

NQTL: Prescription Drug Formulary Tiering

Classification: Prescription drugs

Step 1 – Identify the specific plan or coverage terms or other relevant terms regarding the NQTL and a description of all mental health or substance use disorder and medical or surgical benefits to which each such term applies in each respective benefits classification

Definition:

Formulary Tiering is defined as the process that the plan uses to develop the approved list of drugs covered under the pharmacy benefit plan and to assign such drugs to formulary tiers. Drugs that are not on the formulary may be covered on an exception basis if they are not excluded and if medical necessity can be established based on plan-approved prior authorization criteria or applicable regulations.

Ambetter from Peach State Health Plan (Ambetter) used the following formulary tiers in 2022:

- **Tier 0** - No copayment for those drugs that are used for prevention and are mandated by the Affordable Care Act. Select oral contraceptives, vitamin D, folic acid for women of child bearing age, over-the-counter (OTC) aspirin, and smoking cessation products may be covered under this tier. Certain age limits may apply.
- **Tier 1A** - Lowest copayment for select drugs that offer the greatest value compared to other drugs used to treat similar conditions. Select over-the-counter (OTC) drugs may be covered under this tier.
- **Tier 1B** - Low copayment for those drugs that offer great value compared to other drugs used to treat similar conditions. Select over-the-counter (OTC) drugs may be covered under this tier.
- **Tier 2** - Medium copayment covers brand name drugs that are generally more affordable, or may be preferred compared to other drugs to treat the same conditions.
- **Tier 3** - High copayment covers higher cost brand name and non-preferred generic drugs. This tier may also cover nonspecialty drugs that are not on the Prescription Drug List but approval has been granted for coverage.
- **Tier 4** - Highest copayment is for "specialty" drugs used to treat complex, chronic conditions that may require special handling, storage or clinical management. Prescription drugs covered under the specialty tier require fulfillment at a pharmacy that participates in Ambetter's "specialty" or "hemophilia" networks. For additional information on which

pharmacies are within our "specialty" or "hemophilia" networks, please consult Ambetter website's pharmacy information section.

The formulary is available online at <https://ambetter.pshpgeorgia.com/resources/pharmacy-resources.html>

Step 2 – Identify the factors used to determine that the NQTL will apply to mental health or substance use disorder benefits and medical or surgical benefits

All drugs (medical, mental health and substance use disorder) are treated equally and follow the same process as outlined.

Determinations of tiering status start with a clinical determination of efficacy by the P&T Committee, followed by an economic evaluation by the Strategy Development Committee (SDC)

The P&T Committee provides clinical determination of efficacy for formulary placement based on the following factors^{1,2}:

1. Clinical efficacy
2. Quality of studies
3. Safety
4. Comparable long-term outcomes
5. Comparable populations
6. Ease of use/ease of compliance

Where the P&T Committee determines that two or more drugs are expected to achieve clinically equivalent therapeutic outcomes, SDC assigns drugs to higher or lower tiers based on its evaluation of comparative net cost.

Step 3 – Identify the evidentiary standards used for the factors identified in Step 2, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTL to mental health or substance use disorder benefits and medical or surgical benefits.

¹ Clinical Pharmacy Advisory Committee Desktop Procedure 04: Clinical Pharmacy Advisory Committee Scoring System

² IFP.PHAR.03 Pharmacy and Therapeutics policy

The evidentiary standards applied by the P&T Committee for the factors outlined in Step 2 are as follows:

1. Clinical Efficacy (50 points)

i. Based on the available peer-reviewed, published literature and clinical judgment, clinical efficacy is determined by examining the efficacy of the primary and secondary outcomes of the pivotal clinical trials, and the number of non-responders and the number of patients who withdrew from the trial due to a lack of efficacy. Based on this evaluation, the drug is designated as one of the following with points awarded as follows: “Clearly superior” (41-50 points), “Slightly superior” (31-40 points), “Equal to” (21-30), “Slightly inferior” (11-20) or “Clearly inferior” (0-10).

2. Quality of Studies (10 points)

i. Quality of studies supporting clinical efficacy. The following factors are considered and points are awarded as follows:

- 1) The number of peer-reviewed pivotal studies (0 trials-0 points, 1 trial-1 point, 2 or more trials-2 points)
- 2) Consistency of study results
- 3) Presence of active comparator(s)
- 4) Method of randomization
- 5) Trial design (e.g. double-blind, placebo-controlled, multi-center)
- 6) Description of withdrawals and dropouts
- 7) Determination of study design as optimal
- 8) Measurement of clinically meaningful endpoints
- 9) Reporting of clinically meaningful endpoints

ii. For 1 to 9, one point is awarded if more than 66% of the studies meet the criteria, or 0 points otherwise.

3. Safety (24 points)

i. The drug is deemed “Superior,” “Equal,” or “Inferior” based on the absolute number and frequency (0-8 points) and severity (0-8 points) of adverse reactions, contraindications and black box warnings compared to the comparator drug and the drug, with a higher score representing more safety than the comparator drugs.

ii. The drug is deemed “Superior,” “Equal,” or “Inferior” based on the absolute number (0-4 points) and severity (0-4 points) of drug-drug interactions compared to the comparator drug and the drug, with a higher score representing more safety than the comparator drugs.

4. Other considerations (16 points)

i. The drug is deemed “Superior,” “Equal,” or “Inferior” based on the comparability of long-term outcomes (i.e. availability of long-term outcome data of the drug versus the comparator) with a score awarded between 0 and 6 points, with 6 representing greater availability of such data.

- ii. The drug is deemed “Superior,” “Equal,” or “Inferior” based on comparability of populations (i.e. FDA approved indications or well supported off-label indications, age, race, disease sub-state(s), co-morbid condition(s), functional status, medications tried and failed, hepatic or renal insufficiency). The drug is awarded a score of 0 to 6, with 6 representing a larger applicable patient population for the same indication for the drug against the comparator.
- iii. The drug is deemed “Superior,” “Equal,” or “Inferior” based on ease of use/ease of compliance (i.e. dosing frequency, route of administration or lab work associated with the drug). The drug is awarded a score of 0 to 4, with 4 representing more convenient use of the drug leading to possibly better compliance compared to the comparator.

The scoring system yields a range of scores as follows:

- 78-100, which means that the drug presents significant advantages over current therapies
- 65-77, which means that the drug presents modest benefits over current therapies
- 46-64, which means that use of the drug anticipates equal therapeutic outcomes
- 29-45, which means that the drug may be used under unique circumstances
- 0-28, which means that use of the drug anticipates inferior therapeutic outcomes

Sources: Prescribing information, Phase II or III published trial results, national professional membership society treatment guidelines

Where the P&T Committee determines that two or more drugs are expected to achieve clinically equivalent therapeutic outcomes, SDC evaluates whether net cost savings can be achieved through differential assignment to preferred and non-preferred formulary tiers. Net cost analyses are not absolute values, but are relative cost comparisons between therapeutic alternatives. SDC applies the following factors to recommend preferred status among clinically equivalent drugs based on comparative net cost:

- Net cost definition: net cost is calculated as the average wholesale price (AWP) minus the negotiated pharmacy network rate/discount and any applicable rebate. Net costs are compared among drugs determined by the P&T Committee to achieve clinically equivalent therapeutic outcomes.
- Comparative net cost evidentiary standards:
 - Preferred status is assigned if the drug has significant clinical advantages over current therapies, as determined by the P&T Committee.
 - Preferred status would be assigned if equal therapeutic outcomes are expected compared to other drugs in the class and all of the following scenarios are true:
 - A negotiated manufacturer rebate would make the drug the lowest net cost drug in the class AND
 - The class net cost would be lower AND

- There are no pipeline events to consider (e.g. near term generic, biosimilar, or additional new molecular entity launch within a particular drug class).
- Preferred status *would not* be considered if any of the following are true with respect to new FDA approved products that do not present any significant clinical advantages:
 - There are already lower cost generics or brands available with similar safety and efficacy.
 - The two individual drugs within a combination product are generically available
 - Dosage forms where there is a lower cost generic available, e.g., 1) New brand capsule or brand orally disintegrating tablet when there is a generic tablet, 2) New gel formulation when there is a generic alternative topical available.
 - New dose amounts when there are generic strengths available to achieve the same dose.
 - New extended-release formulations when there is a generic immediate-release.
 - New salt ester when another salt form is generically available.
 - New technology when lower cost options are available (e.g. improved ergonomic design for an injectable or better adhesive for a patch)
- Net cost sources: proprietary manufacturer rebate negotiation, Ambetter claims data, MediSpan cost data

Step 4 – Provide the comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to mental health or substance use disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to medical or surgical benefits in the benefits classification

Formulary Tiering Designation Process:

- The Clinical Pharmacy Advisory Committee (CPAC) reviews all newly approved drugs and newly-approved indications and dosage forms for formulary status and recommendations for utilization management. CPAC approves the final version of the drug monograph, prior authorization criteria (if any), and related documents.
- The CPAC documents are presented to the health plan Pharmacy & Therapeutics (P&T) committee and the Corporate P&T committee. The P&T Committees are tasked to maintain and approve recommended changes to the formulary, drug prior authorization guidelines, and any programs/procedures that affect the utilization of drugs. P&T committee membership consists of internal and external actively practicing physicians and pharmacists. For formulary decisions on drugs used to treat mental health or substance use disorders, the P&T Committee incorporates input from appropriate specialists (e.g., psychiatrists, addiction specialists) who have knowledge and/or experience in treating patients with the specific disease state. Live health plan and Corporate P&T meetings are held on a quarterly basis and evaluate drugs on clinical merit only. First the health plan P&T committee reviews the

CPAC recommendation, then the Corporate P&T committee reviews the recommendation approved by the health plan P&T committee and CPAC and makes a final clinical decision.

- The Strategy Development Committee (SDC) reviews the clinical decision and evaluates financial and operational impacts to make final determinations for formulary placement.
- Finally, this final formulary placement decision is reviewed by the health plan P&T committee to confirm alignment with clinical decisions.
- If a participating provider believes that a certain medication should be added to the formulary, then the physician can follow the formulary change request policy. The drug is then evaluated through the standard review process.

Formulary distribution for M/S drugs (2022):

Tier 1a - 2%
Tier 1b - 55%
Tier 2 - 8%
Tier 3 - 11%
Tier 4 - 19%
Tier 0 - 5%

Formulary distribution for MH/SUD drugs (2022):

Tier 1a - 4%
Tier 1b - 76%
Tier 2 - 4%
Tier 3 - 11%
Tier 4 - 1%
Tier 0 - 5%

Step 5 – Provide the specific findings and conclusions reached by the group health plan or health insurance issuer with respect to the health insurance coverage, including any results that indicate that the plan or coverage is or is not in compliance with this section

Ambetter uses the same formulary tiering decision making process for M/S and MH/SUD drugs. On a quarterly basis, drug formulary reviews go through multiple levels of clinical review from CPAC’s initial evaluation and tiering recommendation to the Corporate P&T committee’s final decision. The process is heavily clinically driven using clinical efficacy, quality of studies, safety, comparable long-term outcomes, comparable populations, and ease of use/ease of compliance as the determining clinical factors for formulary decisions. Each factor is scored using an objective weighted scoring system, which cumulatively determines the formulary tiering recommendation. The sources used for the scoring process include prescribing information, clinical trials, peer-reviewed literature, treatment guidelines and clinical judgment, and these sources are the same regardless of the drug’s category. For tiering decisions, financial factors, which are limited to the value of rebate contracts, net cost, market share and the impact on plan revenue, are only considered where two clinically equivalent drugs exist, and these financial factors are applied equally to both MH/SUD and M/S drugs.

Thus we conclude that the processes, strategies, evidentiary standards, and other factors used to apply Formulary Tiering to MH/SUD drugs, *as written*, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply Formulary Tiering to M/S drugs.

In 2022, a higher proportion of MH/SUD drugs were covered in the lowest copayment tiers (1a and 1b – greatest value drugs) relative to M/S drugs, a much lower proportion of MH/SUD drugs were covered in the highest copayment tier (4 – specialty drugs) relative to M/S drugs, and comparable proportions of MH/SUD drugs and M/S drugs were covered in the higher copayment tier (3 – higher cost brand name and non-preferred generic drugs). Thus for the plan year, in each tier, in operation, the distribution of drugs is either comparable or more favorable to MH/SUD drugs.

Thus we conclude that the processes, strategies, evidentiary standards, and other factors used to apply Formulary Tiering to MH/SUD drugs, *in operation*, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply Formulary Tiering to M/S drugs.

NQTL: Medical Necessity

Classification: Prescription Drugs

Step 1 – Identify the specific plan or coverage terms or other relevant terms regarding the NQTL and a description of all mental health or substance use disorder and medical or surgical benefits to which each such term applies in each respective benefits classification

Medically necessary or medical necessity shall mean health care services that a provider (including physicians, nurse practitioners, physician assistants, and other licensed providers), exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms, and that are:

1. In accordance with generally accepted standards of medical practice;
2. Clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for the patient's illness, injury, or disease; and
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.

Medically necessary health care services may not include experimental and/or investigational technologies

Step 2 – Identify the factors used to determine that the NQTL will apply to mental health or substance use disorder benefits and medical or surgical benefits

N/A – medical necessity criteria are developed for all drugs

Step 3 – Identify any other source or evidence relied upon to design and apply the NQTLs to mental health or substance use disorder benefits and medical or surgical benefits.

Ambetter develops all medical necessity criteria and clinical policies for M/S and MH/SUD prescription drugs.

Step 4 – Provide the comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to mental health or substance use disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical or surgical benefits in the benefits classification

Step 4(a)(i): Identify and define the processes and strategies used to select Medical Necessity standards, definitions, or guidelines

N/A – Ambetter develops all medical necessity criteria and clinical policies for all M/S and MH/SUD prescription drugs.

Step 4(a)(ii): Identify and define the processes and strategies used to develop internal Medical Necessity guidelines or modifications to external guidelines that are created by the Plan

Process for creating a Prior Authorization (PA) policy:

The need to create or revise a prior authorization policy is identified as part of the clinical evaluation process when a new drug is approved by the FDA, a new indication is given to a new dosage form of a drug, a new indication is given for a drug without a new dosage, clinically significant changes are needed due to updates to evidence-based national treatment guidelines or the publication of new study information, and/or there are updates to FDA-approved labeling.

When a new drug product or new indication is approved by the FDA, two clinical pharmacists are assigned to review the drug. A clinical pharmacist will be assigned as the author to complete the new drug review is responsible for creating a PA policy. The other pharmacist will serve as the primary reviewer to the author. The author will create a draft policy, which will be sent to at least two external physician specialists representing the applicable area of specialty and preferably certified by a Board of various American medical specialties (i.e. American Board of Medical Specialties [ABMS], American Board of Physician Specialties (ABPS), and American Osteopathic Association Bureau of Osteopathic Specialists [AOABOS]) for review and feedback. The author will revise the PA policy, if necessary, based on input from specialists. The two clinical pharmacists must agree on the recommendation, or else the Chair of the Clinical Pharmacy Advisory Committee (CPAC), a subcommittee of the Pharmacy Services Pharmacy and Therapeutics (P&T) Committee, will need to further review the recommendation.

The author will present the PA policy to CPAC and makes revisions based on input from CPAC. CPAC members include practitioners with professional knowledge or clinical expertise who have knowledge of the development, review, and the criteria

used to adopt all drug related clinical policies. When CPAC approves the PA policy, the status will be changed from a draft PA policy to an interim PA policy. After CPAC approval, the recommendation is presented at a quarterly P&T Committee meeting, which ultimately approves the recommendation after any further feedback or changes to the recommendation.

Step 4(b): Identify and describe the evidentiary standards relied upon for Medical Necessity guidelines, or modifications to external guidelines that are created by the Plan

Sources:

- The American Hospital Formulary Service (AHFS) Drug Information
- Truven Health Analytics Micromedex DrugDex
- National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium
- Substance Abuse and Mental Health Services Administration (SAMHSA) guidelines
- Clinical Pharmacology
- Lexi-Comp
- The most recent manufacturer's Prescribing Information document and formulary dossier
- Peer reviewed medical literature
- Other reviews and monographs (e.g., The Formulary Monograph Service Inc.)
- Evidence-based medicine resources (e.g., HAYES, EBMS)
- Evidence-based clinical practice guidelines
- Peer-reviewed medical literature appearing in the regular editions for off-label use of drugs and biologicals in an anti-cancer chemotherapeutic regimen

Step 4(c): Identify and define the factors and processes that are used to monitor and evaluate the efficacy and validity of Medical Necessity guidelines

The Quality Oversight Committee meets on a quarterly basis wherein denial rates, appeal rates, are reviewed.

These committees are comprised of appropriate behavioral health practitioners, practicing psychiatrists, Medical Directors, appropriate medical professionals and utilization management program staff.

Updates and revisions to policies and criteria are reviewed annually. During this time, appropriate behavioral health practitioners, including but not limited to psychiatrists, psychologists, and social workers with professional knowledge or clinical expertise in the area being reviewed have an opportunity to give advice or comment on adoption of UM criteria and on instructions for applying the criteria.

Our training and policies ensure appropriate utilization of medical necessity criteria (MNC) and clinical policies for prescription drugs with annual Inter-rater reliability testing. All Utilization Managers applying MNC must pass this annual test. Coverage criteria are evidence-based, standards for medical necessity reviews. We review denial rates, appeal overturn rates and ensure the inter-rater reliability annually.

IRR scores:

Reviewer team averages were over 97% across all teams. The same reviewers were used for all authorization requests for both M/S and MH/SUD drugs.

Step 5 – Provide the specific findings and conclusions reached by the group health plan or health insurance issuer with respect to the health insurance coverage, including any results that indicate that the plan or coverage is or is not in compliance with this section

For each step, the relevant information is the same for M/S and MH/SUD benefits. In addition, the very high IRR averages provide one form of evidence that the MN criteria are clearly communicated and clinically appropriate. Therefore we conclude that, as written and in operation, the processes, strategies, evidentiary standards, and factors used to develop MN criteria for MH/SUD drugs are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to develop MN criteria for medical/surgical drugs.

NQTL: Experimental and Investigational

Classification: Prescription Drugs

Step 1 – Identify the specific plan or coverage terms or other relevant terms regarding the NQTL and a description of all mental health or substance use disorder and medical or surgical benefits to which each such term applies in each respective benefits classification

Prescription drugs determined to be experimental or investigational are excluded from the Plan's definition for medically necessary treatments and services and are excluded from coverage.

Experimental or investigational treatment means medical, surgical, diagnostic, or other health care services, treatments, procedures, technologies, supplies, devices, drug therapies, or medications that, after consultation with a medical professional, we determine to be:

1. Under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration ("USFDA") regulation, regardless of whether the trial is subject to USFDA oversight.
2. An *unproven service*.
3. Subject to USFDA approval, and:
 - a. It does not have USFDA approval;
 - b. It has USFDA approval only under its Treatment Investigational New Drug regulation or a similar regulation; or
 - c. It has USFDA approval, but is being used for an indication or at a dosage that is not an accepted off-label use. An accepted off-label use of a USFDA-approved drug is a use that is determined by *us* to be:
 - i. Included in authoritative compendia as identified from time to time by the Secretary of Health and Human Services;
 - ii. Safe and effective for the proposed use based on supportive clinical evidence in peer-reviewed medical publications; or
 - iii. Not an *unproven service*; or
 - d. It has USFDA approval, but is being used for a use, or to treat a condition, that is not listed on the Premarket Approval issued by the USFDA or has not been determined through peer reviewed medical literature to treat the medical condition of the *member*.
4. *Experimental or investigational* according to the *provider's* research protocols.

Step 2 – Identify the factors used to determine that the NQTL will apply to mental health or substance use disorder benefits and medical or surgical benefits

N/A – E/I treatments are not covered benefits

Step 3 – Identify any source or evidence relied upon to design and apply the NQTL to mental health or substance use disorder benefits and medical or surgical benefits.

Determinations of whether a prescription drug is experimental or investigational are based on the sources and evidentiary standards set forth in the definition below.

Experimental or investigational treatment means medical, surgical, diagnostic, or other health care services, treatments, procedures, technologies, supplies, devices, drug therapies, or medications that, after consultation with a medical professional, we determine to be:

1. Under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration ("USFDA") regulation, regardless of whether the trial is subject to USFDA oversight.
2. *An unproven service.*
3. Subject to USFDA approval, and:
 - a. It does not have USFDA approval;
 - b. It has USFDA approval only under its Treatment Investigational New Drug regulation or a similar regulation; or
 - c. It has USFDA approval, but is being used for an indication or at a dosage that is not an accepted off-label use. An accepted off-label use of a USFDA-approved drug is a use that is determined by *us* to be:
 - i. Included in authoritative compendia as identified from time to time by the Secretary of Health and Human Services;
 - ii. Safe and effective for the proposed use based on supportive clinical evidence in peer-reviewed medical publications; or
 - iii. Not an *unproven service*; or
 - d. It has USFDA approval, but is being used for a use, or to treat a condition, that is not listed on the Premarket Approval issued by the USFDA or has not been determined through peer reviewed medical literature to treat the medical condition of the *member*.
4. *Experimental or investigational* according to the *provider's* research protocols.

Step 4 – Provide the comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to mental health or substance use disorder benefits, as written and in operation, are

comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to medical or surgical benefits in the benefits classification

Step 4(a)(i): Identify the conditions or factors, if any, under which E/I treatments or services are covered

N/A – prescriptions determined to be E/I are not covered

Step 4(b): Briefly describe the processes by which coverage determinations or exceptions are made for E/I Treatments

Same as for Prior Authorization.

Step 4(c): Identify and define the factors and processes that are used to monitor and evaluate the application of E/I Treatment policies

The volume of E/I determinations, coverage denials for E/I services, and appeals is too low to permit meaningful quantitative comparisons between M/S and MH/SUD. However, the same in operation processes and strategies are used to determine whether identified services are E/I, regardless of whether the treated condition is a M/S or MH/SUD condition.

Step 5 – Provide the specific findings and conclusions reached by the group health plan or health insurance issuer with respect to the health insurance coverage, including any results that indicate that the plan or coverage is or is not in compliance with this section

For each step, the relevant information is the same for M/S and MH/SUD benefits. Therefore we conclude that, as written and in operation, the processes, strategies, evidentiary standards, and factors used to design and apply E/I determinations for MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to design and apply E/I determinations for medical/surgical benefits in each classification of benefits.

NQTL: Prior Authorization

Classification: Prescription Drugs

Step 1 – Identify the specific plan or coverage terms or other relevant terms regarding the NQTL and a description of all mental health or substance use disorder and medical or surgical benefits to which each such term applies in each respective benefits classification

Definition:

Prior authorization is applied to identified formulary drugs, formulary exceptions, and exceptions to step therapy and other utilization management policies to ensure that the prescription is medically necessary—i.e. reasonable, necessary, and/or appropriate, based on evidence-based clinical standards of care.

Prior authorization is applied to coverage determinations for which manual review is appropriate (i.e. where auto-adjudication is not appropriate). Prior authorization criteria may require information retrievable from both the pharmacy claims adjudication system and the member's medical charts.

Drugs subject to PA: See attachment

CC.PHARM.55: Prior Authorization Policy Development

Step 2 – Identify the factors used to determine that the NQTL will apply to mental health or substance use disorder benefits and medical or surgical benefits

Factors used to determine that prior authorization will apply to a drug are³:

- a) The abuse potential of the drug:
- b) Whether a new to market molecular entity has been evaluated by the P&T Committee
- c) The possibility for off-label use of the drug

³ CC.PHARM.55: Prior Authorization Policy Development

- d) Any safety or efficacy concerns
- e) The place in therapy of the drug with respect to standard of care

Next, if at least one of these factors is met, and if there is an opportunity to manage cost, then SDC evaluates whether utilization management goals can be met through formulary tiering (FT) and/or a step therapy (ST) policy. PA is generally the preferred strategy when the concerns identified according to the factors above are significant and/or where clinical review is likely to be necessary (as opposed to automated processes pursuant to FT or ST).

Step 3 – Identify the evidentiary standards used for the factors identified in Step 2, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTL to mental health or substance use disorder benefits and medical or surgical benefits.

- a) The abuse potential of the drug:
 - *Evidentiary standard:* abuse potential is determined by the CPAC based on euphoric potential identified in clinical trial results, or based on DEA designation as a controlled substance
 - *Sources:* DEA scheduling, Phase III clinical trial results, package insert or manufacturer dossier
- b) Whether a new to market molecular entity has been evaluated by the P&T Committee
 - *Evidentiary standard:* all new molecular entities are non-formulary until reviewed by the P&T Committee. The Pipeline team tracks all drugs submitted to FDA for approval process and ensures that drugs in Part D protected classes are reviewed within 90 days, and that all other drugs are reviewed within 180 days.
 - *Sources:* P&T Committee review status
- c) The drug is commonly used off-label
 - *Evidentiary standard:* common off-label use is identified when there are on-going clinical trials for other indications, when external specialists providing input to the P&T Committee express high-likelihood of off-label use of the drug due to unavailability of effective therapies for related indications, when a drug is newly approved in a class that is commonly used for various other indications
 - *Sources:* treatment guidelines, specialist opinion, availability of peer-reviewed studies for other clinical indications for the drug, currently on-going clinical trials for other indications
- d) Significant safety or efficacy concerns
 - *Evidentiary standard:* as identified in the P&T scoring sheet review, prescribing information, Phase III clinical trial results
 - *Sources:* see P&T scoring sheet
- e) The drug is not a first-line agent under the prevailing standard of care
 - *Evidentiary standard:* is the drug not a first-line agent
 - *Sources:* treatment guidelines, specialist opinion, study design

Sources:

- The American Hospital Formulary Service (AHFS) Drug Information
- Truven Health Analytics Micromedex DrugDex
- National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium
- Substance Abuse and Mental Health Services Administration (SAMHSA) guidelines
- Clinical Pharmacology
- Lexi-Comp
- The most recent manufacturer's Prescribing Information document and formulary dossier
- Peer reviewed medical literature
- Other reviews and monographs (e.g., The Formulary Monograph Service Inc.)
- Evidence-based medicine resources (e.g., HAYES, EBMS)
- Evidence-based clinical practice guidelines
- Peer-reviewed medical literature appearing in the regular editions for off-label use of drugs and biologicals in an anti-cancer chemotherapeutic regimen

Step 4 – Provide the comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to mental health or substance use disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical or surgical benefits in the benefits classification

Step 4(a): For each benefit subject to Prior Authorization, identify which of the factor(s) in Step 3 were met

This factor-level analysis is available to regulators upon request in the event of a complaint or suspicion of noncompliance.

Step 4(b): Briefly describe the processes by which prior authorization is applied

1. In order for a PA request to be covered, the prescriber must submit information consistent with the developed criteria to obtain approval for the medication. A form for submission of a PA request is posted on Ambetter plan web sites. Use of this form is not required to obtain approval, but the form is provided as guidance on the information that may be necessary to assure prompt review of a PA request.
2. Initial PA requests are reviewed by a Pharmacy Technician (PT) or a licensed Clinical Pharmacist at Pharmacy Services. For requests that meet initial screening criteria, an authorization for approval is entered in the PBM application and the prescriber notified that approval has been granted.

- a. If the request does not contain sufficient information to make an informed decision, the reviewer notifies the prescriber and documents the request for additional information. The additional information notification outlines clinical information that is required for approval.
- b. If the additional information is not received within the timeframes established by NCQA or the state, whichever requires the faster response time, a denial notification is processed in accordance with the process described above.
3. Standard and urgent PA requests are responded to within the applicable timeframe established by NCQA or the state, whichever requires the faster response time.
 - a. For formulary exception requests, verbal notification of the determination for the exception request will be provided no later than 72 hours after the request is received or within 24 hours for urgent requests or when the enrollee is suffering from a serious health condition. A written response will be provided within 48 hours of the verbal notification.
4. When a request does not meet criteria, the request is forwarded to a licensed Clinical Pharmacist for a final determination. Clinical Pharmacists review all denials unless state law requires a physician or other practitioner's review.
5. In the event of a PA denial, the prescriber is faxed notification of the adverse determination, including the reason for the denial, along with a request for use of formulary alternatives (when appropriate). Pharmacy Services provides the Ambetter health plans, on a daily basis, a completed member denial letter for each denial processed.
6. The member denial letter is mailed to the member by Pharmacy Services within three (3) calendar days of making the final determination, not to exceed the timeframes established by NCQA or the state. Both the prescriber notification and the member denial letters include the reason for the denial and language notifying them of their rights to appeal the decision, including contact information at both the Ambetter health plan and any applicable state agencies, if required.
7. The prescriber or the member may request reconsideration of any denial made by Pharmacy Services or the Ambetter health plan Medical Director.

Step 4(c) : Identify and define the factors and processes that are used to monitor and evaluate the application of Prior Authorization

Quantity/Proportion of M/S drugs subject to PA:
Percentage of M/S formulary drugs that currently require prior authorization is **30%**

PA denial rates for M/S:
From 1/1/22 to 11/30/22, **38.1%** of M/S PAs were denied.

PA appeal rates for M/S:

Step 4(c) : Identify and define the factors and processes that are used to monitor and evaluate the application of Prior Authorization

Quantity/Proportion of MH/SUD drugs subject to PA:
Percentage of MH/SUD formulary drugs that currently require prior authorization is **15%**

PA denial rates for MH/SUD:
From 1/1/22 to 11/30/22, **32.2%** of MH/SUD PAs were denied.

PA appeal rates for MH/SUD:

<p>From 1/1/22 to 11/30/22, 3.3% of M/S PA decisions were appealed.</p> <p><u>PA appeal overturn rates for M/S:</u> From 1/1/22 to 11/30/22, 29.1% of M/S PA decisions were overturned.</p> <p><u>IRR scores:</u> Reviewer team averages were over 97% across all teams. The same reviewers were used for all PA requests for both M/S and MH/SUD drugs.</p>	<p>From 1/1/22 to 11/30/22, 2.6% of MH/SUD PA decisions were appealed.</p> <p><u>PA appeal overturn rates for MH/SUD:</u> From 1/1/22 to 11/30/22, 30.0% of MH/SUD PA decisions were overturned.</p> <p><u>IRR scores:</u> Same as for M/S.</p>
<p>Step 5 – Provide the specific findings and conclusions reached by the group health plan or health insurance issuer with respect to the health insurance coverage, including any results that indicate that the plan or coverage is or is not in compliance with this section</p>	
<p>The process for creating a prior authorization policy for a drug is the same for both M/S and MH/SUD drugs. When defined triggers for prior authorization policy development are met, two clinical pharmacists develop the initial prior authorization policy recommendation with input from applicable physician specialists for the drug at issue, which is then reviewed by CPAC and ultimately subject to approval by the P&T Committee on a quarterly basis.</p> <p>The two clinical pharmacists determine whether to recommend a prior authorization policy for a drug based on the drug's abuse potential, whether the drug is new to the market, possible off-label use of the drug, safety/efficacy concerns and the drug's place in therapy with respect to the standard of care. Whether each factor is met is based upon defined evidentiary standards, which are based upon clinical or regulatory sources, such as drug compendiums, prescribing information and peer-reviewed medical literature. The factors, standards and sources for those standards are the same regardless of whether a drug is a M/S or MH/SUD drug.</p> <p>Thus we conclude that the processes, strategies, evidentiary standards, and other factors used to apply Prior Authorization to MH/SUD drugs, <i>as written</i>, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply Prior Authorization to M/S drugs.</p> <p>In operation, a request for prior authorization is subject to the same review process for both M/S and MH/SUD drugs, and the same reviewers are used for M/S and MH/SUD drug authorization reviews. A patient's prescriber requests the prior authorization, which is either approved or denied by a pharmacy technician or licensed clinical pharmacist, with a final determination made by a</p>	

clinical pharmacist. Request approval timelines for all drug categories adhere to NCQA and state standards. Prescribers or patients may request reconsideration of any denial.

In operation, the percentage of MH/SUD drugs requiring prior authorization is much lower than the percentage of M/S drugs requiring prior authorization. The denial rate for MH/SUD drug requests (32.2%) is lower than the denial rate for M/S drug requests (38.1%) indicates that benefit determinations and denials for MH/SUD drugs are in fact performed in a manner that is no more stringent than determinations and denials for M/S drugs. Given that the same reviewers are used for both MH/SUD and M/S drug requests, IRR scores cannot be differentiated for comparative purposes, but the very high score averages (97%) also suggest that reviews are consistent across all requests.

Thus we conclude that the processes, strategies, evidentiary standards, and other factors used to apply Prior Authorization to MH/SUD drugs, *in operation*, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply Prior Authorization to M/S drugs.

NQTL: Step Therapy

Classification: Prescription Drugs

Step 1 – Identify the specific plan or coverage terms or other relevant terms regarding the NQTL and a description of all mental health or substance use disorder and medical or surgical benefits to which each such term applies in each respective benefits classification

Definition: Step Therapy (ST) is the practice of beginning drug therapy for a medical condition with the most cost-effective and safest drug and progressing to other more costly or risky therapy, only if necessary (i.e., members must try drug "A" before they can get drug "B").

Step therapy includes coverage determinations that can be made appropriately through auto-adjudication and determinations that require manual authorizations pursuant to clinical review. ST criteria require information that are retrievable by the pharmacy claims adjudication system. Such information typically include: drug use history, and age.

Step 2 – Identify the factors used to determine that the NQTL will apply to mental health or substance use disorder benefits and medical or surgical benefits

Step therapy is required for a drug where:

- (1) Equal clinical therapeutic outcomes are anticipated between the requested product and the redirected product, and
- (2) Treatment guidelines support the redirected product as the first-line treatment option.

Drugs subject to ST: please see formulary at <https://ambetter.pshpgeorgia.com/resources/pharmacy-resources.html>

Step 3 – Identify the evidentiary standards used for the factors identified in Step 2, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTL to mental health or substance use disorder benefits and medical or surgical benefits.

(1) Equivalence of clinical therapeutic outcomes

(a) *Evidentiary standard:* drugs determined to yield equal or superior therapeutic outcomes under the CPAC scoring system* are determined to provide equivalent clinical therapeutic outcomes

(b) *Sources:* CPAC scoring sheet

**see full description of the factors, sources, and evidentiary standards for the CPAC scoring system in the Formulary Tiering NQTL analysis*

(2) Treatment guidelines support the redirected product as the first-line treatment option

(a) *Evidentiary standard:* a treatment guideline exists to indicate a first-line treatment alternative to the drug under consideration that is clinically acceptable for the indication. If there are multiple choices for a first line agent and some agents are not covered by the plan formulary, the first-line agent will be selected from the agents that are preferred on the formulary.

(b) *Sources:* national treatment guidelines

Step 4 – Provide the comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to mental health or substance use disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to medical or surgical benefits in the benefits classification

<p><u>Medical/Surgical:</u></p> <p><u>Triggers for determining whether to create a ST policy:</u> Same as for PA</p> <p><u>Process for creating a ST policy:</u> Same as for PA</p> <p><u>Quantity/proportion of M/S drugs currently subject to ST:</u> 2% of M/S Drugs are subject to ST</p> <p>Data regarding denials, appeals, and appeal overturns include both ST and PA. Any claim that gets rejected at point of service pursuant to a ST requirement would turn into a PA and be processed as such.</p>	<p><u>MH/SUD</u></p> <p><u>Triggers for determining whether to create a ST policy:</u> Same as for M/S</p> <p><u>Process for creating a ST policy:</u> Same as for M/S</p> <p><u>Quantity/proportion of MH/SUD drugs currently subject to ST:</u> 3% of MH/SUD drugs are subject to ST</p> <p>Data regarding denials, appeals, and appeal overturns include both ST and PA. Any claim that gets rejected at point of service pursuant to a ST requirement would turn into a PA and be processed as such.</p>
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<p><u>Denial rates for failure to complete the required steps</u> Same as PA</p> <p><u>Internal and/or external appeal rates</u> Same as PA</p> <p><u>Appeal overturn rates</u> Same as PA</p>	<p><u>Denial rates for failure to complete the required steps</u> Same as PA</p> <p><u>Internal and/or external appeal rates</u> Same as PA</p> <p><u>Appeal overturn rates</u> Same as PA</p>
<p>Step 5 – Provide the specific findings and conclusions reached by the group health plan or health insurance issuer with respect to the health insurance coverage, including any results that indicate that the plan or coverage is or is not in compliance with this section</p>	
<p>The process for creating a step therapy policy for a drug is the same for both M/S and MH/SUD drugs. When defined triggers for step therapy policy development are met, two clinical pharmacists develop the initial prior authorization policy recommendation with input from applicable physician specialists for the drug at issue, which is then reviewed by CPAC and ultimately subject to approval by the P&T Committee on a quarterly basis.</p> <p>The two clinical pharmacists determine whether to recommend a step therapy policy for a drug based on two factors: 1) Whether there are two drugs with equivalent therapeutic outcomes and 2) Whether treatment guidelines support the redirected drug as the first-line treatment option. The determination as to the former is based on an objective weighted scoring system and the latter is sourced from national treatment guidelines. These factors, standards and sources are the same regardless of whether a drug is a M/S or MH/SUD drug.</p> <p>Thus we conclude that the processes, strategies, evidentiary standards, and other factors used to apply Step Therapy to MH/SUD drugs, <i>as written</i>, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply Step Therapy to M/S drugs.</p> <p>In operation, for both M/S and MH/SUD drugs, authorization approval timelines adhere to NCQA and state standards. Finally, the percentage of MH/SUD drugs subject to Step Therapy is comparable to the percentage of M/S drugs subject to Step Therapy, noting that overall, very few drugs in general require Step Therapy (6/183 MH/SUD and 28/1823 M/S drugs require Step Therapy).</p> <p>Thus we conclude that the processes, strategies, evidentiary standards, and other factors used to apply Step Therapy to MH/SUD drugs, <i>in operation</i>, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply Step Therapy to M/S drugs.</p>	

Individuals Who Performed/Participated in NQTL Analysis

Name	Title	Qualifications
Andrew Bossie	Senior Director, Contracting and Net. Development	Oversee functions related to network contracting
Tina Launhardt	Senior Manager, Credentialing	Oversees functions related to credentialing

NQTL Type: Standards for provider admission to participate in a network, including reimbursement rates

Classification(s): Inpatient (In-network)

Step 1 – Identify the specific plan or coverage terms or other relevant terms regarding the NQTL and a description of all mental health or substance use disorder and medical or surgical benefits to which each such term applies in each respective benefits classification

- Provide a clear description of the specific NQTL, plan terms, and policies at issue
- Identify which M/S and MH/SUD benefits are subject to the NQTL

Step 1(a): Provide a clear description of the specific NQTL, plan terms, and policies at issue.

Access:

Ambetter from Peach State (“Ambetter”) defines the Standards for Provider Admission to Participate in a Network, Including Reimbursement Rates NQTL to mean the performance of initial and ongoing assessments of its organizational providers in compliance with applicable local, state, and federal accreditation requirements, including the collection, verification, and evaluation of information on organizational providers to achieve a decision to approve or deny network participation in Ambetter’s contracted networks of qualified organizational health care providers and home and community-based service providers pursuant to a negotiated and agreed-upon reimbursement methodology. Network access and monitoring, provider credentialing, and reimbursement rate-setting methodologies are three key components of the plan’s integrated strategy for Standards for Provider Admission to Participate in a Network, Including Reimbursement Rates, and are described separately in each step of this comparative analysis for convenience, but ultimately function as integrated components of a comprehensive strategy for this NQTL.

Ambetter ensures that its network has sufficient numbers and types of practitioners who provide primary care, behavioral health care and specialty care to meet the needs and preferences of its membership and adapts its network access, provider reimbursement, and credentialing strategies as needed to meet these needs and preferences. Reimbursement refers to the process of compensating providers for health care services rendered to beneficiaries. Credentialing is the process of obtaining and reviewing documentation to make a threshold determination of whether a provider may be accepted to participate in Ambetter’s network for facilities, suppliers, individual practitioners, and other providers (“providers”). The credentialing process requires providers to submit documentation including, but not limited to, the provider’s education, training, clinical privileges, experience, licensure, accreditation, certifications, professional liability insurance, malpractice history and professional competence. Generally, the terms credentialing and recredentialing include the review of the information and documentation collected, as well as verification that the information is accurate and complete. The Contracting & Network Development Department provides guidance for and oversight of provider network admission and monitoring standards as described in HIM Network Oversight and Reporting Policy (HIM.NTWK.09), Essential Community Providers Policy (HIM.NTWK.03), and Network Adequacy and Accessibility Requirements, Reporting, and Monitoring Policy (HIM.NTWK.02).

*Note: As used in this document the term “Plan” refers to Ambetter from Peach State

Step 1(b): Identify the M/S and MH/SUD benefits/services for which the NQTL is required:

All benefits and services are available from the provider network, which is developed through the Network Access strategy.

Practitioners who practice exclusively within an inpatient setting or freestanding facilities and who provide care for Plan members only as a result of members being directed to the hospital, inpatient setting, or free-standing facility do not require credentialing.

Step 2 – Identify the factors used to determine that the NQTL will apply to mental health or substance use disorder benefits and medical or surgical benefits

Note: although this prompt asks for the “factors used to determine that the NQTL will apply,” because this NQTL applies to 100% of benefits in all classifications, this response reflects the factors used in the design of how this NQTL applies to providers of M/S services as compared to providers of MH/SUD services. This is a more meaningful framing for a comparability and stringency analysis for this NQTL type.

Access:

Ambetter considers the following factors in developing the provider network admission and/or recruitment standards for M/S and MH/SUD Providers:

1. Product License Network Adequacy Requirements
2. Provider/Practitioner Licensing
3. Cultural Needs and Preferences

Note: although this prompt asks for the “factors used to determine that the NQTL will apply,” because this NQTL applies to 100% of benefits in all classifications, this response reflects the factors used in the design of how this NQTL applies to providers of M/S services as compares to providers of MH/SUD services. This is a more meaningful framing for a comparability and stringency analysis for this NQTL type.

Access:

Same as M/S

Credentialing:

N/A - Practitioners who practice exclusively within an inpatient setting or freestanding facilities and who provide care for Plan members only as a result of members being directed to the hospital, inpatient setting, or free-standing facility do not require credentialing.

Reimbursement:

The Plan considers the following factors when setting reimbursement for inpatient MH/SUD and M/S services, and determining that the reimbursement rate is appropriate:

a. Standard Pricing:

- i. The Plan establishes Standard Pricing based on the methodologies used by CMS for Medicare population based on the following factors:
 - 1. The CMS methodologies are the industry standard for inpatient M/S services
 - 2. The CMS methodologies are well documented and supported by objective standards and data accessible to all stakeholders

b. Provider negotiation factors: No one factor is systematically given greater weight and the underlying data is provider and circumstance specific.

- i. Provider necessary to meet federal and state regulatory requirements for network adequacy with locations and/or the required number of practitioners available to meet the population needs within member drive time and distance requirements:
- ii. Provider's certified service offerings providing essential or unique services or supplies:
- iii. Practitioners or facilities rendering care at locations affiliated with in network Providers
- iv. Demonstrated quality performance
- v. Member out of network utilization trend (e.g. reputation, location, quality, services)
- vi. Member requested provider including requests by Broker/Sales Departments
- vii. Member specific single case agreements

Step 3 – Identify the evidentiary standards used for the factors identified in Step 2, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTL to mental health or substance use disorder benefits and medical or surgical benefits.

- Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.
- To the extent the plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Access:

1. Product License Network Adequacy Requirement:

a. *Evidentiary standard:*

- Access Threshold 90% of members must have access to care for prescribed Specialties.
- Time or Distance for County Classification:

Specialty Types	Large Metro		Metro		Micro		Rural		CEAC	
	Distance	Time	Distance	Time	Distance	Time	Distance	Time	Distance	Time
Acute Inpatient Hospitals (Must have Emergency services available 24/7)	10	20	30	45	60	80	60	75	100	110
Critical Care Services - Intensive Care Units (ICU)	10	20	30	45	120	160	120	145	140	155
Inpatient or Residential Behavioral Health Facility Service	15	30	45	70	75	100	75	90	140	155
Skilled Nursing Facilities	10	20	30	45	60	80	60	75	85	95

- b. Sources: Network Adequacy Requirements, Reporting, and Monitoring Policy HIM.NTWK.02, 45 C.F.R. 156.230(a)(2), CMS Qualified Health Plan Issuer Application Instructions

2. Provider / Practitioner Licensing:

- Evidentiary standard:* All network providers must demonstrate Professional Competence. For health care practitioners, verification of applicable education and training upon initial credentialing and maintenance of valid professional licensure for practitioner’s field of practice upon recredentialing, which includes requirements for Continuing Medical Education, are accepted as evidence of maintenance of knowledge and ability in practice area(s) for health care practitioner.
- Source:* Practitioner Credentialing & Recredentialing Policy CC.CRED.01

3. Cultural Needs and Preferences:

a. *Evidentiary standard:*

- i. The Plan assesses the cultural, ethnic, racial, and linguistic needs of its members at enrollment by capturing information on primary language and any other special needs. The Plan maintains the provided information in its system, which tracks enrollment, language, utilization, claims, referrals, and pharmacy information. The availability of practitioners is adjusted within the network (if necessary) based on this information. The Plan utilizes the Provider Directory to notify members of any specialized services, including linguistic capabilities and handicap access, offered by network providers.

b. *Source:* Cultural Competency and Linguistic Assistance Policy CC.QI.CLAS.29

Credentialing:

N/A - Practitioners who practice exclusively within an inpatient setting or freestanding facilities and who provide care for Plan members only as a result of members being directed to the hospital, inpatient setting, or free-standing facility do not require credentialing.

Reimbursement:

1. Standard Pricing Methodology

- a. The Plan establishes Standard Pricing based on the methodologies used by CMS for Medicare population based on the following factors: The CMS methodologies are the industry standard for inpatient M/S services. Industry Standard methodology is applying the pricing components that describes the resources consumed by a rendered services (DRG Weights, RVU's, and Base Units) and establishing a standard rate that should be agreeable to most providers for the pricing component that converts the rendered service into a payment rate. The CMS methodologies are well documented and supported by objective standards and data accessible to all stakeholders.

2. Provider Negotiations

For all providers for whom a Standard Pricing model exists, the targeted pricing level begins with the Standard Pricing described above. The Plan responds to provider-initiated requests to increase this standard pricing where the provider meets one or more of the following factors, and roughly proportionate to the cumulative weight of these factors:

- a. Provider necessary to meet network adequacy with locations and/or the required number of practitioners available to meet the population needs within member drive time and distance requirements:
 - i. Definition, evidentiary standard, and sources: When there is a need identified in the network of participating providers for inpatient services, recruitment is initiated to execute provider agreements to fill network requirements.
- b. Provider's certified service offerings providing essential or unique services or supplies:

- i. Definition, evidentiary standard, and sources: Services not generally found offered by providers in the same specialty type, in the judgement and expertise of the reviewer, including proprietary care delivery models, service techniques, complexity of cases treated, sole manufacturing of devices or trademarks, and for which member care needs may not be met in the plan region(s) served.
- c. Practitioners or facilities rendering care at locations affiliated with in network Providers
 - i. Definition, evidentiary standard, and sources: Non-participating practitioners or facilities rendering care in a participating provider location whether independently owned or under common ownership with the participating provider may allow for negotiation if care cannot reasonably be re-directed to in-network providers.
- d. Demonstrated quality performance
 - i. Definition, evidentiary standard, and sources: High Performing Providers are identified through the partnership with a third-party agency, gathering information from CMS on the providers relative to our market and disclosing the information in a manner to allow the plan to target those deemed as “high performing”.
- e. Member out of network utilization trend (e.g. reputation, location, quality, services)
 - i. Definition, evidentiary standard, and sources: Claims experience demonstrating repeating utilization, typically within the preceding twelve-month period, due to circumstances such as anticipated word of mouth or marketing campaign activity causing member steerage.
- f. Member requested provider including requests by Broker/Sales Departments
 - i. Definition, evidentiary standard, and sources: Incoming requests from either internal or external Sales Agents/Brokers interacting with members or prospective membership and receiving requests to add named Providers to the network of participating providers. Requests directly from members to other plan internal departments such as Customer Service.
- g. Member specific single case agreements
 - i. Definition, evidentiary standard, and sources: Negotiation with an out of network Provider for a single member’s specific case where circumstances drive the required use of the OON provider for the necessary services, devices, supplies. Case may represent unique member conditions, treatment plan, or the continuation of care delivery by out of network providers until transition to a participating provider can reasonably occur.

Step 4 – Provide the comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to mental health or substance use disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical or surgical benefits in the benefits classification.

- *The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.*
- *If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s).*
- *If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.*

In writing Analysis:

Access: Ambetter ensures that its network has sufficient numbers and types of practitioners who provide primary care, behavioral health care and specialty care to meet the needs and preferences of its membership. The Director of Contracting & Network Development provides guidance and oversight over monitoring provider network admission standards as described in HIM Network Oversight and Reporting Policy (HIM.NTWK.09), Essential Community Providers Policy (HIM.NTWK.03), and Network Adequacy, Requirements, and Monitoring Policy (HIM.NTWK.02).

Network adequacy must also be demonstrated to licensing agencies when applying for an insurance plan license to sell a product in a prescribed market area. Ambetter follows CMS Medicare standards plus a select list of additional specialties identified by the plan to enhance market support. Outcomes are monitored using a specific software application, Quest®.

In cases where the Georgia DOI, or other state agency, has additional requirements or different access standards, Ambetter will adhere to the broadest and most stringent standards.

When no regulation or direction exists from a government entity, Ambetter will apply a set of standards developed by Network Development. Annually, Network Development in conjunction with Regulatory Operations will review CMS guidance on current year requirements and update the adequacy and accessibility standards accordingly.

A county must meet the minimum network adequacy requirement, or have a mutually (Centene Commercial Solutions, Ambetter, and Network Development) agreed upon development plan in place, to be included in the service area for QHP filing.

Primary Care Providers (PCPs) adequacy and accessibility will be assessed based on the CMS definition (for instance: Family Medicine, Internal Medicine, General Practice for PCP and Family Medicine, Internal Medicine, and General Practice, Physician Assistant, and Nurse Practitioner for PCP Extended).

Network adequacy and accessibility will be monitored on an ongoing basis which will be no less than quarterly.

