or an appropriate level of care, if applicable.<br>• To review alternative care plans to effectively meet patient's needs.<br><br>**Process for Concurrent Review:**<br>Concurrent Review for in-network outpatient benefits begins when the Plan receives a request for coverage for a continuing course of outpatient treatment that was previously approved and is ending. | **Concurrent Review - Outpatient, In-Network:**<br><br>**Services Requiring Concurrent Review.**<br>Concurrent Review for in-network outpatient benefits begins when the Plan receives a request for coverage for a continuing course of outpatient treatment that was previously approved and is ending.<br><br>**Concurrent review is part of utilization management for the following reasons**:<br>• To detect and better manage over- and under-utilization.<br>• To determine whether continued services are covered under the behavioral benefit:<br>o consistent with the member's coverage<br>o medically appropriate, and<br>o consistent with evidence-based guidelines.<br>• To contribute to decisions about discharge planning, including "step-down" from IOP or PHP to less-intensive outpatient services.<br>• To identify opportunities for quality improvement and cases that are appropriate for referral to supportive case management, or a higher level of care, if applicable.<br>• Assisting in scheduling a follow-up appointment for the member when necessary, to promote members' recovery, resiliency, wellness and continued well-being.<br><br>**Process for Concurrent Review:**<br>Concurrent Review for in-network outpatient benefits begins when the Plan receives a request for coverage for a continuing course of outpatient treatment that was previously approved and is ending. | **Explanation:**<br>Parity compliance is evident by the use of the same processes, standards, factors and appropriately comparable clinical evidentiary standards. This is exhibited in writing and in operation within the body of the M/S and MH/SUD columns. |

| Area | Medical/Surgical (M/S) Benefits | Mental Health/Substance Use Disorder (MH/SUD) Benefits | Explanation |
|---|---|---|---|
| | The reviewer's assessment of whether a continuing course of outpatient treatment is covered is based on whether the member's clinical condition meets criteria for coverage based on the application of nationally recognized clinical guidelines and the terms of the Plan. When the designated reviewer determines whether the continuing course of treatment is medically necessary, the member and provider will be notified of the determination consistent with state, federal or accreditation (NCQA) requirements and applicable appeal rights are provided.<br><br>**Notification Requirements:**<br>Authorization can be obtained by telephone, fax or mail.<br><br>**Responsibility**: For In-Network facilities and providers, the In-Network facility/provider is responsible for cooperating with requests for information, or discussion per contract. Failure to respond or notify before claim submission may result in facility/claim denial or reduced reimbursement, with facility/provider liability. Appeal rights will be provided.<br><br>**Fail First Requirements:**<br>M/S does not apply Fail First Requirements to concurrent review for outpatient benefits.<br><br>**Timeframe to respond:** M/S follows all applicable state and federal or accreditation (NCQA) timeframe requirements.<br><br>**Staff Qualifications:** M/S is staffed by clinical, non-clinical and administrative personnel. All clinical reviews are performed by appropriate clinical staff and a licensed physician reviews any determination of | The reviewer's assessment of whether a continuing course of outpatient treatment is covered is based on whether the member's clinical condition meets criteria for coverage based on the application of nationally recognized clinical guidelines and the terms of the Plan. When [redacted] determines whether the continuing course of treatment is medically necessary, the member and provider will be notified of the determination consistent with state, federal and accreditation requirements and applicable appeal rights are provided.<br><br>**Notification Requirements:**<br>Authorization can be obtained via online or by telephone.<br><br>**Responsibility**: For In-Network facilities and providers, the In-Network facility/provider is responsible for cooperating with requests for information, or discussion per contract. Failure to respond or notify before claim submission may result in facility/claim denial or reduced reimbursement, with facility/provider liability. Appeal rights will be provided.<br><br>**Fail First Requirements:**<br>MH/SUD does not apply Fail First Requirements to concurrent review for outpatient benefits<br><br>**Timeframe to respond:** MH/SUD follows all applicable state and federal or accreditation timeframe requirements.<br><br>**Staff Qualifications:** MH/SUD is staffed by clinical, non-clinical and administrative personnel. All clinical reviews are performed by appropriate clinical staff (e.g., RN, LPC, LCSW) and all adverse | |

| Area | Medical/Surgical (M/S) Benefits | Mental Health/Substance Use Disorder (MH/SUD) Benefits | Explanation |
|---|---|---|---|
| | medical necessity that is the basis of a potential adverse determination and makes the adverse determination.<br><br>[redacted] offers the opportunity for practitioners to discuss coverage determinations and confer with [redacted] Peer Reviewers before a grievance or appeal is submitted. This peer to peer discussion is not considered part of a grievance or appeal process.<br><br>**Clinical Criteria:** M/S clinical staff make determinations using Milliman Care Guidelines (MCG). Internally developed criteria are also used which are created utilizing references and/or guidelines from applicable physician specialty organizations and participating practitioners in the appropriate specialty. Development of criteria also incorporates a review of guidelines from national organizations. | determinations are made by Board Certified Medical Directors or PhDs.<br><br>[redacted] offers the opportunity for practitioners to discuss coverage determinations and confer with [redacted] Peer Reviewers (Board Certified Clinicians with expertise in child or adolescent MH/SUD as applicable, or Adult MH/SUD as applicable), before a grievance or appeal is submitted. This peer to peer discussion is not considered part of a grievance or appeal process.<br><br>**Clinical Criteria:** MH/SUD clinical staff make determinations using nationally recognized clinical guidelines and criteria: LOCUS, CASII, ECSII for MH and ASAM for SUD, as well as Behavioral Clinical Policies for services that are not covered by the National Policies. | |
| Concurrent Review - Inpatient, Out-of-Network: | **Concurrent Review - Inpatient, Out-of-Network:**<br>1. Concurrent review may occur when [redacted] receives a request to extend a previous authorization and this is considered to be an urgent review.<br>**2.** Concurrent Review may also begin after notification of admission and receipt of clinical information, when not previously authorized, as an initial request for urgent review.<br><br>**Concurrent review is part of utilization management for the following reasons**:<br>• To detect and better manage over- and under-utilization.<br>• To determine whether continued services are covered under the medical benefit: | **Concurrent Review - Inpatient, Out-of-Network:**<br>1. Concurrent review may occur when [redacted] receives a request to extend a previous authorization and this is considered to be an urgent review.<br>2. Concurrent Review may also begin after notification of admission and receipt of clinical information, when not previously authorized, as an initial request for urgent review.<br><br>**Concurrent review is part of utilization management for the following reasons**:<br>• To detect and better manage over- and under-utilization.<br>• To determine whether continued services are covered under the behavioral benefit: | **Explanation:**<br>Parity compliance is evident by the use of the same processes, standards, factors and appropriately comparable clinical evidentiary standards. This is exhibited in writing and in operation within the body of the M/S and MH/SUD columns |

| Area | Medical/Surgical (M/S) Benefits | Mental Health/Substance Use Disorder (MH/SUD) Benefits | Explanation |
|---|---|---|---|
| | ○ consistent with the member's coverage<br>○ medically appropriate, and<br>○ consistent with evidence-based guidelines.<br>• To contribute to decisions about discharge or transition of care planning, including "step down" to a lower level of care.<br>• To identify opportunities for quality improvement and cases that are appropriate for referral to case management programs.<br>• Assisting in scheduling follow-up appointments for the member when needed.<br><br>**Process for Concurrent Review:**<br>When the plan has out-of-network benefits:<br>Concurrent review may occur when [redacted] receives a request to extend a previous authorization and this is considered to be an urgent review. Concurrent Review may also begin after notification of admission and receipt of clinical information, when not previously authorized, as an initial request for urgent review<br><br>1) Reviews are conducted by the utilization manager either via fax, onsite, by accessing the EMR through the hospital portal or by telephone. Frequency of review is conducted at the utilization manager's (RN) discretion based on medical necessity and/or level of care. [redacted] staff or its delegate is available to hospital staff to support discharge or transition of care planning for members. | ○ consistent with the member's coverage<br>○ medically appropriate, and<br>○ consistent with evidence-based guidelines.<br>• To contribute to decisions about discharge planning, including "step-down" from Inpatient to IOP (Intensive Outpatient) or PHP (Partial Hospitalization).<br>• To identify opportunities for quality improvement and cases that are appropriate for referral to supportive case management, if applicable.<br>• Assisting in scheduling a follow-up appointment for the member when necessary, to promote members' recovery, resiliency, wellness and continued well-being.<br><br>**Process for Concurrent Review:**<br>When the plan has out-of-network benefits:<br>Concurrent review may occur when [redacted] receives a request to extend a previous authorization and this is considered to be an urgent review. Concurrent Review may also begin after notification of admission and receipt of clinical information, when not previously authorized, as an initial request for urgent review.<br><br>• A concurrent review may be conducted by telephone, on-site, and when available, facilities can provide clinical information via access to Electronic Medical Records ("EMR").<br>• [redacted] posts clinical review criteria used, online through the Provider Express website. CT providers and members are able to access criteria, provided by information within their | |

| Area | Medical/Surgical (M/S) Benefits | Mental Health/Substance Use Disorder (MH/SUD) Benefits | Explanation |
|---|---|---|---|
| | 2) [redacted] posts on its Internet web site the clinical review criteria it uses, and links to any rule, guideline, protocol or other similar criterion it relies upon to make an adverse determination. [redacted] makes its clinical review criteria available upon request.<br>3) When conducting reviews, the utilization manager will collect only the information necessary, including pertinent clinical information, to make the utilization review or benefit determination.<br>4) Potential denials will be reviewed by a physician who is an appropriate clinical peer and who will make the final decision considering all comments, documents, records and other information relevant to the request.<br>5) The requesting practitioner has the right to discuss an adverse determination with the clinical peer who made the decision. This discussion will not be considered as part of the appeal process.<br>6) Reviews may be conducted by a delegate under the terms of an active delegation agreement monitored by the Delegation Oversight Committee.<br><br>**Admission Notification Requirements:**<br>For unscheduled admissions, notification can be submitted via fax or the telephone number on the back of the member's ID card. Notification should occur as soon as reasonably possible.<br><br>**Fail First Requirements:**<br>M/S does not apply Fail First Requirements to concurrent review for Inpatient Benefits<br><br>**Timeframe to respond:** M/S follows all applicable state and federal or accreditation (NCQA) timeframe requirements. | denial letter. They may also request additional information.<br>• If the reviewer (a mid- level clinician, such as a clinical social worker for MH/SUD benefits) believes that an admission or continued stay may not be covered, the facility will be asked for more information concerning the member's clinical condition, treatment and case management plan.<br>• The reviewer's assessment of whether an admission or continued stay is covered is based on whether the member's clinical condition meets criteria for coverage based on the application of nationally recognized clinical guidelines.<br>• When the [redacted] determines that an admission or continued stay at the facility is not medically necessary, and will not be covered, the member, facility and the physician will be notified consistent with state, federal or accreditation requirements and applicable appeal rights are provided. An out-of-network provider may bill the member for non-reimbursable charges.<br><br>**Admission Notification Requirements:**<br>Notification can be submitted via the telephone number on the back of the member's ID card. Notification should occur as soon as reasonably possible.<br><br>**Fail First Requirements:**<br>MH/SUD does not apply Fail First Requirements to concurrent review for outpatient benefits.<br><br>**Timeframe to respond:** MH/SUD follows all applicable state and federal or accreditation timeframe requirements. | |