Requests to Join Network

Providers may request to join a network of participating providers or Ambetter may solicit their participation based on data or information from varying sources such as:

- Non-Participating Provider report of Authorizations Issued and Claims
- Providing Incoming Requests

- Sales and/or Broker Requests or any other internal requests
- Single Case Agreement Requests from Ambetter Utilization Management Department.
- Gaps Identified by the Quest® software solution

Ambetter maintains a streamlined process to respond to written inquiries from providers seeking inclusion in any of Ambetter's participating provider networks, across all benefit classifications. Similar processes exist for outgoing recruitment efforts and can be found in the internal intake process. The incoming process is as follows:

Step 1: Request to become a participating provider is received by Network Management via online web forms.

Step 2: The Network Management Team evaluates whether an existing agreement is in place, or if one is needed. If one is needed, the appropriate Network Management team member will be assigned to outreach.

Step 3: The negotiator will be assigned the and contracting activity based on specialty, region, and/or health system affiliation.

Step 4: The negotiator will research the provider) and determine whether or not a contract will be offered based on network, specialty, and/or geography.

- i. If yes, the negotiator will reach out to the prospect within 2 (two) weeks of receipt of request to gather any additional information needed to create a provider agreement.
- ii. If a request for participation will not be extended, the negotiator will respond to the requestor to provide the rationale for rejecting participation in any or all networks.

Credentialing: N/A - Credentialing is performed by the hospital or freestanding facility; credentialing is not required by the Health Plan.

Provider Reimbursement

The standard approach for M/S In-Patient In-Network reimbursement can be distinguished by the major facility/provider types:

1. Short Term Acute Care Facilities:

- a. Reimbursed based upon MSDRGs. This methodology is a predictable and known form of reimbursement that controls cost for both payors and providers. While this methodology is appropriate for a Medicare population, it has limitation to that of a Marketplace population (non-exhaustive examples include but not limited to: obstetrics, NICU, MH/SUD Psychiatric Facilities, and deliveries). All reimbursement terms are finalized in mutually agreed upon negotiated rates between the Plan and providers of these services.
- b. Per Diem reimbursement. This methodology is utilized for inpatient in-network services at a daily rate to reimburse services delivered for various member levels of care. Plan follows industry standards to leverage available CMS guidelines regarding the types of services contracted at per diem rates as well as the rates themselves.

c. Case Rate reimbursement. This methodology is utilized for inpatient in-network services when it is agreed upon with providers to bundle related services together at a single mutually acceptable comprehensive rate for treatment.

2. Critical Access Hospitals:

a. Reimbursement is based upon industry standard interim per diem rates established by CMS. This methodology is a predictable and known form of reimbursement that controls costs for both the payor and the provider of this type. While this methodology is appropriate for a Medicare population, it has limitations to that of a Marketplace population.

3. Skilled Nursing Facilities:

a. Reimbursement is based upon industry standard patient driven payment model (LTCDRG). This methodology leverages CMS assigned case mix classification criteria that determines the daily reimbursement rate.

b. Per Diem reimbursement. This methodology is utilized for inpatient in-network services at a daily rate to reimburse services delivered for various member levels of care. Plan follows industry standards to leverage available CMS guidelines regarding the types of services contracted at per diem rates as well as the rates themselves.

4. Long Term Acute Care Hospitals:

a. Reimbursed based upon LTCDRGs. This methodology is a predictable and known form of reimbursement that controls cost for both payors and providers. While this methodology is appropriate for a Medicare population, it has limitation to that of a Marketplace population where the members ability to recuperate is heightened thus potentially reducing the admission LOS. All reimbursement terms are finalized in mutually agreed upon negotiated rates between the Plan and providers of these services.

b. Per Diem reimbursement. This methodology is utilized for inpatient in-network services at a daily rate to reimburse services delivered for various member levels of care. Plan follows industry standards to leverage available CMS guidelines regarding the types of services contracted at per diem rates as well as the rates themselves.

5. Hospitals and Facilities that are excluded from CMS IPPS reimbursement:

a. Reimbursement is excluded from the CMS IPPS reimbursement model for Children's and Cancer Hospitals, Psychiatric Hospitals and Residential Treatment Centers. Services are negotiated by either CMS reported cost to charge ratio terms multiplied by billed charges up to a capitation per diem rate or mutually agreed upon per diem rates.

b. Per Diem reimbursement. This methodology is utilized for inpatient in-network services at a daily rate to reimburse services delivered for various member levels of care. Plan follows industry standards to leverage available CMS guidelines regarding the types of services contracted at per diem rates as well as the rates themselves.

- c. Case Rate reimbursement. This methodology is utilized for inpatient in-network services when it is agreed upon with providers to bundle related services together at a single mutually acceptable comprehensive rate for treatment.

Across these facility/provider types, PLAN utilizes two primary pricing methodologies:

1. DRG/Case Rate: A per-admission reimbursement grouping methodology, with weights based on severity, for inpatient hospital services. PLAN uses the payment rates and methodologies published for each hospital facility as the Standard Pricing.
 - a. Inpatient facility classification: Reimbursement for Inpatient Benefit would be dependent on the hospital's classification with Medicare (i.e., Acute Care, Specialty, Critical Access).
 - i. General Acute Care Hospitals.
 - ii. Critical Access Hospitals: Located in rural area and furnish 24-hour emergency services, 7 days a week, and do not exceed 25 IP beds.
 - iii. Children's Hospitals: Predominately servicing age 21 or younger.
 - iv. Cancer Hospital: PPS exempt are designated by National Cancer Institute, organized primarily for treating/researching cancer, and 50% total discharges have principal diagnosis of cancer.
2. Per Diem: a per-day payment negotiated and mutually agreed to
 - a. Hospital classification: Reimbursement for Inpatient Benefit would be dependent on the hospital's classification with Medicare (i.e. Acute Care, Specialty, Critical Access).
 - b. Inpatient Exempt Unit services unit (Medical Rehab) are reimbursed on a per diem basis. The Exempt unit per diem rate is derived by Medicare and adjusted per hospital facility depending on their individual cost reporting.
 - i. Critical Access Hospitals: In accordance with the Medicare methodology, the Plan prices Inpatient Services at Critical Access Hospitals at a per diem basis. The per diem rate is derived by Medicare and adjusted per hospital facility depending on their individual cost reporting.
 - ii. Specialty Hospitals: In accordance with the Medicare methodology, the Plan prices Inpatient Services at Specialty Hospitals at a per diem basis. The per diem rate is derived by Medicare and adjusted per hospital facility depending on their individual cost reporting.

In writing comparability and stringency analysis:

Access: Step 1: As noted in the response to Step 1, Ambetter uses the same defined terms and process for the Provider Network Access NQTL as applied to M/S conditions as it does for MH/SUD conditions. As noted in the response to Step 1, Ambetter utilizes an integrated process of monitoring network adequacy to drive both assertive outbound provider recruitment and fielding/prioritizing requests from OON providers seeking to join the network. This process is identical for providers of M/S services and MH/SUD services. As such, this NQTL is comparable and no more stringent at Step 1 as applied to MH/SUD services as compared to providers of M/S services.

Step 2/3: As noted in the response to Steps 2 and 3, all factors are the same for MH/SUD and M/S providers. In Step 3, differences arise from the need to apply time and distance standard to the different provider types that deliver MH/SUD vs. M/S services based on product licensure requirements that are set externally and not subject to Plan discretion. However, the time and distance standards are comparable across all geographic unit types creating effective equivalence of stringency in the application of this NQTL to MH/SUD and M/S providers.

Step 4: The processes and strategies outlined in Step 4 are the same for MH/SUD and M/S providers.

Taken together, the facts presented in Steps 1-3 and the facts and analysis presented here in Step 4 support the conclusion that, as written, Ambetter implements the Provider Network Access processes, strategies, evidentiary standards, and other factors to MH/SUD benefits in the classification in a manner that is comparable to and no more stringent than the application of these processes, strategies, evidentiary standards, and other factors to M/S benefits in the classification.

Credentialing: N/A - For both MH/SUD and M/S services, Credentialing is performed by the hospital or freestanding facility, credentialing is not required by the Health Plan. Therefore, the provider credentialing processes, strategies, evidentiary standards, and other factors, as written, for mental health/substance use disorder providers, are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and other factors used in the credentialing procedures for medical surgical providers.

Reimbursement: The reimbursement methodology for the inpatient in-network classification is the same for MH/SUD and M/S services at both the standard pricing methodology and negotiation phases of the process. Although there are M/S and MH/SUD provider-specific payment approaches, as described in Step 4, these methodologies are the same for comparable provider types. In particular, the inpatient M/S and MH/SUD levels of care use all use DRGs, per diems, and/or case rates based on the setting in a comparable manner across each provider setting. In addition, as noted in the responses to Steps 2 and 3, the factors considered in the development of the standard pricing (i.e. the initial offer price) and the factors considered in the negotiation from that standard price, are the same for MH/SUD and M/S inpatient services. As such, we conclude that the provider reimbursement methodology is comparable and no more stringent in its application to MH/SUD inpatient services compared to the application to M/S inpatient services in writing.

In operation comparability and stringency analysis:

Access (see Appendix for full set of operations data):

Findings from the Provider Network Adequacy Report:

- Performance Assessment for Necessary Network Providers
 - These standards include practices for practitioner credentialing and ongoing monitoring of the participating providers that meet the qualifications of applicable state and federal government regulations, applicable standards of accrediting bodies, including the National Committee for Quality Assurance (NCQA), and Plan requirements. Annual reports are created to include the cultural, linguistic, PCP/High Volume/High Impact adequacy, provider adequacy levels and provider to member ratios. A Quality Management Committee meeting is held to review the findings and solutions planned for any negative results to ensure a path for improvement is planned to meet targets.
 - A reporting tool is maintained to track progress in all contracting efforts. Reasons for the contracting engagement along with other key drivers such as specialty and outcomes are captured in this SharePoint tool and easily reportable for constant monitoring by contributing staff negotiators and management.
 - *Because the majority of these measures are focused on professional provider types, these findings are discussed in much greater detail in the Outpatient classification analysis below. See Appendix for a detailed snapshot of the Provider Contracting Tool Summary*
- Compliance with Network Adequacy Standards
 - Ambetter ensures that its members are satisfied with its primary care network by conducting an annual performance assessment and measuring its performance against the standards at least annually. The methodology used to review the number and geographic distribution of primary care physicians, specialists and facility providers is included in the Quest® geographic access tool, which allows for direct measurement of performance. Reports are generated, distributed, and reviewed on a weekly basis. Any gaps in adequacy are actions initiated prior to the next weekly reporting period.
 - Because the majority of these measures are focused on professional provider types, these findings are discussed in much greater detail in the Outpatient classification analysis below. Sample report is attached
 - An analysis of the proportion of counties with network gaps for MH/SUD providers relative to M/S providers found the following:

Georgia	Average Network Adequacy (across all counties)
Inpatient Med/Surg	100%
Inpatient MH/SUD	100%

Conclusions: Ambetter experiences generally low levels of grievance and appeals across all classifications of benefits. The rates are lower for behavioral health services (1 grievances related to access to care) than for medical/surgical services (20 grievances related to access to care). Similarly, Ambetter conducted an analysis of Out of Network (OON) claims to identify potential indicator of gaps in network adequacy. As discussed in Section I.C of the Network Adequacy report, this analysis identified no opportunities for improving network transparency or experience identified from the analysis of out of network claims. Further, as noted below, Ambetter's 2021 number and geographic performance and appointment availability standards for Practitioner Availability were exceeded, including comparable standards. This collective data supports a conclusion that the provider contracting process is implemented in a comparable and no more stringent manner between MH/SUD and M/S services.

Based on the Quest® geographic access tool report, the Ambetter network meets the network access requirements in most counties. Gaps are defined to mean that there are specific provider types that do not meet 90% of the access requirements. As noted in the report, Ambetter does not have a disproportionate number of network adequacy gaps for Med/Surg specialty types as compared with Behavioral Health specialty types, nor are the gaps specific to practitioner geographic distribution or types of practitioners or providers. No gaps in network adequacy were identified for M/S or MH/SUD providers in the Inpatient classification. As such, we conclude that this NQTL type is being implemented, in – operation, in a comparable and no more stringent manner for MH/SUD services compared to M/S services.

Reimbursement: To assess the “in operation” comparability and stringency analysis of the provider reimbursement methodology, the plan monitors multiple metrics to identify whether the practices in establishing the standard pricing and negotiating with individual providers (as described and analyzed above) are inadvertently resulting in discriminatory treatment of MH/SUD providers. The plan monitors the ratio of paid to charge-rates as well as availability data for a wide variety of practitioners to ensure that the reimbursement methodology results in equitable access for patients of MH/SUD services compared to M/S services. The table below includes the paid to charge rate data for the most recent period available and these data are updated at regular intervals. This analysis is also updated when the data are updated.

a. Paid to charge ratios

	<u>M/S</u>	<u>M/S</u>	<u>M/S</u>	<u>MH/SUD</u>	<u>MH/SUD</u>	<u>MH/SUD</u>
<u>Classification - IP</u>	<u>Billed Charges</u>	<u>Payment</u>	<u>Charge Ratio</u>	<u>Billed Charges</u>	<u>Payment</u>	<u>Charge Ratio</u>
2021	\$ 788,714,330	\$ 341,810,604	43%	\$ 21,829,956	\$ 7,338,232	34%

These data demonstrate that participating inpatient MH/SUD providers have been paid a lower percentage of their billed charges relative to participating M/S providers in 2021 (through August, 2022, based on available data). However, no gaps in network adequacy were identified for inpatient MH/SUD providers. Therefore, increases to its reimbursement

rates would not increase member access to these providers, and to the contrary would increase member costs due to the indirect impact on member premiums and the direct impact on coinsurance costs.

We also note that all factors, sources, and evidentiary standards for contracting and reimbursing IP providers are the same for M/S and MH/SUD providers. These data therefore are consistent with a conclusion that Ambetter's application of the Standards for Admission to a Provider Network, Including Reimbursement NQTL is applied comparably and no more stringently to MH/SUD providers relative to M/S providers.

Step 5 – Provide the specific findings and conclusions reached by the group health plan or health insurance issuer with respect to the health insurance coverage, including any results that indicate that the plan or coverage is or is not in compliance with this section

- *This discussion should include citations to any specific evidence considered and any results of analyses indicating that the plan or coverage is or is not in compliance with MHPAEA*

As stated in Step 1 above, all plan document terms that set forth Standards for provider admission to participate in a network, including reimbursement rates are the same for MH/SUD and M/S benefits and providers.

Similarly, as stated in steps 2-4 above, all factors, sources, evidentiary standards, and processes that are used to develop Standards for provider admission to participate in a network, including reimbursement rates, as written and in operation, are the same or comparable for all MH/SUD and M/S benefits and providers, with differences arising only based on external requirements such as NCQA accreditation standards or federal and state licensure requirements.

As discussed in Step 4, Ambetter analyzes a wide range of operations measures to monitor the outcome of the methodologies for Standards for provider admission to participate in a network, including reimbursement rates, and has determined that the outcomes of these methodologies are comparable and no more stringent as applied to MH/SUD providers relative to M/S providers. In particular, the impact of Ambetter's processes, strategies, evidentiary standards, and other factors for designing and applying Standards for provider admission to participate in a network, including reimbursement rates has been to create a network that meets all licensing and accreditation requirements for network adequacy and provider access and availability for both MH/SUD and M/S providers, and that notably includes all IP MH/SUD providers in the counties in which it operates. In addition, Ambetter's access and availability analysis of MH/SUD providers identified no opportunities for improving network transparency or experience identified from the analysis of out of network

claims. At the same time, Ambetter's strategy ensures that reimbursement rates to facility-based MH/SUD and M/S providers are competitive and not excessive in order to mitigate members' cost-sharing exposure where coinsurance rates apply.

Based on the foregoing facts and analyses, the Plan concludes that, under the terms of the plan, as written and in operation, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits in the identified classifications are comparable to, and are applied no more stringently than, those used in applying the limitation with respect to medical/surgical benefits in the same classifications.

NQTL Type: Standards for provider admission to participate in a network, including reimbursement rates	
Classification(s): Outpatient (In-Network)	
Step 1 – Identify the specific plan or coverage terms or other relevant terms regarding the NQTL and a description of all mental health or substance use disorder and medical or surgical benefits to which each such term applies in each respective benefits classification	
<ul style="list-style-type: none"> • Provide a clear description of the specific NQTL, plan terms, and policies at issue • Identify which M/S and MH/SUD benefits are subject to the NQTL 	
Step 1(a): Provide a clear description of the specific NQTL, plan terms, and policies at issue:	
All definitions are the same as stated above in the Inpatient In-Network NQTL	
Step 1(b): Identify the M/S benefits/services for which the NQTL is required:	Step 1(b): Identify the MH/SUD benefits/services for which the NQTL is required:
Access: All benefits and services	Access: Same as M/S
Credentialing: All in-network providers must be credentialed.	Credentialing: Same as M/S
Reimbursement: All benefits and services	Reimbursement: Same as M/S

Step 2 – Identify the factors used to determine that the NQTL will apply to mental health or substance use disorder benefits and medical or surgical benefits

Access:

Ambetter considers the following factors in developing the outpatient provider network admission and/or recruitment standards for M/S and MH/SUD Providers:

- 1. Product License Network Adequacy Requirements
- 2. Provider/Practitioner Licensing
- 3. Geographic Distribution of Providers
- 4. Cultural Needs and Preferences
- 5. Population Ratios
- 6. Availability of High-Volume/High Impact Specialty Providers

Credentialing:

Credentialing requirements for M/S and MH/SUD providers are based on the following factors and evidentiary standards:

- 1. State and federal laws and guidelines (including 42 CFR 438.214 and 42 CFR Part 422.204)
- 2. Accreditation guidelines (NCQA, CMS)
- 3. Credentialing by Georgia Department of Community Health Credentialing Verification Organization (CVO)

Reimbursement: Same as Inpatient In-Network NQTL above

Step 3 – Identify the evidentiary standards used for the factors identified in Step 2, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTL to mental health or substance use disorder benefits and medical or surgical benefits.

- *Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.*
- *To the extent the plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.*

Access:

- 1. **Product License Network Adequacy Requirement:**
 - a. *Evidentiary standard:*
 - i. Access Threshold 90% of members must have access to care for prescribed Specialties.
 - ii. Time or Distance for County Classification:

Commented [DS1]: Explain that PSHP adopts Medicaid credentialing

Specialty Types	Large Metro		Metro		Micro		Rural		CEAC	
	Distance	Time	Distance	Time	Distance	Time	Distance	Time	Distance	Time
M/S										
Allergy and Immunology	15	30	30	45	60	80	75	90	110	125
Cardiology	10	20	20	30	35	50	60	75	85	95
Cardiothoracic Surgery	15	30	40	60	75	100	90	110	130	145
Chiropractor	15	30	30	45	60	80	75	90	110	125
Dental	15	30	30	45	60	80	75	90	110	125
Dermatology	10	20	30	45	45	60	60	75	100	110
Emergency Medicine	10	20	30	45	60	80	60	75	100	110
Endocrinology	15	30	40	60	75	100	90	110	130	145
ENT/Otolaryngology	15	30	30	45	60	80	75	90	110	125
Gastroenterology	10	20	30	45	45	60	60	75	100	110
General Surgery	10	20	20	30	35	50	60	75	85	95
Gynecology, OB/GYN	5	10	10	15	20	30	30	40	60	70
Infectious Diseases	15	30	40	60	75	100	90	110	130	145
Nephrology	15	30	30	45	60	80	75	90	110	125
Neurology	10	20	30	45	45	60	60	75	100	110
Neurosurgery	15	30	40	60	75	100	90	110	130	145
Occupational Therapy	10	20	30	45	60	80	60	75	100	110
Oncology - Medical, Surgical	10	20	30	45	45	60	60	75	100	110
Oncology - Radiation	15	30	40	60	75	100	90	110	130	145
Ophthalmology	10	20	20	30	35	50	60	75	85	95
Orthopedic Surgery	10	20	20	30	35	50	60	75	85	95
Physical Medicine and Rehabilitation	15	30	30	45	60	80	75	90	110	125
Physical Therapy	10	20	30	45	60	80	60	75	100	110
Plastic Surgery	15	30	40	60	75	100	90	110	130	145
Podiatry	10	20	30	45	45	60	60	75	100	110
Primary Care – Adult	5	10	10	15	20	30	30	40	60	70

Primary Care – Pediatric	5	10	10	15	20	30	30	40	60	70
Pulmonology	10	20	30	45	45	60	60	75	100	110
Rheumatology	15	30	40	60	75	100	90	110	130	145
Speech Therapy	10	20	30	45	60	80	60	75	100	110
Urology	10	20	30	45	45	60	60	75	100	110
Vascular Surgery	15	30	40	60	75	100	90	110	130	145
Cardiac Catheterization Services	15	30	40	60	120	160	120	145	140	155
Cardiac Surgery Program	15	30	40	60	120	160	120	145	140	155
Diagnostic Radiology (Freestanding; hospital outpatient; ambulatory health facilities with Diagnostic Radiology)	10	20	30	45	60	80	60	75	100	110
Mammography	10	20	30	45	60	80	60	75	100	110
Outpatient Infusion/Chemotherapy	10	20	30	45	60	80	60	75	100	110
Surgical Services (Outpatient or ASC)	10	20	30	45	60	80	60	75	100	110
Urgent Care	10	20	30	45	60	80	60	75	100	110
MH/SUD										
Outpatient Clinical Behavioral Health (Licensed, accredited, or certified professionals)	5	10	10	15	20	30	30	40	60	70
Psychiatry	10	20	30	45	45	60	60	75	100	110

b. Sources: Network Adequacy Requirements, Reporting, and Monitoring Policy HIM.NTWK.02, 45 C.F.R. 156.230(a)(2), CMS Qualified Health Plan Issuer Application Instructions

2. Provider / Practitioner Licensing:

- a. *Evidentiary standard:* All network providers must demonstrate Professional Competence. For health care practitioners, verification of applicable education and training upon initial credentialing and maintenance of valid professional licensure for practitioner’s field of practice upon recredentialing, which includes requirements for Continuing Medical Education, are accepted as evidence of maintenance of knowledge and ability in practice area(s) for health care practitioner.
- b. *Source:* Practitioner Credentialing & Recredentialing Policy CC.CRED.01

3. Geographic Distribution of Primary Care Providers:

- a. *Evidentiary standard:* Primary Care Providers deliver both M/S and MH/SUD services. The geographic requirements for Primary Care Providers are determined according to provider type.
 - i. Family Practitioners/Internal Medicine/General Medicine - Members will have access to at least one adult primary care physicians as described above.
 - ii. Pediatricians - Members will have access to at least one Pediatric primary care physician (PCP) as described above.
 - iii. Women’s Health Care Providers - Members will have access to at least one women’s health care providers (OB-GYN, Mammography,)as described above.
- b. *Source:* Network Adequacy and Accessibility Requirements, Reporting and Monitoring HIM.NTWK.02, 45 C.F.R. 156.230(a)(2), CMS Qualified Health Plan Issuer Application Instructions

4. Cultural Needs and Preferences:

- a. *Evidentiary standard:*
 - i. The Plan assesses the cultural, ethnic, racial, and linguistic needs of its members at enrollment by capturing information on primary language and any other special needs. The Plan maintains the provided information in its system, which tracks enrollment, language, utilization, claims, referrals and pharmacy information. The availability of practitioners is adjusted within the network (if necessary) based on this information. The Plan utilizes the Provider Directory to notify members of any specialized services, including linguistic capabilities and handicap access, offered by network providers.
- b. *Source:* Cultural Competency and Linguistic Assistance Policy CC.QI.CLAS.29

5. Population Ratios:

- a. *Evidentiary standard:*

Specialty	Ratio
M/S	
Primary Care	1:2,000
Pediatrics	1:2,000
Allergy/Immunology	1:15,000
Cardiology	1:3,700
Endocrinology	1:15,000
Hematology/Oncology	1:15,000
Infectious Disease	1: 15,000
Neurology	1: 15,000
Rheumatology	1: 15,000
General Surgery	1: 15,000
OB/GYN	1:2,000
MH/SUD	

Psychiatry	1: 15,000
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b. Source: Network Adequacy and Accessibility Requirements, Reporting and Monitoring HIM.NTWK.02

6. Availability of High Volume/High Impact Specialty Providers:

a. *Evidentiary standard:*

- i. Pursuant to NCQA definitions, the health plan identifies high-volume specialty care practitioners as those who treat a significant portion of the health plan's members, as identified through analysis of the number of visits, based on claim and encounter data. At a minimum, the following high-volume specialists were identified: obstetricians/gynecologists, psychiatrists, clinical psychologists, and licensed mental health professionals.
- ii. Pursuant to NCQA definitions, evaluation to identify high-impact practitioners utilizes an assessment of conditions with serious consequences for the member, requiring significant health system resources, including high-cost medications and therapy options (i.e., chemotherapy and radiation) and increased inpatient and outpatient medical claims. Oncology was selected as high impact specialists since the care of cancer patients from diagnosis through primary treatment is complex, involving several diagnostic and treatment steps. These steps generally include staging, general medical assessments, definitive therapy (surgery or radiation depending on tumor type and stage) to control local disease, and often adjuvant therapy (i.e., radiation therapy, chemotherapy, hormonal therapy, or immunotherapy) to reduce the risk of recurrence. According to the Journal of the National Cancer Institute, oncologists face challenges of providing comprehensive care to cancer patients across the continuum including significant comorbid conditions or psychosocial issues.
- iii. The table below lists the specialty care practitioner standards for each high-volume and high-impact specialty care practitioner type for whom availability is monitored. The health plan conducts an analysis to identify potential opportunities to improve practitioner availability. For each high volume/high impact specialty provider type, the Plan ensures that at least 90% of members have at least 1 practitioner within the identified time or distance standard.

Specialty Types	Large Metro		Metro		Micro		Rural		CEAC		Provider to member ratio
	Distance	Time	Distance	Time	Distance	Time	Distance	Time	Distance	Time	
High volume specialty: Gynecology, OB/GYN	15	30	40	60	75	100	90	110	130	145	1:5,000
High impact specialty: Oncology	10	20	30	45	45	60	60	75	100	110	1:5,000
High-volume BH prescribing: Psychiatrists	10	20	30	45	45	60	60	75	100	110	1:5,000
High-volume BH non-prescribing: Clinical Psychologists	10	20	30	45	45	60	60	75	100	110	1:5,000
High-volume BH non-prescribing: Licensed MH Professionals	10	20	30	45	45	60	60	75	100	110	1:5,000

b. Source: Availability of Practitioners Annual Assessment

Credentialing:

1. **State and federal laws and guidelines:** State and federal policies, regulations, and laws that are used to determine provider credentialing requirements include, (but are not limited to) provisions contained throughout Georgia Department of Insurance laws, and guidance related to healthcare or mental health parity, and federal laws or regulations (including 42 CFR 438.214 and 42 CFR Part 422.204).
2. **Accreditation Guidelines:** Ambetter applies its credentialing standards in accordance with National Committee for Quality Assurance (NCQA) – CR-1 and Net 5. In addition, State regulatory agencies and the Centers for Medicare (CMS) and Medicaid Services standards are used to ensure that members get access to quality care.
3. **Credentialing by Georgia Department of Community Health Credentialing Verification Organization (CVO)**
 - a. Ambetter accepts credentialing determinations by CVO for providers that participate in Georgia Medicaid programs pursuant to state law and does not apply any further credentialing requirements to these providers.

Reimbursement: Same as Inpatient In-Network NQTL above

Step 4 – Provide the comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to mental health or substance use disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical or surgical benefits in the benefits classification.

- *The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.*
- *If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s).*
- *If the plan’s or issuer’s analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert’s qualifications and the extent to which the plan or issuer ultimately relied upon each expert’s evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.*

In writing comparability and stringency analysis:

Access: Same as M/S, as applicable

Credentialing:

Credentialing: Same as M/S, as applicable

Application Process

Ambetter has credentialing policy and procedures for the initial application process and the recredentialing process, which includes the contents and scope of the application, type and scope of practitioners who qualify for membership, and the initial processing steps and recredentialing processing steps in the credentialing procedure. Ambetter adheres to managed care standards 42 CFR Part 438.214 and 42 CFR Part 422.204, National Committee of Quality Assurance (NCQA) and Centers for Medicare and Medicaid Services (CMS).

All new applicants for appointment, who are contracted to deliver professional services

within the service areas defined by Ambetter and whose professional services meet the defined business needs will be given upon request, an application to participate with Ambetter. Credentialing begins with a Completed Application (“Complete Application”). Ambetter uses the CAQH application which must include basic demographic information including name, NPI, license number, servicing address(s), phone, office hours, accepting new patients, age range, education and training information, work history, affirmation questions and attestation to the correctness of the application.

Practitioners who practice exclusively within a State Licensed facility and who provide care only as a result of members being directed to the hospital or another inpatient setting, do not need to be individually credentialed by Ambetter .

Timeline
Ambetter completes review of the health care professional’s application to participate in the Ambetter Network and shall, within 30 days of receiving a Completed Application to participate in the Ambetter Network, notify the health care professional as to whether s/he is credentialed; or whether additional time is necessary to make a determination because of a failure of a third party to provide necessary documentation, or if additional information is necessary, the notice to the health care professional must identify all additional information needed by the plan to make its determination. In such instances where additional time is necessary because of a lack of necessary documentation, Ambetter makes every effort to obtain such information as soon as possible and makes a final determination within 60 days of receiving the necessary documentation.

State Guidance Related to Credentialing
Ambetter accepts for credentialing the Georgia Uniform Healthcare Practitioner Credentialing Application Form or the CAQH Standardized Credentialing Form.

Ambetter monitors sanction/exclusions of the OIG, SAM/EPLS, Georgia Medicaid Exclusion List, and SSDMF monthly

Forms & Requirements:
Ambetter performs primary source verification of all NCQA required data elements. Below is a list of all acceptable verification sources and the required verification time limit. Please note that where a 180 - day time limit is indicated this means that the verification must be conducted within 180 days prior to Credentials Committee approval date.

The following primary source (unless otherwise noted) verifications will be obtained and documented in the application/reapplication:

ITEM	PRIMARY SOURCE
Valid, Current License	<p><u>All Practitioners:</u></p> <p>Internet verification through the appropriate State Licensing Agency or website</p> <p>Verification of licensure is required in all States where the practitioner provides care to members.</p>
Valid, Current DEA Certificate	<p>Copy of current Drug Enforcement Administration (DEA) Certificate or internet confirmation with the United States Department of Justice Drug Enforcement Administration Office of Diversion Control website.</p> <p>DEA or DEA Coverage Plan (applicable only to those specialties eligible to prescribe controlled substances)</p>
<p>Education and Training: Completion of residency training *Initial Credentialing Only</p>	<p><u>Physician:</u></p> <p>If not board certified, written/verbal verification of the highest level of education is verified directly from the residency program (s) designated by the applicant on the application or confirmation from AMA Physician Master File or the AOA Physician Master File/AOA Official Osteopathic Physician Profile.</p> <p><u>Podiatry:</u></p>

<p>Graduation from Medical School/ Professional School *Initial Credentialing Only</p>	<p>If not board certified, written/verbal confirmation of residency training completion directly from the residency program (s) designated by the applicant on the application.</p> <p><u>Non-Physician Professionals:</u> Not Applicable (residency training is N/A)</p> <p><u>Physician:</u></p> <p>If not Board Certified and did not complete a residency program, written confirmation from Medical School, confirmation from AMA Physician Master File, the AOA Physician Master File/AOA Official Osteopathic Physician Profile designated by the applicant on the application or confirmation from the Educational Commission for Foreign Medical Graduates (ECFMG) for international medical graduates licensed after 1986. May be verified by state licensure if licensing board validates that they primary source verify training at this level.</p> <p><u>Podiatry:</u> Written/verbal confirmation of completion of Podiatry Medical School designated by the applicant on the application. May be verified by state licensure if licensing board validates that they primary source verify training at this level.</p> <p><u>Chiropractor:</u> Written/verbal confirmation of completion of Chiropractic College designated by the applicant on the application. May be verified by state</p>		
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	<p>licensure if licensing board validates that they primary source verify training at this level.</p> <p><u>Non-Physician Professionals:</u> Written/verbal confirmation of professional/graduate school completion or confirmation from the National Student Clearing House designated by the applicant on the application. May be verified by state licensure if licensing board validates that they primary source verify training at this level.</p>		
Board Certification	<p><u>Physician:</u></p> <p>Internet query ABMS Board Certification Credentials Profile; AOA Official Osteopathic Physician Profile Report/AOA Physician Master File or AMA Physician Master File with Internet or written confirmation.</p> <p><u>Podiatry:</u> Written confirmation or Internet query of the American Board of Podiatric Surgery OR the American Board of Foot and Ankle Surgery (formerly American Board of Podiatric Orthopedics).</p> <p><u>Chiropractor:</u> Not Applicable</p> <p><u>Non-Physician Professionals:</u> Not Applicable</p>		
Work History (5 years) *Initial Credentialing Only	<u>All Practitioners:</u>		

	<p>Review CV/resume provided and/or completed Ambetter Provider Application or CAQH Application. Continuity of dates is required.</p> <p>At a minimum, five (5) years of work history is reviewed. If the practitioner has fewer than five (5) years of work history, the time frame starts from the initial licensure date.</p> <p>Each gap in employment exceeding six (6) months is clarified either verbally or in writing. A written explanation is required for employment gaps greater than one (1) year.</p>		
Professional Liability Claims History	<p><u>All Practitioners:</u></p> <p>NPDB electronic query. Obtain written confirmation of the last five (5) years of malpractice settlements or judgments paid on behalf of the practitioner. Residency years are included in this five-year period.</p>		
Malpractice Insurance Coverage	<p><u>All Practitioners:</u></p> <p>Current copy of professional liability insurance, or Attestation within credentialing application with amount of coverage, and effective and end dates is also acceptable.</p>		
Hospital Affiliations	<p><u>If applicable:</u></p> <p>Affirmation of Professional Status confirmation.</p>		
National Practitioner Data Bank	<p><u>All Practitioners:</u></p> <p>NPDB electronic query.</p>		

Professional Regulations/Sanction Information	<u>Physician & Physician Assistant:</u> Any pending or completed actions by the State License Board. <u>Podiatry:</u> Any pending or completed actions by the State License Board <u>Chiropractor:</u> Any pending or completed actions by the State License Board <u>Non-Physician Behavioral Health Care Professionals:</u> Any pending or completed actions by the State License Board <u>Non-Physician Practitioners:</u> Any pending or completed actions by the State License Board Verification of State sanctions, restrictions or limitations on scope of practice through the appropriate State Agency is required in all States where the practitioner provides care to members.		
Sanction Activity by Medicare and Medicaid	<u>All Practitioners:</u> 1. NPDB electronic query 2. The US Department of Health & Human Services Office of Inspector General (OIG): List of Excluded Individuals/Entities (LEIE)_(OIG); http://exclusions.oig.hhs.gov/ 3. The Georgia Medicaid Exclusions List 4. System for Award Management (SAM) (EPLS);		

	<p>https://www.sam.gov/content/home.</p> <p>5. The Centers for Medicare & Medicaid Services (CMS) - CMS Preclusion List.</p> <p>6. Social Security Administration Death Master File</p>		
National Provider Identifier (NPI)	<p><u>All Practitioners:</u></p> <p>National Plan Provider Enumeration System (NPPES); https://npiregistry.cms.hhs.gov.</p>		
Application/Reapplication	<p><u>All Practitioners:</u></p> <p>Indicate on application/reapplication:</p> <ol style="list-style-type: none"> 1. Reasons for inability to perform the essential functions of the position, 2. Lack of present illegal drug use, 3. History of loss of license and felony convictions, 4. History of loss or limitation of privileges or disciplinary actions, 5. Current malpractice insurance coverage, 6. Current and signed attestation confirming the correctness and completeness of the application. 		
<p>Approved practitioner sites and their staff are scheduled for the Practitioner orientation at which time they receive their Provider Manual.</p>			

Verification documentation in the file can be either written or verbal and will include copies of the credentialing information. A dated checklist indicating for each verification the source used, the date of the verification and the computer-generated identification of the person who verified the information.

The information/verifications collected and completed must be valid and current and shall not be more than 180 days old at the time of Committee review unless otherwise noted.

Reimbursement:

As part of the generalized standard approach of provider reimbursement, the standard approach for Out-Patient In-Network reimbursement can be described by the major facility/provider types and is applicable when mutually agreed upon:

- 1. Short Term Acute Care Facilities:
 - a. Ambulatory Payment Classification (APC). APC is an industry standard methodology established by CMS that group services into a single reimbursement rate.
 - b. Per Diem reimbursement. This methodology is utilized for outpatient in-network services at a daily rate to reimburse services delivered for various member levels of care. Plan follows industry standards to leverage available CMS guidelines regarding the types of services contracted at per diem rates as well as the rates themselves.
 - c. Case Rate reimbursement. This methodology is utilized for outpatient in-network services when it is agreed upon with providers to bundle related services together at a single mutually acceptable comprehensive rate for treatment.
 - d. Reimbursed based upon Fee For Service (FFS). FFS methodology is an industry standard methodology with CMS guidelines that outline specific services, rates based upon time intervals of services for applicable provider types.

Reimbursement:

Same as M/S, as applicable

- 2. Critical Access Hospitals:**
 - a.** Reimbursement is based upon industry standard Medicare in effect on date of service Cost to Charge Ratio. While this methodology is appropriate for a Medicare population, it has limitations to that of a Marketplace population.
 - b.** Per Diem reimbursement. This methodology is utilized for outpatient in-network services at a daily rate to reimburse services delivered for various member levels of care. Plan follows industry standards to leverage available CMS guidelines regarding the types of services contracted at per diem rates as well as the rates themselves.
 - c.** Case Rate reimbursement. This methodology is utilized for outpatient in-network services when it is agreed upon with providers to bundle related services together at a single mutually acceptable comprehensive rate for treatment.
 - d.** Reimbursed based upon Fee For Service (FFS). FFS methodology is an industry standard methodology with CMS guidelines that outline specific services, rates based upon time intervals of services for applicable provider types.
- 3. Skilled Nursing Facilities:**
 - a.** Medicare does not cover services delivered in an outpatient setting for Skilled Nursing facilities. This provider type has delivered outpatient therapy (PT/OT/ST) services for their respective communities.
 - b.** Reimbursed based upon Fee For Service (FFS). FFS methodology is an industry standard methodology with CMS guidelines that outline specific services, rates based upon time intervals of services for applicable provider types.
- 4. Practitioner Services (PCP/Specialist)**

- a. Reimbursed based upon Fee For Service (FFS). FFS methodology is an industry standard methodology with CMS guidelines that outline specific services, rates based upon time intervals of services for applicable provider types.

5. Ancillary Services

- a. DMEPOS, LAB, Pharmacy, Radiology. Reimbursed based upon Fee For Service (FFS). FFS methodology is an industry standard methodology with CMS guidelines that outline specific services, rates based upon time intervals of services for applicable provider types.
- b. Ambulance. Reimbursed based on CMS Ambulance Fee Schedule with CMS Guidelines that outline the reimbursement, geographic area adjustments and requirements.
- c. Home Health. Reimbursed based on CMS Patient Driven Grouping Model. PDGM have 30 days periods and are categorized into 432 case mix periods for adjusting the payment. Per Diem reimbursement. This methodology is utilized for in-network services at a daily rate to reimburse services delivered for various member levels of care. Plan follows industry standards to leverage available CMS guidelines regarding the types of services contracted at per diem rates as well as the rates themselves
- d. Hospice. Reimbursed based on the Hospice Prospective Payment System where each day of hospice benefit is assigned to a Base Payment Rate and adjusted for geographic factors. Per Diem reimbursement. This methodology is utilized for in-network services at a daily rate to reimburse services delivered for various member levels of care. Plan follows industry standards to leverage available CMS guidelines regarding the types of services contracted at per diem rates as well as the rates themselves
- e. Home Infusion. CMS pays only 6 home infusion therapy HCPCS G Codes and are adjusted by the Geographically Adjustment that mostly cover for professional services. Per Diem reimbursement. This methodology is utilized for in-network services at a daily rate to reimburse services delivered for various member levels of care. Plan follows

industry standards to leverage available CMS guidelines regarding the types of services contracted at per diem rates as well as the rates themselves. Based on S Codes

6. Children's & Cancer Hospitals:
 - a. Ambulatory Payment Classification (APC). APC is an industry standard methodology established by CMS that group services into a single reimbursement rate.
 - b. Case Rate reimbursement. This methodology is utilized for outpatient in-network services when it is agreed upon with providers to bundle related services together at a single mutually acceptable comprehensive rate for treatment.
 - c. Reimbursed based upon Fee For Service (FFS). FFS methodology is an industry standard methodology with CMS guidelines that outline specific services, rates based upon time intervals of services for applicable provider types.
7. Ambulatory Surgical Center CMS pays ASC based on assigned relative weights to APC's in the ASC Medicare Fee Schedule and adjusted based on their Geographical Area.

Across these facility/provider types, PLAN utilizes two primary pricing methodologies:

1. Standard Pricing
 - a. CPT FFS: Ambulatory Payment Classification Group (APC)
 - b. Payment benchmarks (Medicare): Medicare RBRVS published fee schedule or other applicable Medicare published fee schedules.
2. Per Diem/Case Rate: a per-day, negotiated and mutually agreed to all-inclusive payment that encompasses all services rendered per daily occurrence of treatment
 - a. Hospital classification: Reimbursement for outpatient in-network benefits would be dependent on the hospitals classification with Medicare (i.e. Acute Care, Specialty,

Critical Access, ambulatory surgery center, Urgent Care facility) which determines the scope of services inclusive to the per diem payment and subsequent rate setting.

As written comparability and stringency analysis:

Access (see Appendix for full set of operations measures data):

Findings from the Provider Network Adequacy Report:

- Performance Assessment for Necessary Network Providers
 - These standards include practices for practitioner credentialing and ongoing monitoring of the participating providers that meet the qualifications of applicable state and federal government regulations, applicable standards of accrediting bodies, including the National Committee for Quality Assurance (NCQA), and Plan requirements. Annual reports are created to include the cultural, linguistic, PCP/High Volume/High Impact adequacy, provider adequacy levels and provider to member ratios. A Quality Management Committee meeting is held to review the findings and solutions planned for any negative results to ensure a path for improvement is planned to meet targets.
 - A reporting tool is maintained to track progress in all contracting efforts. Reasons for the contracting engagement along with other key drivers such as specialty and outcomes are captured in this SharePoint tool and easily reportable for constant monitoring by contributing staff negotiators and management.
 - *See Appendix for a detailed snapshot of the Provider Contracting Tool Summary*

- Compliance with Network Adequacy Standards

- Ambetter ensures that its members are satisfied with its primary care network by conducting an annual performance assessment and measuring its performance against the standards at least annually. The methodology used to review the number and geographic distribution of primary care physicians, specialists and facility providers is included in the Quest® geographic access tool, which allows for direct measurement of performance. Reports are generated, distributed, and reviewed on a weekly basis. Any gaps in adequacy are actions initiated prior to the next weekly reporting period.
- Because the majority of these measures are focused on professional provider types, these findings are discussed in much greater detail in the Outpatient classification analysis below. Sample report is attached
- An analysis of the proportion of counties with network gaps for MH/SUD providers relative to M/S providers found the following:

Georgia	Average Network Adequacy (across all counties)
Inpatient Med/Surg	100%
Inpatient MH/SUD	100%

Please also see Provider Availability Analysis below

Conclusions: Ambetter experiences generally low levels of grievance and appeals across all classifications of benefits. The rates are lower for behavioral health services (1 grievances related to access to care) than for medical/surgical services (20 grievances related to access to care). Similarly, Ambetter conducted an analysis of Out of Network (OON) claims to identify potential indicator of gaps in network adequacy. As discussed in Section I.C of the Network Adequacy report, this analysis identified no opportunities for improving network transparency or experience identified from the analysis of out of network claims. Further, as noted below, Ambetter’s 2021 number and geographic performance and appointment availability standards for Practitioner Availability were exceeded, including comparable standards. This collective data supports a conclusion that the provider contracting process is implemented in a comparable and no more stringent manner between MH/SUD and M/S services.

Based on the Quest® geographic access tool report, the Ambetter network meets the network access requirements in most counties. Gaps are defined to mean that there are specific provider types that do not meet 90% of the access requirements. As noted in the report, Ambetter does not have a disproportionate number of network adequacy gaps for Med/Surg specialty types as compared with Behavioral Health specialty types, nor are the gaps specific to practitioner geographic distribution or types of practitioners or providers. The average network adequacy for the Inpatient Med/Surg and Inpatient MH/SUD categories is virtually identical. In fact, Ambetter met 100% adequacy for behavioral health practitioners in all 159 Georgia Counties except for psychologists in 5 rural micro counties (Ben Hill, Coffee, Laurens, Pierce, and Toombs) where psychologists are not available. Similarly, Ambetter met 100% adequacy for primary care practitioners except for pediatricians in 16 micro rural counties (butts, Chattooga, Cooks, Dade, Elbert, Evans, Haralson, Harris, Lanier, McDuffie, Morgan, Pierce, Polk, Putman, Tattnall, and Toombs) where there are no pediatricians that met the geographic standard. As such, we conclude that this NQTL type is being implemented, in –operation, in a comparable and no more stringent manner for MH/SUD services compared to M/S services.

Credentialing:

The provider credentialing processes and strategies, as written, for mental health/substance use disorder providers, are comparable to and applied no more stringently than the processes and strategies used in the credentialing procedures for medical surgical providers. For both MH/SUD and M/S services, the credentialing process begins with a completed application. The application requirements are comparable for MH/SUD and M/S services and differ only in that the credentials are customized to the needs and specialty of the provider. Overall, the process followed is the same for both MH/SUD and M/S services. The Plan strives to complete the credentialing process within 60 days of a complete application from the provider. In the state of Georgia to ensure administrative simplification, Ambetter utilizes the credentialing certification for providers that are credentialed by the NCQA accredited Medicaid Credentialing Verification Organization (CVO).

The Plan relies upon (1) State and federal laws and guidelines and (2) accreditation guidelines in creating its provider credentialing processes in writing. The Plan considers Georgia laws and guidance related to parity, and federal laws or regulations (including 42 CFR 438.214 and 42 CFR Part 422.204). The Plan’s credentialing guidelines are based on CMS standards and NCQA guidelines. These factors and evidentiary standards are identical for MH/SUD and M/S services, and are therefore, comparable, and no more stringent.

Reimbursement: The reimbursement methodology for the outpatient in-network classification is the same for MH/SUD and M/S services at both the standard pricing methodology and negotiation phases of the process. Although there are M/S and MH/SUD provider-specific payment approaches for outpatient services in a manner similar to the inpatient classification, as described in Step 4, these methodologies are not discriminatory in their differences. In particular, the inpatient M/S and MH/SUD levels of care use all use FFS codes for professional and ancillary services and a mix of APCs, per diems, and case rates for facility-based outpatient services in a comparable manner across each provider setting. In addition, as noted in the responses to Steps 2 and 3, the factors considered in the development of the standard pricing (i.e. the initial offer price) and the factors considered in the negotiation from that standard price, are the same for MH/SUD and M/S outpatient services. As such, we conclude that the provider reimbursement methodology is comparable and no-more stringent in its application to MH/SUD inpatient services compared to the application to M/S outpatient services in writing.

In operation:

- Credentialing:** Review of credentialed providers demonstrated that Ambetter met the following timelines:
- **M/S:** On average, all M/S providers were credentialed by Ambetter within 9 days of a complete application
 - **MH/SUD:** On average all MH/SUD providers were credentialed by Ambetter within 9 days of a complete application

Ongoing Monitoring: Ambetter monitors sanction/exclusions of the OIG, SAM/EPLS, Georgia Medicaid Exclusion List, and SSDMF monthly for behavioral health practitioners and medical/surgical providers.

Quality Audits: Ambetter has a quality audit team in the Credentialing Department that reviews a subset of behavioral health, medical/surgical provider credentialing files to ensure credentialing standards are met.

Reimbursement:

To assess the “in operation” comparability and stringency analysis of the provider reimbursement methodology, the plan monitors multiple metrics to identify whether the practices in establishing the standard pricing and negotiating with individual providers (as described and analyzed above) are inadvertently resulting in outcomes that may signal a need to re-evaluate the underlying factors, sources, evidentiary standards, or processes to ensure parity compliance. Three key outcomes measures of comparability of outpatient provider reimbursement rates are paid-to-charge ratios, comparison to Medicare fee schedule rates for office visit service codes that are commonly billed by both MH/SUD and M/S providers, and comparison to Medicare fee schedule rates across all relevant service codes for the identified MH/SUD and M/S provider types.

Paid to charge ratios

	M/S	M/S	M/S	MH/SUD	MH/SUD	MH/SUD
Classification	Billed Charges	Payment	Charge Ratio	Billed Charges	Payment	Charge Ratio
OP-facility 2021)	\$ 1,699,039,788.65	\$ 441,908,151.96	32%	\$27,732,769.97	\$3,051,663.05	22%
Prof 2022 (YTD)	\$ 721,441,354.99	\$ 281,122,721.24	39%	\$27,610,751.43	\$12,894,507.84	47%

The plan monitors these ratios on the presumption that the size of the “discount” of the actual paid rate relative to the rate charged by the provider provides evidence of the aggressiveness of the plan’s pricing strategy, and that the comparability of these ratios between M/S and MH/SUD provider types therefore provides evidence of the comparability of the impact or outcome of the plan’s pricing strategy for these provider types. The data above indicates that for outpatient facility services, the current paid-to-charge ratios are lower for MH/SUD OP-facility providers (22%) relative to M/S OP-facility providers (32%). However, the Plan network adequacy for MH/SUD OP-facility providers 100% in the counties in which it operates, so increasing reimbursement to these MH/SUD provider types would not serve to increase their network participation.

For OP professional providers, with the Plan’s data analysis indicates a higher paid-to-charge ratio OP professional MH/SUD providers (47%) than for OP professional M/S providers (39%).

These paid-to-charge ratio data therefore support a conclusion that Ambetter’s application of the Standards for Admission to a Provider Network, Including Reimbursement NQTL is applied comparably and no more stringently to MH/SUD providers relative to M/S providers.

Comparison by CPT Codes and Total Average Payment as a Percentage of Medicare Analysis (data from Calendar Year 2021:

Table 1: Comparability of common office visit codes

Specialty	CPT Code	Average Plan rate for Commercial	Medicare FFS rate for GA	Plan rate as a percentage of Medicare
MD				
Orthopedic Surgery	99203	\$146.40	\$109.68	133%
	99213	\$116.12	\$88.49	131%
Cardiologists	99203	\$163.87	\$109.33	150%
	99213	\$119.55	\$88.17	136%
Internists MD	99203	\$150.67	\$109.36	138%
	99213	\$112.49	\$87.21	129%
Endocrinologists	99203	\$163.36	\$109.40	149%
	99213	\$122.85	\$87.58	140%
Gastroenterologist	99203	\$167.21	\$110.30	152%
	99213	\$124.89	\$87.69	142%
Neurologists	99203	\$160.72	\$108.70	148%
	99213	\$121.16	\$87.43	139%
Pediatrician	99203	\$231.81	\$111.79	207%
	99213	\$115.78	\$89.43	129%
Dermatologists	99203	\$139.07	\$111.07	125%
	99213	\$108.45	\$89.51	121%

Specialty	CPT Code	Average Plan rate for Commercial	Medicare FFS rate for GA	Plan rate as a percentage of Medicare
MD				
Psychiatrists	99203	\$115.15	\$108.60	106%
	99213	\$77.45	\$80.85	96%

Doctoral

Doctoral

Podiatrists	99203	\$141.52	\$111.52	127%
	99213	\$112.99	\$89.67	126%
Chiropractor	99203	\$114.89	\$107.49	107%
	99213	\$90.61	\$85.05	107%

Psychologists	90832	\$93.16	\$73.75	126%
	90791	\$132.02	\$164.58	80%

Masters				
Occupational Therapy	97165	\$104.53	\$100.32	104%
	97166	\$89.84	\$98.51	91%
	97167	\$81.39	\$98.60	83%
	97168	\$58.70	\$69.64	84%
Physical Therapy	97161	\$91.74	\$99.50	92%
	97162	\$81.24	\$97.81	83%
	97163	\$80.97	\$99.21	82%
	97164	\$54.79	\$68.04	81%
Speech Therapy	Initial Office Visit Codes do not exist.	N/A	N/A	N/A

Masters				
LCSW	90832	\$63.89	\$57.35	111%
	90791	\$99.29	\$124.84	80%

To summarize these findings, the following weighted averages were calculated:

- Table 1- Physician providers
 - Psychiatrists Plan Rate for CPT Code 99203 and 99213 as a % of Medicare is **106%** and **96%**
 - M/S physicians average Plan Rate for the identified CPT codes as a % of Medicare is **142%**

- Table 1- Doctoral providers
 - Psychologists average Plan Rate as a % of Medicare for CPT codes 90791 and 90832 is **126%** and **80%**

- Doctoral M/S providers average Plan Rate for the identified CPT codes as a % of Medicare is **117%**
- Table 1- Masters providers
 - LCSW average Plan Rate as a % of Medicare for CPT codes 90791 and 90832 is **111%** and **80%**
 - Masters M/S providers average Plan Rate for the identified CPT codes as a % of Medicare is **88%**

Table 2. Total Average Payment as a Percentage of Medicare (rounded to nearest %)

Provider Type	% of Medicare actual allowed	Provider Type	% of Medicare actual allowed
MD		MD	
Internist	138%	Psychiatrist	97%
Family practice	128%		
Doctoral		Doctoral	
Chiropractor (DC)	104%	Psychologist	86%
Podiatrist (DPM)	127%		
Optometrist (OD)	150%		
Masters		Masters	
Occupational Therapy	103%	CRN Clinical Nurse Spec - Mental Health	81%
Physical Therapy	97%	Licensed Professional Counselor	74%

Speech Therapy	81%	Marriage and Family Therapist (LMFC)	83%
CRN Clinical Nurse Spec	148%	Licensed Social Worker	88%
CRN Practitioner	133%	LCSW	88%
CRNP PCP	126%	Master's Level Therapist	83%

- Table 2- MD
 - MH/SUD MD % of Medicare Actual Allowed average is **97%**
 - M/S MD % of Medicare Actual Allowed average is **133%**
- Table 2- Doctoral
 - MH/SUD Doctoral % of Medicare Actual Allowed average is **86%**
 - M/S Doctoral % of Medicare Actual Allowed average is **127%**
- Table2- Masters
 - MH/SUD Masters % of Medicare Actual Allowed average is **83%**
 - M/S Masters % of Medicare Actual Allowed average is **115%**

Thus for all identified provider types, using Medicare reimbursement rates as a benchmark or common denominator for comparison, significant variability exists across reimbursement by code and by provider type. Comparing MH/SUD professional providers to M/S professional providers with the same level of education and analyzing reimbursement for all services for which Medicare fee schedule rates are available as a benchmark, on average MH/SUD providers are paid a lower comparable or higher percentage of the Medicare rate than M/S providers. However, as noted above, when billed charges are used as the common denominator for comparison, the Plan's analysis indicates that MH/SUD professional providers are paid a higher rate than M/S providers. In addition, as described in the next section below, network gaps were identified for MH/SUD providers at a comparable rate to M/S providers, indicating that the impact of the Plan's reimbursement rates on the provider network is comparable between MH/SUD and M/S providers. ***These data therefore support a conclusion that Ambetter's application of the Standards for Admission to a Provider Network, Including Reimbursement NQTL is applied comparably and no more stringently to MH/SUD providers relative to M/S providers.***

d. Provider availability analysis

Introduction

Managed care health plans often require enrollees to utilize a designated practitioner network. The organization must ensure there are adequate numbers and geographic distribution of primary care, behavioral health, and specialty care practitioners to meet enrollee needs. Ambetter monitors practitioner availability annually against established standards, and initiates actions, as needed, to improve practitioner availability. This report describes the monitoring methodology, results, analysis, and actions for the period of January 1, 2021, through December 31, 2021.

Availability of Primary Care, Specialty Care and Behavioral Health Care Practitioners

Practitioner availability monitoring is completed for primary care practitioners (PCPs), high-volume and high-impact specialty care practitioners (SCPs), and high-volume behavioral health (BH) practitioner types. The health plan defines the mechanism utilized to monitor the type, number and geographic distribution of primary care, high-volume and high-impact specialty care, and high-volume behavioral healthcare practitioners as applicable to monitor the adequacy of the network and how effectively this network meets the needs, preferences, and diversity of the health plan's enrollment.

Standards and Methodology

To evaluate the availability of practitioners who provide primary care, high-volume and high-impact specialty care and high-volume behavioral healthcare services, the health plan annually monitors the following:

- Ratio of number of each type of practitioners to number of enrollees
- Geographic distribution of each type of practitioner (distance and/or driving time to practitioner's office)

Findings of the Ambetter Network Adequacy Report

Section I: Primary Care

Ambetter defines primary care practitioners as family practitioners, general practitioners, pediatricians, and internists. Primary care providers are those that fully accept the duties of a PCP and can be designated as an enrollee’s assigned PCP.

Table 2 lists the primary care practitioner standards, results, and determines if the goal was met for each PCP type for whom availability is monitored. The health plan conducts an analysis to identify potential opportunities to improve practitioner availability.

Section II: Specialty Care

Ambetter identifies high-volume specialty care practitioners as those who treat a significant portion of the health plan’s enrollees, as identified through analysis of the number of visits, based on claim and encounter data. At a minimum, high-volume specialists were identified as Obstetrics & Gynecology (OB/GYN).

Evaluation to identify high-impact practitioners utilizes an assessment of conditions with serious consequences for the enrollee, requiring significant health system resources, including high-cost medications and therapy options (i.e., chemotherapy and radiation) and increased inpatient and outpatient medical claims. Oncology was selected as high impact specialists since the care of cancer patients from diagnosis through primary treatment is complex, involving several diagnostic and treatment steps. These steps generally include staging, general medical assessments, definitive therapy (surgery or radiation depending on tumor type and stage) to control local disease, and often adjuvant therapy (i.e., radiation therapy, chemotherapy, hormonal therapy, or immunotherapy) to reduce the risk of recurrence. According to the Journal of the National Cancer Institute, oncologists face challenges of providing comprehensive care to cancer patients across the continuum including significant comorbid conditions or psychosocial issues.

Section III: Behavioral Healthcare

Ambetter identifies high-volume behavioral healthcare practitioners through analysis of the number of visits, based on claim and encounter data. High-volume behavioral health specialties based on volume of healthcare visits were: Prescribing Psychiatrists and Non-prescribing Clinical Psychologists and Licensed Mental Health Practitioner (LMHP) including Clinical Social Workers, Professional Counselors, Marriage & Family Therapists, etc.

Table 4 lists the BH practitioner standards, results, and determines if the goal was met for each high-volume behavioral healthcare practitioner type for whom availability is monitored. The health plan conducts an analysis to identify potential opportunities to improve practitioner availability.

Practitioner Numeric and Geographic Standards and Results

The tables below list the availability standards and results for the indicated practitioner type and determines if the goal was met for each practitioner type for whom availability is monitored. The health plan conducts an analysis to identify potential opportunities to improve practitioner availability.

Table 2: Primary Care Practitioner Numeric and Geographic Standards and Results

Practitioner Type Primary Care	Standards – Goal 90%	2021 Results	Goal Met?
Primary Care Practitioners: All	Enrollees have at least 1 PCP within 5 miles or 10 minutes of the member's home in Large Metro counties	99.10%	Yes
	Enrollees have at least 1 PCP within 10 miles or 15 minutes of the member's home in Metro counties	97.80%	Yes
	Enrollees have at least 1 PCP within 20 miles or 30 minutes of the member's home in Micro counties	99.90%	Yes
	Enrollees have at least 1 PCP within 30 miles or 40 minutes of the member's home in Rural counties.	100%	Yes
	Enrollees have at least 1 PCP within 60 miles or 70 minutes of the member's home in CEAC counties.	100%	
	At least 1 PCP per 2,500 enrollees	1.153.4	Yes
Primary Care Practitioners:	Enrollees have at least 1 FP/ GP within 5 miles or 10 minutes of the member's home in Large Metro counties	99.10%	Yes

Practitioner Numeric and Geographic Standards and Results

The tables below list the availability standards and results for the indicated practitioner type, and determines if the goal was met for each practitioner type for whom availability is monitored. The health plan conducts an analysis to identify potential opportunities to improve practitioner availability.

Table 4: BH Practitioner Geographic and Numeric Standards and Results

Practitioner Type Primary Care	Standards – Goal 90%	2021 Results	Goal Met?
High-volume BH Prescribing Practitioners: Psychiatrists Obstetrics & Gynecology (OB/GYN)	Enrollees have at least 1 Psychiatrists within 10 miles or 20 minutes of the member's home in Large Metro counties.	99%	Yes
	Enrollees have at least 1 Psychiatrists within 30 miles or 45 minutes of the member's home in Metro counties	100%	Yes
	Enrollees have at least 1 Psychiatrists within 45 miles or 60 minutes of the member's home in Micro counties.	100%	Yes
	Enrollees have at least 1 Psychiatrists within 60 miles or 75 minutes of the member's home in Rural counties.	100%	Yes
	Enrollees have at least 1 Psychiatrists within 100 miles or 110 minutes of the member's home in CEAC counties	100%	Yes
	At least 1 Psychiatrist per 5,000 members	1:607.1	Yes
	High-volume BH Non-prescribing Practitioners:	Enrollees have at least 1 Psychologists 10 miles or 20 minutes of the member's home in Large Metro counties.	99.8%

Family/ General Practitioners (FP/GP)	Enrollees have at least 1 FP/ GP within 10 miles or 15 minutes of the member's home in Metro counties.	97.40%	Yes	Clinical Psychologists	Enrollees have at least 1 Psychologists 30 miles or 45 minutes of the member's home in Metro counties.	98.0%	Yes	
	Enrollees have at least 1 FP/ GP within 20 miles or 30 minutes of the member's home in Micro counties.	99.70%	Yes		Enrollees have at least 1 Psychologists within 45 miles or 60 minutes of the member's home in Micro counties.	98%	Yes	
	Enrollees have at least 1 FP/ GP within 30 miles or 40 minutes of the member's home in Rural counties	100%	Yes		Enrollees have at least 1 Psychologists within 60 miles or 75 minutes of the member's home in Rural counties.	100%	Yes	
	Enrollees have at least 1 FP/GP within 60 miles or 70 minutes of the member's home in CEAC counties.	100%			Enrollees have at least 1 Psychologists within 100 miles or 110 minutes of the member's home in CEAC counties.	100%	Yes	
	At least 1 FP/ GP per 2,500 enrollees	1:276.8	Yes		At least 1 Psychologist per 5,000 members	1:408.4	Yes	
Primary Care Practitioners:	Enrollees have at least 1 Internal Medicine Practitioner within 5 miles or 10 minutes of the member's home in Large Metro counties.	98.20%	Yes		High-volume BH Non-prescribing Practitioners: Licensed Mental Health Professionals (LMHP)	Enrollees have at least 1 LMHP within 10 miles or 20 minutes of the member's home in Large Metro counties.	99.8%	Yes
Internal Medicine (IM) Practitioners	Enrollees have at least 1 Internal Medicine Practitioner within 10 miles or 15 minutes of the member's home in Metro counties	94.00%	Yes			Enrollees have at least 1 LMHP within 30 miles or 45 minutes of the member's home in Metro counties.	98.0%	Yes
	Enrollees have at least 1 Internal Medicine Practitioner within 20 miles or 30 minutes of the member's home in Micro counties	94.50%	Yes			Enrollees have at least 1 Psychologists within 45 miles or 60 minutes of the member's home in Micro counties.	98%	Yes
	Enrollees have at least 1 Internal Medicine Practitioner within 30 miles or 40 minutes of the member's home in Rural counties.	100%	Yes			Enrollees have at least 1 LMHP within 45 miles or 60 minutes of the member's home in Micro counties.	100%	Yes
	90% of members have at least 1 Internal Medicine Practitioner within 60 miles or 70 minutes of the member's home in CEAC counties.	100%	yes			Enrollees have at least 1 LMHP within 60 miles or 75 minutes of the member's home in Rural counties.	100%	Yes
	At least 1 Internal Medicine Practitioner per 2,500 members	06:44.1	Yes					

Primary Care Practitioners:	Enrollees have at least 1 Pediatrics Practitioner within 5 miles or 10 minutes of the member's home in Large Metro counties.	93.80%	Yes
Pediatrics Practitioners (PEDS)	Enrollees have at least 1 Pediatrics Practitioner within 10 miles or 15 minutes of the member's home in Metro counties.	93.70%	Yes
	Enrollees have at least 1 Pediatrics Practitioner within 20 miles or 30 minutes of the member's home in Micro counties.	85.80%	No
	Enrollees have at least 1 Pediatrics Practitioner within 30 miles or 40 minutes of the member's home in Rural counties	90.00%	Yes
	Enrollees have at least 1 Pediatrics Practitioner within 60 miles or 70 minutes of the member's home in CEAC counties.	100.00%	Yes
	At least 1 Pediatrics Practitioner per 2,500 enrollees	1:624.7	Yes

	Enrollees have at least 1 LMHP within 100 miles or 110 minutes of the member's home in CEAC counties.	100%	Yes
	At least 1 Psychologist per 5,000 members	1:408.4	Yes

A. Results and Analysis of the Availability of High-volume & High-impact Specialty Care Practitioners

Table 3: Specialty Care Practitioner Numeric and Geographic Standards and Results

Practitioner Type Primary Care	Standards – Goal 90%	2021 Results	Goal Met?
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High-volume Specialty Care Practitioners: Obstetrics & Gynecology (OB/GYN)	Enrollees have at least 1 OB/GYN within 15 miles or 30 minutes of the enrollee's home in Large Metro areas.	100%	Yes
	Enrollees have at least 1 OB/GYN within 40 miles or 60 minutes of the enrollee's home in Metro areas.	100%	Yes
	Enrollees have at least 1 OB/GYN within 75 miles or 100 minutes of the enrollee's home in Micro areas.	100%	Yes
	Enrollees have at least 1 OB/GYN within 90 miles or 110 minutes of the enrollee's home in Rural areas.	100%	Yes
	Enrollees have at least 1 OB/GYN within 130 miles or 145 minutes of the member's home in CEAC counties	100%	
	At least 1 OB/GYN per 5,000 enrollees	1:402.6	Yes
High-impact Specialty Care Practitioners: Oncologists	Enrollees have at least 1 Oncologist within 10 miles or 20 minutes of the member's home in Large Metro counties.	99.7%	Yes
	Enrollees have at least 1 Oncologist within 30 miles or 45 minutes of the member's home in Metro counties.	99.9%	Yes
	Enrollees have at least 1 Oncologist within 45 miles or 60 minutes of the member's home in Micro counties.	100%	Yes
	Enrollees have at least 1 Oncologist within 60 miles or 75 minutes of the member's home in Rural counties.	100%	Yes

	Enrollees have at least 1 Oncologist within 100 miles or 110 minutes of the member's home in CEAC counties.	100%	Yes	
	At least 1 FP/ GP per 2,500 enrollees	1:525.0	Yes	

The data above demonstrate that Ambetter's network adequacy for MH/SUD providers exceeded the network adequacy for Primary Care and High Volume/High Impact Specialty Care Medical/Surgical providers.

Specifically, for this analysis period, the health plan met the goal for the ratio standards for all MH/SUD practitioner types assessed and for all but one of the M/S provider types assessed. Goals for each geographic area reviewed in this analysis were also met for all prescribing and non-prescribing BH practitioner types observed, though some gaps were identified for M/S providers. Although the goals were met for BH providers, the health plan continues to recruit, contract, and credential all available non-par BH practitioners as new practices enter the service area. The health plan also continues to monitor practitioner availability and address any gaps in BH practitioner availability.

These data support a conclusion that Ambetter's application of the Standards for Admission to a Provider Network, Including Reimbursement NQTL is applied comparably and no more stringently to MH/SUD providers relative to M/S providers.

Step 5 – Provide the specific findings and conclusions reached by the group health plan or health insurance issuer with respect to the health insurance coverage, including any results that indicate that the plan or coverage is or is not in compliance with this section

- This discussion should include citations to any specific evidence considered and any results of analyses indicating that the plan or coverage is or is not in compliance with MHPAEA*

As stated in Step 1 above, all plan document terms that set forth Standards for provider admission to participate in a network, including reimbursement rates are the same for MH/SUD and M/S benefits and providers.

Similarly, as stated in steps 2-4 above, all factors, sources, evidentiary standards, and processes that are used to develop Standards for provider admission to participate in a network, including reimbursement rates, as written and in operation, are generally the same for all MH/SUD and M/S benefits and providers, and differ only where such differences are based on external requirements such as NCQA accreditation standards or federal and state licensure requirements.

As discussed in Step 4, Ambetter analyzes a wide range of operations measures to monitor the outcome of the methodologies for Standards for provider admission to participate in a network, including reimbursement rates, and has determined that the outcomes of these methodologies are comparable and no more stringent as applied to MH/SUD providers relative to M/S providers. In particular, the impact of Ambetter's processes, strategies, evidentiary standards, and other factors for designing and applying Standards for provider admission to participate in a network, including reimbursement rates has been to create a network that meets all licensing and accreditation requirements for network

adequacy and provider access and availability for both MH/SUD and M/S providers, and that notably includes all OP facility-based MH/SUD providers in the counties in which it operates. At the same time, Ambetter’s strategy ensures that reimbursement rates to facility-based MH/SUD and M/S providers are competitive and not excessive in order to mitigate members’ cost-sharing exposure where coinsurance rates apply.

Based on the foregoing facts and analyses, Ambetter concludes that, under the terms of the plan, as written and in operation, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits in the identified classification are comparable to, and are applied no more stringently than, those used in applying the limitation with respect to medical/surgical benefits in the same classification.

NQTL Type: Standards for provider admission to participate in a network, including reimbursement rates

Classification(s): Emergency

Step 1 – Identify the specific plan or coverage terms or other relevant terms regarding the NQTL and a description of all mental health or substance use disorder and medical or surgical benefits to which each such term applies in each respective benefits classification

- Provide a clear description of the specific NQTL, plan terms, and policies at issue
- Identify which M/S and MH/SUD benefits are subject to the NQTL

Step 1(a): Provide a clear description of the specific NQTL, plan terms, and policies at issue:

N/A – all Emergency providers are contracted to deliver services to treat both MH/SUD and M/S conditions, so it is not possible to distinguish between Emergency M/S and Emergency MH/SUD providers.

Step 2 – Identify the factors used to determine that the NQTL will apply to mental health or substance use disorder benefits and medical or surgical benefits

Medical/Surgical: N/A	MH/SUD: N/A
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Step 3 – Identify the evidentiary standards used for the factors identified in Step 2, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTL to mental health or substance use disorder benefits and medical or surgical benefits.

- *Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.*
- *To the extent the plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.*

Medical/Surgical: N/A	MH/SUD: N/A
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<p>Step 4 – Provide the comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to mental health or substance use disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical or surgical benefits in the benefits classification.</p> <ul style="list-style-type: none"> <i>The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.</i> <i>If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s).</i> <i>If the plan’s or issuer’s analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert’s qualifications and the extent to which the plan or issuer ultimately relied upon each expert’s evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.</i> 	
<p>Medical/Surgical: N/A</p>	<p>MH/SUD: N/A</p>
<p>Step 5 – Provide the specific findings and conclusions reached by the group health plan or health insurance issuer with respect to the health insurance coverage, including any results that indicate that the plan or coverage is or is not in compliance with this section</p> <ul style="list-style-type: none"> <i>This discussion should include citations to any specific evidence considered and any results of analyses indicating that the plan or coverage is or is not in compliance with MHPAEA</i> 	
<p>N/A</p>	
<p>NQTL Type: Standards for provider admission to participate in a network, including reimbursement rates</p>	
<p>Classification(s): Prescription Drug – N/A</p>	
<p>Step 1 – Identify the specific plan or coverage terms or other relevant terms regarding the NQTL and a description of all mental health or substance use disorder and medical or surgical benefits to which each such term applies in each respective benefits classification</p> <ul style="list-style-type: none"> Provide a clear description of the specific NQTL, plan terms, and policies at issue Identify which M/S and MH/SUD benefits are subject to the NQTL 	
<p>Step 1(a): Provide a clear description of the specific NQTL, plan terms, and policies at issue:</p> <p>All definitions are the same as state in the Inpatient and Outpatient analyses above</p>	
<p>Step 1(b): Identify the M/S benefits/services for which the NQTL is required:</p> <p>Access: N/A – all pharmacies dispense both MH/SUD and M/S drugs. Thus it is not possible to distinguish between M/S pharmacy providers and MH/SUD pharmacy providers.</p>	<p>Step 1(b): Identify the MH/SUD benefits/services for which the NQTL is required:</p> <p>Access: Same as M/S</p>

Credentialing: <i>N/A</i> – The plan does not apply credentialing requirements separately to prescription drug providers. The plan utilizes CVS Caremark as its pharmacy benefit manager. CVS Caremark’s credentialing practices were developed without regard to whether a pharmacy specializes in mental health, substance abuse, medical and or surgical fields.	Credentialing: Same as M/S
Reimbursement: <i>N/A</i> – Prescription Drug payment methodologies are not implemented on the basis of diagnosis and formulary design is addressed in separate NQTL analyses	Reimbursement: Same as M/S
Step 2 – Identify the factors used to determine that the NQTL will apply to mental health or substance use disorder benefits and medical or surgical benefits	
Medical/Surgical:	MH/SUD:
<i>N/A</i>	<i>N/A</i>
Step 3 – Identify the evidentiary standards used for the factors identified in Step 2, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTL to mental health or substance use disorder benefits and medical or surgical benefits. <ul style="list-style-type: none"> • <i>Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.</i> • <i>To the extent the plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.</i> 	
Medical/Surgical:	MH/SUD:
<i>N/A</i>	<i>N/A</i>
Step 4 – Provide the comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to mental health or substance use disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical or surgical benefits in the benefits classification. <ul style="list-style-type: none"> • <i>The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.</i> • <i>If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s).</i> 	

- *If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.*

Medical/Surgical:	MH/SUD:
N/A	N/A
Step 5 – Provide the specific findings and conclusions reached by the group health plan or health insurance issuer with respect to the health insurance coverage, including any results that indicate that the plan or coverage is or is not in compliance with this section	
<ul style="list-style-type: none"> • <i>This discussion should include citations to any specific evidence considered and any results of analyses indicating that the plan or coverage is or is not in compliance with MHPAEA</i> 	
N/A	

**Appendix
2022 Network Adequacy Report**

Practitioner Availability and Accessibility of Services

Network Development and Contracting is responsible for the development and maintenance of Ambetter's system of providers. The Department works closely with providers to ensure Members have access to providers. It is responsible for the initial build of the provider network and maintenance of existing providers once networks are established.

NQTL: Experimental and Investigational

Classification: ALL

Step 1 – Identify the specific plan or coverage terms or other relevant terms regarding the NQTL and a description of all Mental Health and Substance Use Disorder (MH/SUD) and Medical and Surgical (M/S) benefits to which each such term applies in each respective benefits classification

- Provide a clear description of the specific NQTL, plan terms, and policies at issue
- Identify which M/S and MH/SUD benefits are subject to the NQTL

M/S:

Ambetter from Peach State Health Plan (Ambetter) does not cover services that are experimental or investigative (EOC p. 39, 70); however, exceptions may be made on a case-by-case basis—see CP.MP.36 Experiential Technologies for evaluation criteria. Determinations of whether a treatment or service is experimental or investigational are set forth in Ambetter’s Coverage Policies.

The Plan’s Explanation of Coverage sets forth the following definition for experimental and investigational treatment:

Experimental or investigational treatment means medical, surgical, diagnostic, or other healthcare services, treatments, procedures, technologies, supplies, devices, drug therapies, or medications that, after consultation with a medical professional, *we* determine to be:

1. Under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration (*USFDA*) regulation, regardless of whether the trial is subject to *USFDA* oversight.
2. An *unproven service*.
3. Subject to *USFDA* approval, and:
 - a. It does not have *USFDA* approval;
 - b. It has *USFDA* approval only under its Treatment *Investigational* New Drug regulation or a similar regulation; or

MH/SUD:

Same as M/S

<p>c. It has <i>USFDA</i> approval, but is being used for an indication or at a dosage that is not an accepted off-label use. An accepted off-label use of a <i>USFDA</i>-approved drug is a use that is determined by <i>us</i> to be:</p> <ol style="list-style-type: none"> i. Included in authoritative compendia as identified from time to time by the Secretary of Health and Human Services; ii. Safe and effective for the proposed use based on supportive clinical evidence in peer-reviewed medical publications; or iii. Not an <i>unproven service</i>; or <p>d. It has <i>USFDA</i> approval, but is being used for a use, or to treat a condition, that is not listed on the Premarket Approval issued by the <i>USFDA</i> or has not been determined through peer reviewed medical literature to treat the medical condition of the <i>member</i>.</p> <p>4. <i>Experimental or investigational</i> according to the <i>provider's</i> research protocols. (EOC p. 16-17).</p> <p>The fact that an <i>experimental or investigational treatment or unproven service</i> is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be an <i>experimental or investigational treatment or unproven service</i> for the treatment of that particular condition. (EOC p. 70).</p> <p><u>Source:</u></p> <ul style="list-style-type: none"> • See also <i>CP.CPC.05 – Medical Necessity Criteria</i> • <i>CP.MP.36 - Experiential Technologies</i> 	<p>Source:</p> <ul style="list-style-type: none"> • <i>CC.BH.UM.10, New BH Technologies</i>
<p>Step 2 – Identify the factors used to determine that the NQTL will apply to MH/SUD and M/S benefits</p>	
<p>N/A - all claims are subject to the exclusion for experimental and investigative services, subject to case-by-case determinations based on the evidentiary standards set forth in Step 3</p>	<p>N/A - all claims are subject to the exclusion for experimental and investigative services, subject to case-by-case determinations based on the evidentiary standards set forth in Step 3</p>

Step 3 – Identify any source or evidence relied upon to design and apply the NQTL to MH/SUD and M/S benefits.

- *Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.*
- *Any factors, evidentiary standards, strategies, or processes defined in a quantitative manner must include the precise definitions used and any supporting sources.*

M/S:

Experimental and/or investigational technologies are defined as any drugs, procedures, treatments, devices, supplies, and other health care services (“Service”) that meet any of the following criteria:

1. It is currently the subject of active and credible evaluation (e.g., clinical trials or research) to determine:
 - a. Clinical efficacy, *or*
 - b. Therapeutic value or beneficial effects on health outcomes, *or*
 - c. Benefits beyond any established medical based alternatives.
2. It does not have final clearance from applicable governmental regulatory bodies (such as the US Food and Drug Administration "FDA") and unrestricted market approval for use in the treatment of a specified medical condition or the condition for which authorization of the Service is requested and is the subject of an active and credible evaluation.
3. The most recent peer-reviewed scientific studies published or accepted for publication by nationally recognized medical journals do not conclude, or are inconclusive in finding, that the Service is safe and effective for the treatment of the condition for which authorization of the Service is requested.

Not medically necessary and not investigational: evaluations and clinical recommendations that are assessed according to the scientific quality of the supporting evidence and rationale (e.g., national medical associations, independent panels, or technology assessment organizations). A service is considered not medically necessary and not investigational when any of the following criteria are met:

1. There are no studies of the service described in recent, published peer-reviewed medical literature, *or*
2. There are no active or ongoing credible evaluations being undertaken of the service which has previously been considered not medically necessary, *or*
3. There is conclusive evidence in published peer-reviewed medical literature that the service is not effective, *or*

MH/SUD:

Same as M/S

4. There are no peer-reviewed scientific studies published or accepted for publication by nationally recognized medical journals that demonstrate the safety and efficacy of the use of the service, *or*
5. It is contraindicated.

Where no E/I policy has been created and an authorization request is made for a service that may be E/I: the criteria listed below are weighed on a case-by-case basis:

- A.** The technology should have final approval from appropriate governmental regulatory bodies. Regulatory bodies include the U.S. Food and Drug Administration (FDA) or any other governmental body with authority to regulate the technology. The indication for the technology under review does not need to be the same indication for which the technology has been approved.
- B.** At least two studies published in peer-reviewed medical literature should be available that would support conclusions regarding the effect of the technology and its likely net health impact. Such studies must, by the standards of accepted medical research, be well-designed and well-conducted investigations yielding quality and consistent results, and the results of such studies should demonstrate the effect the technology will have on the disease, injury, illness, or condition in question.

The opinions and evaluations of national medical associations, consensus panels, and other technology evaluation bodies, or other specialists or professionals, who are subject matter experts with respect to the technology, may be taken into consideration according to the scientific quality of the supporting evidence and rationale for such opinions and evaluations.
- C.** The technology should be used to improve net health outcome of a severely disabling or life-threatening condition. The health benefits of the technology must outweigh any harmful effects or risks to the member/enrollee.
- D.** Other established treatment alternatives to the technology should have been exhausted and failed or no established treatment exists.

<p>E. The improvement to be gained by employing the technology should be attainable outside the control setting (i.e., in practice).</p> <p>F. In the case of diagnostic procedures, it is anticipated that the results of the procedure will help determine the best plan of care. There must be some potential intervention or alteration to the current plan of care based on the diagnostic results.</p> <p>G. The member/enrollee fully understands the risks and benefits regarding the requested technology or treatment and has given informed consent.</p> <p>Source:</p> <ul style="list-style-type: none"> • CP.MP.36 – Experimental Technologies • CP.CPC.05 – Medical Necessity Criteria • PY2022 Ambetter EOC; Page 16-17, 21, 70 	
<p>Step 4 – Provide the comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to MH/SUD benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits in the benefits classification</p> <ul style="list-style-type: none"> • Analyses should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation. • If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). • If the Plan’s or issuer’s analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert’s qualifications and the extent to which the plan or issuer ultimately relied upon each expert’s evaluations in setting recommendations regarding both MH/SUD and M/S benefits. 	
<p><u>M/S:</u></p> <p>4(a) - Briefly describe the processes by which Treatments are determined to be E/I</p> <p>The process for developing E/I policies is the same as that for developing Medical Necessity criteria. Please see step 4 of the Medical Necessity NQTL analysis below.</p> <p>4(b) – Briefly describe the processes by which coverage determinations are made for E/I services</p>	<p><u>MH/SUD:</u></p> <p>Same as for M/S</p>

All coverage determinations regarding technologies (i.e., drugs, procedures, devices, services, or supplies) that are or may be considered experimental or investigational must be considered on a case-by-case basis in accordance with the Benefit Plan Contract provisions and applicable state and federal requirements.

In most cases, the treating provider requests prior authorization before ordering any service that is or may be considered E/I, and the coverage determination process follows the prior authorization process. (Please see step 4 of the Prior Authorization NQTL analysis below.)

If a request for reconsideration or retrospective review is submitted for a service that is or may be considered E/I and there is no authorization in the system for the service, the claim is reviewed by the Utilization Management Unit (UM) pursuant to the Level I and Level II process set forth in the Prior Authorization NQTL analysis to determine payment. Any denial requires review by a clinician with appropriate licensure for the treatment or service. The UM professional applies the Plan's E/I policy if one has been created, or the weight of the evidence according to the criteria listed in step 4(a)(i) if no E/I policy has been created for the treatment or application. (Please see step 4 of the Prior Authorization NQTL for applicable policies.)

Source:

- *IFP.UM.05 – Timeliness of UM Decisions and Notifications*
- *CC.UM.04 – Appropriate UM Professionals*

Members can request an *external review* of an *adverse benefit determination* based on the conclusion that a requested healthcare service is *experimental* or *investigational*, except when the requested healthcare service is explicitly listed as an excluded benefit under the terms of the health benefit plan.

To be eligible for an *external review* under this provision, the treating *physician* shall certify that one of the following situations is applicable:

- (1) Standard healthcare services have not been effective in improving the Member's condition;
- (2) Standard healthcare services are not medically appropriate for the Member; or

<p>(3) There is no available standard healthcare service covered by the health plan issuer that is more beneficial than requested healthcare service.</p> <p>The request for an expedited <i>external review</i> under this provision may be requested orally or electronically. For Expedited/Urgent requests, the Member's <i>healthcare provider</i> can orally make the request on the Member's behalf. (EOC p. 84).</p> <p>4(c) – Identify and define the factors and processes that are used to monitor and evaluate the application of E/I Treatment policies</p> <p>The volume of E/I determinations, coverage denials for E/I services, and appeals is too low to permit meaningful quantitative comparisons between M/S and MH/SUD. However, the same operation processes and strategies are used to determine whether identified services are E/I, regardless of whether the treated condition is a M/S or MH/SUD condition. In addition, the Chief Medical Officer for Centene Advanced Behavioral Health sits on the Clinical Policy Committees that review all E/I policies for both M/S and MH/SUD services, and therefore is able to ensure that the approach to developing and applying Ambetter's processes, strategies, and evidentiary standards for E/I determinations is comparable and no more stringent for MH/SUD services.</p>	
<p>Step 5 – Provide the specific findings and conclusions reached by the group health plan or health insurance issuer with respect to the health insurance coverage, including any results that indicate that the plan or coverage is or is not in compliance with this section</p> <ul style="list-style-type: none"> <i>This discussion should include citations to any specific evidence considered and any results of analyses indicating that the plan or coverage is or is not in compliance with MHPAEA</i> 	
<p>For each step, the relevant information is the same for M/S and MH/SUD benefits. Therefore, we conclude that, as written and in operation, the processes, strategies, evidentiary standards, and factors used to design and apply E/I determinations for MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to design and apply E/I determinations for M/S benefits in each classification of benefits.</p>	

NQTL: Medical Necessity Criteria Development

Classification: ALL

MN Step 1 – Identify the specific plan or coverage terms or other relevant terms regarding the NQTL and a description of all MH/SUD and M/S benefits to which each such term applies in each respective benefits classification

- Provide a clear description of the specific NQTL, plan terms, and policies at issue
- Identify which M/S and MH/SUD benefits are subject to the NQTL

Ambetter defines Medical Necessity Criteria Development to mean the development, modification or addition of criteria against which benefit authorization requests are compared to determine whether the benefit is appropriate for the evaluation and treatment of a disease, condition, illness or injury and consistent with the applicable standard of care. For the purposes of this NQTL analysis, medical necessity criteria (MNC) includes third party medical necessity criteria (e.g., InterQual, MCG), level of care criteria (e.g. ASAM), clinical/medical policies, and/or state coverage requirements. Clinical policies are developed for a range of treatments and services that include medical, behavioral health, medical pharmacy benefits, durable medical equipment and devices.

Charges incurred for treatment not *medically necessary* are not *eligible service expenses*. (EOC p. 19).

Ambetter defines “medically necessary” in the Explanation of Coverage as follows:

Medically necessary means *our* decision as to whether any medical service, supply, item, or treatment to diagnose and treat a *member’s illness or injury*:

1. Is consistent with the symptoms or diagnosis;
2. Is provided according to *generally accepted standards of medical practice*;
3. Is not *custodial care*;
4. Demonstrate that the *member* is reasonably capable of improving in his/her functional ability;
5. Is not solely for the convenience of the *provider* or the *member*;
6. Is not *experimental or investigational*;
7. Is provided in the most cost-effective care facility or setting;
8. Does not exceed the scope, duration, or intensity of that level of care that is needed to provide safe, adequate, and appropriate diagnosis or treatment; and
9. When specifically applied to a *hospital* confinement, it means that the diagnosis and treatment of *your* medical symptoms or conditions cannot be safely provided as an outpatient.

Source – See also:

- *CP.CPC.05 – Medical Necessity Criteria policy*
- *Clinical and Payment Policies*
 - *CP.MP.100 Allergy Testing and Therapy*
 - *CP.MP.124 Attention Deficit Hyperactivity Disorder Assessment and Treatment*
 - *CP.MP.96 Ambulatory Electroencephalography*
 - *CP.MP.156 Cardiac Biomarker Testing*
 - *CP.MP.155 EEG in the Evaluation of Headache*
 - *CP.MP.106 Endometrial Ablation*
 - *CP.MP.134 Evoked Potential Testing*
 - *CP.MP.103 Fractional Exhaled Nitric Oxide*
 - *CP.MP.152 Measurement of Serum 1, 25-dihydroxyvitamin D*
 - *CP.MP.50 Drugs of Abuse Definitive Testing*
 - *CP.MP.97 Testing for Select Genitourinary Conditions*
 - *CP.MP.38 Ultrasound in Pregnancy*

MN Step 2 – Identify the factors used to determine that the NQTL will apply to MH/SUD benefits and M/S benefits

M/S:

Ambetter applies the following factors to determine whether to develop or adopt a medical policy:

1. The service is subject to prior authorization or concurrent review;
2. The service is a new or emerging technology, or is a new use for an existing technology;
3. The service has been the subject of a high volume of inquiries from providers or vendors;

Ambetter uses the following sources of guidelines to make medical necessity decisions (listed in order of significance) on a case-by-case basis, based on the information provided on the member’s health status:

1. Federal and State requirements, where applicable (such as an Emergency Order), override all InterQual or Centene policies
2. Centene policies that comply with any applicable state requirements are developed for covered treatments and services for which no InterQual guideline is available, or if InterQual

MH/SUD:

Same as M/S

<p>guidelines determined to be insufficient compared to professional society guidelines, clinical standards of care, and/or peer-reviewed medical literature.</p> <p>3. InterQual guidelines are adopted and applied for all services in the classification for which an InterQual guideline exists and a clinical policy does not. InterQual guidelines are used because they are nationally recognized decision support tools.</p> <p><u>Source:</u></p> <ul style="list-style-type: none"> • CP.CPC.05 – Medical Necessity Criteria policy • CC.UM.02 – Clinical Decision Criteria and Application 	<p><u>Source:</u></p> <ul style="list-style-type: none"> • CC.BH.UM.02 Clinical Criteria
<p>MN Step 3 – Identify any source or evidence relied upon to design and apply the NQTL to MH/SUD benefits and M/S benefits.</p> <ul style="list-style-type: none"> • Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. • Any factors, evidentiary standards, strategies, or processes defined in a quantitative manner must include the precise definitions used and any supporting sources. 	
<p><u>M/S:</u></p> <p>Ambetter applies the following evidentiary standards and sources to determine whether to develop or adopt medical necessity criteria. Decisions are made considering all of the following factors, sources, and evidentiary standards:</p> <p>Medical necessity criteria are developed for all services that are subject to prior authorization or concurrent review.</p> <ol style="list-style-type: none"> 1. The service is subject to prior authorization or concurrent review; <ol style="list-style-type: none"> a. <i>Evidentiary standard:</i> a prior authorization or concurrent review policy has been created, pursuant to the factors, sources, and evidentiary standards set forth in the PA NQTL analysis. b. <i>Source(s):</i> Prior authorization lookup tool <p>Medical necessity criteria are also developed for new and emerging technologies and for services that are the subject of inquiries from providers, plan staff, or vendors, where, as those factors are defined in the Prior Authorization NQTL analysis.</p>	<p><u>MH/SUD:</u></p> <p>Same as for M/S, except that the ASAM Criteria are used for all SUD benefit authorizations.</p>

2. The service is a new or emerging technology, or a new use for an existing technology, and prior authorization would not be cost-effective, but concerns are identified regarding fraud, waste, and abuse, qualify of care/safety, and/or clinical efficacy factors, as determined by the CPC staff
 - a. *Evidentiary standard:* a service is determined to be a new or emerging technology if any of the following are true:
 - A. It is currently the subject of active and credible evaluation (e.g., clinical trials or research) to determine:
 1. Clinical efficacy, *or*
 2. Therapeutic value or beneficial effects on health outcomes, *or*
 3. Benefits beyond any established medical based alternatives.
 - B. It does not have final clearance from applicable governmental regulatory bodies (such as the US Food and Drug Administration (FDA)) and unrestricted market approval for use in the treatment of a specified medical condition or the condition for which authorization of the service is requested and is the subject of an active and credible evaluation.
 - C. The most recent peer-reviewed scientific studies published or accepted for publication by nationally recognized medical journals do not conclude, or are inconclusive in finding, that the service is safe and effective for the treatment of the condition for which authorization of the service is requested.
 - b. The evidentiary standards and sources for concerns regarding fraud, waste, and abuse, qualify of care/safety, and/or clinical efficacy factors are as set forth in the Prior Authorization analysis.

3. The service has been the subject of at least two inquiries from providers or vendors, and prior authorization would not be cost-effective, but concerns are identified regarding fraud, waste, and abuse, qualify of care/safety, and/or clinical efficacy factors, as determined by the CPC staff
 - a. *Evidentiary standard:* At least two inquiries from providers or vendors
 - b. The evidentiary standards and sources for concerns regarding fraud, waste, and abuse, qualify of care/safety, and/or clinical efficacy factors are as set forth in the Prior Authorization analysis.

Source:

- *CP.MP.36 – Experimental Technologies*
- *CP.CPC.01 – Clinical Policy Committee*

Ambetter’s clinical policies are intended to be reflective of current scientific research and clinical practice and judgment. Ambetter uses the following evidentiary standards and sources to develop medical policies:

- A. Federal or State law/guidelines, where applicable (such as an Emergency Order):
 1. Evidentiary standard: federal or state law is applied if a requirement to apply specific medical necessity criteria to benefit determinations for a given service. At present we are not aware of any federal or state law that mandates the use of specific medical necessity criteria in Michigan.
 2. Sources: federal or state law.
- B. Centene clinical policy (including Centene clinical policies in InterQual as custom content);
 1. The following evidentiary standards and sources are applied to create the Plan’s Medical Necessity guidelines:
 - A critical appraisal of the current published medical literature from peer-reviewed publications including systematic reviews, randomized controlled trials, cohort studies, case control studies, and diagnostic test studies with statistically sound methods.
 - Evidence-based guidelines developed by national organizations and recognized authorities.
 - Opinions and assessments by nationally recognized medical associations including physician specialty societies, consensus panels, or other nationally recognized research or technology assessment organizations such as Hayes, UpToDate, or ECRI.
 - Reports and publications of government agencies such as the Food and Drug Administration (FDA), Centers for Disease Control (CDC), or National Institutes of Health (NIH).
 - External review organization recommendations.
- C. If no Plan- or Centene-specific clinical policy exists, then InterQual Clinical Decision Support Criteria are used;
 1. Evidentiary standard: availability of an InterQual guideline
 2. Sources: InterQual, CP.CPC.05 Medical Necessity Criteria

<p>MN Step 4 – Provide the comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to MH/SUD benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits in the benefits classification</p> <ul style="list-style-type: none"> <i>Analyses should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.</i> <i>If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s).</i> <i>If the plan’s or issuer’s analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert’s qualifications and the extent to which the plan or issuer ultimately relied upon each expert’s evaluations in setting recommendations regarding both MH/SUD and M/S benefits.</i> 	
<p><u>M/S:</u></p> <p>4(a)(i) - Identify and define the processes and strategies used to develop internal Medical Necessity guidelines or modifications to external guidelines that are created by the Plan</p> <p>Clinical policies include medical, behavioral health, pharmacy (including drugs covered under both the pharmacy benefit and the medical benefit), and durable medical equipment and devices.</p> <p><i>4(a)(ii) Key steps in the process for developing the standards</i></p> <p>The identified factors, sources, and evidentiary standards for determining whether to create medical necessity criteria are first analyzed by the Corporate Medical Affairs team. If it is determined that a new clinical policy is necessary, the team develops and presents a draft policy to the Clinical Policy Committee (CPC), which meets on a monthly basis.</p> <p>a. Preliminary review of potential policy topics are conducted as follows:</p>	<p><u>MH/SUD:</u></p> <p>4(a)(i) - Identify and define the processes and strategies used to develop internal Medical Necessity guidelines or modifications to external guidelines that are created by the Plan</p> <p>Same as for M/S, except that each step is carried about by a corresponding MH/SUD committee, including the CABH Clinical Policy Subcommittee (CPSC), the CABH Utilization Management Subcommittee (UMSC), and the CABH Quality Improvement Committee (QIC).</p>

- i. A critical appraisal of the current published medical literature from peer-reviewed publications including systematic reviews, randomized controlled trials, cohort studies, case control studies, and diagnostic test studies with statistically sound methods.
 - ii. Evidence-based guidelines developed by national organizations and recognized authorities.
 - iii. Opinions and assessments by nationally recognized medical associations including physician specialty societies, consensus panels, or other nationally recognized research or technology assessment organizations such as Hayes, UpToDate, or ECRI.
 - iv. Reports and publications of government agencies such as the Food and Drug Administration (FDA), Centers for Disease Control (CDC), or National Institutes of Health (NIH).
 - v. External review organization recommendations.
- b. For topics identified through medical management needs, if two requests for the same topic are submitted, a formal medical policy may be developed. Requests identified through financial analysis will follow this policy development process.
- i. The clinical policy staff utilizes the preliminary research to draft a policy. Relevant CPT, HCPCS and ICD-10 codes are identified and included in the policy. A review of historical handling and/or payment of the policy topic is also conducted to share with the CPC as appropriate.
 - ii. Opinions from external physicians are solicited as appropriate, including behavioral health physicians. The policy is sent for CPC review and approval.
 - iii. Subsequent to each new policy approval, the clinical policy staff sends a notice to all medical directors and medical management leadership to inform them of new policies that have been approved by the CPC.
 - iv. The completed policies are reviewed annually or updated more frequently as dictated by current medical literature, medical director or other relevant staff requests and appeals analysis.

Source:

- *CP.CPC.01 – Clinical Policy Committee*

The purpose of the CPC is to provide oversight of the clinical policy process, certifying all clinical policies are reflective of current scientific research and evidence-based clinical standards. The CPC reviews and approves all clinical policies, which includes policies for new and emerging technologies and new uses for existing technologies.

Recommendations from the CPC are summarized and brought to the Michigan Medical Management Committee (MMC) for a determination. Daily oversight and operating authority of utilization management activities are delegated to the MMC. The MMC is responsible for the review and appropriate approval of medical necessity criteria and protocols and utilization management policies and procedures. The MMC coordinates annual review and revision of the Utilization Management Program Description, Work Plan and Annual UM Program Evaluation. These documents are presented to the Quality Improvement Committee (QIC) for review and final approval.

The MMC meets at least six (6) times per year and the Vice President Population Health and Clinical Operations maintains detailed records of all MMC meeting minutes, UM activities, utilization and care management (CM) program statistics and recommendations for UM/CM improvement activities made by the MMC. The MMC submits to the QIC all meeting minutes and written reports regarding all UM/CM studies and activities.

The Quality Improvement Committee (QIC) is the senior leadership committee, accountable to the Plan Board of Directors and Chief Medical Officer. The QIC meets bi-monthly and provides oversight for all clinical quality activities to ensure compliance with contractual requirements, federal and state statutes and regulations, and requirements of accrediting bodies such as the National Committee for Quality Assurance (NCQA). The QIC also provides oversight for all UM and clinical committees, including final approval of all processes and activities for clinical quality and utilization management.

The Clinical Pharmacy Advisory Committee (CPAC) and Pharmacy and Therapeutics (P&T) Committee review and approve all pharmacy policies for pharmaceuticals covered under both the pharmacy and medical benefits. Further information regarding the CPAC and P&T processes is provided in the Formulary Tiering analysis.