| Area | Medical/Surgical (M/S) Benefits | Mental Health/Substance Use Disorder (MH/SUD) Benefits | Explanation |
|---|---|---|---|
| | **Staff Qualifications:** M/S is staffed by clinical, non-clinical and administrative personnel. All clinical reviews are performed by appropriate clinical staff and a licensed physician reviews any determination of medical necessity that is the basis of a potential adverse determination and makes the adverse determination.<br><br>As noted above, [redacted] offers the opportunity for practitioners to discuss coverage determinations and confer with [redacted] Peer Reviewers before a grievance or appeal is submitted. This peer to peer discussion is not considered part of a grievance or appeal process<br><br>**Clinical Criteria:** For concurrent review of inpatient admissions or continued stays, M/S clinical staff make determinations using Milliman Care Guidelines (MCG). | **Staff Qualifications:** MH/SUD is staffed by clinical, non-clinical and administrative personnel. All clinical reviews are performed by appropriate clinical staff (e.g., RN, LPC, LCSW) and all adverse determinations are made by Board Certified Medical Directors or PhDs.<br><br>[redacted] offers the opportunity for practitioners to discuss coverage determinations and confer with [redacted] Peer Reviewers (Board Certified Clinicians with expertise in child or adolescent MH/SUD as applicable, or Adult MH/SUD as applicable), before a grievance or appeal is submitted. This peer to peer discussion is not considered part of a grievance or appeal process.<br><br>**Clinical Criteria:** The reviewer's assessment of whether an admission or continued stay is covered, is based on whether the member's clinical condition meets criteria for continued coverage based on the application of nationally recognized clinical guidelines: (LOCUS, CASII, ESCII, ASAM). | |
| Concurrent Review - Outpatient, Out-of-Network: | **Concurrent Review - Outpatient, Out-of-Network:**<br>When the plan has out-of-network benefits, concurrent review for out-of-network outpatient benefits begins when the Plan receives a request for coverage for a continuing course of outpatient treatment that was previously approved and is ending.<br><br>**Concurrent review is part of utilization management for the following reasons**:<br>• To detect and better manage over- and under-utilization. | **Concurrent Review -Outpatient, Out-of-Network:**<br>When the plan has out-of-network benefits, concurrent review for out-of-network outpatient benefits begins when the Plan receives a request for coverage for a continuing course of outpatient treatment that was previously approved and is ending.<br><br>**Concurrent review is part of utilization management for the following reasons**:<br>• To detect and better manage over- and under-utilization. | **Explanation:**<br>Parity compliance is evident by the use of the same processes, standards, factors and appropriately comparable clinical evidentiary standards. This is exhibited in writing and in operation within the body of the M/S and MH/SUD columns |

| Area | Medical/Surgical (M/S) Benefits | Mental Health/Substance Use Disorder (MH/SUD) Benefits | Explanation |
|---|---|---|---|
| | • To determine whether continued services are covered under the behavioral benefit:<br>  ○ consistent with the member's coverage<br>  ○ medically appropriate, and<br>  ○ consistent with evidence-based guidelines.<br>• To identify opportunities for quality improvement and cases that are appropriate for referral to supportive case management, or an appropriate level of care, if applicable.<br>• To review alternative care plans to effectively meet patient's needs.<br><br>**Process for Concurrent Review:**<br>When the plan has out-of-network benefits, concurrent review for out-of-network outpatient benefits begins when the Plan receives a request for coverage for a continuing course of outpatient treatment that was previously approved and is ending. If the reviewer believes that a continuing course of outpatient treatment may not be covered, the provider will be asked for more information concerning the treatment.<br><br>The reviewer's assessment of whether a continuing course of outpatient treatment is covered is based on whether the member's clinical condition meets criteria for coverage based on the application of nationally recognized clinical guidelines and the terms of the Plan. When the designated reviewer determines whether the | • To determine whether continued services are covered under the behavioral benefit:<br>  ○ consistent with the member's coverage<br>  ○ medically appropriate, and<br>  ○ consistent with evidence-based guidelines.<br>• To contribute to decisions about discharge planning, including "step-down" from IOP (Intensive Outpatient) to less-intensive outpatient services.<br>• To identify opportunities for quality improvement and cases that are appropriate for referral to supportive case management, or a higher level of care, if applicable.<br>• Assisting in scheduling a follow-up appointment for the member when necessary, to promote members' recovery, resiliency, wellness and continued well-being.<br><br>**Process for Concurrent Review:**<br>When the plan has out-of-network benefits, concurrent review for out-of-network outpatient benefits begins when the Plan receives a request for coverage for a continuing course of outpatient treatment that was previously approved and is ending. If the reviewer believes that a continuing course of outpatient treatment may not be covered, the provider will be asked for more information concerning the treatment.<br><br>The reviewer's assessment of whether a continuing course of outpatient treatment is covered is based on whether the member's clinical condition meets criteria for coverage based on the application of nationally recognized clinical guidelines and the terms of the Plan. When [redacted] determines whether | |

| Area | Medical/Surgical (M/S) Benefits | Mental Health/Substance Use Disorder (MH/SUD) Benefits | Explanation |
|---|---|---|---|
| | continuing course of treatment is medically necessary, the member and provider will be notified of the determination consistent with state, federal or accreditation (NCQA) requirements and applicable appeal rights are provided. An out-of-network provider may bill the member for non-reimbursable charges.<br><br>**Notification Requirements:**<br>Authorization can be obtained by telephone, fax or mail.<br><br>**Fail First Requirements:**<br>M/S does not apply Fail First Requirements to concurrent review for outpatient benefits.<br><br>**Timeframe to respond:** M/S follows all applicable state and federal or accreditation (NCQA) timeframe requirements.<br><br>**Staff Qualifications:** M/S is staffed by clinical, non-clinical and administrative personnel. All clinical reviews are performed by appropriate clinical staff and a licensed physician reviews any determination of medical necessity that is the basis of a potential adverse determination and makes the adverse determination.<br><br>[redacted] offers the opportunity for practitioners to discuss coverage determinations and confer with [redacted] Peer Reviewers before a grievance or appeal is submitted. This peer to peer discussion is not considered part of a grievance or appeal process.<br><br>**Clinical Criteria:** M/S clinical staff make determinations using Milliman Care Guidelines | the continuing course of treatment is medically necessary, the member and provider will be notified of the determination consistent with state, federal or accreditation requirements and applicable appeal rights are provided. An out-of-network provider may bill the member for non-reimbursable charges.<br><br>**Notification Requirements:**<br>Authorization can be obtained via online or by telephone.<br><br>**Fail First Requirements:**<br>MH/SUD does not apply Fail First Requirements to concurrent review for outpatient benefits<br><br>**Timeframe to respond:** MH/SUD follows all applicable state and federal or accreditation timeframe requirements.<br><br>**Staff Qualifications:** MH/SUD is staffed by clinical, non-clinical and administrative personnel. All clinical reviews are performed by appropriate clinical staff (e.g., RN, LPC, LCSW) and all adverse determinations are made by Board Certified Medical Directors or PhDs.<br><br>[redacted] offers the opportunity for practitioners to discuss coverage determinations and confer with [redacted] Peer Reviewers (Board Certified Clinicians with expertise in child or adolescent MH/SUD as applicable, or Adult MH/SUD as applicable), before a grievance or appeal is submitted. This peer to peer discussion is not considered part of a grievance or appeal process.<br><br>**Clinical Criteria:** MH/SUD clinical staff make determinations using nationally recognized clinical | |

| Area | Medical/Surgical (M/S) Benefits | Mental Health/Substance Use Disorder (MH/SUD) Benefits | Explanation |
|---|---|---|---|
| | (MCG). Internally developed criteria are also used which are created utilizing references and/or guidelines from applicable physician specialty organizations and participating practitioners in the appropriate specialty. Development of criteria also incorporates a review of guidelines from national organizations. | guidelines and criteria: LOCUS, CASII, ECSII for MH and ASAM for SUD, as well as Behavioral Clinical Policies for services that are not covered by the National Policies. | |
| **D. Retrospective Review Process,** including timeline and penalties. | | | |
| Retrospective Review - Inpatient, In-Network: | **Retrospective Review - Inpatient, In-Network**<br>Services provided at an inpatient level of care when the Plan is notified of the inpatient stay after discharge.<br><br>**Why does the Plan conduct Retrospective Reviews?**<br>Retrospective Review is a component of [redacted] utilization management program. The Medical Director and other clinical staff review hospitalizations and other inpatient admissions, for the following reasons:<br>• to detect and better manage over- and under-utilization;<br>• to determine whether the services reviewed are:<br>o consistent with the member's coverage,<br>o medically appropriate, and consistent with evidence-based guidelines. | **Retrospective Review - Inpatient, In-Network**<br>Services provided at an inpatient level of care when the Plan is notified of the inpatient stay after discharge.<br><br>**Why does the Plan conduct Retrospective Reviews?**<br>Retrospective Review is a component of [redacted] utilization management program. The Medical Director and other clinical staff review hospitalizations and other inpatient admissions, for the following reasons:<br>• to detect and better manage over- and under-utilization;<br>• to determine whether the services reviewed are:<br>o consistent with the member's coverage,<br>o medically appropriate, and consistent with evidence-based guidelines. | **Explanation:**<br>Parity compliance is evident by the use of the same processes, standards, factors and appropriately comparable clinical evidentiary standards. This is exhibited in writing and in operation within the body of the M/S and MH/SUD columns |