Source:

- *CC.UM.02 – Clinical Decision criteria*

For medical necessity determinations for services for which Ambetter does not have a medical policy or InterQual guideline, the health plan Medical Director will consider the following sources, when

<p>available, in the following general order of hierarchy but evaluated and balanced according to professional judgment:</p> <ul style="list-style-type: none"> A. Reports from peer reviewed medical literature, from which a higher level of evidence and study quality is more strongly considered in determinations; B. Professional standards of safety and effectiveness recognized in the US for diagnosis, care, or treatment; C. Nationally recognized drug compendia resources such as Facts & Comparisons®, DRUGDEX®, and The National Comprehensive Cancer Network® (NCCN®) Guidelines D. Medical association publications, such as those from American Society of Addiction Medicine, American College of Obstetricians and Gynecologists, etc.; E. Government-funded or independent entities that assess and report on clinical care decisions and technology such as Agency for Healthcare Research and Quality (AHRQ), Hayes Technology Assessment, Cochrane Reviews, National Institute for Health and Care Excellence (NICE), etc.; F. Published expert opinions, including in UpToDate; G. Opinion of health professionals in the area of specialty involved; H. Opinion of attending provider in case at hand. <p><u>Source:</u></p> <ul style="list-style-type: none"> • CP.CPC.05 – Medical Necessity Criteria policy 	
<p><i>4(a)(ii) - The composition of the committee(s) used to develop the internal standards</i></p> <ul style="list-style-type: none"> ○ Corporate Medical Affairs team <ul style="list-style-type: none"> ✓ Senior Vice President, Deputy Chief Medical Officer ✓ Corporate Medical Directors ✓ Director, Clinical Policy ✓ Manager, Clinical Policy ✓ Medical Policy Analysts ○ Clinical Policy Committee (CPC) composition: <ul style="list-style-type: none"> ✓ Chief Medical Officer (Chair) ✓ One Medical Director from each Plan (at minimum); 	<p><i>4(a)(ii) - The composition of the committee(s) used to develop the internal standards</i></p> <ul style="list-style-type: none"> ○ Centene Advanced Behavioral Health (CABH) Quality Improvement Team <ul style="list-style-type: none"> ✓ Corporate Executive Vice President, Chief Medical Officer ✓ Chief Operating Officer ✓ Behavioral Health Chief Medical Officer ✓ Senior Behavioral Health Medical Directors ✓ CABH Vice President, Program Development & Operations ✓ CABH Senior Director, Quality and Accreditation ○ CABH Clinical Policy Subcommittee (CPSC) composition: <ul style="list-style-type: none"> ✓ Behavioral Health Chief Medical Officer (Chair) ✓ Chief Operating Officer

<ul style="list-style-type: none"> ✓ Senior Corporate Medical Directors ✓ One representative from each Plan’s medical operations department ✓ Corporate clinical policy leadership ✓ Corporate Medical Management Staff ✓ Outside experts and/or relevant interested parties depending upon the specialty area or special needs of the clinical policy <p>○ Medical Management Committee (MMC) composition: The MMC is chaired by a Plan Medical Director. All physician members that are not Plan employees and Plan medical directors of the MMC are voting members. A minimum of two voting members must be present for a quorum. The MMC Chairman will be the determining vote in the case of a tie vote.</p> <ul style="list-style-type: none"> ✓ Network Physicians ✓ Plan Medical Directors ✓ Plan Vice President Population Health and Clinical Operations (VPPH) ✓ Plan Executive Leadership and UM/QI staff (as appropriate but are non-voting members of the committee) <p>○ Quality Improvement Committee (QIC) composition:</p> <ul style="list-style-type: none"> ✓ Chief Medical Officer (Chair) ✓ Medical Director(s) ✓ Vice President Population Health and Clinical Operations (VPPH) ✓ Director, Utilization Management ✓ QI Director(s) ✓ QI staff ✓ Manager, HEDIS Operations ✓ Vice President, Compliance 	<ul style="list-style-type: none"> ✓ Senior Behavioral Health Medical Directors ✓ Behavioral Health Medical Directors ✓ Licensed Doctorate Level Clinical Psychologists ✓ Health Plan Network Behavioral Health Practitioners ✓ Vice President, Clinical Operations ✓ Director, Clinical Operations ✓ Senior Director, Quality and Accreditation ✓ Centene Corporate Clinical Policy Director <p>○ CABH Utilization Management Subcommittee composition:</p> <ul style="list-style-type: none"> ✓ Behavioral Health Chief Medical Officer (Chair) ✓ Chief Behavioral Health Officer ✓ Chief Operating Officer ✓ Senior Medical Directors ✓ Doctorate Level Licensed Psychologists ✓ Vice President, Clinical Operations ✓ Centene Corporate Senior Director, Accreditation ✓ Senior Director, Clinical Administration ✓ Senior Director, Quality and Accreditation ✓ Vice President, Administrative Operations ✓ Vice President of Business Intelligence ✓ Compliance Director ✓ Clinical and Non-Clinical UM Directors and Managers ✓ QI staff. <p>○ CABH Quality Improvement Committee (QIC) composition:</p> <ul style="list-style-type: none"> ✓ Behavioral Health Chief Medical Officer (Chair) ✓ Behavioral Health Chief Medical Officer ✓ Chief Operating Officer ✓ Senior Medical Directors ✓ Medical Directors ✓ Licensed Doctorate Level Clinical Psychologists ✓ Vice President, Clinical Operations ✓ Director, Clinical Operations
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<ul style="list-style-type: none"> ✓ Director, Complaints and Grievances ✓ Director, Operations ✓ Vice President, Pharmacy ✓ Vice President, Contracting & Network ✓ Vendor Management ✓ External Providers 	<ul style="list-style-type: none"> ✓ Corporate Centene Senior Director, Quality and Accreditation ✓ Senior Director, Clinical Administration ✓ Senior Director, Quality and Accreditation ✓ QI Director ✓ QI staff ✓ Compliance Director
<p><i>4(a)(ii) - The selection and use of external or independent experts</i></p> <p>The Plan actively involves participating network practitioners in utilization review activities through the QIC as available and to the extent that there is not a conflict of interest. The Plan’s UM Program Description and policies define when such a conflict may exist and describe the remedy when conflicts occur. Participation in the QIC is one of the primary ways in which network practitioners participate in Health Plan utilization review activities.</p> <p>The network participating physicians provide review and comment for all clinical policies that Ambetter adopts. At minimum 3 network providers are required for committee quorum. Any willing network provider may volunteer to participate in the QIC, but Ambetter invites providers to participate on an ongoing basis only if they demonstrate understanding of Ambetter’s goals to improve member and provider experience through managed care, there are no concerns from the Credentialing, Medical Management, Compliance and Medical Affairs departments in terms of their reputation and legal standing, they agree to a high level of engagement and dialogue to help shape the direction of the health plan, and they demonstrate a high degree of flexibility for scheduling purposes. In alignment with NCQA standards, participating practitioners are representative of the specialties in Ambetter’s network, and at least one is a behavioral healthcare practitioner.</p>	<p>Same as M/S</p>
<p><i>4(c) Identify and define the factors and processes that are used to monitor and evaluate the efficacy and validity of Medical Necessity guidelines</i></p> <p>Ambetter’s training and policies ensure appropriate utilization of clinical policies with annual InterQual training and inter-rater reliability testing. The UMC also assesses staff consistency with the application of UM decision criteria, including criteria used; information sources; and the review process used to approve the provision of services. All Utilization Managers applying MNC must pass this annual test with a 90% pass rate.</p>	<p>Same as M/S</p>

Source:

- *CC.UM.32 Interrater Reliability - Associates, Medical Directors, and Therapists*

Updates and revisions to the MN criteria themselves are reviewed at least annually. During this time, practitioners with appropriate specialization (including but not limited to psychiatrists, psychologists, and social workers with professional knowledge or clinical expertise in the area being reviewed with regard to all MH/SUD criteria) are invited to give advice or comment on adoption of UM criteria and on instructions for applying the criteria.

Questions from health plan UM teams, MDs, and external medical directors are directed to the Corporate Clinical Policy team for research and response. If the research suggests the clinical policy criteria is no longer reflective of nationally recognized standards of care and peer-reviewed medical literature, an ad-hoc policy update will be made and sent for approval through the CPC and plan QIC.

The UMC also reviews denial rates, appeal overturn rates, and a variety of related utilization and UM data on an annual basis to ensure appropriate utilization of services. Specific data related to prior authorizations are provided in the prior authorization NQTL analysis. If the UMC determines that these data deviate significantly from historical trends without reasonable justification (a standard that is assessed qualitatively, according to the totality of the information gathered, as evaluated in the professional judgment of the UMC members), then a decision may be made to reassess and potentially amend relevant medical policies or related policies.

In addition, the Chief Medical Officer for Centene Advanced Behavioral Health sits on the Clinical Policy Committees that review all Medical Necessity policies and for both M/S and MH/SUD services, and therefore is able to ensure that the approach to developing and applying Ambetter's processes, strategies, and evidentiary standards for developing Medical Necessity policies is comparable and no more stringent for MH/SUD services.

MN Step 5 – Provide the specific findings and conclusions reached by the group health plan or health insurance issuer with respect to the health insurance coverage, including any results that indicate that the plan or coverage is or is not in compliance with this section

- *This discussion should include citations to any specific evidence considered and any results of analyses indicating that the plan or coverage is or is not in compliance with MHPAEA*

All factors, sources, and evidentiary standards are equivalent for M/S and MH/SUD benefits. Policies and procedures for evaluating medical necessity for M/S and MH/SUD services are the same or equivalent on all key aspects, with the exception of using the ASAM Criteria for SUD benefits. Although different committees are used for evaluation and decision-making for MH/SUD and M/S services, each committee type has an analogous structure, staffing qualifications, and purpose, and the committees apply the same factors, sources, and evidentiary standards. The only substantive difference is that the Plan uses the ASAM Criteria for all SUD benefit authorizations, in compliance with state law and national standards. Therefore, we conclude that, as written and in operation, the processes, strategies, evidentiary standards, and factors used to develop MN criteria for MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to develop MN criteria for M/S benefits in each classification of benefits.

NQTL: Prior Authorization

Classifications: Inpatient In-Network, Inpatient Out-of-Network

PA Step 1 – Identify the specific plan or coverage terms or other relevant terms regarding the NQTL and a description of all MH/SUD and M/S benefits to which each such term applies in each respective benefits classification

- *Provide a clear description of the specific NQTL, plan terms, and policies at issue*
- *Identify which M/S and MH/SUD benefits are subject to the NQTL*

M/S:

NQTL Definition: Prior Authorization (PA) means a review process that requires the provider or practitioner to make a formal medical necessity request to the Plan prior to the service being rendered in order for the service to be eligible for reimbursement. Upon receipt, the prior authorization request is screened for eligibility and benefit coverage, and the clinical information submitted is assessed for medical necessity and appropriateness of the health care services proposed, including the setting in which the proposed care will take place, according to the Plan’s Medical Necessity criteria or guidelines for the requested service.

MH/SUD:

Definition:
Same as for M/S

<p><u>PY2022 Ambetter EOC language:</u></p> <p>Prior authorization means a decision to approve specialty or other <i>medically necessary</i> care for a <i>member</i> by the <i>member's PCP</i> or <i>provider</i> prior to receiving services. (EOC p. 22).</p>	
<p><u>Inpatient M/S benefits subject to PA:</u></p> <p>All inpatient benefits, including:</p> <ul style="list-style-type: none"> • All emergent/urgent inpatient admissions (within 1 business day of admission) <ul style="list-style-type: none"> ○ Observation stays exceeding 48 hours only <ul style="list-style-type: none"> ▪ Notification is required within 1 business day if admitted ○ Post- stabilization urgent/emergent admissions • Transplants (not including evaluations) • All elective/scheduled admission notifications requested at least 5 days prior to the scheduled date of admit including but not limited to: <ul style="list-style-type: none"> ○ Medical admissions ○ Surgical admissions ○ Hospice care ○ Rehabilitation facilities <p>The Plan does not require PA of emergency room services, or any emergent service required to provide stabilization of an emergent condition.</p>	<p><u>Inpatient MH/SUD benefits subject to PA:</u></p> <ul style="list-style-type: none"> • All elective/scheduled admission notifications requested at least 5 days prior to the scheduled date of admit including but not limited to: <ul style="list-style-type: none"> ○ Residential substance abuse ○ Residential mental health ○ Inpatient ECT <p>The Plan does not require PA of emergency room services, or any emergent service including Psychiatric Acute or Detox admissions, required to provide stabilization of an emergent condition. Notification of inpatient MH/SUD admissions is required within 1 business day of admission, and concurrent review is applied during the course of the stay, but no prior authorization is required. MH/SUD does not utilize an observation status for inpatient care.</p>
<p><u>Sources:</u></p> <ul style="list-style-type: none"> • <i>CC.UM.01 UM Program Description:</i> • <i>IFP.UM.05 Timeliness of UM Decisions and Notifications</i> • Ambetter from Peach State Health Plan website: https://ambetter.pshpgeorgia.com/ <ul style="list-style-type: none"> - Ambetter from Peach State Health Plan Inpatient Prior Authorization Form - Ambetter from Peach State Health Plan Provider Manual - 	<p><u>Sources:</u></p> <ul style="list-style-type: none"> • <i>CC.BH.UM.01 Behavioral Health UM Program Description</i> • <i>CC.BH.UM.13 Addendum: D Behavioral Health Utilization Review</i> • <i>CC.BH.UM.03 – Appropriate Behavioral Health UM Professionals</i> • <i>CC.BH.UM.07 – Utilization Management Timeliness and Notification</i> • Ambetter from Peach State Health Plan website: https:// https://ambetter.pshpgeorgia.com/ <ul style="list-style-type: none"> - Ambetter from Peach State Health Plan Inpatient Prior Authorization Form - Ambetter from Peach State Health Plan Provider Manual

PA Step 2 – Identify the factors used to determine that the NQTL will apply to MH/SUD benefits and M/S benefits	
<p><u>M/S:</u></p> <p>The factors used to decide to require prior authorization for Inpatient In Network Medical/Surgical Services are:</p> <ul style="list-style-type: none"> • State and federal policies, regulations, and laws • High levels of fraud, waste, and abuse • Cost-effectiveness of PA • Quality of Care/Safety Concerns • Clinical Efficacy 	<p><u>MH/SUD:</u></p> <p>Same as for M/S</p>
PA Step 3 – Identify any source or evidence relied upon to design and apply the NQTL to MH/SUD benefits and M/S benefits.	
<ul style="list-style-type: none"> • <i>Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.</i> • <i>Any factors, evidentiary standards, strategies, or processes defined in a quantitative manner must include the precise definitions used and any supporting sources.</i> 	
<p><u>M/S:</u></p> <p>The following factors are evaluated to determine whether to subject a given benefit to PA. Other than compliance with federal and state law, all factors are weighted and balanced according to the strength of the utilization management committee’s findings for that factor.</p> <ul style="list-style-type: none"> ○ State and federal policies, regulations, and laws: For Qualified Health Plans, added benefits covered pursuant to the essential health benefits covered in the state’s benchmark plan are subject to prior authorization as needed to align with the benchmark plan. Other State and federal policies, regulations, and laws that are used to determine if prior authorization should apply to a benefit include, but are not limited to, provisions contained throughout State Public Health Law and Insurance Laws, State DOH regulations, policies pertaining to utilization management practices, and guidance received from the State Insurance Department related to healthcare or mental health parity. <ul style="list-style-type: none"> ○ <i>Evidentiary standard:</i> PA requirements conform to all federal and state laws ○ <i>Source:</i> federal and state law 	<p><u>MH/SUD:</u></p> <p>Same as for M/S</p>

- **High levels of fraud, waste, and abuse:** benefits for which the Special Investigations Unit (SIU) recommends PA due to the volume or intensity of identified or potential fraud, waste, or abuse and the relative infeasibility of provider-specific remedies.
 - *Evidentiary standard:* “high” is a non-quantitative standard based on the SIU’s industry experience and knowledge regarding the estimated volume of providers, claims, or spending determined to be at high risk for fraud, waste, or abuse, and the relative infeasibility of provider-specific remedies, as evaluated and balanced by the consensus opinion of the SIU and recommended to the UMC
 - *Source:* claims and authorizations data, SIU investigation findings, professional judgment of the SIU, professional judgment of the UM committee members

- **Cost-effectiveness of PA:** benefits for which the estimated savings of applying PA are subjectively anticipated to substantially outweigh the administrative cost of applying the limit.
 - *Evidentiary standard:* ballpark, non-numerical projections of cost-effectiveness are based on estimates of the average cost of service, standard estimate of administrative cost of authorizations, anticipated or documented volume of authorizations, relative to health plan size and revenue, as determined and evaluated by consensus opinion of the MMC.
 - *Source:* professional judgment of the MMC members based on experience and industry knowledge

- **Quality of Care/Safety Concerns:** benefits for which prior authorization will substantially enhance the quality of care for our members by promoting continuity of care and service, especially during member transitions between different levels of care and provides a mechanism for identifying potential safety issues
 - *Evidentiary standard:* consensus opinion of the MMC
 - *Source:* peer-reviewed medical literature, industry standards, professional judgment of the UM committee members

- **Clinical Efficacy:** at least one alternative treatment, service, setting is covered and available to meet the member’s treatment needs that may be at least as clinically effective and is more conservative or substantially less costly
 - *Evidentiary standard:* consensus opinion of the UM committee

- *Source:* peer-reviewed medical literature, industry standards, professional judgment of the UM committee members

PA Step 4 – Provide the comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to MH/SUD benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits in the benefits classification

- *Analyses should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.*
- *If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s).*
- *If the plan’s or issuer’s analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert’s qualifications and the extent to which the plan or issuer ultimately relied upon each expert’s evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.*

M/S:

Step 4(a): For each benefit subject to Prior Authorization, identify which of the factor(s) in Step 3 were met

	State requirements	High levels of FWA	Cost-effectiveness of PA	Quality/Safety concerns	Clinical efficacy
M/S benefits					
Hospice		X	X		
Scheduled/Elective Inpatient admission			X	X	X
Transplants			X	X	X
Experimental/investigational				X	X

Step 4(b): Briefly describe the processes by which prior authorization is applied

MH/SUD:

Step 4(a): For each benefit subject to Prior Authorization, identify which of the factor(s) in Step 3 were met

	State requirements	High levels of FWA	Cost-effectiveness of PA	Quality/Safety concerns	Clinical efficacy
MH/SUD benefits					
Residential Treatment		X	X	X	X
ECT				X	
Experimental/investigational				X	X

Step 4(b): Briefly describe the processes by which prior authorization is applied

<p><u>Process:</u></p> <p>Prior authorization reviews are conducted by reviewers in the Utilization Management (UM) Unit by phone call, faxed clinical information, or clinical documentation submitted via secure provider portal from the provider.</p> <ul style="list-style-type: none"> - Level I Review is conducted by utilization management clinicians for all PA requests to determine whether the provider has demonstrated the medical necessity of the service as set forth in the Plan clinical policy. The reviewer will outreach to the provider, to obtain any additional clinical information required to make a determination or send the review to the Medical Director if the medical necessity does not meet criteria and outreach has been unsuccessful. If the first-level reviewer is unable to determine that the requested service meets the clinical guideline or medical policy, the request is automatically elevated for second-level review. - Level II Review is conducted by a Medical Director. If the reviewing Medical Director is unable to determine that the requested service meets the clinical guideline or medical policy, the requesting provider will be notified that the PA request is denied. - For facility admissions, outreach calls are made to facilities to attempt a peer-to-peer conversation prior to the PA approval determination. - Providers may request reconsideration of any decision that is made without a peer-to-peer conversation. - All reviewers must base their determinations solely on the criteria set forth in the clinical guideline or medical policy, to the extent that such guideline or policy is applicable. For any circumstance that is not addressed by the clinical guideline or medical policy, second-level review is required, and the reviewing Medical Director exercises clinical judgment to evaluate the PA request. 	<p><u>Process:</u></p> <p>Same as for M/S, except that medical necessity determinations and discharge planning are based on InterQual guidelines and local and national standards of care, as determined by the Ambetter reviewer, rather than DRG guidance.</p>
<p><u>Frequency of review:</u></p> <p>Following authorization for inpatient admissions, a total anticipated length of stay (LOS) is assigned and documented based on the diagnosis code provided by the facility, using the adopted tool for average LOS. For inpatient benefits that are reimbursed on a DRG basis, anticipated LOS is calculated based on a geometric mean for the given diagnosis code. For inpatient benefits that are reimbursed</p>	<p><u>Frequency of review:</u></p> <p>Same as M/S.</p>

<p>on a per diem basis, anticipated LOS is informed by InterQual or other medical necessity guidelines, as applied to the specific patient’s circumstances according to the clinical judgement of the reviewer. The LOS continues to be monitored throughout the stay and any adjustments or information related to the LOS are documented within the authorization. The average/anticipated LOS, impending outlier date and targeted discharge date are considered in establishing the next review date in order to ensure that review occurs with ample time to gather further clinical information if needed to authorize an extension of the LOS and/or to coordinate discharge and care management when clinically appropriate. The member continues to be followed for discharge planning and potential outlier status over the course of the stay. Ongoing clinical review is obtained for discharge planning purposes. If an admission reaches the LOS threshold per the adopted LOS tool, the UM reviewer requests clinical documentation, evaluates according to the relevant medical policy or clinical criteria, and sends for Advisor Review as needed.</p>	
<p><u>Timelines and deadlines:</u></p> <p>Ambetter timeframes for review are applied based on the level of urgency requested by the provider upon prior authorization unless the Plan identifies the timeframe would jeopardize the health of the member.</p> <p>Urgent Preservice, urgent or expedited prior authorizations decision-making standard is seventy-two (72) hours from receipt of request.</p> <p>The timeframe for standard preservice requests is within 15 business days of receipt of all clinical information needed to complete the review but no more than 14 calendar days.</p> <p>If the determination results in a denial, reduction or termination of coverage, the UM designee provides electronic or written (i.e. email, fax, notice via EMR system, or mail) notification of the denial to the requesting or treating/attending practitioner, not to exceed the original timeframe of 72 hours.</p> <p>Emergency IP: Post-admission notification is required within 1 business day of the admission.</p>	<p><u>Timelines and deadlines:</u></p> <p>Same as M/S.</p>

<p>Non-emergency IP: PA is required any time prior to the admission. CR is obtained prior to the last authorized day.</p> <p><u>Source:</u></p> <ul style="list-style-type: none"> • <i>IFP.UM.05 – Timeliness of UM Decisions and Notifications</i> • <i>CC.UM.04 – Appropriate UM Professionals</i> 	
<p><u>Level I reviewer qualifications:</u></p> <p>A clinician with corresponding credentials and experience in the specific level of care makes initial determinations.</p> <p>Persons performing prior authorization review for inpatient medical/surgical benefits are Licensed Practical Nurses (LPNs) and Registered Nurses (RNs), with state required licensure.</p> <p>Staff who are not qualified healthcare professionals, are under the supervision of appropriately licensed healthcare professionals, and may approve services when there are explicit UM criteria, and no clinical judgment is required.</p> <p><u>Level II reviewer qualifications (includes all denials):</u></p> <p>The Chief Medical Officer/Medical Director is a physician currently licensed (without restrictions) to practice medicine in the designated state.</p> <p>Based on the needs of the Plan, a Medical Officer may be involved in medical decision-making and has knowledge of due process procedures for resolving issues between participating Providers and the Plan, including those related to Prior Authorization (PA) and utilization review.</p> <p>Only medical directors are qualified and authorized to make any adverse determinations of authorization requests. Plan Medical Directors conducting review meet all qualification and requirement standards consistent with state law and NCQA requirements.</p>	<p><u>Level I reviewer qualifications:</u></p> <p>Same as for M/S, except that persons performing prior authorization review for inpatient mental health/substance use benefits are independently licensed behavioral health professional with clinical and preferably utilization management experience (LCSW, LMHC, Psychologist, RN).</p> <p><u>Level II reviewer qualifications (includes all denials):</u></p> <p>Same as for M/S, except that a Board Certified Psychiatrist, or when approved by the State, Doctorate Level Licensed Psychologists (as indicated by case type) determine all medical necessity denials of behavioral health services offered under the plans’ benefits.</p> <p>Plan Medical Directors conducting review meet all qualification and requirement standards consistent with state law and NCQA requirements.</p>

<p><u>Process for submission: and supporting guidance</u></p> <p>Requests can be submitted via Secure Web Portal, Phone, or Fax. Authorization requirements can be checked using the Ambetter Pre Auth Check Tool:</p> <ul style="list-style-type: none"> - Inpatient Prior Authorization Form <p>Utilization Management support documents include the below documents and are located on the Ambetter website:</p> <ul style="list-style-type: none"> o Provider Manual o Provider Resources Guide - https://ambetter.pshpgeorgia.com/provider-resources/provider-toolkit/provider-toolkit-prior-authorization-guide.html 	<p><u>Process for submission and supporting guidance</u></p> <p>Same as for M/S</p>
<p><u>Sources:</u></p> <ul style="list-style-type: none"> • <i>CC.UM.01 – UM Program Description:</i> • <i>IFP.UM.05 Timeliness of UM Decisions and Notifications</i> • <i>CC.UM.04 Appropriate UM Professionals</i> 	<p><u>Sources:</u></p> <ul style="list-style-type: none"> • <i>CC BH UM 01 – Behavioral Health UM Program Description</i> • <i>CC BH UM 03 – Appropriate Behavioral Health UM Professionals</i> • <i>CC.BH.UM.07 – Utilization Management Timeliness and Notification Standards</i> • <i>CC.BH.UM.09 Addendum: J Annual Notice of External Review – Member Appeals</i> • <i>CC.BH.UM.13 Addendum: D Behavioral Health Utilization Review</i>
<p><u>4(b) - In Writing—Comparative analysis</u></p> <p>The definitions and evidentiary standards analyzed for all factors are the same for M/S and MH/SUD services. Policies and procedures for performing PA for M/S and MH/SUD services are the same or equivalent on all key aspects. These aspects include the PA process, timelines and deadlines, first-level reviewer qualifications, and minimum standards for denials. Although different committees are used for evaluation and decision-making for MH/SUD and M/S services, each committee type has an analogous structure, staffing qualifications, and purpose, and the committees apply the same factors, sources, and evidentiary standards.</p>	
<p><u>Step 4(c) : Identify and define the factors and processes that are used to monitor and evaluate the application of Prior Authorization</u></p>	

<p><u>M/S:</u></p> <p>PA was lifted for most benefits during the COVID-19 Public Health Emergency, including all telehealth services.</p> <p>Approvals, turnaround times and denials are reported to the Medical Management Committee meeting regularly. Ambetter also has an annual Utilization Management Program Review annually whereby approvals, denials and any utilization trends are examined.</p> <p>The plan reviews denial rates, appeal overturn rates and Application of Clinical Decision Criteria annually for both M/S and MH/SUD services</p> <p>Data for 1/1/2022 – 11/30/2022 PA denial rates:</p> <ul style="list-style-type: none"> - IP Pre-Service Requests: 2,700 - Denied: 274 - Percent Denied: 10% <p>Appeal rates:</p> <ul style="list-style-type: none"> - IP denials appealed: 24 - Percent of denials appealed: 9% - Overturned: 13 - Denial overturn rate: 54% <p>Inter-rater reliability scores for Plan PA reviewers:</p> <ul style="list-style-type: none"> - Average IRR score: 95% 	<p><u>MH/SUD:</u></p> <p>PA was lifted for most benefits during the COVID-19 Public Health Emergency, including all telehealth services.</p> <p>Denial rates are reviewed monthly for MH/SUD IP services to assess the impact of UM processes.</p> <p>The plan reviews denial rates, appeal overturn rates and IRR testing annually for both M/S and MH/SUD services.</p> <p>Data for 1/1/22 – 11/30/2022 PA denial rates:</p> <ul style="list-style-type: none"> - Total PA requests: 294 - Total PA requests denied: 58 - % of PA requests denied: 20% <p>Appeal rates:</p> <ul style="list-style-type: none"> - IP denials appealed: 3 - Percent of denials appealed: 5% - Overturned: 1 - Denial overturn rate: 33% <p>Inter-rater reliability scores for Plan PA reviewers:</p> <ul style="list-style-type: none"> - Average IRR score: 97%
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In-Operation—Comparative Analysis

Application of Clinical Decision Criteria:

M/S and MH/SUD clinicians and medical directors alike participate in ongoing evaluations of their utilization management determinations to ensure adherence to the criteria on both medical/surgical and behavioral health determinations to promote appropriate and consistent application of clinical criteria in decision making. The evaluation ensures clinical decisions are based on medical criteria, expert clinical opinion, and

supported through a process of interrater reliability (IRR) testing. These steps ensure consistent application of medical policies, quality standards, and established timeframes; and identify areas where additional education and training are necessary. Annual IRR testing is mandatory to achieve and maintain NCQA accreditation.

- *IRR scores:* All clinical staff participate in annual medical necessity training and inter-rater reliability assessment. Staff are audited on a monthly basis to evaluate timeliness of decision-making, appropriateness of applying utilization management criteria and compliance with notification standards. MH/SUD reviewers had an average IRR Pass Rate of 97%, compared to an average IRR Pass Rate of 95% for M/S reviewers. This finding provides evidence that the processes, strategies, evidentiary standards, and other factors used to make PA determinations for MH/SUD services are applied in operation in a manner that is comparable to and no more stringent than they are for PA determinations for M/S services.
- *Daily and monthly audits:* Clinical Quality Reviewers conduct daily reviews of M/S and MH/SUD medical necessity denial and appeal written notifications, and monthly denial and appeal file audits pursuant to the current NCQA Utilization Management Standards and Guidelines. NCQA audit tools are used to ensure appropriate medical necessity level of care criteria and UM decision-making determinations are applied in coordination with NCQA UM 5, UM 6, UM 7, UM 8, and UM 9 Standards. The process supports timely written and electronic notifications are at a reading grade level for members to understand, and how to file an appeal if they disagree with the adverse determination. While the specific items evaluated for each audit vary, a finding that a reviewer failed to meet 90% of the required elements subjects the reviewer to retraining on the relevant processes.

Annual UM quality reviews:

The UM Program is evaluated at least annually, and modifications are made as necessary. The CMO and VPPH evaluate the impact of the UM program by using:

- Member complaint, grievance and appeal data
- The results of member satisfaction surveys
- Practitioner complaint, and practitioner satisfaction surveys
- Relevant UM data
- Practitioner profiles
- Drug Utilization Review (DUR) profiles

The evaluation covers all aspects of the UM Program. Problems and/or concerns are identified and recommendations for removing barriers to improvement are provided. The evaluation and recommendations are submitted to the MMC for review, action and follow-up. The final document is then submitted to the BOD/governing body through the QIC for approval.

For 2022, Ambetter has reviewed eleven months of UM Metrics, which includes our Inpatient and Outpatient Services denials. We identified no trends that suggest changes needed for either M/S or MH/SUD benefits, or that suggest existing or evolving disparities between MH/SUD and M/S, and our overall denial rate has decreased from 2021.

PA denial rates:

For MH/SUD inpatient prior authorization requests, there were 58 denials from a total of 294 requests for a 20% denial rate, compared to M/S where there was 274 denials from 2700 requests, for a 10% denial rate. The appeals rate for MH/SUD was 5% compared to the M/S appeals rate of 54%. While the denial rate is higher for MH/SUD IP prior authorizations, there is a lower appeal rate and significantly lower overturn rate, indicating the denials were appropriate. We also note that the denial rate for MH/SUD authorizations is nearly identical to the corresponding rate for M/S authorizations in the IP Concurrent Review analysis below, which has a much higher denominator but applies the same medical necessity policies, authorization review strategies and processes, and reviewers (with the sole key difference being the timing of the review). In addition, the denial rate for MH/SUD authorizations is lower than corresponding rates for M/S authorizations in the OP Prior Authorization analysis below, which has a much higher denominator but applies the same authorization review strategies and processes, and reviewers, and comparable medical necessity policies. Thus, it is reasonable to conclude from the combined data that these authorization strategies are applied comparatively and no more stringently to MH/SUD services relative to M/S services.

Based on all of these qualitative and quantitative findings, Ambetter concludes that the processes, strategies, evidentiary standards, and other factors used to apply Prior Authorization to MH/SUD services, in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply Prior Authorization to M/S services in the Inpatient classification.

PA Step 5 – Provide the specific findings and conclusions reached by the group health plan or health insurance issuer with respect to the health insurance coverage, including any results that indicate that the plan or coverage is or is not in compliance with this section

- *This discussion should include citations to any specific evidence considered and any results of analyses indicating that the plan or coverage is or is not in compliance with MHPAEA*

Ambetter has determined that PA is applied for MH/SUD benefits in a manner that is comparable to and no more stringent than that of M/S services based on the information presented above that describes in detail the evidentiary standards, processes, strategies, and factors used to impose PA.

As written: All processes, strategies, evidentiary standards, and other factors used to apply PA to MH/SUD benefits, *as written*, are the same as the processes, strategies, evidentiary standards, and other factors used to apply PA to M/S benefits in the IP benefits classification *as written*.

In Operation: IRR and other audit processes are used to carefully monitor the adherence of reviewers to clinical guidelines and medical policies, and IRR scores for MH/SUD reviewers were superior to IRR scores for M/S reviewers. Ambetter concludes that the processes, strategies, evidentiary standards, and other factors used to apply PA to MH/SUD benefits, *in operation*, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply PA to M/S benefits in the IP benefits classification *in operation*.

NQTL: Prior Authorization	
Classifications: Outpatient in-network, Outpatient OON	
Step 1 – Identify the specific plan or coverage terms or other relevant terms regarding the NQTL and a description of all MH/SUD and M/S benefits to which each such term applies in each respective benefits classification	
<ul style="list-style-type: none"> • Provide a clear description of the specific NQTL, plan terms, and policies at issue • Identify which M/S and MH/SUD benefits are subject to the NQTL 	
<u>M/S Definition:</u> Same as for IP	<u>MH/SUD Definition:</u> Same as for M/S
<u>Outpatient M/S benefits subject to PA:</u> <ul style="list-style-type: none"> • Non-emergent air ambulance • DME • Home healthcare • Hospice • Genetic testing • Quantitative urine drug screen • Reconstructive surgery • High tech imaging • Pain management • Cardiac and respiratory therapy <p>All out of network services require prior authorization, excluding emergency room services.</p>	<u>Outpatient MH/SUD benefits subject to PA:</u> <ul style="list-style-type: none"> • Partial Hospitalization Program (PHP) • Intensive Outpatient Program (IOP) • Psychological Testing / Neuropsychological Testing • Electroconvulsive Therapy (ECT) • Transcranial Magnetic Stimulation (TMS) • Applied Behavior Analysis (ABA) • Quantitative urine drug screen <p>All out of network services require prior authorization, excluding emergency room services.</p>

<p><u>Timelines and deadlines:</u></p> <p>Ambetter timeframes for review are applied based on the level of urgency requested by the provider upon prior authorization unless the Plan identifies the timeframe would jeopardize the health of the member.</p> <p>Urgent Preservice, urgent or expedited prior authorizations decision-making standard is seventy-two (72) hours from receipt of request.</p> <p>The timeframe for standard preservice requests is within 15 business days of receipt of all clinical information needed to complete the review.</p> <p>If the determination results in a denial, reduction or termination of coverage, the UM designee provides electronic or written (i.e. email, fax, notice via EMR system, or mail) notification of the denial to the requesting or treating/attending practitioner, not to exceed the original timeframe of 72 hours, or 15 calendar days.</p> <p>Elective outpatient services require provider to submit their prior authorization request within 15 days prior to the elective outpatient service date.</p> <p><u>Source:</u></p> <ul style="list-style-type: none"> • <i>IFP.UM.05 – Timeliness of UM Decisions and Notifications</i> 	<p><u>Timelines and deadlines:</u></p> <p>Same as M/S</p>
<p><u>Process:</u> Same as for IP</p> <p><u>Reviewer qualifications:</u> Same as for IP</p>	<p><u>Process:</u> Same as for IP</p> <p><u>Reviewer qualifications:</u> Same as for IP</p>

<p><u>Sources:</u></p> <ul style="list-style-type: none"> • Ambetter Plan website - https://ambetter.pshpgeorgia.com/ • Pre Auth Check Tool - https://ambetter.pshpgeorgia.com/provider-resources/manuals-and-forms/pre-auth.html <ul style="list-style-type: none"> ○ Provider Manual ○ Evidence of Coverage <p><u>See attachment:</u></p> <ul style="list-style-type: none"> • <i>CC.UM.01 – UM Program Description</i> • <i>IFP.UM.05 – Timeliness of UM Decisions and Notifications</i> • <i>CC.UM.04 – Appropriate UM Professionals</i> • 	<p><u>Sources:</u></p> <ul style="list-style-type: none"> • Ambetter Plan website - https://ambetter.pshpgeorgia.com/ • Pre Auth Check Tool - https://ambetter.pshpgeorgia.com/provider-resources/manuals-and-forms/pre-auth.html <ul style="list-style-type: none"> ○ Provider Manual ○ Evidence of Coverage <p><u>See attachment:</u></p> <ul style="list-style-type: none"> • <i>CC.BH.UM.01 Behavioral Health UM Program Description</i> • <i>CC.BH.UM.03 Appropriate Behavioral Health UM Professionals</i> • <i>CC.BH.UM.07 Utilization Management Timeliness and Notification Standards of UM Decisions and Notifications</i> • <i>CC.BH.UM.09 Addendum: J - Annual Notice of External Review – Member Appeals</i> • <i>CC.BH.UM.13 Addendum: D Behavioral Health Utilization Review</i>
<p>Step 2 – Identify the factors used to determine that the NQTL will apply to mental health or substance use disorder benefits and medical or surgical benefits</p>	
<p><u>M/S:</u></p> <p>Same as for IP</p>	<p><u>MH/SUD:</u></p> <p>Same as for IP</p>
<p>Step 3 – Identify any source or evidence relied upon to design and apply the NQTL to MH/SUD benefits and M/S benefits.</p> <ul style="list-style-type: none"> • <i>Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.</i> • <i>Any factors, evidentiary standards, strategies, or processes defined in a quantitative manner must include the precise definitions used and any supporting sources.</i> 	
<p><u>M/S:</u></p> <p>Same as for IP</p>	<p><u>MH/SUD:</u></p> <p>Same as for IP</p>
<p>Step 4 – Provide the comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to MH/SUD benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits in the benefits classification</p> <ul style="list-style-type: none"> • <i>Analyses should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.</i> 	

- If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s).
- If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.

Step 4(a): For each benefit subject to Prior Authorization, identify which of the factor(s) in Step 3 were met						Step 4(a): For each benefit subject to Prior Authorization, identify which of the factor(s) in Step 3 were met					
	State requirement	High levels of FWA	Cost-effectiveness of PA	Quality or Safety concerns	Clinical efficacy		State requirement	High levels of FWA	Cost-effectiveness of PA	Quality or Safety concerns	Clinical efficacy
M/S benefits						MH/SUD benefits					
Non-emergency air ambulance transport			X			Outpatient:					
DME		X	X			PHP		X	X		X
Home health services		X	X			IOP		X	X		X
Furnished medical supplies		X	X			Psychological Testing		X	X		
Orthotics/prosthetics			X		X	ECT				X	
Genetic testing			X		X	TMS			X		X
Quantitative urine drug screening		X			X	ABA		X	X		X
Reconstructive surgery		X		X	X	Quantitative urine drug screening		X			X
Experimental/investigational				X	X	Experimental/investigational				X	X
High tech imaging			X	X							
Pain management		X		X	X						
Cardiac and respiratory therapy			X								
Step 4(b): Briefly describe the processes by which prior authorization is applied						Step 4(b): Briefly describe the processes by which prior authorization is applied					
<u>M/S:</u>						<u>MH/SUD:</u>					
Same as for IP						Same as for IP					
<u>Frequency of review:</u>						<u>Frequency of review:</u>					
Services that are generally delivered on an unplanned, irregular, and/or non-recurring basis are authorized for each claim or grouping of claims.						Same as M/S.					

<p>For services that are delivered on a planned or regular basis, including pursuant to a documented treatment plan, frequency of review is informed by InterQual or other medical necessity guidelines; however clinical judgement is used to apply the guidelines to the specific patient's circumstances and make a determination regarding the number of days to approve based on the patient's acuity and treatment duration.</p>	
<p><i>Step 4(c) : Identify and define the factors and processes that are used to monitor and evaluate the application of Prior Authorization</i></p> <p><u>M/S:</u></p> <p>PA was lifted for outpatient telehealth services during the COVID-19 Public Health Emergency.</p> <p>Data for 1/1/2022 – 11/30/2022 PA denial rates for all medical necessity denials:</p> <ul style="list-style-type: none"> - Total PA requests: 92,290 - Total PA requests denied: 14,563 - % of PA requests denied: 16% <p>Internal appeal rates:</p> <ul style="list-style-type: none"> - Total # appeals: 1262 - Appeals rate: 9% <p>Overtured appeal rates:</p> <ul style="list-style-type: none"> - Total # overturned: 659 - Overturn rate: 52% <p>Inter-rater reliability scores for Plan PA reviewers:</p> <ul style="list-style-type: none"> - Average IRR score: 95% 	<p><i>Step 4(c) : Identify and define the factors and processes that are used to monitor and evaluate the application of Prior Authorization</i></p> <p><u>MH/SUD:</u></p> <p>PA was lifted for outpatient telehealth services during the COVID-19 Public Health Emergency.</p> <p>Data for 1/1/22 – 11/30/2022 PA denial rates for all medical necessity denials:</p> <ul style="list-style-type: none"> - Total PA requests: 2,742 - Total PA requests denied: 186 - % of PA requests denied: 7% <p>Internal appeal rates:</p> <ul style="list-style-type: none"> - Total # appeals: 11 - Appeals rate: 6% <p>Overtured appeal rates:</p> <ul style="list-style-type: none"> - Total # overturned: 6 - Overturn rate: 55% <p>Inter-rater reliability scores for Plan PA reviewers:</p> <ul style="list-style-type: none"> - Average IRR score: 100%

In-Operation—Comparative Analysis

General strategies for oversight of application of clinical decision criteria, including IRR scores and daily and monthly audits, are the same as described in the prior authorization analysis for inpatient benefits.

14,563 PA requests for M/S services in the OP classification have been denied in 2022, for a denial rate of 16%. 186 PA requests for MH/SUD services in the OP classification were denied in 2022, for a denial rate of 7%. The lower denial rate for MH/SUD provides evidence that authorization determinations are being applied no more stringently to MH/SUD PA requests than to M/S PA requests. This supports that all key processes, strategies, evidentiary standards, and other factors used to design and apply prior authorization are comparable for both MH/SUD and M/S benefits.

Eleven of the 186 PA denials for MH/SUD were appealed for an appeal rate of 6%, compared to an appeal rate of 9% for M/S. Of the 11 cases appealed for MH/SUD, the overturn rate was 55%, as compared to an overturn rate of 52% for M/S. The appeal and overturn rates show alignment and provide evidence that the MH/SUD reviews are not conducted more stringently than M/S reviews.

Based on all of these qualitative and quantitative findings, Ambetter concludes that the processes, strategies, evidentiary standards, and other factors used to apply Prior Authorization to MH/SUD services, in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply Prior Authorization to M/S services in the Outpatient classification.

Step 5 – Provide the specific findings and conclusions reached by the group health plan or health insurance issuer with respect to the health insurance coverage, including any results that indicate that the plan or coverage is or is not in compliance with this section

- *This discussion should include citations to any specific evidence considered and any results of analyses indicating that the plan or coverage is or is not in compliance with MHPAEA*

Ambetter has determined that PA is applied for MH/SUD benefits in a manner that is comparable to and no more stringent than that of M/S services based on the information presented above that describes in detail the evidentiary standards, processes, strategies, and factors used to impose PA.

As written: All processes, strategies, evidentiary standards, and other factors used to apply PA to MH/SUD benefits, *as written*, are the same as the processes, strategies, evidentiary standards, and other factors used to apply PA to M/S benefits in the OP benefits classification.

In Operation: The denial rate for MH/SUD PA requests is nearly identical to the denial rate for M/S PA requests. IRR and other audit processes are used to carefully monitor the adherence of reviewers to clinical guidelines and medical policies, and IRR scores for MH/SUD reviewers were superior to IRR scores for M/S reviewers. Ambetter concludes that the processes, strategies, evidentiary standards, and other factors used to apply PA to MH/SUD benefits, *in operation*, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply PA to M/S benefits in the OP benefits classification.

NQTL: Concurrent Review	
Classifications: Inpatient In-Network, Inpatient OON	
Step 1 – Identify the specific plan or coverage terms or other relevant terms regarding the NQTL and a description of all MH/SUD and M/S benefits to which each such term applies in each respective benefits classification	
<ul style="list-style-type: none"> • Provide a clear description of the specific NQTL, plan terms, and policies at issue • Identify which M/S and MH/SUD benefits are subject to the NQTL 	
<p><u>M/S:</u></p> <p><u>Definition:</u></p> <p>Concurrent Review (CR) is a technique for managing the appropriate utilization of healthcare services under which services are only eligible for reimbursement if provider obtains approval or re-approval from the Plan for the ongoing delivery of a service at defined intervals during a facility stay or course of treatment. The concurrent review process assesses the clinical status of the member, verifies the medical necessity for the treatment rendered and the level of care, facilitates the implementation of the practitioner’s plan of care and promotes timely care, and monitors the quality of care to verify professional standards of care are met. Concurrent review for inpatient hospitalization is conducted throughout the inpatient stay, with each hospital day or days approved based on review of the patient’s condition and evaluation of medical necessity.</p>	<p><u>MH/SUD:</u></p> <p><u>Definition:</u></p> <p>Same as for M/S</p>
<p><u>Inpatient M/S benefits subject to CR:</u></p> <p>Concurrent review is not done selectively; it is performed for all inpatient benefits to determine medical necessity of continued length of stay in addition to prepare for discharge planning. Concurrent review is also performed in the event that UM has not provided any prior authorization for care and a member is admitted to a non-participating facility from an emergency department or notification is made following an admission to a non-participating facility.</p>	<p><u>Inpatient M/S benefits subject to CR:</u></p> <p>Same as for M/S</p>

<p><u>Frequency of review:</u></p> <p>Same as for IP prior authorization</p>	<p><u>Frequency of review:</u></p> <p>Same as for M/S.</p>
<p><u>Review process:</u></p> <p>Same as for Prior Auth IP, except:</p> <p>Continued authorization can be requested by the facility or the provider by fax, phone, or web portal on the last day of the authorized service.</p> <p>For OON inpatient admissions, when the member is considered stable by the treating physician and more than one additional inpatient day is anticipated, the Utilization Management (UM) designee will work with the facility discharge planner or Case Management personnel to attempt to transfer the member's care to a participating facility and physician as soon as possible. When a member is considered unstable, UM will monitor a member's health status through the standard CCR process and as soon as the member is stable, consideration should be given to transferring the member to a participating facility following the steps outlined above if an additional length of stay is anticipated to be greater than one day.</p>	<p><u>Review process:</u></p> <p>Same as for M/S</p>
<p><u>Timelines and deadlines:</u></p> <p>Same as for Prior Auth IP, except CR is obtained prior to the last authorized day.</p>	<p><u>Timelines and deadlines:</u></p> <p>Same as for M/S</p>
<p><u>Initial reviewer qualifications:</u></p> <p>Same as Prior Auth IP</p> <p><u>Qualifications for denials:</u></p>	<p><u>Initial reviewer qualifications:</u></p> <p>Same as Prior Auth IP</p> <p><u>Qualifications for denials:</u></p>

Same as Prior Auth IP	Same as Prior Auth IP
<p><u>Sources:</u></p> <ul style="list-style-type: none"> • Plan website • Pre Auth Check Tool • Plan Provider Manual <p><u>See attachment:</u></p> <ul style="list-style-type: none"> • <i>CC.UM.01 – UM Program Description</i> • <i>IFP.UM.05 – Timeliness of UM Decisions and Notifications</i> • <i>HIM.UM.01.08 – Use of Out-of-Network Providers and Steerage</i> • <i>HIM.UM.01.09 – Management of an Admission to a Non-Participating Facility</i> • <i>CC.UM.04 – Appropriate UM Professionals</i> • 	<p><u>Sources:</u></p> <ul style="list-style-type: none"> • Plan website • Pre Auth Check Tool • Plan Provider Manual <p><u>See attachment:</u></p> <ul style="list-style-type: none"> • <i>CC.BH.UM.01 Behavioral Health UM Program Description</i> • <i>CC.BH.UM.13 Addendum: D Behavioral Health Utilization Review</i> • <i>CC.BH.UM.09 Addendum: J Annual Notice of External Review – Member Appeals</i> • <i>CC.BH.UM.03 Appropriate Behavioral Health UM Professionals</i> • <i>CC.BH.UM.07 Utilization Management Timeliness and Notification Standards</i> • <i>CC.BH.UM.19 Behavioral Health Emergency Services and Post-Stabilization Authorization Subsequent to Emergency Treatment</i>
Step 2 – Identify the factors used to determine that the NQTL will apply to MH/SUD benefits and M/S benefits	
<p><u>M/S:</u></p> <p>N/A: CR is performed for all inpatient benefits</p>	<p><u>MH/SUD:</u></p> <p>Same as for M/S</p>
<p>Step 3 – Identify any source or evidence relied upon to design and apply the NQTL to MH/SUD benefits and M/S benefits.</p> <ul style="list-style-type: none"> • <i>Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.</i> • <i>Any factors, evidentiary standards, strategies, or processes defined in a quantitative manner must include the precise definitions used and any supporting sources.</i> 	

<p><u>M/S:</u></p> <p>N/A: CR is performed for all inpatient benefits</p>	<p><u>MH/SUD:</u></p> <p>Same as for M/S</p>
<p>Step 4 – Provide the comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to MH/SUD benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits in the benefits classification</p> <ul style="list-style-type: none"> <i>Analyses should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.</i> <i>If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s).</i> <i>If the plan’s or issuer’s analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert’s qualifications and the extent to which the plan or issuer ultimately relied upon each expert’s evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.</i> 	
<p>In Writing</p> <p>All inpatient M/S and MH/SUD benefits are subject to CR, and all processes, timelines, reviewer qualifications, and other aspects of CR are the same for M/S and MH/SUD benefits. Thus, as written, the processes, strategies, evidentiary standards, and other factors used to apply CR to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply CR to M/S benefits in the IP classification.</p>	
<p>In Operation</p> <p>The same IRR processes and scores apply to CR as for PA.</p> <p>Data for 1/1/2022 – 11/30/2022</p> <p>M/S Concurrent denial rates:</p> <ul style="list-style-type: none"> - Total Concurrent requests: 16,103 - Total Concurrent requests denied: 974 - % of Concurrent requests denied: 6% <p>Internal appeal rates:</p> <ul style="list-style-type: none"> - Total # appeals: 11 - Appeals rate: 1% <p>Overtaken appeal rates:</p> <ul style="list-style-type: none"> - Total # overturned: 8 	<p>The same IRR processes and scores apply to CR as for PA.</p> <p>Data for 1/1/22 – 11/30/2022</p> <p>MH/SUD Concurrent denial rates:</p> <ul style="list-style-type: none"> - Total Concurrent requests: 3,387 - Total Concurrent requests denied: 234 - % of Concurrent requests denied: 7% <p>Internal appeal rates:</p> <ul style="list-style-type: none"> - Total # appeals: 27 - Appeals rate: 12% <p>Overtaken appeal rates:</p> <ul style="list-style-type: none"> - Total # overturned: 8

<p>- Overturn rate: 72%</p> <p>Inter-rater reliability scores for Plan PA reviewers: Average IRR score: 97%</p> <p>-</p>	<p>- Overturn rate: 30%</p> <p>Inter-rater reliability scores for Plan PA reviewers: Average IRR score: 97%</p>
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In-Operation—Comparative Analysis

974 Concurrent requests for M/S services in the IP classification were denied out of 16,103 total CR requests in 2022, for a denial rate of 6%. 234 Concurrent requests for MH/SUD services were denied out of 3387 total requests in 2022, for a denial rate of 7%. The M/S denial rate is not statistically significantly lower than that of MH/SUD denial rate. The appeals rate for MH/SUD was 12%, and the overturn rate was 30%. In comparison, the appeals rate for M/S was 1% with an overturn rate of 72%. While the MH/SUD appeal rate is higher than M/S, the overturn rate is significantly less indicating the majority of the denials were appropriate. This supports that all key processes, strategies, evidentiary standards, and other factors used to design and apply prior authorization are comparable and no more stringent for both MH/SUD and M/S benefits.