| Area | Medical/Surgical (M/S) Benefits | Mental Health/Substance Use Disorder (MH/SUD) Benefits | Explanation |
|---|---|---|---|
| | **Process for Retrospective Review:**<br><br>**Pre-Claim Retrospective Review ([redacted] receives notification post discharge) – [redacted]** performs a pre-claim retrospective review, for certain inpatient in-network cases, starting with the first day after notification, if the in-network facility did not notify [redacted] in a timely manner or seek prior authorization for the admission and provides extenuating circumstances for the late notification. The review is conducted unless post-discharge review is prohibited by hospital contract. Notification of all review outcomes is communicated in accordance with applicable state, federal or accreditation (NCQA) requirements, and applicable appeal rights are provided.<br><br>**Post-Claim Retrospective Review.**<br>If prior authorization was required and no prior authorization is on file, the claim is denied administratively for no-prior authorization on file. The provider can then appeal for medical necessity review post claim. Notification of all review outcomes is communicated in accordance with applicable state, federal or accreditation (NCQA) requirements and applicable appeal rights are provided.<br><br>**Notification Requirements:**<br>Providers can notify the plan via phone, fax or mail.<br><br>**Timeframe to respond:** M/S follows all applicable state and federal or accreditation (NCQA) timeframe requirements. | **Process for Retrospective Review:**<br><br>**Pre-Claim Retrospective Review ([redacted] receives notification post discharge) – [redacted]** performs a pre-claim retrospective review, for certain inpatient in-network cases, starting with the first day after notification, if the in-network facility did not notify [redacted] in a timely manner or seek prior authorization for the admission and provides extenuating circumstances for the late notification. The review is conducted unless post-discharge review is prohibited by hospital contract. Notification of all review outcomes are communicated in accordance with applicable state, federal or accreditation requirements, and applicable appeal rights are provided.<br><br>**Post-Claim Retrospective Review.**<br>If prior authorization was required and no prior authorization is on file, the claim is denied administratively for no-prior authorization on file. The provider can then appeal for medical necessity review post claim. Notification of all review outcomes are communicated in accordance with applicable state, federal or accreditation requirements and applicable appeal rights are provided.<br><br>**Notification Requirements:**<br>By online or telephone for Pre-Claim Retrospective Review. For Post-Claim Retrospective Review reconsiderations, the provider can notify the plan via phone, online or mail.<br><br>**Timeframe to respond:** MH/SUD follows all applicable state and federal or accreditation timeframe requirements. | |

| Area | Medical/Surgical (M/S) Benefits | Mental Health/Substance Use Disorder (MH/SUD) Benefits | Explanation |
|---|---|---|---|
| | **Staff Qualifications:** M/S is staffed by clinical, non-clinical and administrative personnel. All clinical reviews are performed by appropriate clinical staff and a licensed physician reviews any determination of medical necessity that is the basis of a potential adverse determination and makes the adverse determination.<br><br>**Clinical Criteria:** For retrospective review of inpatient stays, M/S clinical staff make determinations using Milliman Care Guidelines (MCG). | **Staff Qualifications:** MH/SUD is staffed by clinical, non-clinical and administrative personnel. All clinical reviews are performed by appropriate clinical staff (e.g., RN, LPC, LCSW) and all adverse determinations are made by Board Certified Medical Directors or PhDs.<br><br>[redacted] offers the opportunity for practitioners to discuss coverage determinations and confer with [redacted] Peer Reviewers (Board Certified Clinicians with expertise in child or adolescent MH/SUD as applicable, or Adult MH/SUD as applicable), before a grievance or appeal is submitted. This peer to peer discussion is not considered part of a grievance or appeal process.<br><br>**Clinical Criteria:** BH/SUD staff make determinations by utilizing nationally recognized clinical guidelines: (LOCUS, CASII, ESCII, ASAM). | |
| Retrospective Review - Outpatient, In-Network: | **Retrospective Review- Outpatient, In-Network**<br><br>**Retrospective Review** for in-network outpatient benefits begins when the Plan receives notification post-service that the outpatient service occurred.<br><br>**Why does the Plan conduct Retrospective Reviews?**<br>Retrospective Review is a component of [redacted] utilization management program. The Medical Director and other clinical staff review services for the following reasons:<br>• to detect and better manage over- and under-utilization;<br>• to determine whether the services reviewed are—<br>o consistent with the member's coverage,<br>o medically appropriate, and consistent with | **Retrospective Review - Outpatient, In-Network**<br><br>**Retrospective Review** for in-network outpatient benefits begins when the Plan receives notification post-service that the outpatient service occurred.<br><br>**Why does the Plan conduct Retrospective Reviews?**<br>Retrospective Review is a component of [redacted] utilization management program. The Medical Director and other clinical staff review services for the following reasons:<br>• to detect and better manage over- and under-utilization;<br>• to determine whether the services reviewed are—<br>o consistent with the member's coverage, | **Explanation:**<br>Parity compliance is evident by the use of the same processes, standards, factors and appropriately comparable clinical evidentiary standards. This is exhibited in writing and in operation within the body of the M/S and MH/SUD columns |

| Area | Medical/Surgical (M/S) Benefits | Mental Health/Substance Use Disorder (MH/SUD) Benefits | Explanation |
|---|---|---|---|
| | evidence-based guidelines.<br><br>**Process for Retrospective Review:**<br><br>**Pre-Claim Retrospective Review Post-service**<br>When [redacted] is contacted by an in-network provider who was unable to obtain prior authorization due to a qualifying mitigating circumstance a medical necessity review will be conducted for outpatient services. For all other services, the in-network provider can provide this additional information upon appeal.<br><br>When the Medical Director determines that the service was not medically necessary, the member and providers will be notified consistent with state, federal or accreditation requirements and applicable appeal rights are provided.<br><br>**Post-Claim Retrospective Review**:<br>If prior authorization is required and no prior authorization is on file, the claim is denied administratively for no-prior authorization on file. However, the in-network provider can then appeal for medical necessity review post claim. Otherwise, the claim will administratively deny for no-prior authorization on file. If the reviewer believes that the service was not medically necessary, the provider will be asked for more information. If the service is reviewed and determined to be not medically necessary, then the claim will deny in full and provide appeal rights. Upon appeal, a Medical Director determines whether the service was medically necessary, and the provider will be notified of the determination. If denied, then the notice will include appeal rights and follow all applicable state, federal or accreditation requirements. | ○ medically appropriate, and consistent with evidence-based guidelines.<br><br>**Process for Retrospective Review:**<br><br>**Pre-Claim Retrospective Review Post-service**<br>When [redacted] is contacted by an in-network provider who was unable to obtain prior authorization due to a qualifying mitigating circumstance a medical necessity review will be conducted for outpatient services. For all other services, the in-network provider can provide this additional information upon appeal.<br><br>When the Medical Director determines that the service was not medically necessary, the member and providers will be notified consistent with state, federal or accreditation requirements and applicable appeal rights are provided.<br><br>**Post-Claim Retrospective Review**:<br>If prior authorization is required and no prior authorization is on file, the claim is denied administratively for no-prior authorization on file. However, the in-network provider can then appeal for medical necessity review post claim. If the reviewer (a mid-level provider, such as a clinical social worker for MH/SUD benefits) believes that the service was not medically necessary, the provider will be asked for more information. If the service is reviewed and determined to be not medically necessary, then the claim will deny in full and provide appeal rights. Upon appeal, a Board Certified Medical Director determines whether the service was medically necessary, and the provider will be notified of the determination. If denied, then the notice will include appeal rights and follow all applicable state, federal | |

| Area | Medical/Surgical (M/S) Benefits | Mental Health/Substance Use Disorder (MH/SUD) Benefits | Explanation |
|---|---|---|---|
| | | or accreditation requirements. | |
| | **Notification Requirements:**<br>Providers can notify the plan via phone, fax or mail. | **Notification Requirements:**<br>By online or telephone for Pre-Claim Retrospective Review. For Post-Claim Retrospective Review reconsiderations, the provider can notify the plan via phone, online or mail. | |
| | **Timeframe to respond:** M/S follows all applicable state and federal or accreditation (NCQA) timeframe requirements. | **Timeframe to respond:** MH/SUD follows all applicable state and federal or accreditation timeframe requirements. | |
| | **Staff Qualifications:** M/S is staffed by clinical, non-clinical and administrative personnel. All clinical reviews are performed by appropriate clinical staff and a licensed physician reviews any determination of medical necessity that is the basis of a potential adverse determination and makes the adverse determination. | **Staff Qualifications:** MH/SUD is staffed by clinical, non-clinical and administrative personnel. All clinical reviews are performed by appropriate clinical staff (e.g., RN, LPC, LCSW) and all adverse determinations are made by Board Certified Medical Directors or PhDs. | |
| | | [redacted] offers the opportunity for practitioners to discuss coverage determinations and confer with [redacted] Peer Reviewers (Board Certified Clinicians with expertise in child or adolescent MH/SUD as applicable, or Adult MH/SUD as applicable), before a grievance or appeal is submitted. This peer to peer discussion is not considered part of a grievance or appeal process. | |
| | **Clinical Criteria:** M/S clinical staff make determinations using Milliman Care Guidelines (MCG). Internally developed criteria are also used which are created utilizing references and/or guidelines from applicable physician specialty organizations and participating practitioners in the appropriate specialty. Development of criteria also incorporates a review of guidelines from national organizations. | **Clinical Criteria:** MH/SUD clinical staff make determinations using nationally recognized clinical guidelines and criteria: LOCUS, CASII, ECSII for MH and ASAM for SUD, as well as Behavioral Clinical Policies for services that are not covered by the National Policies. | |

| Area | Medical/Surgical (M/S) Benefits | Mental Health/Substance Use Disorder (MH/SUD) Benefits | Explanation |
|---|---|---|---|
| Retrospective Review - Inpatient, Out-of-Network: | **Retrospective Review - Inpatient, Out-of-Network**<br>When the plan has out-of-network benefits, services provided at an inpatient level of care or bed day when the Plan is notified of the inpatient stay after discharge.<br><br>**Why does the Plan conduct Retrospective Reviews?**<br>Retrospective Review is a component of [redacted] utilization management program. The Medical Director and other clinical staff review hospitalizations and other inpatient admissions, for the following reasons:<br>• to detect and better manage over- and under-utilization;<br>• to determine whether the services reviewed are:<br>o consistent with the member's coverage,<br>o medically appropriate, and consistent with evidence-based guidelines.<br><br>**Pre-Claim Retrospective Review ([redacted] receives notification post discharge) –** [redacted] performs a pre-claim retrospective review, for certain inpatient out-of-network cases, starting with the first day after notification, if the out-of-network facility did not notify [redacted] in a timely manner or seek prior authorization for the admission and provides extenuating circumstances for the late notification. A clinical coverage review will be done to determine whether the service is medically necessary, and payment may be withheld if the services are determined not to have been medically necessary. Notification of all review outcomes is communicated in accordance with applicable state, federal or accreditation | **Retrospective Review - Inpatient, Out-of-Network**<br>When the plan has out-of-network benefits, services provided at an inpatient level of care or bed day when the Plan is notified of the inpatient stay after discharge.<br><br>**Why does the Plan conduct Retrospective Reviews?**<br>Retrospective Review is a component of Optum's utilization management program. The Medical Director and other clinical staff review hospitalizations and other inpatient admissions, for the following reasons:<br>• to detect and better manage over- and under-utilization;<br>• to determine whether the services reviewed are:<br>o consistent with the member's coverage,<br>o medically appropriate, and consistent with evidence-based guidelines.<br><br>**Pre-Claim Retrospective Review ([redacted] receives notification post discharge) –** [redacted] performs a pre-claim retrospective review, for certain inpatient out-of-network cases, starting with the first day after notification, if the out-of-network facility did not notify [redacted] in a timely manner or seek prior authorization for the admission. A clinical coverage review will be done to determine whether the service is medically necessary, and payment may be withheld if the services are determined not to have been medically necessary. Notification of all review outcomes is communicated in accordance with applicable state, federal or accreditation requirements, and applicable appeal rights are | **Explanation:**<br>Parity compliance is evident by the use of the same processes, standards, factors and appropriately comparable clinical evidentiary standards. This is exhibited in writing and in operation within the body of the M/S and MH/SUD columns. |

| Area | Medical/Surgical (M/S) Benefits | Mental Health/Substance Use Disorder (MH/SUD) Benefits | Explanation |
|---|---|---|---|
| | requirements, and applicable appeal rights are provided.<br><br>**Post-Claim Retrospective Review –** When the plan has out-of-network benefits, plan documents require the member to obtain a prior authorization for out-of-network inpatient elective (non-emergency) services. If no prior authorization or notification is on file, a clinical coverage review will be done to determine whether the service is medically necessary, and payment may be withheld if the services are determined not to have been medically necessary. If services are determined to be medically necessary, a penalty would be applied to the member unless it is determined there are extenuating circumstances. Notification of all review outcomes is communicated in accordance with applicable state, federal or accreditation requirements, and applicable appeal rights are provided.<br><br>**Notification Requirements:**<br>Providers can notify the plan via phone, fax or mail.<br><br>**Timeframe to respond:** M/S follows all applicable state and federal or accreditation (NCQA) timeframe requirements.<br><br>**Staff Qualifications:** M/S is staffed by clinical, non-clinical and administrative personnel. All clinical reviews are performed by appropriate clinical staff and a licensed physician reviews any determination of medical necessity that is the basis of a potential adverse determination and makes the adverse determination. | provided.<br><br>**Post-Claim Retrospective Review –** When the plan has out-of-network benefits, plan documents require the member to obtain a prior authorization for out-of-network inpatient elective (non-emergency) services. If no prior authorization or notification is on file, a clinical coverage review will be done to determine whether the service is medically necessary, and payment may be withheld if the services are determined not to have been medically necessary. If services are determined to be medically necessary, a penalty would be applied to the member unless it is determined there are extenuating circumstances. Notification of all review outcomes is communicated in accordance with applicable state, federal or accreditation requirements, and applicable appeal rights are provided.<br><br>**Notification Requirements:**<br>By online or telephone for Pre-Claim Retrospective Review. For Post-Claim Retrospective Review reconsiderations, the provider can notify the plan via phone, online or mail.<br><br>**Timeframe to respond:** MH/SUD follows all applicable state and federal or accreditation timeframe requirements.<br><br>**Staff Qualifications:** MH/SUD is staffed by clinical, non-clinical and administrative personnel. All clinical reviews are performed by appropriate clinical staff (e.g., RN, LPC, LCSW) and all adverse determinations are made by Doctoral-Level Medical Directors or PhDs. | |

| Area | Medical/Surgical (M/S) Benefits | Mental Health/Substance Use Disorder (MH/SUD) Benefits | Explanation |
|---|---|---|---|
| | | [redacted] offers the opportunity for practitioners to discuss coverage determinations and confer with [redacted] Peer Reviewers (Board Certified Clinicians with expertise in child or adolescent MH/SUD as applicable, or Adult MH/SUD as applicable), before a grievance or appeal is submitted. This peer to peer discussion is not considered part of a grievance or appeal process.<br><br>**Clinical Criteria:** BH/SUD staff make determinations by utilizing nationally recognized clinical guidelines: (LOCUS, CASII, ESCII, ASAM). | |
| | **Clinical Criteria:** For retrospective review of inpatient stays, M/S clinical staff make determinations using Milliman Care Guidelines (MCG). | | |
| Retrospective Review - Outpatient, Out-of-Network: | **Retrospective Review- Outpatient, Out-of-Network**<br>For outpatient, out-of-network review begins when [redacted] receives notification post-service that the outpatient service occurred when the plan has out-of-network benefits.<br><br>**Why does the Plan conduct Retrospective Reviews?**<br>Retrospective Review is a component of [redacted] utilization management program. The Medical Director and other clinical staff review services for the following reasons:<br>• to detect and better manage over- and under-utilization;<br>• to determine whether the services reviewed are—<br>o consistent with the member's coverage,<br>o medically appropriate, and consistent with evidence-based guidelines. | **Retrospective Review- Outpatient, Out-of-Network**<br>For outpatient, out-of-network review begins when [redacted] receives notification post-service that the outpatient service occurred when the plan has out-of-network benefits.<br><br>**Why does the Plan conduct Retrospective Reviews?**<br>Retrospective Review is a component of [redacted]s utilization management program. The Medical Director and other clinical staff review services for the following reasons:<br>• to detect and better manage over- and under-utilization;<br>• to determine whether the services reviewed are—<br>o consistent with the member's coverage,<br>o medically appropriate, and consistent with evidence-based guidelines. | **Explanation:**<br>Parity compliance is evident by the use of the same processes, standards, factors and appropriately comparable clinical evidentiary standards. This is exhibited in writing and in operation within the body of the M/S and MH/SUD columns. |

| Area | Medical/Surgical (M/S) Benefits | Mental Health/Substance Use Disorder (MH/SUD) Benefits | Explanation |
|---|---|---|---|
| | **Pre-Claim Retrospective Review Post-service**<br>When the plan has out-of-network benefits, the plan requires the member to obtain a prior authorization for select outpatient out-of-network services. If the service requires prior authorization, the claim will administratively deny for failure to obtain a prior authorization and appeal rights are provided. If there are mitigating circumstances for not obtaining a prior authorization, the member can provide this information upon appeal.<br><br>**Post-Claim Retrospective Review**<br>When the Plan requires prior authorization/notification and there is no prior authorization/notification on file when the claim is received, the claim is penalized administratively for lack of a prior authorization/notification on file when the plan has out-of-network benefits. If there are mitigating circumstances for not obtaining a prior authorization, the member can provide this information upon appeal. Notification of all review outcomes is communicated in accordance with applicable state, federal or accreditation requirements.<br><br>Retrospective Review for outpatient, out-of-network benefits applies substantially the same process and uses the same criteria as Retrospective Review for outpatient, in-network benefits, with two differences. First, out-of-network providers and facilities have no obligation to cooperate with the Plan's requests for information, documents, or discussions for purposes of Retrospective Review. The Plan seeks the same types of clinical information from the out-of-network provider or facility. Second, the provider may bill non-reimbursable charges to the member. | **Pre-Claim Retrospective Review Post-service**<br>When the plan has out-of-network benefits, the plan requires the member to obtain a prior authorization for select outpatient out-of-network services. If the service requires prior authorization, the claim will administratively deny for failure to obtain a prior authorization and appeal rights are provided. If there are mitigating circumstances for not obtaining a prior authorization, the member can provide this information upon appeal.<br><br>**Post-Claim Retrospective Review**<br>When the Plan requires prior authorization/notification and there is no prior authorization/notification on file when the claim is received, the claim is penalized administratively for lack of a prior authorization/notification on file when the plan has out-of-network benefits. If there are mitigating circumstances for not obtaining a prior authorization, the member can provide this information upon appeal. Notification of all review outcomes is communicated in accordance with applicable state, federal or accreditation requirements.<br><br>Retrospective Review for outpatient, out-of-network benefits applies substantially the same process and uses the same criteria as Retrospective Review for outpatient, in-network benefits, with two differences. First, out-of-network providers and facilities have no obligation to cooperate with the Plan's requests for information, documents, or discussions for purposes of Retrospective Review. The Plan seeks the same types of clinical information from the out-of-network provider or facility. Second, the provider may bill non-reimbursable charges to the member. | |

| Area | Medical/Surgical (M/S) Benefits | Mental Health/Substance Use Disorder (MH/SUD) Benefits | Explanation |
|---|---|---|---|
| | **Notification Requirements:**<br>Providers can notify the plan via phone, fax or mail.<br><br>**Timeframe to respond:** M/S follows all applicable state and federal or accreditation timeframe requirements.<br><br>**Staff Qualifications:** M/S is staffed by clinical, non-clinical and administrative personnel. All clinical reviews are performed by appropriate clinical staff and a licensed physician reviews any determination of medical necessity that is the basis of a potential adverse determination and makes the adverse determination.<br><br>**Clinical Criteria:** M/S clinical staff make determinations using Milliman Care Guidelines (MCG). Internally developed criteria are also used which are created utilizing references and/or guidelines from applicable physician specialty organizations and participating practitioners in the appropriate specialty. Development of criteria also incorporates a review of guidelines from national organizations. | **Notification Requirements:**<br>By online or telephone for Pre-Claim Retrospective Review. For Post-Claim Retrospective Review reconsiderations, the provider can notify the plan via phone, online or mail.<br><br>**Timeframe to respond:** MH/SUD follows all applicable state and federal or accreditation timeframe requirements.<br><br>**Staff Qualifications:** MH/SUD is staffed by clinical, non-clinical and administrative personnel. All clinical reviews are performed by appropriate clinical staff (e.g., RN, LPC, LCSW) and all adverse determinations are made by Board Certified Medical Directors or PhDs.<br><br>[redacted] offers the opportunity for practitioners to discuss coverage determinations and confer with [redacted] Peer Reviewers (Board Certified Clinicians with expertise in child or adolescent MH/SUD as applicable, or Adult MH/SUD as applicable), before a grievance or appeal is submitted. This peer to peer discussion is not considered part of a grievance or appeal process.<br><br>**Clinical Criteria:** MH/SUD clinical staff make determinations using nationally recognized clinical guidelines and criteria: LOCUS, CASII, ECSII for MH and ASAM for SUD, as well as Behavioral Clinical Policies for services that are not covered by the National Policies. | |