The same IRR processes and scores apply to CR as for PA.

Based on all of these qualitative and quantitative findings, Ambetter concludes that the processes, strategies, evidentiary standards, and other factors used to apply Concurrent Review to MH/SUD services, in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply Concurrent Review to M/S services.

Step 5 – Provide the specific findings and conclusions reached by the group health plan or health insurance issuer with respect to the health insurance coverage, including any results that indicate that the plan or coverage is or is not in compliance with this section

- *This discussion should include citations to any specific evidence considered and any results of analyses indicating that the plan or coverage is or is not in compliance with MHPAEA*

The Plan has determined that CR is applied for MH/SUD benefits in a manner that is comparable to and no more stringent than that of M/S services based on the information presented above that describes in detail the evidentiary standards, processes, strategies, and factors used to impose CR.

As written: All processes, strategies, evidentiary standards, and other factors used to apply CR to MH/SUD benefits, *as written*, are the same as the processes, strategies, evidentiary standards, and other factors used to apply PA to M/S benefits in the CR benefits classification.

In Operation: The denial rate for MH/SUD CR requests is statistically comparable to the denial rate for M/S CR requests. IRR and other audit processes are used to carefully monitor the adherence of reviewers to clinical guidelines and medical policies, and IRR scores for MH/SUD reviewers were superior to IRR scores for M/S reviewers. The Plan concludes that the processes, strategies, evidentiary standards, and other factors used to apply CR to MH/SUD benefits, *in operation*, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply CR to M/S benefits in the IP benefits classification

POLICY AND PROCEDURE

DEPARTMENT: Centene Advanced Behavioral Health Utilization Management	REFERENCE NUMBER: CC.BH.UM.01
EFFECTIVE DATE: 06/17/09	P&P NAME: Behavioral Health Utilization Management Program Description
REVIEWED/REVISED DATE: 5/22/19; 7/19/19; 8/7/19; 3/25/20; 3/24/21; 6/23/21; 3/29/22	RETIRED DATE: N/A
BUSINESS UNIT: Centene Advanced Behavioral Health	PRODUCT TYPE: Medicaid, Marketplace, Medicare
REGULATOR MOST RECENT APPROVAL DATE(S):	

POLICY STATEMENT:

This policy outlines the Centene Advanced Behavioral Health (CABH) Utilization Management program description.

PURPOSE:

To describe the Utilization Management Program.

SCOPE:

CABH Utilization Management and Clinical Operations

POLICY:

CABH Utilization Management and Clinical Operations maintains a Utilization Management Program Description which encompasses the functions of pre-authorization and concurrent review. The program description is consistent with all regulatory and accrediting guidelines. The document is reviewed and revised at least annually and more frequently as needed.

REFERENCES:

1. Current NCQA UM Standards and Guidelines
2. CC.UM.01 Utilization Management Program Description
3. CC.UM.27- Member Appeals System Description

ATTACHMENTS:

2022 CABH UM Program Description, 3/29/22

REGULATORY REPORTING REQUIREMENTS: NA

REVISION TYPE	REVISION SUMMARY	DATE APPROVED & PUBLISHED
Ad Hoc Review	Minor edits. Edited addendum F; updated clinical program activities.	01/30/18
Ad Hoc Review	Minor edits, updated clinical data to reflect contractual requirements. Removed necessary addendums.	03/06/18
Ad Hoc Review	Changed UMSC from 6 time per year to 4.	03/23/18
Ad Hoc Review	Updated the CA specific addendum.	09/14/18
Annual Review	Annual review - Transferred the information for this P & P from the EPC.UM.01 P & P template to the Centene Corporate P & P template and renumbered; updated the BH UM Program Description attached for 2019; and updated entire document to reflect Centene BH UM program services.	02/4/19
Ad Hoc Review	Added the following language on page 15 in the Qualifications and Training section "independent or unrestricted licensed "; removed one state from the LOC table on pg 22 as they have not delegated any UM services to CBH; updated references to InterQual to include the registered trademark; updated terminology from pre-certification to pre-service throughout this document; and removed references to NCQA MBHO Standards and Guidelines from the References section.	5/22/19

Ad Hoc Review	Aligned language on pg 35, for determinations of urgent preservice or expedited prior authorizations in coordination with the converted CC BH UM.07 Policy, <i>Utilization Management Timeliness and Notification Standards</i> ; removed Medicare line of business to its own BH UM Program Description to align with Centene Corporate's P & P's and renumbered it to CC.BH.MCARE.UM.01; corrected grammatical errors; and removed unique requirements for California Medi-Cal Health as this client termed with CBH.	7/19/19
Ad Hoc Review	Added North Carolina – MNC criteria to table and Carolina Complete Health Unique Requirements to Appendix.	8/07/19
Ad Hoc Review	Revised the policy section to reflect UM approval by the CBH QIC, UMSC, and Centene Board of Directors prior to distribution to client health plans.	2/24/20
Ad Hoc Review	Moved Section of InterQual® criteria not utilized due to state requirements and alternative MNC to Attachment A	3/25/20
Ad Hoc Review	Moved Section of State Specific Requirements to Attachments B - G	3/25/20
Ad Hoc Review	Changed all references to “Nebraska Total Care” to “Nebraska Total Care, NHA Expansion.”	5/18/20
Annual Review	Annual Review. Reviewed against 2021 NCQA Standards and Guidelines for Medicaid and Marketplace. Reviewed against Corporate Policy CC.UM.01 UM Program Description. Re-formatted the policy to align with the new template. Changed “CBH” to “Centene Advanced Behavioral Health (CABH)” to reflect name change. Removed Attachments B – G State Specific Requirements, as the content does not apply to CC.BH.UM.01 CABH UM Program Description. Removed Attachment A Unique Requirements “Markets that do not use InterQual”, as this content applies to CC.BH.UM.02 Clinical Decision Criteria and Application for Behavioral Health.	3/24/21
Annual Review	Annual Review. Incorporated CC.MCARE.UM.01, CBH Medicare UM PD (2020) into this document to create one UM PD for all LOBs; Reviewed and aligned MCARE.MM.17, Medicare UM PD (11/20); Reviewed CMS Medicare Managed Care Manual, Chapter 10, Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance Effective January 1, 2020. Removed all revisions prior to 2017. CC.BH.MCARE.UM.01 has been replaced with CC.BH.UM.01.	6/23/21
Annual Review	Annual Review. Reviewed against CC.UM.01 UM Program, 2/22; and NCQA UM Standards and Guidelines.	3/29/22
Ad Hoc	CABH semi-annual oversight of the delegated IROs was added to the 2022 CABH UM Program Description under the Delegation section.	5/6/22

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, the Company's P&P management software, is considered equivalent to a signature.

CENTENE ADVANCED BEHAVIORAL HEALTH

2022

Utilization Management Program Description

Initially Approved March 29, 2022

Revised May 6, 2022

PURPOSE

The purpose of the Centene Advanced Behavioral Health (CABH) Utilization Management (UM) Program Description is to define the structures and processes within behavioral health (BH) Utilization Management and Clinical Operations, including assignment of responsibility to appropriate individuals, to promote fair, impartial, and consistent utilization management decisions and coordination of care for the health plan members.

SCOPE

The scope of the CABH UM Program is comprehensive and applies to eligible client health plan members across product types, age categories, and range of BH diagnoses. The UM Program incorporates all BH care settings including emergency care, specialty care, acute care, short-term care, long term care, and ancillary care services.

GOALS

The goals of the UM Program are to optimize members' health status, sense of well-being, productivity, and access to quality health care, while at the same time actively managing cost trends. The UM Program aims to provide services that are covered benefits, medically necessary, appropriate to the members' condition, rendered in the appropriate setting, and meet professionally recognized standards of care.

IMPLEMENTATION

The UM Program seeks to advocate the appropriate utilization of resources using the following program components: 24-hour nurse triage, telemedicine, prior authorization/precertification, second opinion, concurrent review, ambulatory review, retrospective review for behavioral health care services, and discharge planning activities. Additional program components implemented to achieve the program's goals include tracking utilization of services to guard against over- and under-utilization and interactive relationships with practitioners to promote appropriate practice standards. Referrals to hospital discharge planners regarding long-term needs are initiated promptly. CABH Level I and Level II reviewers are responsible for assuring appropriate utilization of services along the continuum of care.

CONFIDENTIALITY

Confidential information is defined as any data or information that can directly or indirectly identify a member or physician. CABH adheres to the following:

- CABH staff and consultants are required to participate in an annual confidentiality and privacy training;
- CABH Utilization Management Subcommittee members participate in annual confidentiality training, and all meeting minutes are designated as Proprietary and Confidential;
- CABH employees can access and disclose confidential information only as necessary to fulfill assigned duties and responsibilities;
- Medical information sent by mail or fax to the attention of the recipient is clearly marked "personal and confidential";
- Members' BH treatment information is stored in a software system protected under multiple levels of security by system configuration, which includes user access passwords;
- Confidential information is destroyed by a method that induces complete destruction when no longer needed; and
- CABH abides by all federal and state laws governing the issue of confidentiality.

AUTHORITY

The Board of Directors has ultimate authority and accountability for the oversight of the quality of care and services provided to members; and delegated senior quality executive accountability and oversight to the CABH Chief Operating Officer. They oversee the development, implementation, and evaluation of the Quality Improvement Program. Daily oversight and operating authority of UM activities are delegated to the CABH Quality Improvement Committee (QIC). The responsibilities of the CABH UM Program are supervised by the CABH Chief Behavioral Health Medical Officer, Vice President of Clinical Operations, Vice President of UM, and the CABH UM Subcommittee (UMSC), including the review and approval of medical necessity criteria, BH UM protocols, and BH UM standard operating procedures (SOPs). The UMSC is responsible for reviewing all utilization management issues and related information and making recommendations to the CABH QIC as necessary. The CABH UM Program Description is annually reviewed and approved by the UMSC and QIC.

The CABH Chief Behavioral Health Medical Officer has operational responsibility for and provides support to the CABH UM Program. The CABH Chief Behavioral Health Medical Officer, Vice President of Clinical Operations, and Vice President of UM, as assigned by the CABH Chief Operating Officer, are the senior executives responsible for implementing the UM Program including cost containment; activities pertaining to utilization review, complex, controversial, or experimental services; successful operation of the CABH UMSC; and the BH UM Program implementation, monitoring, and directing. In addition to the CABH Chief Behavioral Health Medical Officer, Senior Medical Directors provide additional support of the BH UM Program.

The Chief Behavioral Health Medical Officer's responsibilities include, but are not limited to, coordination and oversight of the following activities:

- Development/revision of BH UM SOPs as necessary to meet state and federal statutes and regulations and accrediting body requirements;
- Monitor compliance of the UM Program;
- Provide clinical support to the UM staff in the performance of their UM responsibilities;
- Assure medical necessity criteria used in the UM process are appropriate and reviewed by physicians and other practitioners according to policy;
- Assure the medical necessity criteria are applied in a consistent manner;
- Assure review of cases that do not meet medical necessity criteria are conducted by physicians or other healthcare professional as appropriate, in a manner that meets all pertinent statutes, regulations and CABH policy, and takes into consideration the individual needs of the involved members and assessment of the local delivery system;
- Review, approve, and sign (if required) denial letters for cases that do not meet medical necessity criteria after appropriate review has occurred;
- Assure the medical necessity appeal process is carried out in a manner that meets all applicable contractual requirements, as well as all federal and state statutes and regulations, is consistent with all applicable accreditation standards, and is done in a consistent and efficient manner;
- Provide a point of contact for practitioners calling with questions about the BH UM process;
- Communicate/consult with practitioners in the field as necessary to discuss BH UM issues;
- Assure there is appropriate integration of physical, behavioral, and social health services for client health plan members;
- Participate in and provide oversight to the UMSC and all other physician committees or subcommittees.
- Recommend and help monitor corrective action as appropriate for practitioners with identified deficiencies related to BH UM.
- Serve as a liaison between BH UM and Centene Corporate departments as indicated;
- Support client health plans educate their network practitioners and providers regarding UM issues; and
- Report and/or assign a delegate to report UM activities to the CABH QIC as needed.

INTEGRATION WITH OTHER PROGRAMS

The BH UM process utilizes quality indicators as a part of the review process and provides the results to the CABH UMSC and QIC. The utilization of services is inter-related with the quality and outcome of the services.

Any adverse information that is gathered through interaction between CABH UM Level I or Level II reviewers and the client health plans' practitioner or provider network is also vital to the recredentialing process. The information is forwarded to the client health plans' QI Department in the format prescribed by the client health plan for review and resolution as needed. The client health plans' Chief Medical Director or Medical Director determines if the information warrants additional review by their Peer Review or Credentialing Committee.

BH UM SOPs and BH clinical policies serve as integral components in preventing, detecting, and responding to fraud, waste, and abuse among client health plans' networks and members. CABH UM works closely with the CABH Senior Director of Compliance, client health plan when indicated, and the Centene Special Investigations Unit to assist in the resolution of identified potential issues.

CABH UMSC SCOPE

Daily oversight and operating authority of UM activities are delegated by the CABH QIC to the UMSC. The UMSC is responsible for the review and appropriate approval of medical necessity criteria and protocols and BH UM SOPs. The CABH UMSC annually reviews and approves the CABH UM Program Description, QI/UM Work Plan, and CABH UM Program Evaluation, which are then presented to the CABH QIC for review and approval. The UMSC monitors and analyzes relevant data to detect and correct patterns of potential or actual inappropriate over- or under-utilization, which may impact health care services, coordination of care, and appropriate use of services and resources, as well as member and practitioner experience with the UM process. Analysis of the above tracking and monitoring processes, as well as status of corrective action plans, as applicable, are reported to the Plan's QIC.

UMSC	
Charter Statement	The CABH UMSC is a standing subcommittee of the CABH QIC with oversight and operating authority of behavioral health clinical and UM activities.
Purpose	The purpose of the UMSC is to review and monitor the appropriateness of behavioral healthcare provided to client health plan members. The UMSC is responsible for the review and appropriate approval of medical necessity criteria and protocols, and utilization management policies and procedures, including a list of procedures requiring prior authorization.
Responsibilities	<ul style="list-style-type: none"> • Annually review and approve the CABH UM program description, QI/UM work plan and annual UM evaluation; • Conduct 12-month reviews, and revisions as needed, to behavioral health standard operating procedures; • Annually review and approve behavioral health medical necessity level of care criteria; • Review behavioral health utilization management activities • Examine reports of the appropriateness of care for trends or patterns of under or over-utilization and refer for performance improvement or corrective action when indicated;
Oversight Committee	CABH Quality Improvement Committee
Committee Chair	Chief Behavioral Health Medical Officer, individual meetings may be chaired by an Associate Medical Director and VP, Clinical Operations at the discretion of the Chief Behavioral Health Medical Officer.
Committee Composition	<ul style="list-style-type: none"> • Chief Operating Officer • Behavioral Health Chief Medical Officer (Chairperson) • Senior Medical Directors • PHD/PsyD Licensed Psychologists • Vice Presidents of Health Plan Strategy (Facilitator) • Vice President, Clinical Operations • Vice Present, Utilization Management • Vice President, Analytic Solutions (Behavioral Health) • Vice President, Program Development & Operations (Behavioral Health) • Staff Vice President, Operations • Senior Director, Compliance • Senior Director, Product Development & Innovation • Senior Director, Specialty Programs (Behavioral Health) • Senior Director, Quality and Accreditation • Directors, Utilization Management • Centene Director, Accreditation • Director, Grievance & Appeals • Director, Training • Senior Manager, Referral & Authorization • Manager, Ethics and Compliance • Denials Manager • Quality Manager • Behavioral Health HEDIS Manager • QI Specialists II • Clinical Informatics Analyst
Frequency	Quarterly, with additional meetings scheduled per CABH's needs
Attendance Required	50% of scheduled meetings.

UMSC	
Quorum	Minimum of 50% of committee members, including the Behavioral Health Chief Medical Officer or and one (1) Behavioral Health Senior Medical Director, and two (2) Behavioral Health Medical Directors must be present for a quorum. There are voting and non-voting participants. The Committee Chair has the determining vote in the case of a tie vote.
Agenda	Meetings are agenda driven. All agendas and minutes follow a standard format. Agenda items for the next meeting are developed by the Committee Chair
Recorder	Delegated committee designee
Minutes/Meeting Packets	Draft minutes are completed no later than within 30 days of the meeting, or as needed for regulatory reporting. Minutes are stored in a secure area. Meeting packets are distributed by secure means to committee members prior to the scheduled meeting date with sufficient time to provide review of meeting materials, as applicable based on need for prior review and privacy/sensitivity of materials.
Decision Authority	The CABH UMSC is authorized by the CABH QIC to make all decisions related to the behavioral health UM Program, with decisions made by consensus of the committee. Individuals are responsible to raise issues at committee meetings.
Evaluation	The committee reviews the charter annually.
Confidentiality	The proceedings of the CABH UMSC are considered "Privileged and Confidential" and are treated as such.

UTILIZATION MANAGEMENT PROCESS

The UM process encompasses the following program components:

- 24-hour Nurse Triage;
- Referrals;
- Second Opinions;
- Prior Authorization;
- Pre-Certification;
- Concurrent Review;
- Ambulatory Review;
- Post-Service (Retrospective) Review;
- Discharge Planning; and
- Care Coordination.

The process is complete when the requesting practitioner and member (when applicable) have been notified of the determination.

QUALIFICATIONS AND TRAINING

Appropriately licensed, qualified health professionals supervise the BH UM process and all medical necessity decisions. A physician or other appropriately licensed health care professional (as indicated by case type) reviews BH medical necessity denials offered under the client health plans' benefits. Personnel employed by or under contract to perform utilization review are appropriately qualified, trained, and hold current professional licensure. This licensure is specific to the client health plans if required by state regulations. Staff who are not qualified healthcare professionals, who are under the supervision of appropriately licensed healthcare professionals may approve services when there are explicit UM criteria, and no clinical judgment is required.

UM employee compensation includes hourly fees and salaried positions. All staff completing UM reviews and decisions are required to sign an affirmative statement regarding compensation annually. Compensation or incentives to staff or agents based on the amount or volume of adverse determinations; reductions or limitations on lengths of stay; benefits; services; or frequency of telephone calls or other contacts with health care practitioners or members is prohibited. CABH does not permit or provide compensation or anything of value to its employees, agents, or contractors based on:

- The percentage of the amount by which a claim is reduced for payment, the number of claims or the cost of services for which the person has denied authorization or payment, decisions that result in under-utilization; or
- Any other method that encourages the rendering of an adverse determination.

CABH determines appropriate staffing based on client health plan needs and/or contract that may include, but are not limited to the following:

Chief Behavioral Health Medical Officer and Senior Medical Directors

The CABH Chief Behavioral Health Medical Officer and Senior Medical Directors are Board-Certified psychiatrists that hold active unrestricted state licensure to practice medicine.

The CABH Chief Behavioral Health Medical Officer, CABH Senior Medical Directors, CABH Medical Directors, and CABH licensed PHDs/PsyDs when indicated by client health plans' state contracts, supervise all medical necessity decisions, and conduct Level II medical necessity reviews (as allowed by state contract).

CABH Medical Directions and Licensed Psychologists

CABH client health plan Medical Directors and licensed PhD/PsyD clinicians are involved in implementing, monitoring, and directing the behavioral health care aspects of the CABH UM program for client health plans. They may participate in UM rounds to assist in identifying behavioral health care needs and integrating behavioral and physical care, and participate on the CABH QIC, UMSC and Clinical Policy Subcommittee.

Board-Certified Clinical Consultant Panel

CABH maintains a panel of Board-Certified consultants with expertise in various mental health and substance use areas who may be asked by the Medical Director to consult on complex cases when a medical necessity decision is needed. Board-Certified Clinical Consultants may also be contacted to avoid a conflict of interest. CABH defines a conflict of interest as participation in any case review in which objectivity may not be maintained. No individual may participate in a quality of care or medical necessity decision regarding any case in which they have been professionally involved in the delivery of care. Peer reviewers may not participate in decisions on cases where the reviewer is the consulting practitioner or where the reviewer's partner, associate, or relative is involved in the care of the member, or cases in which the practitioner or other consultant has previously reviewed the case.

Vice President of Clinical Operations / Vice President of Utilization Management

The CABH Vice President of Clinical Operations and Vice President of Utilization Management are Masters' Level licensed clinicians with experience in UM operations and activities. Depending on product line, each oversee the day-to-day operational activities of the CABH UM Program. They report to the CABH Chief Operating Officer. In collaboration with the Chief Behavioral Health Medical Officer, they assist with the development of the BH UM strategic vision in alignment with the corporate and CABH objectives, policies, and procedures.

Utilization Management Director/ Manager

The UM Director/Manager is either a registered nurse, Doctorate level or Masters' level licensed behavioral health clinician with experience in UM Operations and activities. The UM Director/Manager directs and coordinates the activities of the team including supervision of staff responsible for Level I reviews, referrals, prior authorization, and concurrent reviews. The UM Director/Manager reports to the Vice President of Clinical Operations or the Vice President of Utilization Management, which is dependent on the product line.

Referral Specialists

Referral Specialists are individuals with significant administrative experience in a health care setting. Experience with diagnosis and CPT coding is preferred. Referral Specialists work with providers to collect demographic and other data necessary for preauthorization and may have the authority to approve services for which there are explicit criteria or algorithms. Referral Specialists cannot make clinical determinations, referring BH clinical decisions to a UM Director/Manager/Psychologist/MD. Behavioral Health Referral Specialists report to and are supervised by the CABH Director or Manager, Referral Services, or a qualified designee.

MEDICAL NECESSITY REVIEW

Behavioral health covered services are those medically necessary services provided to members as outlined in the Centene Master Services Behavioral Health Agreement and client health plan shared service document. Medical necessity means the covered services requested are based on generally accepted behavioral health practices considering conditions at the time of treatment. Medically necessary services are those that are:

- Appropriate and consistent with the diagnosis of the treating practitioner and the omission of which could adversely affect the member's medical or BH condition;
- Compatible with the standards of acceptable medical practice in the community;
- Provided in a safe, appropriate, and cost-effective setting given the nature of the diagnosis and the severity of the symptoms;
- Not provided solely for the convenience of the member, the practitioner, or the facility providing the care;
- Not primarily custodial care unless custodial care is a covered service or benefit under the member's evidence of coverage and appropriate; and
- There is no other effective and more conservative or substantially less costly treatment, service, and setting available.

Medical necessity determinations are made by appropriate BH professionals based on the members' covered BH benefits defined by the client health plans' certificate of coverage, provided by the health plan to their members.

There are two levels of medical necessity review:

1. Level I review is conducted by a licensed clinician appropriately trained in the principles, procedures, and standards of utilization and medical necessity review. A Level I reviewers utilize the Change Healthcare's InterQual®, the American Society of Addiction Medicine's (ASAM) criteria, or applicable client health plan Community Based Services medical necessity criteria, while taking into consideration the individual member needs and complications at the time of the request, in addition to the local delivery system available for care. Other factors considered when applying criteria to a given individual situation includes the members' age, co-morbidities, complications, progress of treatment, psychosocial situation, and home environment. At no time does a Level I review result in a reduction, denial, or termination of service. Adverse determinations can only be made by a Medical Director or Peer Reviewer during a Level II review.
2. Level II review is conducted on a case-by-case basis by a Board-Certified Psychiatrist that holds an active unrestricted medical license. Level II reviews are requested when a medical necessity determination cannot be made on the Level I review; or services are considered experimental in nature or are new applications to an existing BH technology. Level II reviews are conducted with consideration given to continuity of care, individual member needs at the time of the request, and the local delivery system available for care. A board-certified consultant may be consulted in making the medical necessity determination. The Medical Director reviews all potential medical necessity denials for medical appropriateness and has authority to implement an adverse determination which results in reduction, suspension, denial, or termination of services.

Clinical Criteria

The goal in UM is to help guide best practice medicine in the most efficient and economical manner while addressing patient-specific needs. To that end, the clinical decision criteria utilized aligns the interests of the health plan, the practitioner, and the member. The UM criteria are nationally recognized, evidence-based standards of care and include input from recognized medical experts. UM criteria and the policies for application are reviewed and approved at least annually and updated as appropriate. CABH UMSC includes appropriate practitioners that are involved in developing, adopting, and reviewing criteria. Clinical criteria are utilized as an objective screening guide and are not intended to be a substitute for physician judgment. Utilization review decisions are made in accordance with currently accepted BH practices, while taking into consideration the individual member needs and complications at the time of the request, in addition to the local delivery system available for care.

CABH uses InterQual guidelines to determine medical necessity and appropriateness of BH care, or when required by the client health plan, state specific clinical criteria may be applied. Change Healthcare plays an integral role in healthcare, serving more than 50% of America's hospitals, 20% of U.S. physicians and 96% of the top health plans. InterQual is developed by generalist and specialist physicians representing a national panel from academic as well as community-based practice, both within and outside the managed care industry. InterQual provides a clear, consistent, evidence-based platform for care decisions that promote appropriate use of services, enhance quality, and improve health outcomes. CABH uses InterQual's Level of Care and Care Planning Criteria to determine BH medical necessity and appropriateness of care across the BH care continuum. CABH also applies the American Society of Addiction Medicine (ASAM) criteria to determine medical necessity and level of care for substance use services.

Clinical BH Policies, and Evaluation of New BH Technologies or New Applications to Existing BH Technologies

A client health plan may request a review of a new BH technology for inclusion in the members' benefit coverage, or client health plan network practitioners may ask for authorization of a new BH technology or a new application to an existing BH technology that lacks medical necessity criteria. The CABH Clinical Policy Subcommittee (CPSC) is responsible for considering the requests, and evaluates new BH technologies or new applications of existing BH technologies to consider the development of a BH clinical policy as a resource to determine medical necessity. The CPSC develops, and at least annually updates clinical BH policies related to diagnosis treatment recommendations. The CPSC holds regulatory scheduled BH Technology Work Group meetings that include subject matter expert professionals who review published scientific evidence, applicable government regulatory body information, CMS's National and Local Coverage Decisions database/manual when indicated, and input from relevant specialists and professionals who have expertise in the technology. Recommendations are made by the BH Technology Work Group to the CPSC as to whether a BH clinical policy is indicated, or if based on the research and review the efficacy of the BH technology is not evidenced the work group may not recommend the BH technology further clinical policy development.

Clinical Practice Guidelines

Clinical practice guidelines are used to support medical necessity determinations. They contain best practices from nationally recognized organizations such as the American Psychiatric Association and the American Academy of Child and Adolescent Psychiatry. Level I and Level II reviewers apply the guidelines to support medical necessity decisions which are consistent with national evidence-based practices. The BH clinical practice guidelines are available on the Clinical Policy SharePoint site and distributed by client health plans to their networks.

Requests and Access to BH Medical Necessity Clinical Criteria

Treating client health plan network and out of network practitioners, or members may request the medical necessity clinical criteria on which a BH authorization or adverse determination was based. CABH provides the requestor with the medical necessity criteria on which a BH UM determination was made and logs the requests. The client health plan is responsible for developing and distributing a Provider Manual for their network as a quick reference guide and a comprehensive orientation that contains critical information about their UM processes along with the plans' clinical policies.

Interrater Reliability

The CABH BH Training Team annually assesses the consistency UM decision-making among Level I and Level II reviewers. The assessment is performed as a periodic review reported to the CABH UMSC and incorporated into the CABH Annual UM Program Evaluation to evaluate the application of BH medical necessity criteria across reviewers. When an opportunity for improvement is identified through this process, the UM leadership takes corrective action. Newly hired UM staff are required to successfully complete interrater reliability testing prior to being released from training oversight.

BH LEVELS OF CARE

CABH ensures members receive high quality behavioral health care services, in the least restrictive setting to meet their individualized needs. CABH has defined the following levels of care and described the minimum services associated with each level of care. Each level of care includes individualized treatment planning that addresses the member's BH needs. Client health plans determine the BH levels of care that are part of the members' benefit coverage.

Acute Psychiatric Inpatient Hospitalization

Acute hospitalization is the highest level of care for psychiatric and substance abuse services; this facility-based care may occur in a psychiatric or detoxification unit of a general hospital or at a freestanding psychiatric facility. Key elements include: the facility is licensed as a hospital, 24-hour medical and nursing care is provided, and care is supervised by behavioral health specialists. This level of care also includes 23-hour observation beds or beds that provide an equivalent or greater intensity of nursing and medical care.

Crisis Stabilization

Crisis stabilization services provide 24-hour medical and nursing care, serving as a diversion to acute psychiatric inpatient services. Crisis stabilization services are provided by behavioral health specialists at facilities that are not licensed as hospitals.

Residential Treatment

Residential treatment describes a longer term 24-hour program for severe mental health and/or substance use disorders (MH/SUD). Care at a Residential Treatment Center (RTC) or Psychiatric Residential Treatment (PRTF) is medically monitored, with 24-hour onsite nursing services and medical provider availability. This level of care is expected to provide a range and intensity of diagnostic, therapeutic, life skills, rehabilitation and milieu-behavioral health services that cannot be provided by a combination of outpatient or community-based services. Each member's treatment plan should address their specific MH/SUD needs, set discharge criteria, barriers to discharge, and ensure the treatment is the least restrictive option. Family therapy should occur 2-3 times a week to ensure the member can successfully reintegrate back to their home and community unless there is an identified valid reason why this is not clinically appropriate or feasible.

Partial Hospitalization

Partial hospital programs provide services at least 4 hours a day/3 days a week. These facility-based services are of similar intensity to acute hospital services (e.g., on-site nursing, psychiatric, and behavioral health services are available as needed by the member) but are provided less than 24 hours a day. A specific treatment goal for this level of care is improving symptoms and level of functioning sufficiently for the member to return to a lesser level of care. Partial hospital programs for children and adolescents are expected to have family therapy sessions at least once a week.

Day Treatment

Day treatment programs can be either free-standing or hospital-based and provide frequent behavioral monitoring, and intervention and access to frequent medication management by a behavioral health specialist when necessary. Individuals in this level of care are unable to be treated by or have not responded to behavioral health services such as individual/ family/group therapy, medication management, etc. and are experiencing an exacerbation of a longstanding psychiatric disorder, are at risk of deteriorating, or cannot reach identified goals due to significant functional impairments associated with the mental health diagnosis. The program must provide an integrated program of rehabilitation counseling, education, therapeutic, and/or family services at least 25 hours in a week to address an individual's MH/SUD needs, with a specific treatment goal of reduction in severity of symptoms and improvement in level of functioning sufficient to return the member to a lower level of care.

Intensive Outpatient

Intensive outpatient programs must provide an integrated program of rehabilitation, counseling, education, therapeutic, and/or family services preferably 9 hours in a week (minimum of 6 hours a week) to address an individual's behavioral health needs. A specific treatment goal of this level of care is reduction in severity of symptoms and improvement in level of functioning sufficient to return the member to outpatient treatment follow-up and/or self-help support groups.

Community Based Services

Community-based services, where available, should be utilized when traditional services, such as therapy and/or medication management have been attempted and are inadequate to prevent a member from deteriorating and requiring a higher level of care. For children and adolescents, requests for this level of care must clearly document that the child is at imminent risk of out-of-home placement due to functional impairments associated with a behavioral health diagnosis. In all cases, the treatment plan should use techniques that are time-limited and support the goal of enhanced autonomy and the least restrictive environment possible. The treatment plan should be updated monthly and reflect efforts to reduce the frequency of service or clinical documentation for inability to decrease the usage of community-based services.

Outpatient Treatment

Outpatient treatment may be comprised of evaluation services, individual, group, and/or family therapy, and medication management services provided by behavioral health specialists. The treatment plan should be updated monthly (every 30 days) and reflect efforts at targeting symptom reduction, increase community tenure, and enhance independence.

Prior Authorization

Prior authorization may be required by the client health plan. When required, the requesting provider or practitioner requests authorization of a BH service prior to the service being rendered. Upon receipt, the prior authorization request is screened by the UM staff for eligibility and benefit coverage, level of care requested and medical necessity. Prior authorization is never required for emergency services or urgent care services.

CLINICAL INFORMATION

Clinical information to determine the medical necessity and authorization of a BH service request may be submitted by phone, facsimile, or electronically by the practitioner or facility. Although the BH treating practitioner may designate one or more individuals as contacts this does not preclude CABH from contacting the requestor or contacts provided when there is unreasonable delay or when the designated individual is unable to provide the necessary information or data requested.

Clinical information is required for BH services that require prior authorization and/or certification, and only the minimally necessary information is obtained. The clinical information requested is not overly burdensome for the member, the practitioner/staff, or the health care facility staff. Only information necessary to certify the admission, procedure or treatment, length of stay, or frequency or duration of services is collected. Information needed to perform the review may include, as applicable, but is not limited to:

- Office and hospital records
- A history of the presenting problem
- Clinical or mental status exam notes
- Diagnostic testing results
- Treatment plans and progress notes
- Patient psychosocial history or assessments
- Information on consultations with the treating practitioner
- Evaluations from other healthcare practitioners and providers
- Photographs
- Information regarding benefits of the service or procedure
- Information regarding the local delivery system
- Patient characteristics and information
- Information from responsible family members
- LOCUS, CALOCUS, or other level of care assessment
- Physical or behavioral health screenings and results

Clinical information received, as well as rationale for the medical necessity determination and/or level of care is documented and maintained in the clinical documentation system.

Second Opinions

A second opinion may be requested when there is a question concerning diagnosis, or when requested by a member of the member's health care team, including the member, parent, guardian, or others with custodial responsibilities. Authorization for a second opinion is granted to the client health plans' network practitioner or an out-of-network practitioner if there is no in-network practitioner available. The second opinion is provided at no cost to the member.

Out-of-Network BH Services

If a member requires BH services that are not available from the client health plans' qualified network, the client health plan adequately and timely (i.e., according to the client health plans' network practitioner availability and accessibility standards) covers services out-of-network for members. The decision to authorize use of an out-of-network practitioner is based on continuity of care, availability, and location of an in-network practitioner of the same specialty and expertise, and complexity of the case. Client health plan network practitioners are prohibited from making referrals for designated BH with which the practitioner or a member of the practitioner's family has a financial relationship.

Concurrent Review

The concurrent review process assesses the clinical status of the member, verifies the need and level of continued hospitalization or ongoing ambulatory care, facilitates the implementation of the practitioner's plan of care, promotes timely care, determines the appropriateness of treatment rendered, and monitors the quality of care to verify professional standards of care are met. Information assessed during the review includes:

- Clinical information to support the appropriateness and level of service proposed,
- Member status, including any diagnosis change during stay, to determine special requirements to facilitate a safe discharge to another level of care,
- Additional days/service/procedures proposed, and
- Reasons for extension of the treatment or service.

Concurrent review of inpatient acute care is conducted throughout the inpatient stay, with each hospital day approved based on review of the patient's condition and evaluation of medical necessity. Concurrent review can occur on-site or telephonically. The frequency of reviews is based on the severity/ complexity of the member's condition and/or necessary treatment and discharge planning activity and are not routinely conducted daily. If, at any time, services cease to meet inpatient or ambulatory criteria, discharge criteria are met and/or alternative care options exist, the CABH Level I reviewer contacts the facility and obtains additional information to justify the continuation of services. When medical necessity for the case cannot be determined, the case is referred to the CABH Medical Director for review. Discharge planning services are assessed during the admission review and each concurrent review, meeting the objective of planning for the most appropriate and cost-effective alternative to inpatient care. If at any time the UM staff become aware of potential quality of care issues, the concern is referred to the client health plan Quality team for investigation and resolution.

Discharge Planning

Discharge planning is a method of coordinating care, controlling costs, and arranging for the appropriate services upon discharge from the hospital. For members who no longer meet medical necessity for acute inpatient care, discharge planning assists the member in receiving the timely, appropriate, safe, and cost-effective continued BH treatment at the least restrictive level of care.

Discharge planning occurs as early as possible in a members' hospital stay. The Level I reviewer assess the members' post-hospital needs and works with the facility's UM staff to arrange for BH services needed before the member is discharged from the hospital. Community-based agencies are included in the discharge planning as appropriate.

Coordination of Services

Coordination of services and benefits is a key function of client health plans' care management team during the members' BH acute inpatient episode of care as well as for complex or special needs cases. CABH supports the client health plans' care management team synchronize the members' medical, behavioral health, social, and financial needs. The client health plan care managers promote continuity of care by ensuring appropriate referrals and linkages are made for the member to the applicable provider or community resources, even if the services are outside of the required core benefits or when the member has met the benefit limitation.

Post-service (Retrospective) Review

Post-service review is an initial review of BH services that were rendered, and the member is no longer in treatment. The process encompasses services performed by a client health plan participating or non-participating practitioner without notification and/or authorization by CABH and there was no opportunity for concurrent review. CABH reviews the request for post-service authorization based on the supporting clinical documentation to determine medical necessity and when indicated meets the administrative waiver of notification. When the clinical information provided meets medical necessity the request is authorized. If the supporting documentation is questionable, a Level II review is requested.

Significant Lack of Agreement

When there is significant lack of agreement between the CABH Level I reviewer and practitioner regarding the appropriateness of certification during the initial review or appeal process, additional information may be requested.

"Significant lack of agreement" indicates:

- Tentatively a service cannot be certified;
- The case is referred to the Medical Director or Peer Reviewer for review; and
- The Level I review has spoken with or attempted to speak to the treating practitioner to request additional information.

Timeliness of Utilization Management Decisions

Utilization management decisions are made in a timely manner to accommodate the clinical urgency of the situation and to minimize any disruption in the provision of BH health care. Established timelines are in place for client health plan practitioners to notify CABH of a service request and for CABH to make UM decisions and subsequent BH notifications to the member and practitioner. CABH regularly monitors and reports the timeliness of UM decision making to the CABH UMSC.

For pre-scheduled services requiring prior authorization, the provider must notify CABH within five (5) days prior to the requested service date. Prior authorization is never required for emergent or urgent care services. Facilities are required to notify CABH of BH acute care inpatient admissions within one (1) business day following the admission. Once the member's emergency medical condition is stabilized, certification for BH hospital admission or authorization for follow-up care is required as stated above. All decisions and notifications are provided within the timeframes as noted in the CABH SOP, *Utilization Management Timeliness and Notification Standards*.

Denial Notices

A denial of BH services, also called an adverse determination, is a reduction, suspension, denial, or termination of any service based on medical necessity or benefit limitations. The CABH Medical Director or Peer Reviewer may recommend an alternative BH service to the service being requested. If the requesting requestor does not agree to the recommended alternative, the initial requested service may be denied. However, if the requesting provider and/or member agree with the alternative service and the care is authorized, the requestor has essentially withdrawn the initial BH service request, which is not considered a denial.

Upon the medical necessity denial determination by the Level II reviewer, the requestor receives a verbal when applicable, and a written BH adverse notification. CABH applies the specific turnaround times for the BH medical necessity denial notification based on the line of business, clinical urgency, and type of review, or when indicated the client health plan state required turnaround time. The turnaround time is measured from the date of the request for the BH service to the date of the BH written notification. CABH uses client health plan approved letter templates. The written BH denial notification is easily understandable and includes the member-specific reason/rationale for the determination, specific criteria and availability of the criteria used to make the decision as well as the availability, process, and timeframes for appeal of the decision.

Verbal notification of a denial determination may be communicated. Verbal notification does not replace electronic or written notification of denial decisions, but when provided, CABH may extend the Medicare and Marketplace time frame for urgent preservice and concurrent electronic or written denial notification decisions an additional 3 calendar days following verbal notification. For Medicaid decisions, verbal notification does not extend the electronic or written notification time frame. Medicare, Marketplace, and Medicaid verbal denial determinations must include the following requirements and are documented within the management system:

- Verbal notification requires communication with a live person; CABH may not leave a voicemail;
- CABH records the time and date of the notification and the staff member who spoke with the practitioner or member; and
- CABH provides verbal notification within the time frames specified for an urgent concurrent or urgent preservice request.
- The time, date, and name of the CABH UM staff who offered the availability of the opportunity for the peer-to-peer discussion is documented in the clinical documentation system notes.
- Treating practitioners are provided the opportunity to discuss the UM denial decision with a CABH Peer Reviewer who made the initial denial determination. If the CABH Peer Reviewer who made the initial denial determination is unavailable, the peer-to-peer review is conducted with an alternate CABH Peer Reviewer, which is classified as a Peer-to-Peer Review.
- At the time of verbal notification to the treating practitioner/facility of an adverse determination, the licensed UM staff notifies the requester of the opportunity for the treating physician to discuss the case directly with the Medical Director or applicable practitioner reviewer making the medical necessity determination. The time and date of both the verbal denial notification and the offer of physician reviewer availability is documented in the clinical documentation system notes.
- Practitioner/facility notification that a physician or other appropriate reviewer is available to discuss the denial decision is also included in the written denial notification.

Once CABH issues a denial determination, the treating practitioner has three (3) business days to request a peer-to-peer review to provide additional insights or information regarding the members' clinical status to the Peer Reviewer who rendered the initial denial determination. If the attending practitioner disagrees with the denial determination, they may file an appeal as outlined in the written denial determination notification.

Admitting Physician Concurrence is required for Medicare members before a denial of a continued inpatient stay (that has been initially approved). Lack of response from the admitting physician is considered a concurrence. A denial notification letter may be sent at this point. The CABH UM staff must confirm and document with the admitting facility that the member has been given their discharge/appeal information. Initial reviews and leveling of care do not require physician concurrence.

Appeal of an Adverse BH UM Determination

As delegated by the client health plan, CABH manages the first level of client health plan member appeals. A member appeal is a request to change or reverse a previous adverse medical necessity determination. The client health plan manages medical necessity appeals beyond the first level, provider appeals, and member grievances based on an adverse benefit or administrative determination. Members, their authorized representative (with written consent from the member as dictated by CMS or State contract) that includes a legal representative of a deceased member's estate, or the treating practitioner acting on behalf of the member may appeal based on an adverse BH medical necessity determination. Expedited appeals are available to members for any urgent care requests and do not require written member consent for a healthcare practitioner to act on the member's behalf. Punitive action is not taken against a practitioner who requests an expedited resolution or supports a member's appeal.

Members, or their authorized representative, are provided a reasonable timeframe to file an appeal. The content of an appeal including the clinical care aspects are fully investigated and documented. Members, or their authorized representative, have the right to submit comments, records, documentation, and other information relevant to the appeal in person or in writing. A physician of the same or similar specialty who was not involved in the initial adverse determination, and is not a subordinate of the physician who made the initial denial determination evaluates the medical necessity based on the clinical information to determine whether the appeal is overturned, partially overturned, or upheld. CABH receives, reviews, resolves, and provides the member, or their authorized representative, with written or electronic notification of the decision within the type of appeal review and line of business turnaround time.

Independent/External Appeals

The client health plan manages all levels of member appeals beyond the first level managed by CABH when delegated by the client health plan.

MEMBER EXPERIENCE WITH BH UM PROCESSES

CABH supports the Centene CAHPS team with the annual Medicaid, Medicare, and Marketplace ECHO Survey analyses and recommends interventions based on the analyses to improve member satisfaction with the BH UM services that the client health plans can choose to adopt at their discretion. The client health plans manage their network providers' experience with BH UM processes. Each client health plan manages member and provider complaints. CABH supports the client health plans with complaints they receive based on BH UM processes. An aggregate total number and nature of the complaints CABH receives from the client health plans are reported quarterly and annually to the UMSC and QIC.

COMMUNICATION

Members and practitioners can access UM staff through a toll-free number at least eight hours a day during normal business hours for inbound or outbound calls regarding BH UM issues or questions about the BH UM process. TDD/TTY services for deaf, hard of hearing, or speech-impaired members are available. The client health plans, at their discretion, publish the phone numbers in their plans' Member Handbook, on their website, or in member letters. Additionally, language assistance for members to discuss BH UM issues is provided either by bilingual staff or through language line services.

Inbound and outbound communications may include directly speaking with practitioners and members; or fax, electronic or telephone communications (e.g., sending email messages or leaving voicemail messages). Staff identifies themselves by name, title, and organization name when initiating or returning calls regarding UM issues.

After normal business hours, and holidays, the 24-hour Nurse Advice Line team is responsible for inbound behavioral health calls via a toll-free number. All behavioral health UM inquiries are documented in the OMNI System. The CABH Customer Care Professionals (CCPs) monitor the OMNI System daily and follow-up on the behavioral health UM inquiries the next calendar day.

In addition, the Nurse Advice Line team reports the behavioral health calls to the respective client health plan for possible follow-up by the plans' Care Management Team. As part of the triage process, CABH staff may direct the member, as appropriate, to their PCP or an emergency department. Under no circumstances does CABH staff offer medical advice. At any time, members may also contact Nurse Advice Line team, which provides 24-hour healthcare assistance and advice.

PRACTITIONER – MEMBER COMMUNICATION

CABH does not prohibit or restrict a BH treating practitioner acting within the lawful scope of practice from advising or advocating on a members' behalf as follows:

- The member's health status, medical or behavioral care or treatment options, including any alternative treatments that may be self-administered;
- Any information the member needs to decide among all relevant treatment options;
- The risks, benefits and consequences of treatment or absence of treatment;
- The member's right to participate in decision regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

SHARING INFORMATION

CABH shares individual member clinical and demographic information among various teams (e.g., certification, and discharge planning) via the clinical documentation system to avoid duplicate requests for information from members or practitioners.

MEDICAL RECORDS ACCESS

CABH does not maintain or release members' medical records. The client health plans are responsible for medical record requests.

EMERGENCY SERVICES

Emergency Medical, Behavioral Health, and Substance Use inpatient and outpatient services are covered when (1) furnished by a provider qualified to furnish these services and (2) needed to evaluate or stabilize an emergency medical/behavioral health condition. An emergency medical/behavioral health condition means a medical, mental health, or substance use-related condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

- Placing the physical or behavioral health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part;
- Serious harm to self or others due to an alcohol or drug use emergency; Injury to self or bodily harm to others; or
- With respect to a pregnant woman having contractions: (1) that there is inadequate time to effect a safe transfer to another hospital before delivery, or (2) that transfer may pose a threat to the health or safety of the woman or the unborn child.

Emergency services are available 24 hours a day/ 7 days per week. Prior authorization is not required for emergency services and coverage for such is based on the severity of the symptoms at the time of presentation.

When a client health plan network practitioner, or CABH representative, instructs a member to seek emergency services, the medical screening examination and other medically necessary emergency services are covered without regard to whether the condition meets the prudent layperson standard. Once the members' emergency condition is stabilized, certification for hospital admission or prior authorization for follow-up care is required.

CABH never denies authorization for emergency services based on the practitioner's or the facility's failure to notify CABH of the screening and treatment within the required timeframes, except as related claim filing timeframes managed by the health plan. Members who have an emergency medical condition are not required to pay for subsequent screening and treatment needed to diagnose the specific condition or stabilize the member.

MENTAL HEALTH AND SUBSTANCE USE PARITY

CABH complies with the Mental Health Parity and Addiction Equity Act (MHPAEA) as it applies to its Medicaid Managed Care Organizations as described in section 1903(m) of the Social Security Act (the Act); Medicaid Alternative Benefit Plans (ABPs) as described in the Act; and Children's Health Insurance Programs (CHIP) under title XXI of the Act. The client health plan is responsible for ensuring that benefit limitations for mental health or substance use disorder (MH/SUD) are comparable to those for medical/surgical benefits and do not impose less favorable limitations on MH/SUD benefits compared to medical/surgical benefits, including with respect to annual and lifetime dollar limits, financial requirements, or treatment limits (see COMP.46).

ANNUAL UM PROGRAM EVALUATION

The CABH UM Program is evaluated annually. The evaluation addresses the effectiveness of the program, and includes aspects of the UM Program structure, organization, resources, and activities that are monitored and reported to the CABH UMSC and QIC quarterly and/or annually as noted on the CABH QI/UM Work Plan.

The evaluation process includes the results of the activity, a quantitative analysis that trends outcomes over time and in comparison with the performance goals, and previous reported outcomes to demonstrate improvements or lack of improvement; a qualitative analysis that addresses interventions that successfully improved the outcomes and barriers that may have impacted a decline in the outcomes; opportunities for improvement based on the identified barriers; and interventions based on the opportunities for improvement as part of the next year's UM Program.

The final document is submitted to the Board of Directors or the CABH executive leader designee, the CABH UMSC and QIC for their review and approval.

DELEGATION

Independent Review Organizations (IROs), accredited by NCQA or URAC may authorize final BH utilization management decisions on CABH's behalf. The Centene Corporate Third-Party Risk and Contract Teams evaluate each delegated entity's capacity to perform the proposed delegated activities prior to the execution of a delegation agreement. A mutually agreed upon delegation agreement, is signed by authorized parties from the Centene Corporate Third-Party Risk and/or Contract Teams and the IRO. The agreement includes, but is not limited to, the following elements:

- Responsibilities of Centene and the delegate;
- Specific activities being delegated;
- Frequency and type of reporting (i.e., minimum of semiannual reporting);
- The process by which Centene evaluates the delegate's performance;
- Explicit statement of consequences and corrective action process if the delegate fails to meet the terms of the agreement, up to and including revocation of the delegation agreement; and
- The process for providing member experience and clinical performance data to the delegate when requested.

Corporate Third-Party Risk and/or Centene Corporate Compliance designees, conduct an annual evaluation and documentation review that includes the delegate's program, applicable policies and procedures, applicable file reviews, and review of meetings minutes for compliance with state and federal requirements and accreditation standards.

If the delegation arrangement includes the use of protected health information (PHI) the delegation agreement also includes PHI provisions, typically accomplished in the form of a Business Associate Agreement signed by the delegated entity.

IROs are delegated CABH final behavioral health utilization management determinations. Semi-annually CABH meets with each delegated IRO to review utilization management reports, outcomes, and analyses as indicated on the CABH IRO Work Plan provided to each IRO. IRO report results that do not meet CABH performance goals noted on the IRO Work Plan are addressed, opportunities for improvement indicated, and recommended actions are implemented. CABH maintains meeting agendas and notes for each IRO that are shared with the Corporate Third Party Risk and Contract teams for review.

Centene Corporate Third Party Risk and Contract teams retain accountability for all functions and services delegated, and as such monitors the performance of the delegated entity through annual approval of the delegate's programs (Credentialing, Utilization Management, Care Management, Quality, etc.) routine reporting of key performance metrics, and annual or more frequent evaluation to determine whether the delegated activities are being carried out according to Centene Corporate regulatory requirements and accreditation standards. Centene Corporate retains the right to reclaim the

POLICY AND PROCEDURE

DEPARTMENT: Centene Advanced Behavioral Health Utilization Management	REFERENCE NUMBER: CC.BH.UM.02
EFFECTIVE DATE: 9/8/04	P&P NAME: Clinical Decision Criteria and Application for Behavioral Health
REVIEWED/REVISED DATE: 2/18/19; 6/6/19; 6/14/19; 3/25/20; 6/26/20; 7/20/20; 10/21/20, 12/7/20; 6/23/21; 9/22/21; 10/28/21; 11/23/21; 12/22/21; 3/29/22	RETIRED DATE: N/A
BUSINESS UNIT: Centene Advanced Behavioral Health	PRODUCT TYPE: Medicaid, Marketplace & Medicare
REGULATOR MOST RECENT APPROVAL DATE(S):	

POLICY STATEMENT:

This policy outlines how clinical support criteria is used in determining medical necessity.

SCOPE:

This policy applies to Centene Advance Behavioral Health (CABH) Operations.

PURPOSE:

To ensure clinical decisions made utilize all relevant clinical information and are based on objective and evidence-based criteria considering individual circumstances and local delivery systems.

DEFINITIONS:

Medical Director: As used in this policy is a collective term for the CABH Behavioral Health Chief Medical Officer, Senior Medical Director, or Medical Director.

UM Designee: Member of CABH UM/Clinical Operations Departments appropriately trained in the principles, procedures, and standards of utilization and medical necessity review. See CC.BH.UM.03 Appropriate Behavioral Health UM Professionals for staff titles, qualifications and reporting structure.

POLICY:

CABH and delegated vendors (as applicable) use written clinical support criteria to evaluate medical necessity, level of care, and/or clinical appropriateness of behavioral healthcare that requires approval. They work collaboratively to ensure members have timely access to high quality behavioral healthcare and appropriate healthcare resources. The medical necessity criteria and the procedures for applying them are reviewed annually and updated as appropriate.

PROCEDURE:

I. Clinical Criteria

A. Objective, evidence-based clinical criteria:

1. CABH behavioral health medical necessity criteria are adopted from nationally recognized resources based on current scientific medical evidence and clinical practice as decision support tools to evaluate medical necessity, level of care, and/or clinical appropriateness of behavioral healthcare services requiring approval. CABH ensures members have timely access to high quality behavioral healthcare and appropriate behavioral healthcare resources.
2. CABH applies InterQual Criteria for behavioral health inpatient, residential/PRTF, partial hospitalization, intensive outpatient and outpatient therapy, American Society of Addiction Medicine (ASAM) criteria for substance use services, state specific medical necessity criteria for community based behavioral health services, CALOCUS/LOCUS, or MCG® as appropriate.
3. CMS approved behavioral health Local Coverage Determinations (LCD) and National Coverage Determinations (NCD) are also applied to determine Medicare medical necessity UM decisions.
4. Community Based Services (CBS) for specific behavioral health services may be required by a state for health plans that manage Medicaid. CABH will collaborate with the health plan to develop and implement the medical necessity criteria as noted below:
 - The health plan will provide CABH UM with the state required CBS behavioral health medical necessity criteria;

- CABH will place the CBS behavioral health medical necessity criteria in a CABH CBS template;
 - Once a draft of the health plan specific CBS criteria is created a copy of the document will be forwarded to the health plan for their review and approval. The draft will also be presented at the CABH Utilization Management Subcommittee (UMSC) for their review and approval.
 - Once approved the CABH Level I and Level II reviewers working with the health plan will receive training to educate them on the criteria;
 - The criteria will be placed on the CABH MNC SharePoint site for accessibility, and upon request available for distribution to members and practitioners/providers; and
 - The health plan will notify CABH of any updates and/or revisions to the criteria. CABH will make the necessary revisions as per the process noted above.
5. While clinical practice guidelines from nationally recognized organizations are not used as criteria for medical necessity determinations, based on national standards of practice they support behavioral health medical necessity decisions.
 6. CABH utilizes medical necessity criteria as an objective screening guide, and not intended to substitute for physician judgment. Utilization review decisions are made in accordance with the currently accepted medical and/or behavioral health care practices, taking into consideration the members' individual member needs and characteristics at the time of the request, such as:
 - Age;
 - Comorbidities;
 - Complications;
 - Progress of treatment;
 - Psychosocial situation; and
 - Home environment, when applicable.
 7. Consideration is given to available services in the local delivery system and their ability to meet the members' specific medical and behavioral health care needs when UM criteria are applied.
 8. Practitioners with professional knowledge and clinical expertise in behavioral health are involved in the development, review, and adoption of all medical necessity criteria, and clinical policies. Licensed and Board Certified/Board Eligible Psychiatrists, Doctorate Level Licensed Psychologists, Masters' Level Licensed Clinicians, and Registered Nurses are voting members of the CABH Quality Improvement Committee (QIC), Utilization Management Subcommittee (UMSC), and Clinical Policy Subcommittee (CPSC).
 9. Annually, CABH Peer Advisors, and UM/Clinical staff are required to sign an Affirmative Statement About Incentives. Compensation or incentives to CABH staff or agents based on the amount or volume of adverse determinations; reductions or limitations on lengths of stay, benefits, services; or frequency of telephone calls or other contacts with health care practitioners or patients is prohibited.
- B. Annual Review of Criteria**
1. Annually or when updates are indicated, InterQual, MCG, ASAM, other applicable criteria, and state specific services as well as the procedures for applying such criteria, are reviewed, and approved by the CABH UMSC, and QIC.
 2. Annually or when updates are indicated, CABH behavioral health treatment-related clinical policies are reviewed and approved by the CABH Clinical Policy Subcommittee (CPSC) and QIC.
- C. Availability of Criteria**
- Client health plans notify practitioners and providers of the availability of the behavioral health medical necessity criteria used to make the behavioral health medical necessity decision through the plans' provider orientations, Provider Manual, Provider Toolkit available on the client health plans' website, Provider Newsletters, and client approved Notices of Action. The communications include notification that treating providers may, at any time, request UM criteria pertinent to a specific authorization by contacting CABH or may discuss the medical necessity UM decision with the Level II Peer Reviewer who made the initial medical necessity determination.

II. Clinical Criteria Application

A. Levels of Clinical Review

Clinical criteria are applied to determine medical necessity and/or appropriate level of care for the service being requested. Two levels of UM clinical review are available for all authorization requests, Level I and Level II.

1. Level I reviews are conducted by Masters' Level licensed clinicians or RNs who were appropriately trained in the principles, procedures, and standards of utilization management and medical necessity review. At no time does a Level I review result in a reduction, denial, or termination of a service. A Level I review is conducted based on the following:

- a. InterQual Criteria for behavioral health inpatient, residential/PRTF, partial hospitalization, intensive outpatient and outpatient therapy, American Society of Addiction Medicine (ASAM) criteria for substance use services, state specific medical necessity criteria for community based behavioral health services, CALOCUS/LOCUS, MCG®, behavioral health NCDs/LCDs, and individual member needs and characteristics at the time of the request including age, co-morbidities, complications, progress of treatment, psychosocial situation, and home environment, when applicable.
 - b. The local delivery system availability and ability to meet the specific member's medical and behavioral health care needs are also considered.
2. Level II reviews are conducted by CABH Peer Reviewers, who are actively practicing Board Certified/Board Eligible licensed Psychiatrists or when indicated, Doctorate Level Licensed Psychologists, appropriately trained in the principles, procedures, and standards of utilization management and medical necessity review. A board-certified behavioral health specialist may be consulted in making a medical necessity determination. Adverse determinations must be determined during a Level II review by a Peer Reviewer. A Level II review is conducted based on the following:
- a. InterQual Criteria for behavioral health inpatient, residential/PRTF, partial hospitalization, intensive outpatient and outpatient therapy, American Society of Addiction Medicine (ASAM) criteria for substance use services, state specific medical necessity criteria for community based behavioral health services, CALOCUS/LOCUS, MCG®, behavioral health NCDs/LCDs, and individual member needs and characteristics at the time of the request including age, co-morbidities, complications, progress of treatment, psychosocial situation, and home environment, when applicable.

III. Consistency in Application of Criteria

1. CABH makes UM decisions in a fair, impartial, and consistent manner. Written criteria based on Evidenced Based Medicine (EBM), Evidenced Based Practices (EBP) and specific procedures for applying those criteria in an appropriate manner are utilized for all utilization decisions. Annually CABH evaluates the consistency of application of the criteria by the health care professionals involved in utilization review via an inter-rater reliability survey and case audits. Assessment and evaluation of the consistency of application of Medical Necessity Criteria is conducted by the CABH Training Team.
2. On a monthly basis, the Utilization Management Managers/Supervisors conduct chart audits against criteria to ensure policy compliance and the appropriate application of behavioral health medical necessity criteria. Results are shared with the UM staff members and used for ongoing evaluation of performance.
3. UM clinical staff will score 90% or greater on their case review audits overall, and 90% or greater on the items related to appropriate application of Medical Necessity Criteria.
4. When the audit scores do not meet the performance goals a Corrective Action Plan and Re-audit at least quarterly may be indicated.
5. Individual UM staff performance included as part of ongoing performance evaluation.
6. Review of problem/complex cases during weekly UM "rounds". Weekly clinical rounds are conducted by the CABH Medical Director to evaluate determinations and discuss complex cases. New behavioral health UM staff is required to successfully complete interrater reliability testing within ninety (90) days of hire. Provide ongoing staff training on the application of Medical Necessity Criteria by discussing problem or complex cases and decision-making during UM Rounds.
7. Annual Interrater Reliability (IRR) testing is performed on all CABH clinical staff involved in behavioral health UM decision making to ensure consistency in determinations and documentation. (Refer to CC.UM.02.05 – Interrater Reliability.)
8. All current InterQual®, MCG, ASAM, LOCUS/CALOCUS (Medicaid and Marketplace only) users will be tested at least yearly. This includes all CABH Medical Directors, Registered Nurses, and appropriately licensed behavioral health clinicians.
9. New CABH employees, including temporary employees, must be tested after initial InterQual®, MCG, ASAM, LOCUS/CALOCUS (Medicaid and Marketplace only) training within ninety (90) days, but before the end of their 90-day orientation regardless of any pre-employment test. If this testing coincides with the annual testing, it may be used for both. If there are more than 30 days separating the new employee and annual testing, it must be repeated.
10. Temporary employees who do not pass the applicable IRR testing are ineligible for assignment.
11. CABH Managers and Clinical Trainers will receive scores for their respective staff. A score of <90% for any subset is considered failure. Successful demonstration of the application of InterQual®, MCG, ASAM, and/or LOCUS/CALOCUS/CASII (Medicaid and Marketplace only) proficiency and the UM process must be validated through audits and testing prior to release from orientation.
12. Staff will be kept updated related to any changes to all medical necessity criteria as needed based on when changes occur.

13. At least annually, the Corporate Vice President of Medical Management Operations (VPMM), in conjunction with the Corporate and CABH Medical Management Training departments (IRR team), will initiate and conduct the IRR testing to assess the consistency with which physician, non-physician and clinical staff reviewers apply UM criteria. Additionally, clinical trainers and managers of UM clinical staff are required to test as well.
14. CABH is responsible for supplying a copy of the current medical necessity criteria IRR test and test results to the Vice President, Medical Management (VPMM) for the integrated plans.
15. For those utilizing InterQual® Criteria, the IRR will consist of a test derived from Change Healthcare's IRR test applicable for the current InterQual® criteria used to make UM decisions. Separate tests will be created for each InterQual® subset.
16. The IRR team prepares an email communication outlining the staff requirements for completing the test and emailing results to CABH's Chief Behavioral Health Medical Officer, or designee, as well as instructions on how to use the online system and the date parameters for testing to be completed.
17. The IRR team distributes the IRR email to CABH with a copy to the CABH Trainer for distribution to appropriate staff. All staff testing is required to take the subset tests related to all areas for which they perform review.
18. Once testing is completed, the IRR team prepares summary information. The CABH Chief Behavioral Health Officer and Chief Behavioral Health Medical Officer will receive the scores for CABH staff.
19. Any CABH staff with a score of <90% for any subset must attend retraining and successfully retest within 30 days of retraining.
20. At the conclusion of the retesting timeframe, the IRR team reviews the aggregate scores to identify any knowledge deficits that are applicable to CABH. If so, a corrective action plan (CAP) is developed at the corporate level by the IRR team within 30 days of identification and disseminated to the CABH Trainers. In collaboration with the Chief Behavioral Health Officer, CABH Behavioral Health Medical Officer, CABH Leadership team, and the CABH Trainers address the CAP and retraining.
21. An individual CAP should be created for any CABH staff member with a final score of <90% for any subset category. A passing score in all subsets is required. A CAP may include precepting an individual or retraining an individual. Inability to pass retesting as a condition of the CAP will be subject to further action as defined by the health plan VPMM, up to or including termination.
22. A department CAP will be created when there is a cumulative score of <90% for any one question. A corrective action plan may include precepting individuals or retraining the department.
23. When an opportunity for improvement is identified through this process, CABH leadership takes corrective action through the continuous quality improvement process.
24. CABH reports the final results of the annual IRR testing to UMSC and QIC.
25. In addition to the annual IRR testing, at least annually, the CABH Chief Behavioral Health Medical Officer and Vice President, Clinical Operations and Vice President, UM assesses the consistency with which behavioral health Medical Directors, peer reviewers/clinical consultants, and other behavioral health UM staff making clinical decisions apply UM criteria in decision making. The assessment is performed as a periodic review by the Chief Behavioral Health Medical Officer, or designee to compare how behavioral health staff members manage the same case or some forum in which the staff members and physicians evaluate determinations. This inter-rater reliability assessment will include decision-making for several levels of care and results are reviewed with the Reviewers and presented to the CABH UMSC and QIC.
26. CABH Medical Directors are required to take the annual IRR test, within the same testing period as the CABH UM/Clinical teams. The CABH Medical Directors are required to take the IRR for the InterQual®, ASAM, MCG, and LOCUS/CALOCUS (Medicaid and Marketplace only) products used by CABH.
27. CABH Medical Directors involved in behavioral health medical review activity will undergo IRR testing before the end of the ninety (90) day orientation period and then at least annually. If more than 30 days separate the new employee and annual testing it must be repeated. Testing will be done more frequently than once per year if the need is identified. The IRR testing will focus on the correct application of clinical criteria as well as the appropriateness of identifying quality issues.
28. Data regarding each CABH Medical Director's test results and peer review participation will be collected and tracked over time. It may be determined that additional education and/or increased supervision of review decisions is necessary based on the tracked results. A score of 90% or greater is required to pass the InterQual test. If a CABH Medical Director does not achieve a passing score, they will be required to attend retraining and retake the test within the specified timeframe or within 30 days of retraining. If the CABH Medical Director again does not achieve a passing score upon retaking the test they will be required to comply with the sanctions outlined in the CC.UM.02.05 Corporate Medical Management Interrater Reliability Policy.
29. If a CABH Medical Director completed the IRR Test achieving a passing score during their 90-day training period, and that date falls within 30 days of the annual testing period they are exempt from the annual test.
30. Level I and Level II reviewer individual IRR results is collected and tracked over time. It may be determined that additional education and/or increased supervision of review decisions is necessary based on the results. Testing

may be done more frequently than once per year if the need is identified. The IRR testing focuses on the correct application of clinical criteria as well as the appropriateness of identifying quality issues. Medical Directors and Licensed Mental Health Professionals also participate in Peer Review discussions three times per year. The purpose of Peer Review is to measure compatibility amongst Medical Directors and Therapists to ensure fairness and equality in the process of medical necessity review.

REFERENCES:

Current NCQA UM Standards and Guidelines
 State and/or Federal Contracts
 CC.UM.02 Clinical Decision Criteria and Application Policy and Procedure
 CC.UM.02.05 Interrater Reliability Policy and Procedure
 UM.04 Appropriate UM Professionals Policy and Procedure
 CP.CPC.01 Clinical Policy Committee Policy and Procedure
 CP.CPC.05 Medical Necessity Criteria Policy and Procedure

ADDENDUM:

Addendum A – CABH HP State Specific Medical Necessity Criteria
 Addendum B – MCG - Non-Covered Outpatient Level of Care
 Addendum C - Iowa Total Care Unique Requirements
 Addendum D – Oregon Trillium Community Health Plan Unique Requirements
 Addendum E – Ohio Buckeye Health Plan Unique Requirements
 Addendum F- Illinois Health Plan Unique Requirements
 Addendum G- North Carolina, Carolina Complete Health

REVISION LOG

REVISION TYPE	REVISION SUMMARY	DATE APPROVED & PUBLISHED
Ad Hoc Review	Fixed formatting and grammatical issues, updated the Addendum to reflect current client's; incorporated language from CC.UM.02, CC.UM.02.05, and CC.UM.02.18 for consistency across organizational policies and procedures; updated the References and Definitions section. Transitioned information from this Policy and Procedure for the Medicare product and renumbered it to CC.BH.MCARE.UM.02. Added the State of PA to Addendum A.	6/14/19
Ad Hoc Review	Added Addendum B - Iowa Total Care Unique Requirements to reflect Iowa Department of Human Services MCO Contract-MED-20-001, Section 11.2.4 Medical Necessity of Mental Health Services.	3/25/20
Ad Hoc Review	Addendum A updated to reflect current MNC.	5/18/20
Annual Review	All references to "Nebraska Total Care" changed to "Nebraska Total Care, NHA Expansion."	6/26/20
Ad Hoc Review	Addendum D – Ohio Buckeye Health Plan Unique Requirements developed with content from "Use of ASAM Criteria® for Substance Use Disorder Treatment in Hospitals; Requests for Emergency Hospitalization Under ORC 5122.10 Memo."	7/20/20
Ad Hoc Review	Updated formatting of Addendum B - Iowa Total Care Unique Requirements.	10/21/20
Ad Hoc Review	Updated Addendum A. Removed "State CBS guidelines" from OH Community Based Services MNC section, page 2, after confirmation from Health Plan that InterQual is the only MNC used for OH Community Based Services. Added Oregon MNC to the grid including InterQual for Mental Health Inpatient MNC, ASAM for Substance Use Disorder MNC, State CBS guidelines and InterQual for	12/7/20

	Community Based Services MNC and Corporate Clinical Policy CP.BH.104 for Applied Behavior Analysis MNC, page 2. Updated the naming convention for CP.MP.104 Applied Behavior Analysis MNC to CP.BH.104 as this policy was adapted from a medical policy to a behavioral health policy.	
Annual Review	Annual Review. Aligned with Corporate policy CC.UM.02, Clinical Decision Criteria and Application and CC.UM.02.05 Interrater Reliability Policy and Procedure, and updated Section 4.3 with Medical Director and Therapist IRR and Peer Review in coordination with CC.UM.02.05 Interrater Reliability. Incorporated CC.BH.UM.30, Non-Covered Outpatient Level of Care - MCG as Addendum B, retired CC.BH.UM.30, and re-lettered Addendums previous B – D to C - E. Changed “Therapist” to “Licensed Mental Health Professional” in Section 4.3. Clarified CALOCUS/LOCUS MNC used for Medicaid/Marketplace only. Procedure section (1) 1.5 updated to reflect for Medicaid/Marketplace only. Replaced Attachment with Addendum. Removed revisions before 2017. Updated the policy format to the new template and updated CBH to CABH (Centene Advanced Behavioral Health).	6/23/21
Ad Hoc Review	Updated Addendum A1 to add Oregon’s TCHP CBS MNC for mental health.	07/15/2021
Ad Hoc Review	Relabeled Addendum A1 to Addendum A.	07/22/21
Ad Hoc Review	Meridian IL MNC added to Addendum A.	07/23/21
Ad Hoc Review	Update made to Addendum A: Removed InterQual® SUD from SUD MNC criteria and added ASAM Added “Quarterly GA CBS MNC updates” to Georgia’s Mental Health MNC Updated formatting for Addendums C, D and E.	9/22/21
Ad Hoc Review	Revisions made to Addendum A: Revisions to Meridian IL Medicaid SUD MNC -Removed InterQual® -Added ASAM Revisions to Meridian IL Medicaid MH MNC -Added ABA MNC and FHS Provider Notice	10/28/21
Ad Hoc Review	Revisions made to Addendum A: Added InterQual® to Ohio’s MNC for SUD Addendum F created to address the Illinois health plan’s unique requirements: • Meridian Medical Management Policy I.06 (Determination of Medical Necessity) for Medicare, Medicaid & Medicaid Expansion Plan • House Bill HB2595 (Public Act 102-0579) for Medicaid & Marketplace	11/23/21
Ad Hoc Review	Addendum A (CABH/Plan MNC) revisions made as follows: Removed MCG from Georgia SUD/MH MNC. Added Quarterly GA DBHDD Manuel CBS MNC and ABA MNC to Georgia MH MNC. Added IA PMIC MNC to the MH MNC for RTC.	12/22/21

Annual Review	Annual review; Aligned the PHCO SOPs, CC.UM.02 Clinical Decision Criteria and Application Policy and Procedure, 12/21; CC.UM.02.05 Interrater Reliability Policy and Procedure, 10/21; and UM.04 Appropriate UM Professionals Policy and Procedure, 10/21 with the CABH SOP. Aligned with the 2022 NCQA UM Standards and Guidelines. Per recommendation from the Subject Matter Expert (SME): “Evidenced Based Medicine” and “Evidenced Based Practices (EBP)” was added to Section III (1) and “within ninety (90) days of hire” was added to Section III (6). Addendums A-F reviewed. No content changes. Added processes to implement and review state required CBS behavioral health medical necessity criteria;	3/29/22
Ad Hoc Review	Addendum G created to address Carolina Complete Health definition of Medical Necessity; NC.UM.02.13 Tracking Disclosure of Medical Necessity Criteria; and NC.UM.02.18 Physician Inter-Rater Reliability processes managed by the health plan.	6/28/22

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, the Company’s P&P management software, is considered equivalent to a signature.

POLICY AND PROCEDURE

DEPARTMENT: Centene Advanced Behavioral Health Utilization Management	REFERENCE NUMBER: CC.BH.UM.03
EFFECTIVE DATE: 12/01/07	P&P NAME: Appropriate Behavioral Health UM Professionals
REVIEWED/REVISED DATE: 4/11/18; 6/18/19; 8/20/19; 6/26/20, 6/23/21, 12/22/21, 3/29/22	RETIRED DATE: N/A
BUSINESS UNIT: Centene Advanced Behavioral Health	PRODUCT TYPE: Medicaid, Medicare, Marketplace
REGULATOR MOST RECENT APPROVAL DATE(S):	

POLICY STATEMENT:

This policy details Centene Advanced Behavioral Health (CABH) requirements for utilization management staffing.

SCOPE:

This policy applies to CABH Medical Affairs and UM/Clinical Operations.

PURPOSE:

To ensure qualified licensed behavioral health professionals assess the clinical information used to support utilization management (UM) decisions.

POLICY:

1. Appropriately licensed, qualified behavioral health professionals supervise the CABH UM process and all behavioral health medical necessity decisions. A physician or other appropriately licensed behavioral health care professional (as indicated by case type) reviews all behavioral health medical necessity denials of behavioral healthcare services offered under the member's respective Health Plan's behavioral health benefits.
2. Appropriately licensed, qualified health professionals supervise the utilization management process and all behavioral health medical necessity decisions and recommendations. A psychiatrist or other appropriately licensed health care professional (as indicated by case type) reviews all medical necessity denials of healthcare services offered under the behavioral health benefits. Appropriate practitioners include CABH Senior Vice President and Behavioral Health Chief Medical Officer, Senior Medical Directors, Medical Directors, Certified Addiction Medicine Specialists, and when indicated, Doctorate Level Licensed Psychologists.
3. Qualified licensed behavioral health professionals, who are appropriately trained in the principles, procedures, and standards of utilization management and medical necessity review, conduct authorization and/or concurrent reviews utilizing generally accepted evidenced-based clinical criteria and may approve services. Licensed supervisory staff such as the CABH Senior Vice President and Behavioral Health Chief Medical Officer, Senior Medical Directors, or UM Directors/Managers/Supervisors:
 - Provide supervision of assigned UM staff
 - Participate in staff training
 - Monitor for consistent application of criteria by UM staff for each level and type of UM decision
 - Monitor documentation for accuracy and appropriateness
 - Are available to UM staff on site or via telephone
4. Non-licensed staff may collect non-clinical data and structured clinical data for preauthorization and concurrent review, under the supervision of appropriately licensed behavioral health professionals. They may also have the authority to approve (but not to deny) services for which there are explicit criteria. Non-licensed staff do not conduct any activities requiring evaluation or interpretation of clinical information. All non-licensed staff are supervised by licensed staff and have qualified licensed staff available to them for assistance at all times.

PROCEDURE:

1. Appropriate staffing is determined based on membership and health plan client contract requirements. Personnel employed by or under contract to perform behavioral health utilization review are appropriately trained, qualified, and currently licensed in the State as applicable.

Licensed Behavioral Health Professionals

Practitioners who review potential denials of care based on medical necessity must meet the requirements of the CABH Senior Vice President and Behavioral Health Chief Medical Officer, Senior Medical Director, or Medical Director job description held by the Human Resource Department, which include, but are not limited to:

- Education, training, or professional experience in medical or clinical practice.
- A current, unrestricted license to practice medicine in the state unless otherwise allowed by state statutory requirements.

A. CABH Senior Vice President and Behavioral Health Chief Medical Officer

The CABH Senior Vice President and Behavioral Health Chief Medical Officer oversees the clinical aspects of the CABH Utilization Management Program and provides direct support to the UM staff in performance of their UM responsibilities. Based on need, a Senior Medical Director/Medical Director may also be involved in medical necessity review.

B. CABH Senior Medical Directors and Medical Directors

The CABH Senior Medical Directors and Medical Directors supervise all behavioral health medical necessity decisions and conducts Level II medical necessity reviews.

C. Behavioral Health Provider

A behavioral health provider is a CABH clinically licensed senior UM/Clinical leader involved in implementing, monitoring, and directing the CABH UM program.

D. Board-Certified Clinical Consultants

In some cases, the clinical judgment needed for UM decisions is narrowly specialized. In these instances, the Medical Director may consult with a board-certified physician from the appropriate specialty for additional or clarifying information when making medical necessity determinations/ denials. Appropriate documentation of their clinical judgment will be provided (CC.BH.UM.05, Use of Board-Certified Consultants).

E. CABH Vice President of UM/Clinical Operations

The CABH Vice President (VP) of UM/Clinical Operations is a licensed Doctorate or Masters' Level Licensed Clinicians with experience in utilization management activities. The Vice President of UM/Clinical Operations is responsible for overseeing the day-to-day operational activities of the UM Program.

F. UM Leaders

The CABH UM leaders are Doctorate or Masters' Level Licensed Clinicians. The Utilization Management Directors/Managers direct and coordinate the daily activities of the department, including supervision of the licensed and non-licensed UM staff, and in conjunction with the CABH VP of UM/Clinical Operations, assists with the development of the UM strategic vision in conjunction with the company objectives, policies, and procedures.

Non-Licensed UM Staff

A. CABH Behavioral Health Referral Specialists

CABH Behavioral Health Referral Specialists are individuals with significant administrative experience in the health care setting. Experience with diagnosis and CPT coding is preferred. Referral Specialists work with providers to collect demographic and other data necessary for preauthorization and may have the authority to approve services for which there are explicit criteria or algorithms. Referral Specialists cannot make behavioral health clinical determinations, referring all behavioral health clinical decisions to a CABH UM Director/Manager. Behavioral Health Referral Specialists report to and are supervised by the CABH Director, Referral Services Director or Manager, or a qualified designee.

2. Affirmative Statement about Incentives:

All individuals involved in UM decision making annually sign an 'Affirmative Statement about Incentives' acknowledging that UM decisions are based on appropriateness of care and existence of coverage. The organization does not reward practitioners or other individuals for issuing denials of coverage or care. There are no financial incentives for UM decisions makers that would encourage decisions that result in underutilization of services. (CC.BH.UM.06, Affirmative Statement about Incentives).

REFERENCES:

UM.01 - Utilization Management Program Description
UM.04 – Appropriate UM Professionals
UM.04.01 – Affirmative Statement About Incentives
CC.BH.UM.06, Behavioral Health Affirmative Statement About Incentives
NCQA Health Plan Standards and Guidelines, UM 4, Appropriate Professionals
42 CFR § 422.562(a)(4)
42 CFR § 423.562(a)(5)

ATTACHMENTS:

Addendum A- Georgia Peach State
Addendum B- North Carolina, Carolina Complete Health

REGULATORY REPORTING REQUIREMENTS: N/A**REVISION LOG**

REVISION TYPE	REVISION SUMMARY	DATE APPROVED & PUBLISHED
Ad Hoc Review	Changed policy number from CCL.202 to EPC.UM.202 and updated company name references	7/24/17
Annual Review	Annual review, no content changes.	4/11/18
Ad Hoc Review	Transferred the information from the EPC.UM.202 Qualifications of UM Personnel and renumbered policy number to CC.BH.UM.03; updated name of P & P, removed references to "Company" and replaced with CBH; updated the References section; and incorporated language from CC.UM.04 for consistency across the organization.	6/18/19
Ad Hoc Review	Fixed formatting issues, corrected typos, and grammatical errors.	8/20/19
Annual Review	Annual review – no content changes. Vetted CC.BH.UM.03 with CC.UM.04 to ensure alignment with Corporate Policy, and the 2020 NCQA UM Standard UM 4: Appropriate Professionals to ensure compliance with 2020 NCQA UM Standards.	6/26/20
Annual Review	Annual Review. Reviewed against the 2021 NCQA Standards and Guidelines for all product lines. Reviewed against Corporate Policy CC.UM.04 Appropriateness of UM Professionals and added CFR 42 CFR § 422.562(a)(4) as references. Revised 2.1.2 to remove the following: 'chiropractors, physical therapists, dentists (DDSs), nurse practitioners (as allowed by state contract), and pharmacists (RPhs). Removed revision log entries before 2017. Added "Designees" to Policy Section 2. Included 24/7 availability only required for certain markets in Policy 5 Section. Included additional state licenses are required for certain states/contracts for Procedure 2.1.3.	6/23/21
Ad Hoc Review	Addendum A (Georgia Peach State) requirements based on Georgia Families Medicaid contract.	12/22/21
Annual Review	Aligned and revised with CC.UM.04, Appropriate Professionals revised 10/21; and 2022 NCQA UM Standard UM 4, Appropriate Professionals. Policy Statement added and Scope and Purpose revised to align with CC.UM.04 Appropriate Professionals revised 10/21. Policy item #2 added. Added "CABH Senior Vice President and Behavioral Health Chief Medical Officer, Senior Medical Directors" to Policy item #3. Licensed Behavioral Health Professionals and Non-Licensed UM Staff sections added to the Procedure section. UM.01 - Utilization Management Program Description, UM.04 – Appropriate UM Professionals, UM.04.01 – Affirmative Statement About Incentives, CC.BH.UM.06, Behavioral Health Affirmative Statement About Incentives and NCQA Health Plan Standards and Guidelines, UM 4, Appropriate Professionals added to the Reference section. Addendum A reviewed by the Compliance Department; no content changes made.	3/29/22
Ad Hoc Review	Addendum B (NC CCH Medicaid) added to address North Carolina General Statutes Chapter 58. Insurance § 58-50-61. Utilization Review, Section D.	6/28/22

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, the Company's P&P management software, is considered equivalent to a signature.

POLICY AND PROCEDURE

SCOPE:

DEPARTMENT: Centene Advanced Behavioral Health Utilization Management	REFERENCE NUMBER: CC.BH.UM.07
EFFECTIVE DATE: 5/12/04	P&P NAME: Utilization Management Timeliness and Notification Standards
REVIEWED/REVISED DATE: 7/29/19; 8/12/19; 9/06/19. 12/06/19, 3/25/20; 5/18/20; 6/26/20; 7/13/20; 9/24/20, 12/22/20, 6/23/21; 9/22/21; 12/22/21; 3/29/22	RETIRED DATE: N/A
BUSINESS UNIT: Centene Advanced Behavioral Health	PRODUCT TYPE: Medicaid, Marketplace, Medicare
REGULATOR MOST RECENT APPROVAL DATE(S): NA	

SCOPE:

This policy applies to CABH.

PURPOSE:

To ensure utilization management (UM) decisions are made in a timely manner to accommodate the clinical urgency of the situation and to minimize any disruption in the provision of behavioral health care.

DEFINITIONS:

24 hours: 24 hours is equivalent to 1 calendar day, unless otherwise specified

72 hours: 72 hours is equivalent to 3 calendar days, unless otherwise specified

Concurrent Request: A request for authorization of behavioral health services made while a member is in the process of receiving the requested medical care or services, even if CABH did not approve the earlier care. A concurrent review is any review for an extension of previously approved ongoing course of treatment over a period of time or number of treatments. If a request to extend a course of treatment beyond the period of time or number of treatments previously approved by CABH does not meet the definition of urgent care, the request may be handled as a new request and decided within the timeframe appropriate for the type of decision (i.e., preservice or post-service).

Emergency Medical/Behavioral Health Condition: A medical/behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairments of bodily functions, or serious dysfunction of any bodily organ or part.

Medical Necessity: Covered services that are prescribed based on generally accepted medical practices in light of conditions at the time of treatment. Medically necessary services are: appropriate and consistent with the diagnosis of the treating provider and the omission of such could adversely affect the member's medical/behavioral health condition; compatible with the standards of acceptable medical/behavioral health practice in the community; provided in a safe, appropriate, cost-effective setting given the nature of the diagnosis and severity of the symptoms; not provided solely for the convenience of the member, the physician, or the facility providing the care; those for which there are no other effective and more conservative or substantially less costly treatment, service or setting available.

Non-urgent Request: A request for behavioral health care or services for which application of the time periods for making a decision does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

Post-Stabilization Services: Covered services related to an Emergency Medical/Behavioral Health Condition, provided after a member is stabilized, in order to maintain the stabilized condition, or to improve or resolve the member's condition.

Post-service Request (Aka Retrospective Request): An initial request for a medical necessity review to authorize behavioral health services received from a member, or the members' authorized representative, after the member was discharged or terminated treatment, and no previous authorizations or denial of services is on file.

Pre-service Request: A request for coverage of behavioral health care or services that CABH must approve, in part or in whole, in advance of a member obtaining the services. Prior authorization and pre-certification are preservice decisions.

Urgent Care: any request for care or treatment with respect to which the application of the time periods for making non-urgent care determinations:

- Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment, or jeopardize safety of the member or others due to the member's psychological state; or
- In the opinion of a practitioner with knowledge of the member's medical or behavioral health condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.

POLICY:

CABH has maximum allowable turnaround time (TATs) requirements for determine behavioral health services based on the type of utilization review and urgency based on the members' clinical status. CABH measures timeliness of behavioral health notifications from the date the request is received from the member or the member's authorized representative, even if CABH does not have all the information necessary to make the decision, to the date when it notifies the member and practitioner, as applicable. Time of receipt for urgent requests does not have to occur during normal business hours. CABH may extend the decision time frame under certain circumstances (*Refer to Addendum A, or when indicated, client health plan Addendum in accordance with federal and/or state contractual requirements*). All relevant information related to UM requests for behavioral health services are documented in the clinical documentation system. All telephonic inbound and outbound communication will be delivered using proper telephone etiquette. Each call begins with staff identifying their name, title, and organization name when initiating or returning calls regarding UM.

CABH monitors and reports timeliness of UM decision-making for Medicaid, Marketplace, and Medicare lines of business quarterly and annually at the CABH Utilization Management Committee (UMSC) and Quality Improvement Committee (QIC).

PROCEDURE

I. MEDICAID:

A. Timeliness of Client Health Plan Provider Notification to CABH

1. For all pre-scheduled services requiring prior authorization, client health plan participating providers must notify CABH UM within five business days, (or per contract requirements), prior to the requested service date.
2. Prior authorization is *not required* for emergent or urgent care services. Once the member's emergency medical condition is stabilized, authorization for hospital admission or follow-up care is required as described in this policy.
3. Facilities are required to notify CABH of behavioral health inpatient admissions within one business day following the admission, or as specified in the provider contract.

B. Timeliness of CABH UM Decision-Making and Behavioral Health Notifications

1. All TATs are maximum time allowed. Behavioral health UM decisions should be made as expeditiously as the member's health condition requires. Timeframes are based on the requirements of the accreditation bodies; or where federal or state contractual requirements are more stringent. The date/time that CABH receives the request is documented in the management system.
2. Level I reviewers (licensed UM staff) make reasonable attempts (minimum of one attempt) to obtain complete clinical information. CABH may elect to make additional outreach attempts to obtain clinical information for urgent or complex requests, or to meet state requirements or business needs. Administrative denials for lack of clinical information are not issued for any requests where insufficient information has been received if at minimum, a diagnosis is

included with the request. For denials due to insufficient clinical information, the decision is a medical necessity decision, and the denial notice must describe the specific information needed to make the decision (e.g., history and physical exam documentation, lab values, current nursing notes, etc.).

3. Notifications of behavioral health UM decisions are documented in the clinical documentation system. Verbal notification includes the date and time of the notification, as well as who was notified of the decision.
 - When approved services are communicated by verbal notification CABH will provide the authorization number, authorization dates, number of units, and must recite the following “disclaimer”: *“Authorization is not a guarantee of benefits or payment. Payment of benefits is subject to any subsequent review of medical/behavioral health information or records, the patient’s eligibility on the date the service is rendered, and any other contractual provisions of the plan.”*
 - When voicemail is reached by CABH for verbal notifications of approved services, the CABH UM staff will leave a message using the following verbiage: *Hi, this is <insert name> from your health plan; your doctor sent in a request. We made a decision & I wanted you to know the outcome. You can call me back at xxx-xxx-xxxx, call member services from 8 am to 8 pm or follow up with your doctor to discuss this further. Thank you, have a great day!*
 - Verbal notification of a denial determination may be communicated. Verbal notification requires communication with a live person; CABH may not leave a voicemail. Verbal notification does not replace electronic or written notification of denial decisions, but when provided, CABH may extend the Medicare and Marketplace time frame for urgent preservice and concurrent electronic or written denial notification decisions an additional 3 calendar days following verbal notification. For Medicaid decisions, verbal notification does not extend the electronic or written notification time frame. Medicare, Marketplace, and Medicaid verbal denial determinations must include the following requirements and are documented within the management system;
 - ✓ CABH records the time and date of the notification and the staff member who spoke with the practitioner or member; and
 - ✓ CABH provides verbal notification within the time frames specified for an urgent concurrent or urgent preservice request.
 - ✓ The time, date, and name of the CABH UM staff who offered the availability of the opportunity for the peer-to-peer discussion is documented in the clinical documentation system notes.

C. Non-urgent Preservice Decisions/Notification:

1. Decisions for non-urgent, preservice prior authorization requests are made within 14 calendar days of receipt of the request
 - If a decision cannot be made due to lack of necessary information, the UM designee makes reasonable attempts (minimum of one attempt) to obtain the additional information within the original 14 calendar day timeframe. If there is no response or continued lack of necessary information, a determination is made based on the available information.
 - If the request lacks clinical information, or for other situations outside CABH’s control, the decision timeframe *may* be extended once (refer to Addendum A, or client health plan addendum if client health plan state regulatory requirements differ from CABH)

D. Urgent Preservice Decisions/Notification:

1. Decisions for an urgent preservice request are made as expeditiously as the members’ health condition requires but no later than 72 hours/three calendar days of receiving the request.
 - A request is considered urgent when a practitioner indicates the member will suffer adverse health consequences without the care or treatment that is the subject of the request. CABH can also consider a request urgent if following the non-urgent preservice timeframe could seriously jeopardize the member’s life, health, or ability to attain, maintain, or regain maximum function, or jeopardize the life, health, or safety of the member or others due to the member’s psychological state.
 - If a determination cannot be made due to lack of necessary information, the UM designee makes reasonable attempts (minimum of one attempt) to obtain the additional information

within the original 72 hours/three-day timeframe. If there is no response or continued lack of necessary information, a determination can be made based on the available clinical information, even if the only information is the diagnosis. If the request lacks clinical information, or for other situations outside CABH's control, the decision timeframe *may* be extended once (refer to Addendum A, or client health plan addendum if client health plan state regulatory requirements differ from CABH). CABH may deny the request if all necessary information is not provided within this timeframe. The appeal process may be initiated at this time if desired.

- Determination notifications, electronic or written (i.e., email, fax, notice via an EMR system, or mail), are sent to the requesting or treating/attending practitioner within 72 hours/three calendar days of receipt of request. The facility is also notified, as applicable. Requirements for adverse determination/denial letters are outlined in CC.BH.UM.08, Adverse Determinations.
- Verbal notification of an urgent preservice denial determination may be communicated. Verbal notification requires communication with a live person; CABH may not leave a voicemail. Verbal notification does not replace electronic or written notification of denial decisions, but when provided, CABH may extend the Medicare and Marketplace time frame for urgent preservice and concurrent electronic or written denial notification decisions an additional 3 calendar days following verbal notification. For Medicaid decisions, verbal notification does not extend the electronic or written notification time frame. Verbal denial determinations must include the following requirements and are documented within the management system:
 - ✓ CABH records the time and date of the notification and the staff member who spoke with the practitioner or member; and
 - ✓ CABH provides verbal notification within the time frames specified for an urgent concurrent or urgent preservice request.
 - ✓ The time, date, and name of the CABH UM staff who offered the availability of the opportunity for the peer-to-peer discussion is documented in the clinical documentation system notes.
- If an urgent preservice request is received that does not meet the definition of "urgent", CABH may reclassify the request as non-urgent, and applies the following process:
 - ✓ UM staff contacts the requesting practitioner to verify if the request is urgent; if the requesting practitioner *agrees* the request is not urgent and can be handled as a non-urgent preservice request, the agreement by the practitioner is documented and the process for non-urgent preservice requests is followed.
 - ✓ If the requesting practitioner *does not agree* the request can be handled as non-urgent and provides additional clinical information that meets the definition of an urgent request, UM staff document the information and follow the above process for urgent preservice requests.
 - ✓ If the requesting practitioner *does not agree* the request can be handled as non-urgent and *does not provide* additional clinical information to support the urgency of the request, the case is sent to the Medical Director for review. The Medical Director uses their discretion to:
 - Reclassify the request as non-urgent based on the information received.
 - Follow the above process for urgent preservice requests based on the information received.
 - Initiate a peer-to-peer discussion with the provider to resolve whether the request meets the definition of urgent.

E. Urgent Concurrent Decisions/Notification:

1. Decisions for urgent concurrent review are issued within 72 hours/three days of receipt of the request for services. An urgent concurrent review is a request for services made while the member is in the process of receiving care; typically associated with inpatient care or ongoing ambulatory care.
2. CABH may extend the timeframe for making urgent concurrent decisions for up to 14 calendar days once due to lack of information. The member or member's representative must be notified of the decision as expeditiously as required by the member's health but no later than the expiration of the extension. (Please refer to Addendum A, or client health plan addendum when more stringent)
3. When request to extend a course of ongoing ambulatory treatment beyond the time or number of treatments previously approved does not meet the definition of "urgent care", the request may be handled as a new request and under the applicable timeframe.
4. Decisions for urgent concurrent review are issued within 72 hours/three days of receipt of the request for services. An urgent concurrent review is a request for services made while the member is in the process of receiving care; typically associated with inpatient care or ongoing ambulatory care.
5. CABH may extend the timeframe for making urgent concurrent decisions for up to 14 calendar days once due to lack of information. The member or member's representative must be notified of the decision as expeditiously as required by the member's health but no later than the expiration of the extension. (Please refer to Addendum A, or client health plan addendum when more stringent)
6. When request to extend a course of ongoing ambulatory treatment beyond the time or number of treatments previously approved does not meet the definition of "urgent care", the request may be handled as a new request and under the applicable timeframe.
7. CABH considers the content of the request when determining if an outpatient concurrent request meets the definition of "urgent care", and whether applying non-urgent timeframes could lead to adverse health consequences for the member and/or cause an unnecessary disruption in care.
8. Decision notifications, electronic or written (i.e., email, fax, notice via EMR system, or mail), are sent to the requesting or treating/attending practitioner in all cases within the original 72 hours/three calendar day timeframe. The facility is also notified, as applicable. Requirements for adverse determination/denial letters are outlined in policy *CC.BH.UM.08, Adverse Determinations*. members may need to be notified of an urgent concurrent decision if mandated by state contract requirement or business needs. CABH may inform the hospital Utilization Review (UR) team of inpatient urgent concurrent decisions, with the understanding that UR staff will inform the attending/treating practitioner. Verbal notification of a denial does not extend the TAT for Medicaid members.
9. For service authorization decisions not reached within the timeframes specified in section E, 4-7 noted above, notification is made on the date that the timeframe expires.

F. Post-service Decisions/Notification (retrospective review):

CABH renders post-service (retrospective) medical necessity post-service decisions and subsequent written member and provider notification no later than 30 calendar days from receipt of the request. Post service requests are not considered urgent requests and the post service review timeframe is followed.

G. Notice of Action for Previously Approved Services

1. When a service request for ongoing treatment for a previously approved service request is received, CABH reviews the members' clinical status in coordination with the applicable national recognized medical necessity criteria for the continuation and extent of ongoing services.
2. If the determination results in a termination, suspension, or reduction of a previously approved treatment request, the UM designee notifies the member and provider in accordance with the notification standards as stated herein, and issue a written or electronic notification notice at least ten calendar days before the intended action.

II. MARKETPLACE

A. Timeliness of Provider Notification

1. For all pre-scheduled services requiring prior authorization, participating providers must notify CABH within the timeframe outlined in the state specific provider manual prior to the requested service date.

2. Prior authorization is *not required* for emergent or urgent care services. Post-stabilization services *do not require* authorization. Once the member's emergency medical condition is stabilized, certification for hospital admission or authorization for follow-up care is required as stated above.
3. Facilities are required to notify CABH of all inpatient admissions within one (1) business day following the admission.
4. Timeliness of UM Decision Making and Notifications are maximum timeframes. UM decisions should be made as expeditiously as the member's health condition requires. Time of receipt is when the request is made by the member or the member's representative to CABH according to CABH's filing procedures, regardless of whether CABH has all the information necessary to make the decision, and whether CABH is open for business on the date/time the request is received. The date/time of receipt is documented for all requests.
5. Reasonable attempts (minimum of one attempt) are made in all cases to obtain complete clinical information. CABH may elect to make additional outreach attempts to obtain clinical information for urgent or complex requests, or to meet state requirements or business needs. Administrative denials for lack of clinical information are *not* issued for any requests where insufficient information has been received if at minimum, a diagnosis is included with the request. For denials due to insufficient clinical information, the decision is a medical necessity decision, and the denial notice must describe the specific information needed to make the decision (e.g., history and physical exam documentation, lab values, current nursing notes, etc.).
6. All notification of behavioral health UM decisions are documented in the clinical documentation system; notification by telephone includes the date and time of the notification, as well as who was notified of the decision. When verbally notifying the practitioner of any approval, staff will give the authorization number, authorization dates, and number of units and must recite the "disclaimer": "Authorization is not a guarantee of benefits or payment. Payment of benefits is subject to any subsequent review of medical information or records, members' eligibility on the date the service is rendered and any other contractual provisions.
7. The date of written behavioral health denial notification is included in the date field of the UM denial notification letter.

B. Nonurgent Preservice Decisions

1. Determinations for nonurgent preservice authorization requests are made within 14 calendar days of the request.
2. If a determination cannot be made due to lack of necessary information, the UM designee will make at least two (2) documented attempts (or per state regulation), to obtain the additional information within the original timeframe.
3. If there is no response or continued lack of necessary information, a determination is made based on the available information.
4. If the request for authorization is approved, the UM staff notifies the requesting practitioner of the approval by telephone, fax, or email, with the member being notified in writing, not to exceed the original determination period.
5. If the request lacks clinical information, or CABH is unable to make a decision due to matters beyond its control, it may extend the decision timeframe once (*Please refer to Addendum A, or client health plan addendum if more stringent*).
 - Within the original request turn-around time (TAT), the member or member's authorized representative is notified of the specific information needed to make the decision, the extension, and the expected date the determination will be made.
 - Notification must be in writing and include the reason for the delay and the member's right to file an expedited grievance if they disagree with the extension.
 - The extension period begins on the date CABH receives member/member authorized representative's response (regardless of whether all information is included), or no response is received by the end of the time period given to supply the information.
6. If the determination results in a denial, reduction, or termination of coverage, the CABH Medical Director, or designee, notifies the treating practitioner verbally within one (1) business day after the decision is made, not to exceed the original determination period. Verbal notification does not replace electronic or written notification of denial decisions, but when provided. Verbal notification requires:
 - Communication with a live person; CABH may not leave a voicemail; and

- CABH records the time and date of the notification and the staff member who spoke with the practitioner or member.
7. When CABH provides verbal notification of a denial decision it has an additional 3 calendar days following verbal notification to provide electronic or written notification. Written or electronic notice of the decision, including reason, right to a peer-to-peer discussion, right to appeal and the appeal process is issued to the treating practitioner, facility, and member within three (3) calendar days of verbal notification, not to exceed the original determination period. Requirements for adverse determination/denial letters are outlined in policy *CC.BH.UM.08, Adverse Determinations*.