| Area | Medical/Surgical (M/S) Benefits | Mental Health/Substance Use Disorder (MH/SUD) Benefits | Explanation |
|---|---|---|---|
| **E. Emergency Services** | **EMERGENCY:**<br>The sudden and unexpected onset of an illness or injury with severe symptoms whereby a Prudent Layperson, acting reasonably, would believe that emergency medical treatment is needed.<br><br>An Emergency related to mental health care exists when a Member is at risk of suffering serious physical impairment or death; or of becoming a threat to himself/herself or others; or of significantly decreasing his/her functional capability if treatment is withheld for greater than 24 hours.<br><br>The presenting symptoms of the patient, as coded by the provider on the appropriate claim form or the final diagnosis, whichever reasonably indicates an emergency medical condition, shall be the basis for determining whether such services are for an Emergency. Determination of whether a condition is an Emergency for purposes of this Plan rests exclusively within our discretionary authority.<br><br>**EMERGENCY SERVICES:**<br>Evaluation of an emergency medical condition and treatment to keep the condition from getting worse. | **EMERGENCY:**<br>The sudden and unexpected onset of an illness or injury with severe symptoms whereby a Prudent Layperson, acting reasonably, would believe that emergency medical treatment is needed.<br><br>An Emergency related to mental health care exists when a Member is at risk of suffering serious physical impairment or death; or of becoming a threat to himself/herself or others; or of significantly decreasing his/her functional capability if treatment is withheld for greater than 24 hours.<br><br>The presenting symptoms of the patient, as coded by the provider on the appropriate claim form or the final diagnosis, whichever reasonably indicates an emergency medical condition, shall be the basis for determining whether such services are for an Emergency. Determination of whether a condition is an Emergency for purposes of this Plan rests exclusively within our discretionary authority.<br><br>**EMERGENCY SERVICES:**<br>Evaluation of an emergency medical condition and treatment to keep the condition from getting worse. | **Explanation:**<br>The same definitions for **Emergency and Emergency Services** apply to both M/S and MH/SUD benefits as defined by [redacted]<br>There are no other, separately applicable, definitions of "Emergency" or "Emergency Services." |
| **F. Pharmacy Services**<br><br>Include all services for which prior-authorization is required, any step-therapy or "fail first" requirements, any other NQTLs.<br><br>Tier 1: | Prior authorization, step-therapy, and quantity limits apply to any drugs and services listed on the formulary, regardless of therapeutic class.<br><br>**Prior Authorization:**<br>[redacted] applies prior authorization to any drug that is on formulary that is subject to a prior authorization criterion (drug policy), non-formulary drug requests and requests for step-therapy or quantity limit exception. Prior authorization requests are denied when the information provided does not meet prior authorization criteria, insufficient information was provided and when the drug is not covered.<br><br>**Quantity Limits:**<br>Quantity Limits: [redacted] limits drug benefit coverage to quantities that are consistent with FDA- | | **Explanation:**<br>The processes, strategies, criteria, evidentiary standards, and factors used to apply prior authorizations/step-therapy/quantity limits to Pharmacy benefits are the same for M/S and MH/SUD. |

| Area | Medical/Surgical (M/S) Benefits | Mental Health/Substance Use Disorder (MH/SUD) Benefits | Explanation |
|---|---|---|---|
| | approved dosing as well as treatment guideline recommendations. Quantity limits are developed by the formulary team and presented to the Pharmacy and Therapeutics (P & T) Committee for review and a decision as to implement or not.<br><br>**Step-Therapy:**<br>[redacted] uses step-therapy by requiring the use of a preferred medication prior to beginning another medication for the same condition or in the same therapeutic class. The step-therapy is based on using a proven, clinically effective prescription prior to trying a medication with less evidence of clinical effectiveness or higher cost. Step-therapy is created based on FDA labeling, national treatment guidelines as well as peer-reviewed literature. Once a protocol is developed, it is brought to the P & T Committee for review and a decision as to implement or not.<br><br>**Factors Used for Determining Appropriate Prior Authorization, Step-Therapy and Quantity Limits Criteria:**<br>Factors used for determining appropriate prior Authorization, step-therapy, and quantity limits criteria on M/S and MH/SUD benefits are:<br>FDA Approved Drug Labeling<br>• Compendia and other clinical practice supported indications<br>• Overutilization<br>• Increased cost<br>• Clinical practice guidelines<br>• Peer reviewed journals<br>• Authoritative compendia<br>• Adherence barriers<br>• Products associated with a high percentage of fraud.<br><br>These factors are applied equally to all M/S and MH/SUD benefits, in addition to all other therapeutic classes of drugs listed on the formulary. | | |
| Tier 2: | Same regardless of tiers. | | Refer to explanation in Tier 1. |
| Tier 3: | Same regardless of tiers. | | Refer to explanation in Tier 1. |

| Area | Medical/Surgical (M/S) Benefits | Mental Health/Substance Use Disorder (MH/SUD) Benefits | Explanation |
|---|---|---|---|
| Tier 4: | Same regardless of tiers. | | Refer to explanation in Tier 1. |
| **G. Prescription Drug Formulary Design**<br><br>How are formulary decisions made for the diagnosis and medical necessary treatment of medical, mental health and substance use disorder conditions? | [redacted] formularies consist of brand-name and generic medications that have been reviewed and selected by the P & T Committee for quality, safety, cost savings, and effectiveness. [redacted] formularies are not segregated; placement of drugs on formularies for the treatment of medical conditions and drugs for the treatment of MH/SUD conditions is based on clinical evidence and standards of care. [redacted] formularies are developed to offer drugs that demonstrate clinical safety and efficacy. Formulary decisions are guided by current clinical practice guidelines and evidence-based medicine, FDA approved drug labeling, peer reviewed journals, and authoritative compendia.<br><br>**P & T Committee:**<br>The P & T committee is an advisory committee responsible for developing, managing, updating, and administering the formulary system. The P & T committee is comprised of primary care and specialty physicians, pharmacists, and other healthcare professionals. The full formulary is reviewed annually at the beginning of each calendar year through the committee. The P & T Committee convenes four times per year during which the formulary is addressed. The P & T Committee continuously evaluates clinical information to determine the placement of drugs on formularies to ensure safe and appropriate use of medications across all therapeutic categories.<br><br>**P & T Committee Review Process:**<br>• Prior to each meeting, the list of drugs for review are forwarded to members to ensure no conflict of interest exists and formulary decisions are impartial.<br>• New drugs on the market or requests for additions to formulary are evaluated by staff pharmacists using peer-reviewed references.<br>• Additions to formulary can be requested by participating providers, pharmacy services, and/or medical management. The drug is then reviewed at the respective P & T Specialty Subcommittee and forwarded to the P & T Committee for final review and vote for approval or denial.<br>• Criteria considered include: clinical safety and efficacy, bioequivalence and/or therapeutic equivalence (if applicable), pharmacokinetic and pharmacodynamic properties, effectiveness in treatment practice and place in therapy, intermediate and long-term outcomes of treatment, and pharmacoeconomic data.<br>• [redacted] uses clinical evidence from the following sources in making decisions regarding formulary selection: government agencies, medical associations, national commissions, peer-reviewed journals, and authoritative compendia. | | **Explanation:**<br>The process for reviewing and selecting drugs for the formulary is the same for all therapeutic drug classes and is not more stringent for MH/SUD drugs than for M/S drugs. |

| Area | Medical/Surgical (M/S) Benefits | Mental Health/Substance Use Disorder (MH/SUD) Benefits | Explanation |
|---|---|---|---|
| Describe the pertinent pharmacy management processes, including, but not limited to, cost-control measures, therapeutic substitution, and step therapy. | [redacted] does not segregate its formularies by drugs used to treat MH/SUD versus physical illness. [redacted] formularies are designed by neutral and reasonable factors independent of whether a particular drug is prescribed to treat a M/S condition or a MH/SUD condition. These factors include safety, cost, efficacy, and/or generic versus brand name.<br><br>**Pharmacy Management Processes:**<br>• Prior authorizations, step-therapy and quantity limits are utilization management tools used to guide and regulate utilization of certain drug therapies for both clinical and fiscal purposes.<br>• Prior authorization is applied to drugs across all therapeutic categories in which the use of a particular medication is being managed to ensure the patient receives necessary, appropriate, high-quality care in a cost-effective manner. Prior authorizations may be implemented to promote best practices and safe utilization.<br>• The drug formularies also incorporate step-therapy techniques which encourage the use of more cost-effective therapies while following FDA approved treatment guidelines. Drugs are considered for step-therapy protocol when there is high utilization, excessive cost, specific/limited use, and/or safety/toxicity concerns. Similarly, drugs are considered for prior authorization when there the drug is associated with high utilization, excessive cost, specific/limited use, and/or safety/toxicity concerns. | | **Explanation:**<br>Pharmacy management processes including cost-control measures, therapeutic substitution, and step-therapy are the same for M/S and MH/SUD and are not applied more stringently for MH/SUD drugs than for M/S drugs. |
| What disciplines, such as primary care physicians (internists and pediatricians) and specialty physicians (including psychiatrists) and pharmacologists, are involved in the development of the formulary for medications to treat medical, mental health and substance use disorder conditions. | The P & T Committee is comprised of primary care and specialty physicians, pharmacists, and other healthcare professionals. | | **Explanation:**<br>Appropriate representation from multiple disciplines are involved in the development of the formulary. |
| **H. Case Management**<br><br>What case management services are available? | **Case Management:** M/S offers the following case management programs. The purpose of these programs is to help members regain optimum health and/or improved functional capacity and improve self-management skills.<br>• Complex Management Program<br>• Disease Management Programs<br>  ○ Hypertension<br>  ○ Heart Failure | **Case Management:** MH/SUD offers MH case management for patients with complex behavioral health conditions. Case management will help members in a supportive way, to navigate their benefits, find services, providers, etc. For SUD, in addition to a 24/7 hotline to help find local services, members can benefit from referral to a care advocate for on-going support. | **Explanation**:<br>MH/SUD and M/S do not require participation in any of its supportive case management programs and non-participation does not limit benefits or services in any way. Therefore, case management services are not a treatment limitation (NQTL). |