C. Urgent Pre-Service Decisions:

1. Determinations for urgent preservice care are issued within 72 hours/3 calendar days from date of receipt of the request for service. If an urgent preservice request is received that does not meet the definition of “urgent”, CABH may reclassify the request as nonurgent.
2. Where allowed, a one-time extension (refer to Addendum A, or client health plan addendum when more stringent) may be implemented if additional information is necessary prior to issuing a determination.
3. Within 24 hours of the receipt of the request, CABH notifies the member (or the member’s authorized representative) and/or requesting practitioner in writing of the need for an extension and the specific information necessary to make the decision.
A specified time frame for submission of the additional information, of at least 48 hours, must be given.
4. CABH makes a decision within 48 hours of receiving the additional information (even if the information is incomplete) or within 48 hours of the end of the specified period given to supply the additional information (even if no response is received), whichever is earlier.
5. CABH may deny the request if all necessary information is not provided within this timeframe. The appeal process may be initiated at this time if desired.
6. Reasonable attempts are made in all cases to obtain complete clinical information. Administrative denials for lack of clinical information are not issued for any requests where insufficient information has been received if at minimum, a diagnosis is included with the request. For denials due to insufficient clinical information, the decision is a medical necessity decision, and the denial notice must describe the specific information needed to make the decision (e.g., lab values, current nursing notes, etc.).
7. Extending the timeframe past 48 hours must be requested by member or if the member voluntarily agrees to the extension.
8. If the request is *approved*, the UM staff notifies the requesting or treating/attending practitioner of the decision by telephone, fax, or email, along with the member via written notice, within 72 hours/three (3) calendar days after the decision is made, not to exceed the original determination period or subsequent extension.
9. In all cases the requesting or treating/attending practitioner must be notified. The facility (e.g., hospital, rehabilitation facility, etc.) or other treating practitioner is also notified, as applicable.
10. Member notification of urgent preservice approvals is **not** required as the attending or treating practitioner is acting as the member’s representative; members may also be notified of urgent preservice authorization approvals, as mandated by state contract requirement or business needs.
11. If the determination results in a *denial*, reduction or termination of an urgent pre-service request, the CABH Medical Director or designee may notify the practitioner orally within one (1) business day of the determination not to exceed the original determination period or subsequent extension, and issue a written or electronic notice of the decision including reason, right to a peer-to-peer discussion, right to appeal and the appeal process to the treating practitioner, facility and member within three (3) calendar days after the oral notification.
12. If an urgent preservice request is received that does not meet the definition of “urgent”, CABH may reclassify the request as nonurgent.
13. Post service requests (i.e., service have already been received by the member) are not considered urgent requests and the post service/retrospective review timeframe is followed.
14. UM staff will contact the requesting practitioner to verify if the request is urgent; if the requesting practitioner *agrees* the request is not urgent and can be handled as a nonurgent preservice request, the agreement by the practitioner is documented and the process for nonurgent

preservice requests will be followed.

15. If the requesting practitioner *does not agree* that the request can be handled as a nonurgent request and does not provide additional clinical information to support the urgency of the request, the case will be sent to the CABH Medical Director for review. The CABH Medical Director will use their discretion to:
 - Reclassify the request as nonurgent based on the information received; or
 - Follow the above process for urgent preservice requests based on the information received; and
 - Initiate a peer-to-peer discussion with the practitioner to resolve whether the request meets the definition of urgent.

D. Urgent Concurrent Decisions/Notification

1. An urgent concurrent review occurs while the member is in the process of receiving the care, typically associated with inpatient care or ongoing ambulatory care. Determinations for urgent concurrent continued stay review are issued within 24 hours/1 calendar day of the request.
2. When concurrent urgent care services were approved initially, the notification period begins on the date of the concurrent review. CABH documents the date of the concurrent review and the decision notification in the UM denial file.
3. CABH determines when an outpatient concurrent request meets the definition of “urgent care”, and whether applying nonurgent timeframes could lead to adverse health consequences for the member and/or cause an unnecessary disruption in care. When the request to extend a course of ongoing outpatient treatment beyond the period of time or number of treatments previously approved does not meet the definition of “urgent care”, the request may be handled as a new request under the applicable time frame. CABH may extend the timeframe for making urgent concurrent decisions in the following situations:
 - If the request to extend urgent concurrent care is not made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments, CABH may treat it as an urgent pre-service decision and make the decision within 72 hours.
 - If the request to approve additional days for urgent concurrent review are related to care not previously approved by CABH, and documents that it made at least one attempt and was unable to obtain needed clinical information within the initial 24 hours after the request for coverage of additional days, CABH has up to 72 hours to make the decision.
 - CABH contacts the member who voluntarily agrees to extend the decision-making time frame. This contact is documented in the documentation system.
4. When ongoing care is approved, the UM staff notifies the requesting practitioner of the decision by telephone, fax, or email, along with the member via written notification, within 24 hours/ one (1) calendar day of the request. In all cases the requesting or treating/attending practitioner must be notified. The facility is also notified, as applicable.
5. When the determination results in a denial, reduction, or termination of coverage, the UM designee provides electronic or written (i.e., email, fax, notice via EMR system, or mail) notification of the denial to the requesting or treating/attending practitioner and facility are notified. Notification does not exceed the original 24 hours/one (1) calendar day timeframe. The UM designee provides a client health plan approved written or electronic notice of the decision including reason, right to a peer-to-peer discussion, right to appeal, and the appeal process to the member within 24 hours/1 calendar day of the request. Requirements for adverse determination/denial letters are outlined in *CC.BH.UM.08, Adverse Determinations*.
6. For inpatient urgent concurrent denials, CABH may inform the hospital Utilization Review (UR) Department staff of the decision, with the understanding that UR staff will inform the attending/treating practitioner.
7. Verbal denial notification may be provided to the treating/attending practitioner for urgent concurrent requests within 24 hours/1 calendar day of the request. Although not required, verbal notification of the denial to the requesting or treating/attending practitioner is recommended for urgent concurrent requests. The written or electronic notice of the decision must be issued no later than three (3) calendar days after the verbal notification. Verbal denial determinations must include the following requirements and are documented within the management system:

- ✓ CABH records the time and date of the notification and the staff member who spoke with the practitioner or member; and
- ✓ CABH provides verbal notification within the time frames specified for an urgent concurrent or urgent preservice request.
- ✓ The time, date, and name of the CABH UM staff who offered the availability of the opportunity for the peer-to-peer discussion is documented in the clinical documentation system notes

E. Post-Service Decisions

1. Post-service medical necessity decisions are determined after the members' treatment has ended. Post-service decisions are not considered urgent requests.
2. Medical necessity post-service decisions including written member and practitioner notification occur no later than 30 calendar days from receipt of the request.
3. When the request lacks clinical information, CABH may extend the post-service time frame up to 15 calendar days, under the following conditions:
 - Before the end of the time frame the organization asks the member or the member's representative for the information necessary to make the decision, and
 - The organization gives the member or the member's authorized representative at least 45 calendar days to provide the information.
4. The extension period for the decision begins:
 - The date when CABH receives the member's response (even if not all of the information is provided); or
 - The last date of the time period given to the member to supply the information, even if no response is received from the member or the member's authorized representative.
 CABH may deny the request if it does not receive the information within the time frame, and the member may appeal the denial.

F. Notice of Action for Previously Approved Services

1. CABH reviews the members' clinical status in coordination with the applicable nationally recognized medical necessity criteria for the continuation and extent of ongoing services.
2. If the determination results in a termination, suspension, or reduction of a previously approved treatment request, the CABH Medical Director, or designee, will notify the practitioner and member in accordance with the notification standards as stated herein and issue a written or electronic notification notice at least 10 days before the intended Action.

III. MEDICARE

A. Clinical Review of Standard Organization Determinations

1. UM decisions will be made as expeditiously as the member's health condition requires. For requests meeting the definition for standard determination, the decision and notification will be made no later than 14 calendar days after receipt of the request.
2. CABH requires supporting medical information to make clinically based organization determinations, for both contracted and non-contracted providers. All providers, regardless of contract status, are required to make reasonable and diligent efforts to expeditiously gather and forward all necessary information to CABH in meeting the required time frame.
3. If additional information is necessary prior to issuing a determination, CABH UM will make a minimum of one attempt to gather information. The attempts including method, date and time of request and point of contact will be documented in the clinical documentation system for reporting and tracking purposes. If clinical information is not obtained after one documented attempt, the CABH UM will send the request to the Medical Director for review. If the request was made by a contracted provider on behalf of the member, and the provider has not responded to the requests for additional information, the Medical Director may, but is not required to make an additional attempt via call or fax to obtain information. If the requested information is not obtained, a Level II review is completed by the Medical Director. The Medical Director will render the decision based on the clinical information available at the time of the review.
4. CABH may decide to extend the decision timeframe by up to an additional 14 calendar days (not to exceed 28 calendar days from receipt of original request) when:
 - The member requests the extension; and/or
 - The extension is justified and in the member's interest due to the need for additional information from a noncontract provider that may change the decision

to deny an item or service.

- When an extension is granted, CABH UM updates the Line Item - *Type* to reflect “standard extension”, and call the member and send the *Notice of Right to an Expedited Grievance* letter to the member and the requesting provider to include the reasons for the delay and inform the member of the right to file an expedited grievance if he or she disagrees with CABH ’s decision to grant an extension.
 - The standard organization determination will be made as expeditiously as the members’ health condition requires, but no later than the expiration of the extension (up to 28 days total from receipt of the initial request).
5. CABH UM Level I reviewers conduct an initial medical necessity review for the organizational determination using the Local Coverage Determination (LCD), National Coverage Determination (NCD) and/or InterQual or Milliman Care Guidelines (MCG) as indicated.
 6. When the request does not appear to meet established medical necessity criteria, the request is forwarded to the CABH Medical Director for a Level II review. Only the Medical Director can make a partial or full adverse Organization Determination.
 - When the CABH Medical Director determines that a Board-Certified Consultant review is necessary, the Medical Director will refer the case for review as outlined in *CC.BH.UM.05, Board-Certified Consultants*.
 - The Medical Director will render a determination within 14 calendar days of when the initial organization determination was received.
 - The Medical Director and/or PA Nurse documents all relevant information related to the clinical decision in the clinical documentation system.

B. Expedited Organizational Determinations

1. Behavioral health UM decisions will be made as expeditiously as the member’s health condition requires. For requests meeting the definition for expedited determination, the decision and notification will be made no later than 72 hours after receipt of the request by CABH.
2. CABH requires supporting medical information to make clinically based organization determinations, for both contracted and non- contracted providers. All providers, regardless of contract status, are required to make reasonable and diligent efforts to expeditiously gather and forward all necessary information to CABH in meeting the required time frame.
 - If additional information is necessary prior to issuing a determination, CABH UM will make one attempt to obtain additional information. All attempts including method, date, and time of each request, and point of contact will be documented in the clinical documentation system for reporting and tracking purposes. When possible, attempts will be made during business hours in the providers’ time zone.
 - CABH UM will call the requesting provider within 1 calendar day of receipt of the request indicating the specific information needed to make the determination. They may also send a fax request for additional information and create a reminder task in the clinical documentation system to follow-up on the request the following day.
 - ✓ If the necessary clinical information is not received by close of business on the second day after one (1) attempt, CABH UM will send the request to the Medical Director with the information provided for Level II review. If the request was made by a contracted provider on behalf of the member, and the provider has not responded to the requests for additional information, the Medical Director may, but is not required to make an additional call attempt to obtain the specific information necessary to make the determination. If the requested information is not obtained, a Level II review is completed by the Medical Director.
 - ✓ The Medical Director will render the decision based on the clinical information available at the time of the review.
3. CABH will extend the 72-hour time frame by up to 14 calendar days if the member requests the extension. CABH may also extend the time frame by up to 14 calendar days if a need for additional information from a noncontract provider is justified and

documentation supports how the delay is in the best interest of the member. CABH UM or Medical Director must provide documentation in the clinical documentation system that justifies the reason for the extension.

- If an extension is granted, CABH UM updates the Line Item-*Type* within the authorization to reflect “expedited extension.” They will call the member and send the *Notice of Right to an Expedited Grievance* letter to the member and the requesting provider within 48 hours of receipt to include the reasons for the delay and inform the member of the right to file an expedited grievance if he or she disagrees with CABH’s decision to grant an extension.
 - The organization determination will be made as expeditiously as the member’s health condition requires.
 - Expedited organization determinations are made no later than the expiration of the extension (up to 17 days total from receipt of the initial request).
4. CABH UM conducts a medical necessity review of the organization determination request using the Local Coverage Determination (LCD), National Coverage Determination (NCD) and InterQual/MCG, as applicable.
 - If the request does not appear to meet established medical necessity criteria, the request is forwarded to the Medical Director or other appropriate health care professional for a Level II review. Only the Medical Director/Healthcare Professional can make a partial or full adverse organizational determination.
 - When the CABH Medical Director determines that a Board-Certified Consultant review is necessary, the Medical Director will refer the case for review as outlined in *CC.BH.UM.05, Board-Certified Consultants*.
 - Medical Director Review will occur within 24 hours of the initial review of the organization determination request, or sooner, allowing sufficient time to notify the member and provider within 72 hours of when the initial organization determination was received.
 5. The Medical Director, or designee, documents all relevant information related to the clinical decision in the clinical documentation system.

C. Withdrawal of a request

1. The requestor may withdraw the initial request in writing or verbally at any time before the decision is rendered.
2. CABH will void the authorization and document in a void authorization note the reason for the withdrawal by the provider, member, or member representative.
3. The provider and member will be notified via fax or phone that the Prior Authorization service type request has been withdrawn.

D. Notification of Organizational Determinations

1. Standard Determination Notifications
 - If the request was approved, CABH UM notifies the member and requesting provider of the decision after the decision is made, not to exceed the original 14 calendar day determination period or subsequent extension by providing verbal notification, voicemail, or written client health plan approved notification utilizing the members’ preferred, contact information, and language preference, which may include via fax or email for communicating the client health plan approved *Notice of Authorization of Services* letter.
 - If the request is denied, in whole or in part, based on medical necessity, the Medical Director, or designee, will notify the member and the provider verbally and in writing (letter, email or fax) of the determination within the original 14 calendar day determination period or subsequent extension. The verbal notification is a best practice, however, is not required by CMS. Written notification is required. Verbal denial determinations must include the following requirements and are documented within the management system:

- ✓ CABH records the time and date of the notification and the staff member who spoke with the practitioner or member; and
- ✓ CABH provides verbal notification within the time frames specified for an urgent concurrent or urgent preservice request.
- ✓ The time, date, and name of the CABH UM staff who offered the availability of the opportunity for the peer-to-peer discussion is documented in the clinical documentation system notes
- A request that is denied in part is a partially favorable decision since the item or service is partially covered.
- A client health plan CMS approved initial Denial Notice is issued. The Notice will be addressed to the member (or authorized representative) and copied to the treating physician and facility. The notice includes:
 - ✓ The specific reason for the denial that considers the member's presenting medical condition, disabilities, and special language requirements, if any. The letter will not contain any medical codes and will include lay language descriptions of all procedures or services.
 - ✓ The members' right to submit additional evidence in writing or in person
 - ✓ A description of both the standard and expedited reconsideration processes and time frames and how to make the request.
 - ✓ The right to appoint a representative to file an appeal on the member's behalf and/or to submit additional evidence in writing or in person
 - ✓ A description of the additional levels of appeal up to and including Independent Review Entity (IRE), Administrative Law Judge (ALJ), Medicare Appeals Council or Federal District Court and State Fair Hearing, if applicable.

2. Expedited Organizational Determination Notifications

- If the request is approved, CABH UM or designee notifies the member and requesting provider of the decision by the member's designated preference, if known. This includes telephone, voicemail, fax, or email as expeditiously as the member's health condition requires, but no later than 72 hours after receiving the request. CABH also provides written communications and notices described in this guidance in alternate formats and languages consistent with Section 1557 of the Affordable Care Act and Section 504 of the Rehabilitation Act of 1973. In addition, CABH's fax and e-mail or web-based portal systems must meet the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy and security requirements. If the member agrees, CABH may deliver written notices by fax or e-mail. Please see Medicare Marketing Guidelines regarding electronic communication with members.
- CABH notifies the member of approved services, and will not exceed the 72-hour timeframe. The documentation of the verbal/voicemail notification will include:
 - ✓ Date and time of the notification
 - ✓ Contact name and phone number notified of the decision
 - ✓ When CABH UM was unable to contact the member and requesting provider verbally, written notification will be made using the client health plan approved Notice of Authorization letter, or utilizing the members' preferred contact information, which may include fax or email. Note: Voicemail is considered a successful verbal contact. The Notice will be addressed to the member (or authorized representative) and copied to the treating physician and facility. If CABH UM was unable to contact the member to provide verbal notification, the CABH UM, in a good faith effort, satisfies the notice requirement based on the following:
 - The good faith effort is documented in writing and included in the case file;
 - Written notification of the decision is sent to the member within the applicable timeframe; and
 - CABH UM is not at fault for his/her inability to reach the member by phone.

If a good faith effort was made, but the PA Nurse or designee was unable to provide verbal notice or leave a voicemail, he/she must mail the letter by the second day to ensure the letter has been placed in the mail courier's (US Postal Service, FedEx, etc.) box within 72 hours.

- When the CABH Medical Director is unable to approve the request, the requesting provider will be offered a peer-to-peer consultation prior to issuance of an adverse determination. If the determination results in a denial, reduction, or termination of an expedited organization request based on medical necessity, CABH will notify the member and the provider verbally within 24 hours of the determination not to exceed the determination period. If the peer-to-peer consultation occurs after an adverse determination is issued, the appeal process will be followed. A request denied in part is a partially favorable decision since the item or service is partially covered.
- Admitting Physician Concurrence is required before a denial of a continued inpatient stay (that has been initially approved). Lack of response from the admitting physician is considered a concurrence. A denial notification letter may be sent at this point. The CABH UM staff must confirm and document with the admitting facility that the member has been given their discharge/appeal information. Initial reviews and leveling of care do not require physician concurrence.
- When verbal denial determinations are issued for an expedited organizational determination, the verbal notification must include the following requirements and are documented within the management system:
 - ✓ CABH records the time and date of the notification and the staff member who spoke with the practitioner or member; and
 - ✓ CABH provides verbal notification within the time frames specified for an urgent concurrent or urgent preservice request.
 - ✓ The time, date, and name of the CABH UM staff who offered the availability of the opportunity for the peer-to-peer discussion is documented in the clinical documentation system notes
- Verbal notification is followed by a written client health plan approved adverse expedited organization determination letter. When CABH UM was unable to verbally notify the member, they must overnight the letter by the second day to ensure the member has the notice within 72 hours. If CABH was successful in verbally notifying the member, he/she must mail the notification and/or any other state required forms to the member (or authorized representative), treating physician, and facility within three (3) calendar days after providing verbal notification. The notice includes:
 - ✓ The specific reason for the denial that considers the member's presenting medical condition, disabilities, and special language requirements, if any;
 - ✓ The member's right to submit additional evidence in writing or in person;
 - ✓ A description of both the standard and expedited reconsideration processes and time frames, including conditions for obtaining an expedited reconsideration, and how to make the request;
 - ✓ The right to appoint a representative to file an appeal on the member's behalf;
 - ✓ A description of the additional levels of appeal up to and including Independent Review Entity (IRE), Administrative Law Judge (ALJ), Medicare Appeals Council or Federal District Court; and
 - ✓ The Notice will be reviewed by management prior to being sent to ensure letter accuracy, including specific denial rationale, and written in easily understandable language.

3. Denial of Request for Expedited Review Timeframe

- If CABH decides not to expedite an organization determination, the request is automatically transferred to the standard time frame and CABH makes a determination within 14 calendar days of the initial request. CABH promptly gives the member verbal and written notice of the decision not to process the organization determination as an expedited request including member's rights to file an expedited grievance. CABH delivers the written notice using the client health plan approved Notice of *Right to an Expedited Grievance* form to the member within three (3) calendar days. The notice:
 - ✓ Explains that the organization determination is being processed using the 14-day time frame for standard determination requests;
 - ✓ Informs the member about the right to file an expedited grievance if the member disagrees with the Plan's decision not to expedite the determination and provides instructions about the expedited grievance process and time frames.
 - ✓ Informs the member of their right to resubmit a request for an expedited organization determination along with a physician's support statement if they believe that applying the standard time frame could seriously jeopardize the life or health of the member or the member's ability to gain maximum function.

IV. STAR+PLUS MEDICAID-MEDICARE PLAN (MMP) DETERMINATIONS AND NOTIFICATION OF ORGANIZATIONAL REVIEW

- A. Standard Determinations must provide notice of authorization decisions that meet the timing requirements set forth in 42 C.F.R. § 438.404 as expeditiously as the members' health condition requires and no later than three (3) business days after receipt of the request for service.
- B. For expedited service authorization decisions, including concurrent hospitalization decisions, where the treating provider indicates or the STAR+PLUS MMP determines that the standard timeframe could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function, CABH must provide notice of authorization decisions that meet the timing requirements set forth in 42 C.F.R. § 438.404, and must make a decision and provide notice as expeditiously as the members' health condition requires and no later than one (1) business day after receipt of the request for service.
- C. CABH provides written communications and notices in alternate formats and languages consistent with Section 1557 of the Affordable Care Act and Section 504 of the Rehabilitation Act of 1973. In addition, CABH fax and e-mail or web-based portal systems must meet the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy and security requirements. If the member agrees, CABH may deliver written notices by fax or e-mail. Please see Medicare Marketing Guidelines regarding electronic communication with members.

REFERENCES:

NCQA UM Standards and Guidelines
 Code of Federal Regulations – 42 CFR 438.404 and 42 CFR 438.210 (d)(1), 438.404; 42 CFR § 422.570
 State and/or Federal Contracts
 CC.UM.05 Timeliness of UM Decisions and Notifications (Medicaid)
 HIM.UM.05 Timeliness of UM Decisions and Notifications (Marketplace)
 MCARE.MEDM.08. Part C Organization Determinations (Medicare)

ADDENDUMS:

CC.BH UM.07.01A Medicare Work Process for Standard Organization Determination
 CC.BH UM.07.01B Medicare Work Process for Expedited Organization Determination
 CC.BH.UM.07.02 Concurrent Review Work Process
 Addendum A - OH – Buckeye Health Plan
 Addendum B - IN – Managed Health Services
 Addendum C - NE - Nebraska Total Care Health Plan
 Addendum D – MS - Magnolia Health Plan
 Addendum E – MO - Home State Health Plan
 Addendum F – AR - Arkansas Health & Wellness Health Plan

Addendum G – NH - New Hampshire Health Families Health Plan
 Addendum H – NV - Silver Summit Health Plan
 Addendum I – TN - Ambetter of Tennessee Health Plan
 Addendum J – SC - Absolute Total Care
 Addendum K – OR - Trillium Community Health Plan
 Addendum L – Marketplace - Ambetter Utilization Determinations Timeframes
 Addendum M- WI - Managed Health Services
 Addendum N- Georgia Peach State

REVISION LOG

REVISION TYPE	REVISION SUMMARY	DATE APPROVED & PUBLISHED
Annual Review	Annual review – no content change.	04/26/17
Ad Hoc Review	Updated Addendum L – Massachusetts Health Plan Unique Requirements. Provider and Member will be notified verbally and within two hours and in writing within 24 hours of admission.	5/17/17
Ad Hoc Review	Changed policy number from CCL.229 to EPC.UM.229 and updated company name references	7/28/17
Ad Hoc Review	Changed the product type for the policy.	12/6/17
Ad Hoc Review	Removed market specific Addendums for Florida, Georgia, Illinois, Texas, and Washington. Made minor edits throughout the policy.	4/13/18
Ad Hoc Review	Updated policy to reflect and align with the corporate policy CC.UM.05	5/18/18
Ad Hoc Review	Transferred the information from the EPC.UM.229 UM Timeliness & Notification Standards Policy and Procedure to the Centene P & P template, and renumbered. Updated this Policy and Procedure to reflect accreditation standards, updated Addendums to reflect only clients that have delegated to CBH.	3/7/19
Ad Hoc Review	Updated this P & P to reflect and align with the updated, Corporate policy, CC.UM.05 and CC.HIM.UM.05 Timeliness of UM Decisions and Notifications Policy and Procedures for consistency across Centene organizations; updated the References and Definitions section for clarity; updated and reformatted the Addendum section.	6/12/19
Ad Hoc Review	Added unique requirements for Carolina Complete Health (CCH) Unique Requirements.	8/12/19
Ad Hoc Review	Added CC.BH.UM.07.01 Administrative Denials Work Process and CC.BH.UM.07.02 Concurrent Review Work Process to the Addendums section.	9/6/19
Ad Hoc Review	Added Addendum J, SC specific contract language to section 5.2, Urgent Preservice Decisions/Notification (Urgent or Expedited Prior Authorizations) for Medicaid/Marketplace	12/6/19
Ad Hoc Review	Removed Addendum for Carolina Complete Health (CCH). Carolina Complete Health (CCH) is now using state required policies, and not CBH policies.	3/25/20
Ad Hoc Review	Updated Addendum G to include New Hampshire timeliness and notification requirements. Consolidated NHHF state specific policy content from CC.BH.UM.07.NH, Utilization Management Timeliness and Notification Standards – New Hampshire into CBH policy CC.BH.UM.07, Utilization Management Timeliness and Notification Standards, Addendum G on 3/25/2020.	03/25/20

REVISION TYPE	REVISION SUMMARY	DATE APPROVED & PUBLISHED
	Retired CC.BH.UM.07.NH, Utilization Management Timeliness and Notification Standards – New Hampshire on 5/1/20.	
Ad Hoc Review	Changed all references to “Nebraska Total Care” to “Nebraska Total Care, NHA Expansion.”	5/18/20
Annual Review	Added “refer to Addendums” in Purpose Section. Added reference to Addendums in the Purpose Statement to apply the specific health plan Addendums that did not align with the stated timeliness standards. Added Addendum K - Oregon Trillium Community Health Plan Unique Requirements Addendum created.	6/26/20
Annual Review	Updated Page 3, Section 5.1.5.; Page 6, Section 5.2.6.3.1.; and Page 9, Section 5.3.5.4.1 to include “For Medicaid decisions, providing verbal notification does not extend the electronic or written notification time frame,” to reflect 2020 NCQA Standard UM 5: Timeliness of UM Decisions.	6/26/20
Ad Hoc Review	Revised Addendum I Ambetter of Tennessee section Pages 3 – 5 (Sec 5.1.1; 5.1.6) to eliminate the verbiage “or within seventy-two (72) hours, whichever is earlier.” Revised Addendum I Ambetter of Tennessee section Pages 5 – 8 (Sec 5.2.1; 5.2.6) to eliminate the verbiage “or within seventy-two (72) hours, whichever is earlier.”	7/13/20
Ad Hoc Review	Added verbiage related to reconsideration to Page 6, Section 5.2.6.1. and Page 7, Section 5.2.7. Updated extension requirements on Page 5, Section 5.2.5. and Page 9, Sections 5.3.3.3. – 5.3.3.4.2. to ensure compliance with NCQA UM Standard 5: Timeliness of UM Decisions.	9/24/20
Ad Hoc Review	Added Ambetter Utilization Determination Timeframes grid to Unique Requirement Addendum L for the following markets : Absolute Total Care, Arizona Complete Health, Arkansas Total Care, Buckeye Community Health Plan, Coordinated Care, Home State Health, Ambetter Illinois, Magnolia, Managed Health Services, Meridian, New Hampshire Health Families, Ambetter of North Carolina Inc., Peach State Health Plan, PA Health &Wellness, Ambetter of Tennessee, Sunflower Health Plan, Sunshine Health, Superior Health, Silver Summit Health Plan, Western Sky Community Care	1/13/21
Annual Review	Annual review. Replaced Cenpatico with Centene Advanced Behavioral Health. Replaced CBH with CABH. Removed revisions prior to 2017. Aligned the entire policy with CC.UM.05 Medicaid Timeliness of UM Decisions and Notifications Policy and Procedure and HIM.UM.05, Timeliness of UM Decision-making to align with Marketplace policy; Added NCQA requirement for Medicaid: “Providing verbal notification does not extend the electronic or written notification timeframe.”; Moved Addendum UM.7-01 Administrative Denial Work Process to CC.BH.UM.08, Adverse Determinations Added Addendum M, Managed Health Services, WI. REVISIONS:	6/23/21

REVISION TYPE	REVISION SUMMARY	DATE APPROVED & PUBLISHED
	<p>Reviewed and transferred relevant information from CC.BH.MCARE.UM.07 including verbiage to Purpose section (CABH following CMS guidelines) and Policy section (adding in Medicare and CABH reporting), Medicare Procedure bullets 1-9 and Definitions section (Grievance, Medical Director, Organizational Determination, Reconsideration/Appeal and Representative).</p> <p>Removed the MCARE.MM.05 Clinical Criteria and Application Policy and Procedure MCARE.MM.07 Medical Necessity Review Process Policy and Procedure MCARE.MM.09 Standard Organizational Determination Policy and Procedure</p> <p>MCARE.MM.12 – Determination of Organization Determinations Policy and Procedure</p> <p>Aligned:</p> <p>MCARE.MM.08 Part C Organization Determinations MCARE.MM.13 Medical Necessity Review MCARE.MM.18 Inpatient Concurrent Review</p> <p>Addendums added:</p> <p>Addendum N- Ohio- Buckeye Health Plan (Medicare) CC.BH. UM.07.01A Work Process for Standard Organization Determination CC.BH. UM.07.01B Work Process for Expedited Organization Determination</p> <p>Added ASAM to Medicare section</p> <p>Replaced “UM” with “Referral Specialists” in regard to staff answering calls during normal business hours for Procedure Medicare</p> <p>Updated wording to align with Concurrent Review process in section</p> <p>Replaced Attachment with Addendum.</p>	
Ad Hoc Review	Reformatted document and added sections A – C to the policy to reflect the sections for each LOB. Reformatted all Addendums (Except K and L).	9/22/21
Ad Hoc Review	<p>Updated the policy section to more explicitly include the requirements for verbal adverse determinations by LOB, and documentation requirements.</p> <p>Nonurgent preservice TATs updated to 14 calendar days to align with the most stringent TAT timeframe for all LOBs</p> <p>Addendum O created, with approval from the health plan, to address requirements related to Georgia Medicaid (Peach State Health Plan) from the Georgia Families Medicaid contract and health plan requirements</p>	12/22/21
Ad Hoc Review	Updated addendum H (Nevada), with health plan approval, to include additional state regulations.	2/22/22
Annual Review	<p>Aligned SOP with CC.UM.05 Timeliness of UM Decisions (Medicaid), 9/21; HIM.UM.05 Timeliness of UM Decisions and Notifications, 10/21; MCARE.MEDM.08. Part C Organization Determinations (Medicare), 4/21; and current NCQA UM Standards.</p> <p>Scope, Purpose and Definitions (timeframes and post-service request) updated to align with CC.UM.05 Timeliness of Um Decisions. Headers labeled A-G added</p>	3/29/22

REVISION TYPE	REVISION SUMMARY	DATE APPROVED & PUBLISHED
	<p>to the Medicaid Procure section. Headers labeled A-3 added to the Marketplace Procedure section. Headers labeled A-D added to the Medicare Procedure section. Due to adding new headers, prior information was reformatted to new header structure and additional information was added. Added Procedure section IV STAR+PLUS MEDICAID-MEDICARE PLAN (MMP) DETERMINATIONS AND NOTIFICATION OF ORGANIZATIONAL REVIEW. Addendums A-O reviewed by the Compliance Department. Addendum N (Ohio Medicare) was merged with Addendum A (Ohio). Addendum O (Georgia) was relabeled to Addendum N. Addendums 01 A, 02 A and B reviewed by the SMEs.</p>	

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, CABH 's P&P management software, is considered equivalent to a signature.

POLICY AND PROCEDURE

DEPARTMENT: Centene Advanced Behavioral Health Utilization Management	REFERENCE NUMBER: CC.BH.UM.09
EFFECTIVE DATE: 06/14/17	P&P NAME: Member Appeals
REVIEWED/REVISED DATE: 7/25/18; 3/04/19; 7/31/19; 12/10/19; 6/26/20, 6/23/21; 9/22/2; 11/23/21; 12/22/21; 3/29/22	RETIRED DATE: N/A
BUSINESS UNIT: Centene Advanced Behavioral Health	PRODUCT TYPE: Medicaid, Medicare, Marketplace
REGULATOR MOST RECENT APPROVAL DATE(S): NA	

SCOPE:

This policy applies to Centene Advanced Behavioral Health.

PURPOSE:

To offer a full and fair process for resolving members' disputes and responding to members' requests to reconsider a decision they find unacceptable regarding their care and service. The policy meets all Federal and State regulatory requirements, including an appeal process.

MARKETPLACE, MEDICAID, AND MEDICARE DEFINITIONS:

- **Action/Adverse Determination:** the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or part of payment for a service; the failure to provide services in a timely manner; or the failure to act within the time frames specified for making or notifying the member of such action.
- **Appeal:** Request for a Client health plan to reconsider a previous decision regarding an adverse determination. A member or authorized representative of a member may appeal any adverse decision. There may be several levels of appeal and the appeal process may be conducted internally or externally or both as required by State/Federal regulations.
- **Expedited Appeal:** a request to change an adverse determination regarding urgent care as defined below. Additionally, requests for an expedited appeal review must be granted to any request concerning admissions, continued stay or other health care services for a member who has received emergency services but has not been discharged from a facility.
- **External appeal:** a request for an independent, external review of the final adverse determination made by the Client health plan through its internal appeal process. This may include, but is not limited to, Independent Review Entity, Administrative Law Judge, Medicare Appeals Council, Quality Improvement Organization, or State Fair Hearing.
- **Post-service appeal:** a request to change an adverse determination for care or services that have already been received by the member; regarding a request for reimbursement of services received.
- **Pre-service appeal:** regarding a request for provision of service; a request to change an adverse determination for care or service that the Client health plan must approve, in whole or in part, in advance of the member obtaining care or services.
- **Same-or-similar specialist:** practitioner with similar credentials and licensure as those who typically treat the condition or health problem in question in the appeal or who has experience treating the same problems as those in question in the appeal, in addition to experience treating similar complications of those problems.
- **Urgent care:** any request for medical care or treatment, with respect to which the application of the time period for making non-urgent care determinations, could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on the prudent layperson's judgment or, in the opinion of a practitioner with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

MEDICARE FAST TRACK APPEALS DEFINITIONS

- **Independent Review Entity:** An independent entity contracted by CMS to review Centene's adverse reconsiderations of organization determinations.
- **Organization Determination:** Any determination made by Centene with respect to any of the following:
 - ✓ Payment for temporarily out of the area renal dialysis services, emergency services, post-stabilization care, or urgently needed services,
 - ✓ Payment for any other health services furnished by a provider other than services the member believes are covered under Medicare, or, if not covered under Medicare, should have been furnished, arranged for, or reimbursed by Centene,

- ✓ Centene's refusal to provide or pay for services, in whole or in part, including the type or level of services, that a member believes should be furnished or arranged for by Centene,
 - ✓ Discontinuation of a service if a member believes that continuation of the services is medically necessary, or
 - ✓ Failure of Centene to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide a member with timely notice of an adverse determination, such that a delay would adversely affect the health of the member
- **Beneficiary and Family Centered Care Quality Improvement Organization (QIO):** Organizations comprised of practicing doctors and other health care experts under contract to the Federal government to monitor and improve the care given to members. QIOs review complaints raised by members about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, SNFs, HHAs, the Plan, and ambulatory surgical centers. The QIOs also review continued stay denials for enrollees receiving care in acute inpatient hospital facilities as well as coverage terminations in SNFs, HHAs and CORFs.
 - **Reconsideration:** A member's first step in the appeal process after an adverse organization determination; the Plan or independent review entity may reevaluate an adverse organization determination, the findings upon which it was based, and any other evidence submitted or obtained.
 - **Representative:** An individual appointed by a member or other party, or authorized under State or other applicable law, to act on behalf of a member or other party involved in an appeal (i.e., a QIO review). Unless otherwise stated, the representative has all of the rights and responsibilities of a member or party in obtaining an organization determination or in dealing with any of the levels of the appeals process, subject to the applicable rules described in the CMS regulations and requirements.

POLICY:

CABH INTERNAL APPEALS GENERAL REQUIREMENTS

1. For Marketplace, allowing at least 180 calendar days after notification of the denial for the member, or the member's authorized representative including the treating practitioner, with the member's written consent to file an appeal.
2. For Medicare and Medicaid, allowing at least 60 calendar days after notification of the denial for the member or the member's authorized representative including the treating practitioner, with the member's written consent to file an appeal.
3. Documenting the substance of the appeal and any actions taken in the management system.
4. Full investigation of the substance of the appeal, including any aspects of clinical care involved.
5. The opportunity for the member to submit written comments, documents or other information relating to the appeal.
6. Appointment of a new person to review an appeal who was not involved in the initial determination and who is not the subordinate of any person involved in the initial determination.
7. Appointment of at least one person to review an appeal who is a behavioral health practitioner in the same or a similar specialty.
8. The decision for a preservice appeal and written notification to the member within 30 calendar days of receipt of the request.
9. The Marketplace and Medicare decisions for a postservice appeal and written notification to the member within 60 calendar days of receipt of the request.
10. For Medicaid, the decision for a postservice appeal and written notification to the member within 30 calendar days of receipt of the request.
11. The decision for an expedited appeal and written notification to the member within 72 hours of receipt of the request.
12. Notification to the member about further appeal rights.
13. Referencing the benefit provision, guideline, protocol, or other similar criterion on which the appeal decision is based.
14. Giving members reasonable access to and copies of all documents relevant to the appeal, free of charge, upon request.
15. Including a list of titles and qualifications, including specialties, of individuals participating in the appeal review.
16. Allowing an authorized representative to act on behalf of the member.
17. Providing client health plan approved written notices of the appeals process to members in a culturally and linguistically manner.
18. Continued coverage pending the outcome of an appeal.

19. The Referral Specialists have two separate queues in CRM. The CABH Referral Specialist queue in CRM and the CNC_UtilizatioManagement_WB in OMNI must be responded to within 5-business day for outpatient requests. Inpatient requests must be cleared within 2 hours during normal business hours. The CABH RS Escalations queue inquiries must be responded to within 48 hours of the task being entered into the RS queue.

PROCEDURE:

I. MARKETPLACE

A. General Requirements

1. A member, legal representative(s) of a deceased member's estate, or an authorized representative of a member acting on their behalf (with written consent from the member) may appeal an adverse determination regarding their care and service. A health care practitioner with knowledge of the member's medical condition, acting on behalf of the member (with written consent from the member as dictated by state contract, as applicable), may also file an appeal. Punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal.
2. Members are provided a reasonable timeframe to file an appeal, i.e., no longer than 180 calendar days from the date of the Marketplace Client health plan's notification of adverse determination or within the timeframes as designated by the state Department of Insurance, if more stringent.
3. The Marketplace Client health plans reviews, resolves and provides the member with written or electronic notification of the appeal decision as quickly as the member's health condition requires but no later than:
 - Pre-service appeals - 30 calendar days (or per state timeframes if more stringent, refer to client health plan addendum)
 - Post-service appeals - 60 calendar days (or per state timeframes if more stringent, refer to client health plan addendum)
 - Expedited appeals - 72 hours (or per state timeframes if more stringent, refer to client health plan addendum)
4. The timeframe for disposition of standard and expedited appeals may be extended for up to 14 calendar days if the member, the member's authorized representative, or health care practitioner acting on behalf of the member requests the extension or voluntarily agrees to the extension. For any extension not requested by the member, Marketplace Client health plans gives the member written notice of the reason for the delay and obtain the member's consent for the extension. If the member does not consent to the extension, the appeal is decided with the information available before the timeframe expires. An appeal may be withdrawn by written request from the person who filed the appeal.
5. Continued coverage pending the outcome of the appeal of concurrent care decision is allowed until the end of the approved treatment period or determination of the appeal (subject to regulatory and contractual obligations). Continued coverage pending outcome of the appeal only applies to denial, reduction, or termination of coverage for an ongoing course of treatment for which coverage was previously approved. It does not apply to requests for extensions.
6. Members that express language barriers and or special needs can obtain assistance using the Client health plans Language Line/TDD to file their appeal. If the member files their appeal using the interpreter or TDD service, then the Client health plan notifies the member of the resolution of their appeal using that same resource. All appeal notices are based on members' cultural and linguistic needs, as applicable.

B. Filing an Appeal

1. An appeal may be filed orally or in writing, and received via mail, telephone, facsimile, electronic mail, or in person. Members must confirm an oral appeal request in writing (other than for an expedited request). Members must file an appeal request within 180 calendar days of the Marketplace Client health plan's notice of adverse action to the member, or per timeframes dictated by state regulation, if more stringent.
2. CABH, on behalf of the client health plan, assists any member requesting assistance in understanding an adverse determination notice and in filing an appeal, including any member with special communication needs.
3. Members appealing urgent care services may request an expedited appeal. An expedited appeal review may be requested orally by the member, the member's authorized representative, or a health care practitioner acting on the member's behalf and begins upon such request. A practitioner with knowledge of the member's condition may request an expedited appeal on a member's behalf; written member consent is not required for expedited appeals requested by the provider.

4. An expedited appeal request must be granted to all requests concerning admissions, continued stay or other health care services for a member who has received emergency services but has not been discharged from the facility. CABH must provide an expedited appeal if a physician demonstrates that the standard timeframe for an appeal decision could seriously jeopardize the life or health of the member or the member's ability to regain maximum function. Expedited appeals are not available for post-service requests.
5. If CABH denies a request for an expedited appeal, the appeal must automatically be transferred to the standard timeframe. For Marketplace Client health plan members, a reasonable attempt must be made to provide oral notification of the expedited request denial and followed up with written notice within 2 calendar days (CFR 438.410).

C. Appeal Acknowledgment

1. CABH sends a written member appeal acknowledgement letter within 5 business days of the receipt of the request for appeal. CABH uses a client health plan approved acknowledgement letter, which includes:
 - The date the appeal was received.
 - The member's right to choose additional representation by anyone, including an attorney, physician, advocate, friend, or family member to represent him or her during the appeal process. The designation of their authorized representative must be submitted to the Client health plan in writing.
 - The member's right to submit comments, documents, or other information relevant to the appeal. In the case of expedited appeal requests, the member is informed of the limited time available to provide the information.
 - The member's right to present information relevant to the appeal within a reasonable distance so that the member can appear in person if desired.
 - Notification of members' rights and the appeal process in a culturally and linguistically appropriate manner.
 - The timeframe for resolution of the appeal and further appeal rights, if any.
 - The member acknowledgement letter includes the members' right and the information for the member to request a client health plan Grievance Panel for those client health plans that are required to offer the Grievance Panel. Should the member request the Panel for the appeal, the client health plan Coordinator facilitates a panel that includes the CABH Medical Director, not involved in the prior decision, who is authorized to take corrective action, and one additional client health plan staff member.

D. Appeal Investigation

1. CABH fully investigates and documents the content of the appeal including all aspects of clinical care involved, without giving deference to the denial decision. All information is considered regardless of whether the information was submitted or considered in the initial determination.
2. The appeal is reviewed by a person or people who were not involved in the prior adverse decision. The appointed person is neither the individual who made the adverse determination nor a subordinate of such individual; however, the practitioner who made the initial adverse determination may review the case and overturn the previous decision.
3. Appeals with regard to whether a particular treatment, drug or other item is experimental, investigational or not medical necessity or appropriate is reviewed by a clinical peer who holds an active, unrestricted license to practice medicine or a health profession, who is board-certified if applicable, and who is of the same-or-similar health care professional and has similar credentials and licensure and appropriate training and experience as those who typically treat the condition or health problem in question in the appeal.

E. Appeal Resolution

1. CABH resolves pre-service appeals with written or electronic notification of the decision within 30 calendar days of the pre-service appeal request (or per state regulation timeframes, if more stringent; refer to client health plan addendum).
2. CABH resolves post-service appeal with written or electronic notification of the decision within 60 calendar days of receipt of the appeal request (or per state regulation timeframes, if more stringent; refer to client health plan addendum).
3. CABH resolves expedited appeals as expeditiously as the member's health condition requires, but no later than 72 hours (or per state regulation timeframes, if more stringent; refer to client health plan specific addendum) after the appeal request is made.
4. CABH, may extend the appeal resolution notification time frame, for pre-service or post-service appeals up to 14 calendar days to obtain additional information in the following circumstances:
 - The member requests an extension; or
 - The member voluntarily agrees to extend the appeal time frame.

Written notification of the reason for the delay is provided to the member, if the member has not requested the extension, and the member's consent for the extension is obtained. If the member does not consent to the extension, the appeal is decided with the information available before the timeframe expires.

5. If CABH fails to meet the above resolution timeframes, the member may submit their appeal for an external independent review.
6. CABH, on behalf of the client health plan, sends the appellant a client health plan approved written notification of the appeal resolution determination. When the adverse decision is upheld in whole or part, the client health plan approved written appeal decision must include the following elements:
 - Date of the appeal resolution.
 - Specific reasons for the appeal decision, in easily understood language. The reason for the decision is provided in plain language that a layperson would understand and does not include abbreviations or acronyms that are not defined in the notice, or procedure codes that are not explained.
 - A reference to the benefit provision, guideline, protocol, or other similar criterion on which the appeal decision was based.
 - Notification that the member can obtain a copy free of charge, upon request, of the actual benefit provision, guideline, protocol, or other similar criterion on which the appeal decision was based with any new or additional evidence.
 - Notification that the member is entitled to receive, upon request and at no additional cost, reasonable access to and copies of all documents relevant to the appeal including any new or additional evidence. Relevant documents include documents and records relied upon in making the appeal decision and documents and records submitted while making the appeal decision.
 - A list of titles and qualifications, including specialty of the individual conducting the medical necessity review, of individuals participating in the appeal review. (Participant names do not need to be included in the written notification to members but must be provided to members upon request).
 - A description of the next level of appeal, with an Independent Review Organization (IRO), as applicable, along with any relevant written procedures and contact information (appeal rights are required whenever the organization makes a decision that is partially or fully upheld).
 - Notification is given to the member and the provider/facility.
7. For expedited appeals, initial notification of the appeal decision may be provided orally to the party requesting the appeal and must be provided within 72 hours of receipt of the appeal request (or per state timeframes if more stringent; refer to client health plan addendum). If initial notification is oral, a client health plan approved written notification must be sent to the member and provider/facility no later than 3 calendar days after the initial oral notification, or per state contract requirements if more stringent (refer to client health plan addendum). CABH may inform the hospital UR department staff of the appeal decision, with the understanding that UR staff informs the attending/treating practitioner.
8. When CABH completely overturns the initial denial determination, the appeal notice must state the decision and the date. CABH authorizes the disputed services promptly and notifies the client health plan promptly pays for the disputed services if the member continues to receive the services while the appeal was pending.

F. External Independent Review

Marketplace members have the right to external appeal processes, which are managed by the client health plan, and communicated by CABH in the client health plan approved appeal resolution letter:

1. A member, their legal representative, or provider (with the member or legal guardian's written consent) may request an external third-party binding review by an IRO after the Client health plan's internal grievance/appeal process has been exhausted, as applicable, and defined by the state regulations for all medical necessity denials. The request may be concurrent in the case of expedited appeals.
2. The parties to an IRO include Client health plan, as well as the member, his/her legal representative, or the representative of a deceased member's estate.
3. The request for an IRO must be submitted within one hundred twenty (120) calendar days from the date of the notice of action regarding their expedited or standard appeal (or per state timeframes if more stringent). The Client health plan assists the member or their representative with filing the appeal, as requested.
4. The member is not required to bear the costs of the IRO, including filing fees.
5. The Client health plan has no material professional, familial, or financial conflicts of interest with the IRO.
6. The Client health plan does not attempt to interfere with the IRO's proceedings or appeal decision.
7. The Client health plan conducts a preliminary review within five (5) business days (immediately for expedited) to provide the IRO, or Department of Insurance as required, with information regarding the eligibility of the member, whether the requested services are a covered benefit, the status of the internal appeal, and any necessary forms required. The Client health plan alerts the member, IRO if already assigned, or state regulatory entity as required, if there are any identified issues with the request for external review.
8. The member is notified in writing within one (1) business day of the preliminary review whether the request is complete but not eligible for external review and the reasons for its ineligibility or, if the request is not

complete, the additional information needed to make the request complete. The Client health plan allows the member to correct the filing within the filing timeframe or within 48 hours of the notification.

9. The Client health plan, on a rotating basis of contracted IROs, or the state regulatory agency as applicable, selects the IRO to complete the review.
10. The Client health plan cooperates with the IRO in the hearing process and submit a copy of the member's internal appeal of the Client health plan's action; the contents of the internal appeal file including research, medical records and other documents used to make their decision and a summary of the member's appeal; the evidence used by the Client health plan to make its decision; and a copy of the notice of resolution provided to the member and to the IRO within 5 business days of the notice or the required timeframe noted in Appendix A if more stringent.
11. The IRO conducts a thorough review in which it considers all previously determined facts, allows the introduction of new information, considers and assesses sound medical evidence and makes a decision that is not bound by the decisions or conclusions of the internal appeal.
12. The IRO decision is made within the parameters set by the state or if the state does not set a standard, within 45 calendar days of the request.
13. The Client health plan maintains data from the IRO on each appeal case and use this information in evaluating its medical necessity decision-making process.
14. The member is notified of the IRO decision, including the time and procedure for claim payment or approval of service, in the event the IRO overturns the organization's decision.
15. The Client health plan implements the IRO's decision within the time frame specified by the IRO.
16. The member is notified, in writing or electronically with each eligible appeal of the right to request an external independent review and the contact information of the Independent Review Organization.

G. Annual Notice of External Review Rights

CABH is not delegated to provide annual notice of external review rights to the member as this is a Health Plan responsibility. However, should CABH be delegated this function in the future *Addendum J, Annual Notice of External Review* would be provided to the appropriate membership.

H. Documentation and File Requirements

1. All appeals requests are documented and kept on file in a centralized location for a period of no less than ten (10) years. Appeal files contain at a minimum:
 - Documentation of the substance of the appeal and actions taken, including name of the member and associated provider and/or facility. Documentation includes the member's reason for appealing the denial and any additional clinical or other information included with the appeal request.
 - Investigation of the appeal, including any aspect of clinical care involved.
 - As applicable if members do not submit information relevant to the appeal in the specified timeframe.
 - All actions taken related to the appeal, including previous denial or appeal history and any follow-up activities associated with the original denial and conducted prior to the current appeal being received.
 - Date of appeal reviews and the name and credentials of the reviewer(s) who made the appeal decision.
 - Notifications include documentation of verbal and written notifications of acknowledgement, resolution, etc. of the appeal.
 - All other correspondence and records associated with the appeal.
 - Minutes or transcripts of appeal proceedings, if any.
2. Summaries of appeal actions, trends, and root causes are reported at least annually to the CABH Utilization Management Subcommittee, and Quality Improvement Committee to evaluate achievements and opportunities for improvement.