| Area | Medical/Surgical (M/S) Benefits | Mental Health/Substance Use Disorder (MH/SUD) Benefits | Explanation |
|---|---|---|---|
| | ○ Metabolic Syndrome<br>○ Chronic Kidney<br>○ Diabetes<br>○ Cancer<br>○ COPD<br>○ Asthma<br>○ CAD-Post MI<br>○ Disease Management General<br>• Transplant Case Management Program<br>• Emergency Room Avoidance Program<br>• QuitCare Smoking Cessation Program | | |
| What case management services are required? | Member participation is voluntary for all case management programs. | Member participation is voluntary and non-participation does not limit benefits or services in any way. Thus, case management/care advocacy services are not a treatment limitation. (Not an NQTL). | |
| What are the eligibility criteria for case management services? | Eligibility criteria vary depending upon the program.<br><br>For example, the eligibility criteria for the QuitCare Smoking Cessation Program are:<br>• Self-referral; or<br>• Pharmacy claims showing fill of Chantix; or<br>• Other referrals (e.g., provider). | [redacted] uses sophisticated analytics to guide individuals into care along the path to recovery, including identifying those at risk. [redacted] Care Management model includes medical-behavioral integration, data driven identification and stratification for complex case management, post facility/acute care follow-up, and internal or external (provider or member) direct referrals. | |
| **I. Process for Assessment of New Technologies**<br><br>Definition of experimental/investigational: | **EXPERIMENTAL OR INVESTIGATIONAL:**<br>A service, supply, device, procedure or medication (collectively called "Treatment") will, in our sole discretion, be considered Experimental Or Investigational if any of the following conditions are present:<br><br>1. The prescribed Treatment is available to you or your Eligible Dependents only through participation in a program designated as a clinical trial, whether a federal Food and Drug Administration (FDA) Phase I or Phase | **EXPERIMENTAL OR INVESTIGATIONAL:**<br>A service, supply, device, procedure or medication (collectively called "Treatment") will, in our sole discretion, be considered Experimental Or Investigational if any of the following conditions are present:<br><br>1. The prescribed Treatment is available to you or your Eligible Dependents only through participation in a program designated as a clinical trial, whether a federal Food and Drug Administration (FDA) Phase I | **Explanation:**<br>The same definition for **Experimental or Investigational** applies to both M/S and MH/SUD benefits as defined by [redacted]<br>There is no other, separately applicable, definition of "Experimental or Investigational." |

| Area | Medical/Surgical (M/S) Benefits | Mental Health/Substance Use Disorder (MH/SUD) Benefits | Explanation |
|---|---|---|---|
| | II clinical trial, or an FDA Phase III experimental research clinical trial or a corresponding trial sponsored by the National Cancer Institute, or another type of clinical trial, or<br>2. A written informed consent form or protocols for the Treatment disclosing the experimental or investigational nature of the Treatment being studied has been reviewed and/or has been approved or is required by the treating facility's Institutional Review Board, or other body serving a similar function or if federal law requires such review and approval, or<br>3. The prescribed Treatment is subject to FDA approval and has not received FDA approval for any diagnosis or condition.<br><br>If a Treatment has multiple features and one or more of its essential features is Experimental Or Investigational based on the above criteria, then the Treatment as a whole will be considered to be Experimental Or Investigational and not covered. | or Phase II clinical trial, or an FDA Phase III experimental research clinical trial or a corresponding trial sponsored by the National Cancer Institute, or another type of clinical trial, or<br>2. A written informed consent form or protocols for the Treatment disclosing the experimental or investigational nature of the Treatment being studied has been reviewed and/or has been approved or is required by the treating facility's Institutional Review Board, or other body serving a similar function or if federal law requires such review and approval, or<br>3. The prescribed Treatment is subject to FDA approval and has not received FDA approval for any diagnosis or condition.<br><br>If a Treatment has multiple features and one or more of its essential features is Experimental Or Investigational based on the above criteria, then the Treatment as a whole will be considered to be Experimental Or Investigational and not covered. | |
| Qualifications of individuals evaluating new technologies: | [redacted] involves appropriate practitioners in developing, adopting and reviewing criteria.<br>• [redacted] Physician Quality Improvement Committee (PQIC) evaluates each criterion set including new technologies for accuracy, adherence to evidence-based guidelines/literature and adherence to local standard of care. It is expected that community physician committee members will obtain input from appropriate sub-specialty providers as necessary.<br>• The committee is comprised of at least five but no more than ten participating community practitioners representing both primary care | [redacted] involves appropriate practitioners in developing, adopting and reviewing criteria.<br>• [redacted]Physician Quality Improvement Committee (PQIC) evaluates each criterion set including new technologies for accuracy, adherence to evidence-based guidelines/literature and adherence to local standard of care. It is expected that community physician committee members will obtain input from appropriate sub-specialty providers as necessary.<br>• The committee is comprised of at least five but no more than ten participating community practitioners representing both primary care | **Explanation:**<br>The same qualifications of individuals reviewing **Experimental or Investigational** applies to both M/S and MH/SUD benefits, as defined by [redacted] |

| Area | Medical/Surgical (M/S) Benefits | Mental Health/Substance Use Disorder (MH/SUD) Benefits | Explanation |
|---|---|---|---|
| | practitioners and common community-based specialties<br>• Prior to implementing new medical protocols or substantially or materially altering existing medical protocols, [redacted] obtains input from physicians actively practicing in Connecticut and practicing in the relevant specialty areas. [redacted] also seeks input from physicians who are not employees or consultants, other than to the extent a person is an employee or consultant solely for the purpose of providing this input. | practitioners and common community-based specialties<br>• Prior to implementing new medical protocols or substantially or materially altering existing medical protocols, [redacted] obtains input from physicians actively practicing in Connecticut and practicing in the relevant specialty areas. [redacted] also seeks input from physicians who are not employees or consultants, other than to the extent a person is an employee or consultant solely for the purpose of providing this input. | |
| Evidence consulted in evaluating new technologies: | Evidence consulted includes: MCG, Hayes and medical journals published, in addition to standards and hierarchy included in the [redacted] Experimental, Investigational or Unproven Services Medical Policy.<br><br>To determine whether a device, medical treatment, supply or procedure is proven safe and effective the following hierarchy of reliable evidence is used: 1. Published formal technology assessments and/or high quality meta analyses. 2. Well-designed randomized studies published in credible, peer-reviewed literature. 3. High quality case-control or cohort studies. 4. Historical control studies, or case reports and/or case series. 5. Reports of expert opinion from national professional medical societies or national medical policy organizations.<br><br>Any time new codes come out, they are reviewed by [redacted] and determined if they are covered; Experimental/Investigational, require prior authorization; etc. and then are vetted through the Medical Policy Committee (MPC). | Evidence consulted includes: MCG, Hayes and medical journals published, in addition to standards and hierarchy included in the [redacted] Experimental, Investigational or Unproven Services Medical Policy.<br><br>To determine whether a device, medical treatment, supply or procedure is proven safe and effective the following hierarchy of reliable evidence is used: 1. Published formal technology assessments and/or high quality meta analyses. 2. Well-designed randomized studies published in credible, peer-reviewed literature. 3. High quality case-control or cohort studies. 4. Historical control studies, or case reports and/or case series. 5. Reports of expert opinion from national professional medical societies or national medical policy organizations.<br><br>Any time new codes come out, they are reviewed by [redacted] and determined if they are covered; Experimental/Investigational; require prior authorization; etc. and then are vetted through the Medical Policy Committee (MPC). | **Explanation:**<br>The same evidence in evaluating **Experimental or Investigational** applies to both M/S and MH/SUD benefits, as defined by [redacted] |

| Area | Medical/Surgical (M/S) Benefits | Mental Health/Substance Use Disorder (MH/SUD) Benefits | Explanation |
|---|---|---|---|
| | | | |
| **J. Standards for provider credentialing and contracting** | **Providers must meet all credentialing criteria outlined in the [redacted] Corporate Credentialing Policy and all regulatory requirements. In addition to NCQA guidelines, the following are required**:<br>Each Applicant must complete a CAQH application that includes, without limitation:<br>1. A current and signed attestation/release by the practitioner granting [redacted] permission to review records of and to contact any professional society, hospital, insurance carrier, employer, entity, institution, or organization that has or may have records/information concerning the Applicant;<br>2. Reasons for any inability to perform the essential functions of the position, with or without accommodation;<br>3. Lack of present illegal drug use or chemical dependency;<br>4. Disclosure of any and all loss of professional license(s);<br>5. Disclosure of any and all misdemeanors (except minor traffic violations) and felony convictions;<br>6. Disclosure of any and all loss or limitation of professional privileges or disciplinary activity;<br>7. A complete list of all professional education/training completed;<br>8. Completed disclosure statements including questions on license disciplinary actions; criminal felony or misdemeanor coif we do the screenshot will that show convictions or civil judgments that involved dishonesty, fraud, deceit or misrepresentation; disciplinary actions by any federal programs; any other disciplinary actions or restrictions; and responses to applicable "YES" answers; | **Providers must meet all credentialing criteria outlined in the [redacted] Credentialing Plan and all regulatory requirements. In addition to NCQA guidelines, the following are required**:<br>Each Applicant must complete a [redacted] application form that includes, without limitation:<br>1. A current and signed attestation/release by the Clinician granting [redacted] unlimited permission to review records of and to contact any professional society, hospital, insurance carrier, employer, entity, institution, or organization that has or may have records/information concerning the Applicant;<br>2. Reasons for any inability to perform the essential functions of the position, with or without accommodation;<br>3. Lack of present illegal drug use or chemical dependency;<br>4. Disclosure of any and all loss of professional license(s);<br>5. Disclosure of any and all misdemeanors (except minor traffic violations) and felony convictions;<br>6. Disclosure of any and all loss or limitation of professional privileges or disciplinary activity;<br>7. A complete list of all professional education/training completed;<br>8. Completed disclosure statements including questions on license disciplinary actions; criminal felony or misdemeanor convictions or civil judgments that involved dishonesty, fraud, deceit or misrepresentation; disciplinary actions by any federal programs; any other disciplinary actions or restrictions; and responses to applicable "YES" answers; | **Explanation:**<br>M/S and BH/SUD use comparable processes, strategies, evidentiary standards and factors in credentialing and contracting providers. Some inherent differences are found, where necessary, as they relate to specific M/S or MH/SUD requirements, such as unique MH provider types (e.g., Board-Certified Behavior Analysts (BCBAs) for ABA treatment of Autism). |

| Area | Medical/Surgical (M/S) Benefits | Mental Health/Substance Use Disorder (MH/SUD) Benefits | Explanation |
|---|---|---|---|
| | 9. Clinical Privilege information, where applicable (signed attestation form may be used); and<br>10. A signed statement regarding the correctness and completeness of the application.<br><br>**Required Documents**<br>• Professional liability malpractice insurance with liability limits of $1/$3million for all practitioners;<br>• List of 5-year work history including month and year, on application or copy of resume/CV, complete explanations for gaps in work history of 6months or more;<br>• A current copy of the DEA and/or CDS certificate (where required by state), if applicable; in each state where physician or prescribing practitioner practices;<br>• W9 form;<br>• Copy of Educational Commission for Foreign Medical Graduates (ECFMG) certificate, if applicable; and<br>• Any other documents required by state regulations. | 9. Clinical Privilege information, where applicable (signed attestation form may be used); and<br>10. A signed statement regarding the correctness and completeness of the application.<br><br>**Required Documents**<br>• Professional liability malpractice insurance with liability limits of $1/$3million for physicians and $1/$1million for non-physician Clinicians, including evidence of participation in state patient compensation or catastrophic loss funds, if applicable;<br>• List of 5-year work history including month and year, on application or copy of resume/CV, complete explanations for gaps in work history of 6months or more;<br>• A current copy of the DEA and/or CDS certificate (where required by state), if applicable; in each state where physician or prescribing Clinician practices;<br>• W9 form;<br>• Copy of Educational Commission for Foreign Medical Graduates (ECFMG) certificate, if applicable; and<br>• Any other documents required by state regulations or client requirements.<br>. | |
| Is the provider network open or closed? | Open | Open | |

| Area | Medical/Surgical (M/S) Benefits | Mental Health/Substance Use Disorder (MH/SUD) Benefits | Explanation |
|---|---|---|---|
| What are the credentialing standards for **physicians?** | **Except as required by state law, these requirements may include, but are not limited to, the following: Along with the general standards,**<br>• MDs/DOs must be certified through the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA) within 5 years of completion of training.<br>• DMDs/DDS must be certified through the American Board of Medical Specialties (ABMS) or the American Board of Oral/Maxillofacial Surgery (ABOMS) within 5 years of completion of training.<br>• Physicians must have hospital admitting privileges at a participating hospital or an admitting arrangement by a participating practitioner.<br>• Application must not be ineligible, excluded, or debarred from participation in Medicare, Medicaid, and/or any other state or federal health care program. Regardless of the contracted line of business, for example, Medicare, Medicaid or Commercial, [redacted] does not contract with providers excluded from state or federal health care programs.<br>• Applicant is required to provide details on all affirmative responses to Disclosure Questions on the Credentialing Application, which may be reviewed by Credentialing Committee for a determination of applicant's acceptance into [redacted] Network.<br>• Have no misrepresentation, misstatement or omission of a relevant fact on the application.<br>• A current and unrestricted DEA registration is required. | **Except as required by state law, these requirements may include, but are not limited to, the following:**<br>• Physicians must be board certified by the American Board of Psychiatry and Neurology. (ABPN) or the American Osteopathic Association (AOA) Board of Psychiatry or have completed a residency in psychiatry or a joint psychiatric residency program with another specialty that is approved by ABPN or the AOA.<br>• Physicians without a residency in Psychiatry may be accepted if they are board certified by the American Board of Addiction Medicine (ABAM) or the American Board of Preventative Medicine (ABPM).<br>• Physician Addictionologists must be certified by the American Board of Addiction Medicine (ABAM) or have added qualifications in Addiction Psychiatry through the American Board of Psychiatry or Neurology (ABPN).<br>• Developmental Behavioral Pediatricians (DBP) must be board certified specifically in DBP by the American Board of Pediatrics (ABP) or have completed the respective Fellowship.<br>• Physician clinical privileges, if applicable, must be in good standing at a Facility, as attested to on the clinician application form.<br>• Application must not be ineligible, excluded, or debarred from participation in Medicare, Medicaid, and/or any other state or federal health care program. Regardless of the contracted line of business, for example, Medicare, Medicaid or Commercial, [redacted] does not contract with providers excluded from state or federal health care programs.<br>• Applicant is required to provide details on all affirmative responses to Disclosure Questions on | |

| Area | Medical/Surgical (M/S) Benefits | Mental Health/Substance Use Disorder (MH/SUD) Benefits | Explanation |
|---|---|---|---|
| | | the Credentialing Application, which may be reviewed by Credentialing Committee for a determination of applicant's acceptance into [redacted] Network.<br>• Have no misrepresentation, misstatement or omission of a relevant fact on the application.<br>• Clinicians with prescriptive authority will be licensed, certified and/or registered as required.<br>• For physician and nurse Clinicians prescribing controlled substances in a state where he/she sees [redacted] enrollees, a current and unrestricted DEA registration is required. States not requiring a DEA registration for prescriptive authority would not be included in this requirement. Prescribing of controlled substances may also require a current and unrestricted state-controlled substance certificate (CDS), if applicable in the state. Other clinicians with prescriptive authority will be licensed, certified and/or registered as required.<br>• [redacted] does not require hospital privileges. However, if the applicant attests to having hospital privileges, the following applies:<br>o Staff privileges must be in good standing at a participating hospital and the Clinician must primarily use participating hospitals to provide services to enrollees.<br>o Physicians without hospital staff privileges must have an acceptable process for providing inpatient care. | |

| Area | Medical/Surgical (M/S) Benefits | Mental Health/Substance Use Disorder (MH/SUD) Benefits | Explanation |
|---|---|---|---|
| What are the credentialing standards for licensed **non-physician providers**? Specify type of provider and standards; e.g., nurse practitioners, physician assistants, psychologists, clinical social workers. | **Non-Physician Practitioners Include**:<br>Advanced Practice Registered Nurses, Physician Assistants, Chiropractors, Certified Nurse Midwives, Optometrists, Dieticians/Nutritionists, Audiologists, Physical Therapists, Occupational Therapists, Speech Therapists, Nurse Practitioners and Naturopaths;<br><br>Education requirements for non-physician providers are verified as part of their licensure.<br>**Along with the general standards,**<br>• Practitioners must have hospital admitting privileges at a participating hospital or an admitting arrangement by a participating practitioner (applies to the following non-physician providers: Advanced Practice Registered Nurses, Physician Assistants, Certified Nurse Midwives, and Nurse Practitioners).<br>• Application must not be ineligible, excluded, or debarred from participation in Medicare, Medicaid, and/or any other state or federal health care program. Regardless of the contracted line of business, for example, Medicare, Medicaid or Commercial, [redacted] does not contract with providers excluded from state or federal health care programs.<br>• Applicant is required to provide details on all affirmative responses to Disclosure Questions on the Credentialing Application, which may be reviewed by Credentialing Committee for a determination of applicant's acceptance into Credentialing Entity's Network.<br>• Have no misrepresentation, misstatement or omission of a relevant fact on the application.<br>• A current and unrestricted DEA registration is required or a prescribing arrangement (applies to non-physician providers with authority to prescribe under their licenses). | **Non-Physician Practitioners Include**:<br>• **A doctoral and/or master's level psychologist** who is licensed by the state for independent practice and has a doctoral/master's level clinical degree from an accredited college or university; or<br>• **Psychologist with prescriptive privileges** as permitted by state regulations only; or<br>• **A doctoral and/or master's level social worker** who is licensed by the state for independent practice; or master's level psychiatric clinical nurse specialist who is licensed, certified or registered by the state in which they practice.<br>• **Nurses with prescriptive authority** must be licensed, certified and/or registered in Psychiatric / Mental Health as required by the state. State laws determine whether supervision by a physician or collaborative practice is required. State law also determines whether certification in behavioral health nursing through the American Nursing Credentialing Center (ANCC) or other national certification (such as the American Academy of Nurse Practitioners (AANP) for Family Nurse Practitioners with MH experience) is required.<br>• **Nurse Clinicians** prescribing controlled substances in a state where he/she sees [redacted] enrollees, a current and unrestricted DEA registration is required. States not requiring a DEA registration for prescriptive authority would not be included in this requirement. Prescribing of controlled substances may also require a current and unrestricted state-controlled substance certificate (CDS), if applicable in the state.<br>• **Physician Assistants** who are licensed in the state they practice. | |

| Area | Medical/Surgical (M/S) Benefits | Mental Health/Substance Use Disorder (MH/SUD) Benefits | Explanation |
|---|---|---|---|
| | | • **Other doctoral and/or master's level behavioral health care specialists**, including professional counselor, marriage and family counselor, mental health counselor, who is licensed to practice independently in the state in which they practice.<br>• **Other behavioral health Clinician licensed by the state** for independent practice and required by the state to be accepted for [redacted] participation. Possess a current professional license without restrictions, conditions or other disciplinary action.<br>• **Clinicians with prescriptive authority** will be licensed, certified and/or registered as required.<br>**For all applicants:**<br>• Application must not be ineligible, excluded, or debarred from participation in Medicare, Medicaid, and/or any other state or federal health care program. Regardless of the contracted line of business, for example, Medicare, Medicaid or Commercial, [redacted] does not contract with providers excluded from state or federal health care programs.<br>• Applicant is required to provide details on all affirmative responses to Disclosure Questions on the Credentialing Application, which may be reviewed by Credentialing Committee for a determination of applicant's acceptance into Optum's Network.<br>• Have no misrepresentation, misstatement or omission of a relevant fact on the application.<br>• Application must not be ineligible, excluded, or debarred from participation in Medicare, Medicaid, and/or any other state or federal health care program. Regardless of the contracted line of business, for example, Medicare, Medicaid or Commercial, [redacted] does not contract with | |

| Area | Medical/Surgical (M/S) Benefits | Mental Health/Substance Use Disorder (MH/SUD) Benefits | Explanation |
|---|---|---|---|
| | | providers excluded from state or federal health care programs.<br>• Applicant is required to provide details on all affirmative responses to Disclosure Questions on the Credentialing Application, which may be reviewed by Credentialing Committee for a determination of applicant's acceptance into [redacted] Network. | |
| What are the credentialing/contracting standards for unlicensed personnel; e.g., home health aides, qualified autism service professionals and paraprofessionals? | [redacted] does not credential unlicensed practitioners. | Behavior Analysts must be certified, by the Board-Certified Behavior Analyst (BCBA) with active certification from the national Behavior Analyst Certification Board. Behavior Analysts are licensed in the state of Connecticut. | |
| **K. Exclusions for Failure to Complete a Course of Treatment**<br><br>Does the Plan exclude benefits for failure to complete treatment? | No | No | Not applicable as an NQTL |
| **L. Restrictions that limit duration or scope of benefits for services**<br><br>Does the Plan restrict the geographic location in which services can be received; e.g., service area, within California, within the United States? | No | No | Not applicable as an NQTL |

| Area | Medical/Surgical (M/S) Benefits | Mental Health/Substance Use Disorder (MH/SUD) Benefits | Explanation |
|---|---|---|---|
| Does the Plan restrict the type(s) of facilities in which enrollees can receive services? | No | No | Not applicable as an NQTL |
| **M.** Does the Plan restrict the types of provider specialties that can provide certain M/S and/or MH/SUD benefits? | **All providers (including OON)** must practice within their scope of license.<br><br>**In-Network providers** must also practice within the scope of services per their network contract, as credentialed.<br>. | **All providers (including OON)** must practice within their scope of license; or certification if non-licensed provider type such as BCBA.<br><br>**In-Network providers** must also practice within the scope of services per their network contract, as credentialed. | **Explanation:**<br>M/S and MH/SUD are comparable in requirements for providers when providing services in and out of network. |
| **N.** Network Adequacy | [redacted] follows the Connecticut Insurance Department (CID) recommendations for:<br><br>• Access standards, including population density and ratios of specific provider types in communities such as: Metro, Suburban, Rural.<br>• Standards are estimated using desired driving distance (miles) and driving time (minutes) from the member's residence to a provider's location.<br>• Based on CID Standards, the goal is that 90% of [redacted] members are within the miles & distance standards for the provider types.<br>• If the needed provider/facility type is not available within the standards for miles & minutes, or providers within the standard limits are not accepting new patients, or in cases where continuity of care is imperative, or there is a language barrier; the member may contact Member Services for assistance. [redacted] validates the need, and the member is authorized to see an Out- | [redacted] follows CMS recommendations, all applicable CT state and/or federal laws and abide by all applicable accrediting organizations, in the application of:<br>• Access standards, including population density and ratios of specific provider types in communities such as: Metro, Suburban, Rural.<br>• Standards are estimated using desired driving distance (miles) and driving time (minutes) from the member's residence to a provider's location.<br>• Based on Standards, 90% of [redacted] members are within the miles & distance standards for [redacted] provider types.<br>• If the needed provider/facility type is not available within standards for miles & minutes, or providers within the standard limits are not accepting new patients, or in cases where continuity of care is imperative, or there is a language barrier; the member may contact the phone number on the back of their membership card for assistance. [redacted] validates the need, | **Explanation:**<br>M/S and MH/SUD are comparable in developing network adequacy, consistent with applicable access standards. |

| Area | Medical/Surgical (M/S) Benefits | Mental Health/Substance Use Disorder (MH/SUD) Benefits | Explanation |
|---|---|---|---|
| | of-Network provider. **Note: With Prior Authorization to see an Out-of-Network provider, the member will be charged the <u>In-Network</u> copay or Coinsurance.**<br>• Note: Emergency (ER) care is not subject to In-network policies. Emergency care should be sought as soon as possible. | and the member is authorized to see an Out-of-Network provider. **Note: With Prior Authorization to see an Out-of-Network provider, the member will be charged the <u>In-Network</u> copay or Coinsurance.**<br>• Note: Emergency (ER) care is not subject to In-network policies. Emergency care should be sought as soon as possible. | |
| **O.** In-Network Provider Reimbursement | **<u>Provider Reimbursement:</u>**<br>[redacted] contracting methodology is based on fee schedules with the percentage of the CMS rates as a benchmark for reimbursement.<br><br>[redacted] standard physician fee schedule is developed using CMS Relative Value Units (RVUs) as a guide to develop the reimbursement rate to the providers. [redacted] utilizes a set of internally developed base rates by specialty category (via CPT ranges) as a starting point. RVUs are used to check the relativities among the codes to ensure they are properly aligned.<br><br>Rates are then adjusted based on a variety of factors including, supply/demand, geography, physician specialty, license level, and competitor networks. Physician rates are negotiated on a group by group basis. [redacted] may consider member access by geography and specialty in negotiating rates. [redacted] goal in negotiating in-network provider rates is to ensure the mix of reimbursement rates in the market, when compared to utilization, is reasonable and | **<u>Provider Reimbursement:</u>**<br>[redacted] reimburses providers based on a standard network fee schedule. The standard approach is to reimburse at 100% of the fee schedule.<br><br>[redacted]standard fee schedule is developed using CMS national RVUs as a guide to develop the reimbursement rate to the providers. RVU is the Relative Value Unit used by the CMS RVRBS. The RVUs are obtained from the CMS Physician Fee Schedule Final Rule, Addendum B, which is posted on the CMS.gov website. The RVU for a specific code represent the relative resources required to perform that service compared to other services. [redacted] utilizes a set of internally developed base rates as a starting point. RVUs are used to check the relativities among the codes to ensure they are properly aligned.<br><br>Rates are then adjusted based on a variety of factors including, supply/demand, geography, license level, and market conditions. [redacted] evaluates fee schedules on an annual basis (or more frequent depending upon updates from CMS) and any necessary adjustments are made to remain competitive in the marketplace. In addition, when an RVU is not available for a given code other sources are used by [redacted] to | **<u>Explanation:</u>**<br>MH/SUD and M/S use comparable methodologies for provider fee schedules based on CMS RVUs and use comparable factors for adjusting these rates and/or negotiating provider contracts. |

| Area | Medical/Surgical (M/S) Benefits | Mental Health/Substance Use Disorder (MH/SUD) Benefits | Explanation |
|---|---|---|---|
| | affordable for members and payers located in the market.<br><br>Reimbursement variations by physician specialty (e.g., cardiologist vs. internist) for the same Evaluation & Management (E&M) code: Reimbursement can be different by specialty. For example, an orthopedic surgeon may be paid a higher rate than a podiatrist due to their higher level of education and training. Additionally, as already indicated, market dynamics, including provider leverage, competitor networks, scarcity of provider type in the market, and the need for provider type in network impact provider reimbursement.<br><br>Reimbursement variations by provider license type (e.g., MD, RN, PA): Physicians are paid a higher level of payment than a RN or PA. These types of providers are called midlevel and they are paid at 85% of the physician fee schedule within the group practice where they participate. | assess the relativities and ensure consistent alignment. Other data and information sources can include the Fair Health database and rates/relativities obtained through studies from third-party vendors, consultation with subject matter experts on the services, and other market information.<br><br>**Negotiation of Fee Schedules:**<br>[redacted] physician rates are negotiable and [redacted] considers the factors in Reimbursement for in-network individual providers and Group Practices are determined through a negotiated process. During contract negotiations, [redacted] applies the following factors to determine reimbursement for in-network providers for MH/SUD services:<br>• Applicable CMS or other rate-setting methodology and benchmark reimbursement data for the provider type;<br>• Member access by geography and specialty;<br>• Impact on total cost relative to market and affordability;<br>• Market dynamics, including provider leverage, competitor networks, scarcity of provider type in the market, and the need for provider type in network;<br>• Quality and efficiency; and/or<br>• Provider type (rates may be adjusted for specialists, higher acuity facility types or non-physician provider types like physician assistants or social workers).<br><br>While some variation may exist for all services, In-Network Provider Reimbursement generally is based on external rate sources for services provided by the same provider type in the same geography, with the additional negotiation factors as needed. | |

| Area | Medical/Surgical (M/S) Benefits | Mental Health/Substance Use Disorder (MH/SUD) Benefits | Explanation |
|---|---|---|---|
| **P.** Out-of-Network (OON) Methodology (Method for determining usual, customary and reasonable charges) | **UCR is based upon** average in-network discounts.<br><br>**Facility OON** is either negotiated as a single case agreement, or if negotiations fail, a default of 50% of billed charges is used.<br><br>**Provider OON**: Rates are 100%, 110% 160%, 175% or 275% of Medicare. | **UCR is based upon** comparable costs for the same services in the geographic area (market standards).<br><br>**Facility OON** is either negotiated as a single case agreement, or if negotiations fail, a default of 50% of billed charges is used.<br><br>**Provider OON**: Rates are 100%, 160%, 175% or 275% of Medicare MNRP. | **Explanation:**<br>Both M/S and MH/SUD use the same reimbursement methodologies for OON Facility and OON Provider. |
| **Q.** Restrictions on provider billing codes | Providers may only bill for services within their scope of licensure/practice. In addition, providers must bill in accordance with national coding and billing guidelines.<br><br>For In-Network providers, billing should also be consistent with their contracted fee schedule and reimbursement requirements.<br><br>CPT/HCPCS: [redacted] follows AMA and CMS coding standards. If we feel that a code is being billed outside of the appropriate AMA and CMS coding guidelines, we develop edits to restrict providers from utilizing inappropriate code and or code/modifier combinations.<br><br>ICD-10-CM: We utilize CDC ICD-10- CM coding guidelines and develop code edits and policies to ensure they are being followed appropriately. | Providers may only bill for services within their scope of licensure/practice. In addition, providers need to bill/code in accordance with national coding and billing guidelines.<br><br>For In-Network providers, billing should also be consistent with their contracted fee schedule and reimbursement requirements.<br><br>CPT/HCPCS: [redacted] follows AMA and CMS coding standards, consistent with ASAM guidelines and clinical criteria. This would include having claim systems configured to ensure that restrictions that AMA or CMS have provided are implemented to facilitate appropriate billing practices.<br><br>ICD-10-CM: We utilize CDC ICD-10 coding guidelines. | **Explanation:**<br>Both [redacted] and [redacted] place comparable restrictions on provider billing codes in accordance with national coding and billing guidelines. |