II. **MEDICAID AND MEDICARE**

A. General Requirements

1. Members are notified by the client health plan upon enrollment of the procedure for requesting, processing, and resolving Member appeals. The notification explains specific instructions about how to contact the client health plans' Member Services Department and identifies the designated staff who process appeals.
2. Members may have only one level of internal appeal. Members must exhaust the CABH internal appeal processes prior to requesting a client health plan State Fair Hearing (SFH). Should CABH fail to adhere to the notice and timing requirements within the State contract and 42 C.F.R 438.408, the member is deemed to have exhausted the internal appeal process and may initiate a SFH.
3. A Member, or Authorized Representative acting on the Member's behalf or a Provider, acting on behalf of the Member and with the Member's written consent, may file an appeal. If the Member chooses to elect an authorized representative, the Member's written consent is required before the CABH can process the request. Once the signed Authorized Representative Designation Form or other written, signed authorization designation is received, the resolution time clock begins.

4. A Member, or Member Authorized Representative, may file an appeal orally or in writing. CABH gives Members reasonable assistance in completing forms and taking other procedural steps of the Member Appeals System, including, but not limited to, auxiliary aides and services, such as providing translation services, communication in alternative languages and toll-free numbers with TTY/TDD and interpreter capability.
 5. CABH gives the Member written notice of any action within the timeframes for each type of action and will not create barriers to timely due process.
 6. CABH Appeals documents the appeal and completes a task in the member relations documentation system.
 7. CABH considers all comments, documents, records, and other information submitted by the Member or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination, if applicable.
 8. CABH provides the Member a reasonable opportunity, orally and in writing, to present evidence, testimony, and make legal and factual arguments. CABH informs the Member of the limited time available in advance of the resolution timeframe for appeals and in the case of expedited resolution.
 9. CABH provides the Member and his or her representative, free of charge and in advance of the resolution timeframe for an appeal: the Member's case file, medical records involved, other documents and records, and any new or additional evidence used in the case upon the Member's request. The client health plan includes information regarding appeals in their Provider Manual and Member Handbook, including procedures and timeframes.
 - The client health plan provides a copy of the Provider Manual to all providers/ subcontractors at the time the client health plan enters into agreements with said providers/subcontractors.
 - A Member Handbook is distributed to all Members by the client health plan upon enrollment.
 - The information is also posted on the client health plan's web site and communicated annually through the Member and Provider Newsletters/Manuals.
 10. CABH includes, as parties to the appeal, the Member and his or her representative or the legal representative of a deceased Member's estate.
 11. CABH maintains a record/log of all appeals that the client health plan will make available to the State agency and CMS in electronic format upon request. The log will be specific to the Member; entries in the log will not be intermingled with entries of Members from the Plan's other lines of business. At minimum, the log will include:
 - The Member's name and Member ID number;
 - The name of the appellant if not the Member;
 - The date of filing and description of the issue;
 - The date of each review, or if applicable, review meeting;
 - The resolution at each level of the appeal, if applicable;
 - The date and description of the resolution at each level, if applicable;
 - The date of the Member notification.
 12. The CABH Utilization Management Subcommittee and Quality Improvement Committee quarterly and annually tracks appeals to identify trends. The trends are reviewed for identification of appropriate interventions and recommendations. An analysis of the member appeals is included in the annual CABH Utilization Management Program Evaluation.
 13. The client health plan electronically provides the State agency with a monthly report of the appeals in accordance with the requirements outlined in the Contract, to include, but not be limited to: Member's name and Medicaid number, summary of appeals; date of filing; current status; resolution and resulting corrective action. Reports with Member identifying information are redacted and available for public inspection.
 14. CABH assures that no punitive action is taken against a Provider or Member who files an appeal, requests an expedited appeal on behalf of a member, or supports a member's appeal or request for an expedited appeal.
 15. All Member appeals are resolved and notification sent as expeditiously as the member's health condition requires, within State contract timeframes (refer to client health plan specific addendum, when indicated) and no longer than dates stated with 42 C.F.R.438.408.
 16. CABH maintains records of all client health plan appeals. A copy of records of disposition of appeals will be retained for ten (10) years. If any litigation, claim negotiation, audit, or other action involving the documents or records has been started before the expiration of the ten (10) year period, the records shall be retained until completion of the action and resolution of issues which arise from it or until the end of the regular ten (10) year period, whichever is later.
- B. Appeal Filing
1. The appeal process for addressing Member appeals are requests for review of a previous medical necessity adverse (denial) decision by CABH.

2. The Member, Member's Authorized Representative or Provider acting on behalf of the Member, with the Member's written consent, may file an appeal. An appeal must be filed within 60 calendar days from the date on the adverse benefit determination notice or within 10 calendar days if the Member is requesting to continue benefits during the appeal investigation.
3. A member appeal request may be submitted several ways:
 - The Member may call in to CABH's toll-free number. All inquiries received are validated the confirm the inquiry is an appeal. CABH Appeals is notified of the appeal and obtains the appeal information and documents details of the request within the clinical documentation system.
 - The Member may request an appeal either orally or in writing.
 - The Member may submit the appeal by phone, mail, fax, email or in person.
 - If a member would like an authorized representative, the Member must complete the Member Authorized Representative Designation Form or provide other written, signed documentation authorizing the person to act on their behalf. If the Member chooses to elect an authorized representative, the Member's written consent is required before CABH can process the request. Once the Authorized Representative Designation Form is received, the resolution time clock begins. (Refer to Addendum A, Authorized Representative Designation Form)
 - CABH provides members with reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, auxiliary aides and services, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.
4. Appeal resolution timeframes are as follows:
 - Pre-Service Standard Appeal resolution and notification within 30 calendar days from the date the appeal was received by CABH (or per state timeframes if more stringent, refer to the client specific addendum).
 - Post-Service Standard Appeal resolution and notification for Medicaid is 30 calendar days from the date appeal was received by the Plan (or per state timeframes if more stringent, refer to the client specific addendum). Post-Service Standard Appeal resolution and notification for Medicare is within 60 calendar days of receipt of the request.
 - Expedited Appeal resolution within 72 hours from the date the appeal was received by CABH. CABH maintains an expedited review process for appeals when CABH determines the Member request or the Provider indicates (in making the request on the Member's behalf or supporting the Member's request) that taking the time for a standard resolution could seriously jeopardize the Member's life, health, or ability to attain, maintain, or regain maximum function.
5. CABH acknowledges all oral and written pre-service and post-service appeals within 10 calendar days of the receipt of a request for the appeal using the client health plan approved acknowledgement letter.
6. Client health plan approved written expedited appeals acknowledgement occurs at the same time the resolution is determined and is included in the client health plan approved written notice used to acknowledge and resolve the appeal. Reasonable efforts are made to provide expedited appeal resolution notification orally, as well as in writing.
7. Upon the members' request the member or their representative has the right to examine the case file and receive free of charge the medical records, and any other documents and records, including any new or additional evidence considered, relied upon, or generated by CABH considered in connection with the appeal of the adverse determination before and during the appeals process.
8. CABH will provide the Member with reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments in reference to the appeal. CABH will also inform the Member of the limited timeframe for providing such information prior to the resolution of both standard and expedited appeals.
9. CABH ensures that the individuals who make decisions on appeals are individuals who were not involved in any previous level of review or decision-making nor a subordinate of any such individual, and who, if deciding any clinical decisions, are health care professionals who have the appropriate clinical expertise, as determined by the state agency, in treating the member's condition or disease; including appeals of denials lacking medical necessity.
10. Client health plan approved form and/or letter templates that are in the CABH appeals documentation system. Member communications, including appeal notices are provided in easily understood language and format, are available in alternative formats and in an appropriate manner that takes into consideration those with special needs. If the client health plan has State specific forms and/or templates, those will be utilized.
11. Member communications identifies that a member may continue to receive benefits pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the Member may be required to pay the costs of these services.

C. Pre-service and Post-service (Standard) Appeal Process

1. The CABH Appeal Coordinator is responsible for managing standard appeals from when the appeal request is received and through to resolution.
 2. The client health plan approved Member Appeal Acknowledgement Letter is created and available in the clinical documentation system. The acknowledgement letter includes notification of Member rights and appeal processes in a culturally and linguistically appropriate manner, along with the following: Member's right to choose additional representation by anyone, including an attorney, physician, advocate, friend, or family member to represent him or her during the appeal process. The designation of their Authorized Representative must be submitted to the Plan in writing:
 - The Member's right to submit comments, documents, or other information relevant to the appeal;
 - The Member's right to present information relevant to the appeal within a reasonable distance so that the member can appear in person if desired;
 - The timeframe for resolution of the appeal;
 - The Member's right to have the specified benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the member may be required to pay for the cost of those services;
 - Need for missing information, if applicable.
 3. A client health plan approved Appeal Acknowledgement Letter is sent within ten (10) calendar days of the receipt of the appeal request (or per state contract timeframe if more stringent, refer to client health plan addendum).
 4. CABH Appeals creates an appeal in the documentation system; requests additional information as applicable and submits the file to the CABH Level II reviewer for review.
 5. Appeal resolution must be completed within 30 calendar days of receipt of the request.
 6. The approved client health plan appeal resolution letter contains:
 - The appeal outcome;
 - The appeal determination date; further appeal rights, if any, including the client health plan SFH process, continuation of benefits and circumstances in which the Member may be held liable for service costs.
 - When the initial adverse decision is upheld in whole or part, the written appeal decision notification must include the following elements when applicable:
 - ✓ Specific reasons for the appeal decision, in easily understood language. Easily understandable notification includes a complete explanation of the reason for the denial in plain language that does not include abbreviations or acronyms that are not defined, health care codes that are not explained, or medical jargon that a layperson would not understand.
 - ✓ A reference to the specific benefit provision, guideline, protocol, or other similar criterion on which the appeal decision was based.
 - ✓ Notification that the Member can obtain, upon request and free of charge, a copy of the actual benefit provision, guideline, protocol, or other similar criterion on which the appeal decision was based with any new or additional evidence.
 - ✓ Notification that upon request, the Member is entitled to receive at no cost, reasonable access to and copies of all documents relevant to the appeal including any new or additional evidence. Relevant documents include documents and records relied upon in making the appeal decision and documents and records submitted in the course of making the appeal decision.
 - ✓ For medical necessity appeals, the title and qualification of the Peer Reviewer including specialty of the individual(s) conducting the medical necessity review (Physician reviewer names do not need to be included in the written notification to members, but must be provided to Members upon request).
 - ✓ A description of the next level of appeal to an external organization (i.e., State Fair Hearing or Independent Review Organization (IRO), etc.) as applicable, along with any relevant written procedures and contact information.
 - ✓ Appeal rights are required and provided whenever the organization makes a partially or fully upheld decision.
 7. CABH sends the client health plan approved resolution letter to members for overturned, partially approved/upheld, and upheld determinations, which are available in the members' file within the documentation system.
 8. The Clinical Appeal Coordinator is responsible for updating and closing the case in the member relations documentation system. Letters will be created and available in the clinical documentation system.
- D. Pre-service and Post-service (Standard) Appeal Extensions
1. If CABH determines that the extension may produce information in the Member's favor, CABH Appeals, or the member may request a 14-calendar day extension.

2. If the Member or Member representative is not satisfied with the decision to extend the timeframe, the Member may file a grievance with the client health plan.
 3. CABH must demonstrate to the client health plan how the extension benefits the member and that the need for additional information is in the member's favor. The client health plan communicates this to the State for their approval of the extension, and make reasonable efforts to provide prompt oral notification to the Member of the delay. Once the State approves the extension, the client health plan will notify CABH Appeals. CABH Appeals will provide the member client health plan approved written notification of the State's extension approval by the State within 2 calendar days of State approval to extend appeal resolution timeframe.
 4. CABH Appeals will resolve the appeal as expeditiously as the Member's health condition requires, and no later than the date the extension expires.
- E. Expedited Appeal Process
1. CABH Appeals is responsible for managing Expedited Appeals from the date of appeal request through to resolution.
 2. CABH Appeals calls the Member acknowledging the Expedited Appeal and informs the Member of the limited time available for submission of additional materials to be considered in the expedited appeal investigation.
 3. CABH processes expedited appeal requests concerning admissions, continued stay or other health care services for a member who has received emergency services but has not been discharged from the facility. CABH must provide an expedited appeal if a physician demonstrates that the standard timeframe for an appeal decision could seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function.
 4. Client health plans' State contracts may dictate other situations where Expedited Appeals are allowed (refer to client health plan addendum).
 5. When the Expedited Appeal request is determined not to meet criteria for urgent care, the Standard Appeal process will be followed, and a client health plan approved letter will be sent to Member notifying them of appeal request change to the standard processing timeframe.
 6. When CABH denies a request for an Expedited Appeal, the appeal must automatically be transferred to the standard processing timeframe. A reasonable attempt must be made to provide oral notification of the denied expedited request with followed up of written notice within 2 calendar days (CFR 438.410), or per state contract requirements if more stringent (refer to client health plan addendum).
 7. CABH Appeals creates an appeal file in the documentation system; requests additional information as applicable and submits to Peer Reviewer for review.
 8. The resolution of the Expedited Appeal must be completed within 72 hours of receipt of the Expedited Appeal request.
 9. Once a resolution is determined, reasonable attempts are made to verbally notify the Member. A client health plan approved Expedited Appeal Resolution letter will be issued following oral notification attempts and documented in the system.
 10. The client health plan approved Expedited Appeal Resolution letter will contain the appeal outcome, the date it was completed and further appeal rights, if any, including the State Fair Hearing process, continuation of benefits and circumstances in which the Member may be held liable for service costs. When the adverse decision is upheld in whole or part, the written appeal decision notification must include the following elements when applicable:
 - Specific reasons for the appeal decision, in easily understood language. Easily understandable notification includes a complete explanation of the reason for the denial in plain language that does not include abbreviations or acronyms that are not defined, health care codes that are not explained, or medical jargon that a layperson would not understand
 - A reference to the specific benefit provision, guideline, protocol, or other similar criterion on which the appeal decision was based.
 - Notification that the Member can obtain, upon request and free of charge, a copy of the actual benefit provision, guideline, protocol, or other similar criterion on which the appeal decision was based with any new or additional evidence.
 - Notification that the Member is entitled to receive, upon request and at no cost, reasonable access to and copies of all documents relevant to the appeal including any new or additional evidence. Relevant documents include documents and records relied upon in making the appeal decision and documents and records submitted in the course of making the appeal decision.
 - For medical necessity appeals, a list of titles and qualifications of the individual(s) conducting the medical necessity appeal review. (Physician reviewer names do not need to be included in the written notification to members, but must be provided to Members upon request).

- A description of the next level of appeal to an external organization (i.e., State Fair Hearing or Independent Review Organization (IRO), etc.) as applicable, along with any relevant written procedures and contact information (appeal rights are required and provided whenever the organization makes a decision that is adverse to the Member).

11. CABH Appeals is responsible for updating/closing the case in the documentation system.

F. Expedited Appeal Extensions

1. A 14-calendar day extension may be considered when CABH Appeals determines that the extension may produce information in the Member's favor, or the member requests the extension.
2. When the member does not consent to the extension, the appeal will be decided with the information available before the timeframe expires.
3. CABH must obtain the client health plan's approval for the extension. The client health plan must obtain applicable State consent for the extension, and will notify CABH Appeals once the extension is approved.
4. If the Member or Member representative is not satisfied with the decision to extend the timeframe, the Member may file a grievance with the client health plan. The client health plan will resolve the grievance as expeditiously as the Member's health condition warrants and no later than the date the extension expires.
5. An appeal may be withdrawn by written request from the person who filed the appeal.

G. Appeal Investigation

1. CABH will fully investigate and document the content of the appeal including all aspects of clinical care involved, without giving deference to the denial decision. All information will be considered regardless of whether the information was submitted or considered in the initial determination. Any additional information required to review the appeal request should be requested at this time and that request documented in the clinical documentation system. If no additional information is available, per the Provider and/or Member, this should also be documented.
2. The documentation, at a minimum, is the member's reason for appealing the initial denial decision, additional clinical or other information provided with the appeal request, previous denial or appeal history, and follow-up activities associated with the denial and conducted before the current appeal.
3. The appeal will be reviewed by a person or people who were not involved in the prior adverse decision. The appointed person will neither be the individual who made the adverse determination nor a subordinate of such individual; however, if additional clinical information is received and meets criteria for coverage, the practitioner who made the initial adverse determination may review the case and overturn the previous decision. A nurse, pharmacist, or other appropriate qualified licensed health professional may also overturn the prior adverse decision if additional clinical information is received with the appeal request and the additional information meets criteria for coverage.
4. Appeals with regard to whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate will be reviewed by a clinical peer who holds an active, unrestricted license to practice medicine, or a health professional who is board-certified, if applicable and who is of the same-or-similar health care profession and has similar credentials and licensure and appropriate training and experience as those who typically treat the condition or health problem in question in the appeal.
5. For appeals resulting from medical necessity review of out-of-network requests, the reason for an upheld appeal decision must explicitly address the reason for the request (e.g., if the request is related to accessibility issues, that may be impacted by the clinical urgency of the situation, the appeal decision must address whether or not the requested service can be obtained within the organization's accessibility standards).

H. Inability to Process an Appeal

1. CABH Appeals may receive appeal requests that are unable to be processed for one of the following reasons:
 - An appeal request is received outside of the sixty (60) calendar day timeframe;
 - The Member is not eligible for benefits or services at the time of the appeal request.
2. CABH Appeals is responsible for updating/closing the case in the documentation system. A client health plan approved Unable to Process letter will be created and available in the documentation system and sent to the Member.
3. If the Member or Member representative is not satisfied with the decision to not process the appeal, the Member may file a grievance with the client health plan.

I. Continuation of Benefits

1. CABH will continue the Member's benefits during the appeal process based on the following:
 - The member files the appeal within ten (10) calendar days of the date on the written adverse notification.
 - The Member files a timely appeal in accordance with 42 CFR 438.402;
 - The action involves the termination, suspension, or reduction of a previously authorized course of treatment;

- The services were ordered by an authorized provider;
 - The authorized period has not expired; and
 - The Member requests an extension of benefits.
2. When CABH continues or reinstates the member's benefits while the appeal is pending, CABH will continue providing the benefits until one of the following occurs:
 - Determination of the appeal, subject to regulatory and contractual obligations;
 - The Member withdraws the request for an appeal; or
 - The Member's authorization expires or the Member reaches his/her authorized service limits.
 3. If the final resolution of the appeal is upheld the client health plan may recover the costs of the services furnished while the appeal was pending to the extent that the services were furnished solely because of the requirement to continue benefits during the appeal.
 4. If services were not furnished while the appeal was pending, and the appeal resolution reverses the initial decision to deny, limit or delay services, CABH must authorize or provide the disputed services as quickly as the Member's health condition requires.
 5. If services were furnished while the appeal was pending, and the appeal resolution is to overturn the initial denial decision, CABH will authorize the services, and the client health plan will pay for disputed services in accordance with State policy and regulations.

III. **MEDICARE FAST TRACK APPEALS**

- A. Members receive proper notification as required by the Centers for Medicare and Medicaid Services (CMS) of their right to an expedited review by a Beneficiary Family Centered Care - Quality Improvement Organization (BFF-QIO).
- B. Fast Track Appeals Process for Non-Hospital Setting: SNF, HHA or CORF
 1. Members have the right to a fast appeal if they feel services are ending too soon from one of these facilities:
 - A Medicare-covered skilled nursing facility (SNF)
 - A Medicare-covered home health agency (HHA)
 - A Medicare-covered comprehensive outpatient rehabilitation facility (CORF)
 2. All members receiving covered provider services receive a Notice of Medicare Non-Coverage (NOMNC) from the provider (SNF, HH, CORF) at least two calendar days/visits in advance of the services ending. If the provider, hospital, or facility has not sent the NOMNC within the required timeframe, it is the health plan's responsibility to ensure that the member receives the NOMNC. This notice is in the clinical documentation system for this purpose.
 3. Exclusions to receiving the NOMNC include the following:
 - If the member never received Medicare covered care in one of the covered settings (e.g., admission to a SNF will not be covered due to lack of a qualifying hospital stay or face-to-face visit was not conducted for the initial episode of home health care)
 - If services are being reduced (e.g., a HHA providing physical therapy and occupational therapy discontinues the occupational therapy)
 - If members are moving to a higher level of care (e.g., home health care ends because a member is admitted to a SNF)
 - When members exhaust their benefits (e.g., a member reaches 100 days of coverage in a SNF, thus exhausting their Medicare Part A SNF benefit)
 - If a member requests coverage in the above situations, the plan must issue the Notice of Denial of Medical Coverage/IDN found in the clinical documentation system.
 - If members end care on their own initiative (e.g., a member decides to revoke the hospice benefit and return to standard Medicare coverage)
 - If a member transfers to another provider at the same level of care (e.g., a member transfers from one SNF to another while remaining in a Medicare covered SNF stay)
 - If a provider discontinues care for business reasons (e.g., HHA refuses to continue care at a home with a dangerous animal or because the member was receiving physical therapy and the provider's physical therapist leaves HHA for another job)
 - If a member requests coverage in the above situations, the plan must issue the Notice of Denial of Medical Coverage/IDN, found in the clinical documentation system.
 4. The member will receive this notification regardless of whether or not the member agrees that the services should end. This notice explains the following:
 - The date the covered services will end
 - Information on the member's right to get a detailed notice about why covered services are ending
 - The member's right to a fast appeal and information on how to contact the BFCC-QIO in the member's state to request a fast appeal.

5. If the member does not agree covered services should end, the member may request an expedited review of the case by contacting the BFCC-QIO listed on the NOMNC. The member must ask for a fast appeal no later than noon of the first day after the member receives the NOMNC, or the day before coverage ends.
6. When the BFCC-QIO receives the member's request to appeal, the BFCC-QIO will notify the CABH Appeals contact. CABH Appeals issues a client health plan approved "Detailed Explanation of Non-Coverage" (DENC) letter to the member and will provide a copy to the BFCC-QIO in addition to any applicable medical records, no later than close of business on the day the BFCC-QIO notifies CABH that the member requested an appeal. The DENC will include:
 - Explanation of why the member's services are no longer covered
 - Citation of the applicable Medicare coverage rule or policy, including the applicable Medicare policy or information on how the member can get a copy of the policy that's being used to explain why coverage is ending
 - Description of how the applicable coverage rule or policy applies to the member's specific situation
 If the provider, hospital, or facility has not sent the notice within the required timeframe, it is CABH's responsibility to ensure that the member receives the notice. This notice is in the clinical documentation system for this purpose.
7. The member may ask for copies of any materials that the plan sends to the BFCC-QIO, which CABH will provide. The BFCC-QIO will look at all medical information received and will decide by close of business the day after receiving all requested information.
8. If the BFCC-QIO decides the services are ending too soon, CABH will continue to authorize the SNF, HHA or CORF services as long as medically necessary.
9. If the BFCC-QIO decides that the services should end, the member will not be responsible for paying for any SNF, HHA or CORF services provided before the termination date on the NOMNC. If the member continues to get services after the coverage end date, the member may have to pay for these services.

C. Fast Track Appeals Process for Inpatient Hospital Setting

1. Within two calendar days of inpatient admission and prior to discharge, the hospital provides the member with a notice called "An Important Message from Medicare about Your Rights (IM)." This notice lists the BFCC-QIO's contact information and explains:
 - Member's right to receive all medically necessary hospital services
 - Member's right to be involved in any decisions made about the hospital or doctor services
 - Member's right to know who will pay for the services
 - Member's right to receive necessary services after discharge
 - Member's right to appeal a discharge decision and the steps for appealing the decision
 - Member responsibility for payment of continuing stay in the hospital
 - Member's right to get a detailed notice about why their services are ending
2. If the provider, hospital, or facility has not sent the notice within the required timeframe, it is CABH's responsibility to ensure that the member receives the notice. This notice is in the documentation system for this purpose.
3. If the member does not agree covered services should end, the member may request an expedited review of the case by contacting the BFCC-QIO listed on the IM. The member must ask for a fast appeal no later than the day the member was scheduled to be discharged from the hospital.
4. If the member asks for the appeal within the required time frame, the member can remain in the hospital while the BFCC-QIO is making their decision. If the member misses the deadline to request a fast appeal, the member may still call the BFCC-QIO and request a fast appeal, but different rules and time frames may apply.
5. When the BFCC-QIO receives the member's request to appeal, the BFCC-QIO will notify CABH and the hospital. CABH issues a "Detailed Notice of Discharge (DND)" letter to the member and will provide a copy to the BFCC-QIO no later than noon of the day after the BFCC-QIO notifies Centene that the member requested an appeal. The DND will include:
 - Explanation of why the member's services are no longer reasonable and necessary, or are no longer covered
 - Citation of the applicable Medicare coverage rule or policy, including the applicable Medicare policy, premium, or information on how the member can get a copy of the policy
 - Description of how the applicable coverage rule or policy applies to the member's specific situation
6. The member may ask for copies of any materials that the plan sends to the BFCC-QIO regarding the hospital discharge which CABH will provide. The BFCC-QIO will look at all medical information received and will decide within one calendar day of receiving all requested information.

7. If the BFCC-QIO decides the member is being discharged too soon, CABH will continue to authorize the member's hospital stay as long as medically necessary.
8. If the BFCC-QIO decides that the member is ready to be discharged, the member will not be responsible for payment incurred through noon of the day after the BFCC-QIO makes their decision.

REFERENCES:

CC.UM.27 Member Appeals System Description
 HIM.UM.08 Appeal of Adverse UM and Benefit Determinations
 MCARE.UM.10, Fast Track Appeals
 Current NCQA Client health plan Standards and Guidelines
 Current NCQA UM Standards and Guidelines
 State and/or Federal Contract Requirements
 42 C.F.R. 422.624
 CMS Medicare Managed Care Manual Chapter 13/18
 Medicare.gov "Your Right to a Fast Appeal"
 CMS.gov - Hospital Discharge Appeal Rights
 CMS.gov – Instructions for Notice of Medicare Non-Coverage (NOMNC)

ADDENDUM:

Addendum A – Authorized Representative Designation Form
 Addendum B – Appeal of Adverse Determination or Notice of Action, Decision-Making and Notification Timeliness Standards
 Addendum C – Indiana – Ambetter/MHS Requirements
 Addendum D – IA MED-20-001 Amendment 5 Executed
 Addendum E – New Hampshire –New Hampshire Healthy Families Unique Requirements
 Addendum F – Nevada – Silver Summit Client Health Plan Unique Requirements
 Addendum G – OR- Trillium Community Client Health Plan Unique Requirements
 Addendum H- Illinois Client Health Plan Unique Requirements
 Addendum I- Georgia Peach State Health Plan Requirements
 Addendum J- CABH Annual Notice of External Review
 Addendum K- North Carolina, Carolina Complete Health

REVISION LOG

REVISION TYPE	REVISION SUMMARY	DATE APPROVED & PUBLISHED
Annual Review	Annual review. Updated policy language. Removed markets no longer delegated. Changed policy name from EPC.QI.231 to EPC.APP.231	7/25/18
Ad Hoc Review	Transferred the information from the EPC.APP.231 and EPC.APP.231 (HIM) Clinical Appeals Policy and Procedure to the Centene P & P template, and renumbered to CC.BH.UM.09. Updated this Policy and Procedure to reflect accreditation standards and removed references to MBHO Accreditation, updated attachments to reflect only clients that have delegated appeals to CBH.	3/04/19
Annual Review	Aligned this Policy and Procedure to the Corporate Policy and Procedure and updated the reference, attachment, and definitions sections.	7/31/19
Ad Hoc Review	Updated Policy Section 4 to reflect Section 1557 grievances to Section 1557 Coordinator at CBH.	12/10/19
Ad Hoc Review	Added Attachment G - OR, Trillium Community Client health plan AOR requirements.	6/26/20
Ad Hoc Review	Updated page 20, section 4.4. To include Medicare Line of Business in order to reflect 2020 NCQA UM Standards.	6/26/20
Ad Hoc Review	Updated page 26, section 5.12. To include Medicare Line of Business in order to reflect 2020 NCQA UM Standards.	
Ad Hoc Review	Added Record Maintenance requirements to Attachment E – New Hampshire Healthy Families Unique Requirements. Consolidated NHHF state specific policy content from CC.BH.UM.09.01.NH, Clinical Appeals – New Hampshire into CBH policy CC.BH.UM.09, Member Grievance	

REVISION TYPE	REVISION SUMMARY	DATE APPROVED & PUBLISHED
	and Appeals System Description, Attachment E on 6/26/2020. Retired CC.BH.UM.09.01.NH, Clinical Appeals – New Hampshire on 5/1/20.	
Ad Hoc Review	Added “Unable to Process an Appeal” section to page 28, section 5.14 in order to maintain alignment with Corporate SOP CC.QI.11 “Member Grievance and Appeals System Description.”	
Annual Review	Annual Review. Reviewed against the 2021 NCQA Standards and Guidelines. Reviewed against Corporate Policy CC.UM.27 Member Appeals System Description. Removed the following to align with CC.UM.27, according to CFR (42 CFR 438, Subpart F, Grievance and Appeals System). A written follow up to an oral appeal is no longer required): 1.4 Standard oral appeal requests must be followed in writing (please see section 3 Appeal Process below). 3.3.2. Unless the member requests an expedited resolution, an oral appeal must be followed by a written, signed appeal. 3.3.4. Further, unless the member or member’s authorized representative requests an expedited resolution, an oral appeal must be followed by a written, signed appeal per 42 C.F.R. 438.402. Aligned policy format to the new template and changed CBH to CABH (Centene Advanced Behavioral Health). Added Attachment H, IA MED-20-001 Amendment 5 Executed to attachments. Incorporated the Medicare processes into the policy. Need review of Fast Track regarding Skilled Nursing Facility (SNF), Home Health (HH), Comprehensive Outpatient Rehabilitation Facility (CORF), and Inpatient care in Purpose section. Added definitions related to Medicare: Beneficiary and Family Centered Care Quality Improvement Organization (QIO): Independent Review Entity: Organization Determination: Reconsideration: Representative. Added item #4 to Policy section. Added to Procedure section: Fast Track Appeals Process for Inpatient Hospital Setting (Medicare Only); Added to reference section regarding: CMS Medicare Managed Care Manual, Chapter 13 Medicare.gov “Your Right to a Fast Appeal”, CMS.gov –Hospital Discharge Appeal Rights. Replaced CC.BH.MCARE.UM.12 with CC.BH.UM.09	6/23/21
Ad Hoc	Changed policy title from Member Grievances and Appeals to Member Appeals. Updated Addendum P&P titles to Member Appeals. Aligned the Expedited Appeals section with the CC.UM.27, Member Appeals System Description, and HIM.UM.08, Appeal of Adverse UM and Benefit Determinations Removed the Member Grievances section for alignment with CC.UM.27 Member Appeals System Description, and HIM.UM.08 Appeal of Adverse UM and Benefit Determinations. CABH is not delegated Member Grievances by any of CABH client health plans Reformatted SOP to improve appeals process flow Addendum D (MHS Indiana) Medicaid & Medicare requirements have been added to Addendum C (Indiana Ambetter). Addendum D is now IA MED-20-001 Amendment 5 Executed. The original Addendum H for IA MED-20-001 Amendment 5 Executed has been removed).	9/22/21
Ad Hoc	Addendum H created to address unique requirements from House Bill HB2595 (Public Act 102-0579) for Illinois Medicaid & Marketplace client health plans	11/23/21
Ad Hoc	Addendum I created to address requirements related to Georgia Medicaid (Peach State Client health plan) from the Georgia Families Medicaid contract and GA.QI.42 Appeal Policy	12/22/21
Ad Hoc	Addendum F updated with state requirements from the Consolidated Nevada Request for Proposal (Section 7.8.10.11). Replaced ‘contractor’ with CABH.	2/22/22

REVISION TYPE	REVISION SUMMARY	DATE APPROVED & PUBLISHED
Annual Review	<p>Annual Review: Document updated to align with CC.UM.27 Member Appeals System Description, 5/21; HIM.UM.08 Appeal of Adverse UM and Benefit Determinations, 1/22; MCARE.UM.10, Fast Track Appeals, 11/21; NCQA UM Standards; Compliance review of all client health plan addendum; added Marketplace section G <i>Annual Notice of External Review Rights</i> to identify that CABH is not delegated the function, but the process is in place in the event delegated, and Addendum J, CABH Annual Notice of External Review to evidence NCQA UM 8, Element B requirements. Addendums A and B reviewed by the SME. Addendums C-I reviewed by compliance. Addendum C (IN) revisions: Added Medicare & MMP/Duals requirements in regard to Expedited Reconsiderations based on MCARE.AG.24 Part C Medicare Advantage Appeals and Medicare Managed Care Manual (Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance <i>Effective January 1, 2020</i>). Addendum E (NH) revisions: Added Ambetter to the Business Units and Background Sections. Added NH Medicaid unique requirements regarding denying an expedited appeal request (NH Healthy Families Medicaid 2022 Member Handbook Page 138) and filing an appeal (NH.UM.08 Appeal of UM Decisions). Replaced 7 years with 10 years for the Medicaid and Marketplace timeframe for holding onto appeal records/documents (NH Medicaid Contract Section 4.6.3.6 Page 145, NH.UM.08 Appeal of UM Decisions and HIM.UM.08 Appeal of Adverse UM and Benefit Determinations). Added NH Marketplace unique requirements regarding expedited appeal timeframes (HIM.UM.08 Appeal of Adverse UM and Benefit Determinations (NH Addendum)), appeal acknowledgement (HIM.UM.08 Appeal of Adverse UM and Benefit Determinations) and timing/notification for standard and expedited appeals (NH State Statutes Section 415-A:4-b - Appeal Procedure). Addendum F (NV) revisions: Replaced request for a standard appeal from 90 days to 60 days per Nevada Medicaid State Contract Section 7.8.10.6.3 and the 2022 SilverSummit Member Handbook Page 58. Replaced expedited appeal turnaround time from 3 business days to 72 hours per Nevada Medicaid State Contract Section 7.8.10.9.1.3 and the 2022 SilverSummit Member Handbook Page 60.</p>	3/29/22
Ad Hoc	<p>Added Section 16 to CABH Internal Appeals General Requirements Allowing an authorized representative to act on behalf of the member to meet NCQA UM 8, Internal Appeals Standard, Element A, factor 16. Per Subject Matter Expert, Section 19 was added to CABH Internal Appeals General Requirements addressing Referral Specialist response time frames for Provider complaints/inquiries via CRM and OMNI queues. Addendum K (North Carolina Medicaid) created to address Carolina Complete Health unique requirements based on NC.UM.01 Utilization Management Program Policy and Description and NC.QI.11 Member Grievance and Appeals System Description.</p>	6/28/22

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, the Company's P&P management software, is considered equivalent to a signature.

POLICY AND PROCEDURE

DEPARTMENT: Centene Advanced Behavioral Health Utilization Management	REFERENCE NUMBER: CC.BH.UM.10
EFFECTIVE DATE: 09/08/04	P&P NAME: Evaluation of New Behavioral Health Technologies
REVIEWED/REVISED DATE: 5/26/17, 3/23/18; 6/24/19, 9/25/19; 9/24/20; 9/22/21; 6/3/22	RETIRED DATE: N/A
BUSINESS UNIT: Centene Advanced Behavioral Health	PRODUCT TYPE: Medicaid, Marketplace, Medicare
REGULATOR MOST RECENT APPROVAL DATE(S):	

SCOPE:

Centene Advanced Behavioral Health (CABH) evaluates the inclusion of new behavioral health (BH) technologies and the new applications of existing BH technologies such as, but not limited to, BH procedures, pharmaceuticals, or devices, and provides the health plans with recommendations in coordination with the health plans' benefit coverage and applicable state and/or federal requirements.

CABH is not delegated responsibility for evaluating new BH technologies related to behavioral health procedures, pharmacological treatments or behavioral health devices for any health plan client, State, or other entity. However, when apprised of new BH technologies or a request for the evaluation or utilization of new BH technologies is received, CABH will follow an evaluation process, and forward the information to the appropriate designated Health Plan, State Agency, or other entity per contract, in a timely manner for final review and decision.

POLICY:

1. A BH technology is considered experimental or investigational if it meets any of the following criteria:
 - A. It is currently the subject of active and credible evaluation (e.g., clinical trials or research) to determine:
 1. Clinical efficacy;
 2. Therapeutic value or beneficial effects on health outcomes;
 3. Benefits beyond any established medical based alternatives.
 - B. It does not have final clearance from applicable governmental regulatory bodies (such as the US Food and Drug Administration (FDA)) and unrestricted market approval for use in the treatment of a specified BH condition or the condition for which authorization of the service is requested and is the subject of an active and credible evaluation.
 - C. The most recent peer-reviewed scientific studies published or accepted for publication by nationally recognized medical journals do not conclude, or are inconclusive in finding, that the service is safe and effective for the treatment of the condition for which authorization of the service is requested.
2. Under no circumstance is this policy to be construed as an acknowledgement or acceptance by the health plans to cover experimental or investigational BH technologies where such technologies are not included in the benefits set forth in the Benefit Plan Contract or by applicable state and federal requirements.
3. The health plans reserve the right to refuse coverage of a BH experimental or investigational technology on the grounds that such coverage is not required under the member/enrollee's benefit plan. Approval of an experimental technology with respect to a particular case does not guarantee coverage of the same technology with respect to any other cases.
4. The BH technology should have final approval from appropriate governmental regulatory bodies. Regulatory bodies include the U.S. Food and Drug Administration (FDA) or any other governmental body with authority to regulate the technology. The indication for the BH technology under review does not need to be the same indication for which the technology has been approved.
5. The criteria listed below should be weighed when evaluating the medical necessity of a BH technology that is or may be experimental or investigational.
 - Where medical necessity of a technology is confirmed, steps should be taken by the health plan to ensure that the BH technology is furnished by a participating or in-state provider to the extent possible.
 - At least two studies published in peer-reviewed medical literature should be available that would support conclusions regarding the effect of the technology and its likely net health impact. Such studies must, by the standards of accepted medical research, be well-designed and well-conducted investigations yielding quality and consistent results, and the results of such studies should demonstrate the effect the technology will have on the disease, injury, illness, or condition in question.
 - The opinions and evaluations of national medical associations, consensus panels, and other technology evaluation bodies, or other specialists or professionals, who are subject matter experts with respect to the technology, may be taken into consideration according to the scientific quality of the supporting evidence and rationale for such opinions and evaluations.

- The technology should be used to improve net health outcome of a severely disabling or life-threatening condition. The health benefits of the technology must outweigh any harmful effects or risks to the member/enrollee.
- Other established BH treatment alternatives to the technology should have been exhausted and failed or no established treatment exists.
- The improvement to be gained by employing the technology should be attainable outside the control setting (i.e., in practice).
- In the case of diagnostic procedures, it is anticipated that the results of the procedure will help determine the best plan of care. There must be some potential intervention or alteration to the current plan of care based on the diagnostic results.
- The health plans' member/enrollee fully understands the risks and benefits regarding the requested technology or treatment and has given informed consent.

REFERENCES:

Current NCQA UM Standards and Guidelines
 CP.MP.36 Experimental Technologies, 2/22

ATTACHMENTS: N/A

REVISION TYPE	REVISION SUMMARY	DATE APPROVED & PUBLISHED
Annual Review	No content changes	03/23/18
Ad Hoc Review	Transitioned information from the EPC.UM.211 Policy and Procedure to the Centene P & P template and renumbered to CC.BH.UM.10; added 5.3; and incorporated language from CP.MP.36 Experimental Technologies for consistency across the organization.	6/24/19
	Minor revision to Section 2.1.1.3: Benefits equal to or beyond any established medical based alternatives. Section 3.2 At least two studies from two unrelated groups or investigators published in peer-reviewed medical literature should be available that would support conclusions regarding the effect of the behavioral health technology and its likely net behavioral health impact. Such studies must, by the standards of accepted medical research, be well-designed and well-conducted investigations yielding quality and consistent results, and the results of such studies should demonstrate the effect the behavioral health technology will have on the disease, injury, illness, or condition in question.	9/25/19
Annual Review	CC.BH.UM.10 Evaluation of New Technology vetted against NCQA Standard UM 10: Evaluation of New Technology to ensure compliance with 2020 NCQA UM Standards. "Centers for Medicare and Medicaid Services (CMS)" added to Page 2 Section 2.2 to ensure compliance with NCQA Standard UM 10: Evaluation of New Technology.	9/24/20
Annual Review	Updated policy to new template format. Removed revisions prior to 2017. Replaced CBH with CABH. Removed "The indication for the behavioral health technology under review does not need to be the same indication for which the technology has been approved." from Section 3 Criteria (3.1).	09/22/2021
Annual Review	Aligned the policy with CP.MP.36 Experimental Technologies, 2/22; and 2022 NCQA UM 10, Evaluation of New Technology.	6/3/22

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, the Company's P&P management software, is considered equivalent to a signature.

POLICY AND PROCEDURE

DEPARTMENT: Centene Advanced Behavioral Health Utilization Management	REFERENCE NUMBER: CC.BH.UM.13
EFFECTIVE DATE: 12/01/07	P&P NAME: Behavioral Health Utilization Review
REVIEWED/REVISED DATE: 10/31/17; 02/12/19; 7/16/19; 2/7/20; 3/25/20; 6/26/20; 12/13/20, 3/24/21, 6/28/21; 9/22/21; 11/2/21; 11/23/21; 12/22/21; 3/29/22;	RETIRED DATE: N/A
BUSINESS UNIT: Centene Advanced Behavioral Health	PRODUCT TYPE: Medicaid, Medicare, Marketplace
REGULATOR MOST RECENT APPROVAL DATE(S):	

SCOPE:

This policy applies to all directors, officers, and employees of Centene Corporation, its affiliates, health plans, and subsidiary companies (collectively, the "Company"). This policy and procedure applies to all Centene Advanced Behavioral Health (CABH), a Centene company, staff involved in the design, implementation, operations, and management of the CABH Utilization Management (UM) Program services for all lines of business and product types. This policy and procedure applies to consultants, and temporary workers who may receive physician/provider calls, contacts, or complaints whether written or verbal regarding our services or staff.

PURPOSE:

To outline guidelines for behavioral health utilization review of all levels of care, ensuring that all CABH staff involved in the Utilization Management (UM) process consistently perform utilization review according to the CABH's UM review criteria.

POLICY:

1. Utilization review is conducted to assess medical necessity and appropriateness of initial and continued care for behavioral health services at all levels of care.
2. Utilization review criteria are utilized as an objective screening guide and are not intended to be a substitute for physician judgment. Utilization review decisions are made in accordance with currently accepted medical or health care practices, while taking into consideration the individual member needs and complications at the time of the request, in addition to the local delivery system available for care.
3. All review decisions are made in accordance with behavioral health UM review criteria and take into account special circumstances of each case that may require a deviation from the norm stated in the criteria. Please refer to the addendums for plan specific special circumstances. Notice or other review procedures contrary to the requirements of the health insurance policy or member health benefit plan will be implemented. The frequency of utilization reviews for behavioral health services is based solely on the complexity or severity of the member's condition, or on necessary treatment and discharge planning activity. The severity of the members' condition may be reflected by overt symptoms that require a certain level of containment or care.
4. Medical necessity determinations are based upon medical information available at the time of the utilization review and reviewed against approved medical necessity criteria.
5. The behavioral health Medical Director (or other appropriately licensed physician) or Peer Reviewer, reviews all potential behavioral health medical necessity denials for medical appropriateness and has authority to implement an adverse determination which results in reduction, suspension, denial, or termination of authorizations for clinical services requested.
6. Information will be accepted from any reasonably reliable source to assist in making an informed decision about the medical necessity of care. Hospitals, physicians, and other providers will not be routinely required to numerically code diagnoses or procedures to be considered for certification, but such codes may be requested, if available. Complete copies of all medical records on all members reviewed will not be routinely requested. CABH will only require the sections of the medical record necessary in that specific case to certify medical necessity or appropriateness of the admission or extension of stay, or frequency or duration of service. For purposes other than an appeal or a legal request, reimbursement is provided for reasonable costs of medical record duplication, unless otherwise provided for by contract or law (Medicaid and Medicare only).
7. Behavioral Health Utilization Managers apply criteria and perform clinical reviews for pre-service, concurrent, and retrospective authorization requests. Behavioral health Utilization Managers have access to consultation with licensed physicians and behavioral health professionals with various professional specialties and license types.

Behavioral health Utilization Managers are specifically prohibited from making adverse medical necessity determinations. If initial clinical review indicates a potential medical necessity issue, the care request is referred to an appropriate peer reviewer as designated by the Medical Director.

8. Certifications are not reversed unless new information is obtained that indicates the original information substantially misrepresented the clinical circumstances that existed when the original request for services was received. For reductions or terminations in a previously certified course of treatment, the determination is issued far enough in advance of the reduction or termination to allow for an appeal of the determination to be completed.
9. A Utilization Manager may not require as a condition of treatment approval, or for any other reason, the observation of a psychotherapy session, or the submission or review of a mental health therapist's process or progress notes. This does not preclude the Utilization Manager from requiring submission of a member's medical record.
10. A licensed clinician, under the supervision of the Medical Director, directs the UM Department and is responsible for the day-to-day activities during the utilization review process. Licensed staff are available to conduct medical necessity reviews and non-clinical administrative are used as support. Non-clinical administrative staff may be used for the following functions:
 - 10.1. Review of outpatient treatment requests for completeness of information
 - 10.2. Collect and transfer of non-clinical data; and
 - 10.3. Perform activities that do not require evaluation or interpretation of clinical information.

PROCEDURE:

1. Utilization Review for Inpatient, Residential Treatment, and Partial Hospitalization:
 - 1.1. This process may also be followed for Intensive Outpatient treatment at the facility's or provider's request.
 - 1.2. When the CABH Utilization Management (UM) Department is notified of a member's admission to a facility, a CABH Utilization Manager performs a pre-certification and/or admission review with the Utilization Review (UR) representatives, or with behavioral health providers at the admitting facilities.
 - 1.2.1. The CABH Utilization Manager obtains information to assess medical necessity at the current or requested level of care from the attending or admitting physician, or primary psychotherapist, or other health care providers designated by the facility as the contact for utilization review.
 - 1.3. The CABH Utilization Manager reviews the information and determines whether the clinical information presented meets medical necessity criteria for continued stay.
 - 1.3.1. If the information presented Does Not Meet Medical Necessity Criteria:
 - 1.3.1.1. The request is forwarded to the Peer Reviewer.
 - 1.3.1.2. The Peer Reviewer consults with qualified board-certified sub-specialty psychiatrists when the Peer Reviewer determines the need, when a request is beyond his/her scope, or when a health care provider provides good cause, in writing.
 - 1.3.1.3. For both mental health and chemical dependency service continued stay requests, the physician, or treating provider is notified about the opportunity for a telephonic Peer-to-Peer (physician concurrence) with the Peer Reviewer to discuss the plan of treatment. The Peer Reviewer initiates a minimum of one telephonic attempt to contact the treating provider within 24 hours prior to issuing a clinical determination. All attempts to reach the requestor are documented in the member record in the clinical documentation system. If the time period allowed to provide the information expires without receipt of additional information, a decision is made based on the information available.
 - 1.3.1.3.1. **MEDICARE ONLY:** Treating Physician Concurrence (Peer-to-Peer) is required with the admitting physician before denial of a continued inpatient stay (that has been initially approved). Lack of response from the attending physician (AP), after 1 telephonic attempt for peer-to-peer with AP, is considered concurrence. It is appropriate to issue the denial notification letter at this point. The CABH Utilization

Manager must confirm with the admitting facility that the member has been given their discharge/appeal information. Admission reviews and leveling of care do not require physician concurrence.

1.3.2. Information presented Meets Medical Necessity Criteria:

- 1.3.2.1. If the available necessary information collected by the Utilization Manager meets the medical necessity criteria, the Utilization Manager will approve the requested service within 72 hours/three calendar days of receipt of the request, depending on contractual, state, or NCQA requirements.
- 1.3.2.2. All approval decisions are based on the information available to the treating provider at the time the care is provided.
- 1.3.2.3. Approval notices are provided orally to attending physician/provider of record and the facility. The notice includes:
 - 1.3.2.3.1. An authorization tracking number;
 - 1.3.2.3.2. Number of days or services approved;
 - 1.3.2.3.3. If extension of continued stay, total number of days or services approved;
 - 1.3.2.3.4. Next anticipated review point; and
 - 1.3.2.3.5. Date of admission or service initiation.
- 1.3.2.4. CABH follows the verbal approval notice with a written or electronic notice to the provider of record, and the facility after the stay is completed. Providing verbal notification does not extend the electronic or written notification timeframe.
- 1.3.2.5. The CABH Utilization Manager documents the utilization review information, number of certified days, and verbal certification notice information in the member's record in the clinical data management system.
- 1.3.2.6. The Utilization Manager determines the next review date using the number of days or services authorized based on the individual's severity or complexity of illness, intensity of services needed and discharge planning activity.

2. Discharge Planning

- 2.1. CABH Utilization Managers work with inpatient staff to proactively identify member needs upon discharge. CABH Utilization Managers coordinate transfers to lower levels of care when appropriate,
- 2.2. The CABH Utilization Manager shares appropriate clinical and demographic information with other divisions for purposes of discharge planning and care coordination to avoid duplicate requests for information from members and providers.

3. Utilization Review for Outpatient and Intensive Outpatient Treatment:

- 3.1. Practitioners submit completed Outpatient Treatment Requests (OTRs) forms or CDMS forms by mail or fax or via web portal to request additional services.
- 3.2. These forms are date stamped upon receipt in accordance with mail distribution procedures.
- 3.3. Eligibility is checked and the form is processed for utilization review.
- 3.4. If the member has lost eligibility, does not have the benefit requested or there is another administrative issue that renders the member ineligible, an appropriate letter is sent to the provider, and the processing of the request is discontinued.
- 3.5. If the form is not completed correctly, or if it is incomplete to the extent that relevant information is missing that might affect a clinical decision to continue or discontinue authorization of services, the CABH Utilization Manager calls the provider and/or Medical Consenter to obtain the missing information.
- 3.6. CABH Utilization Managers review the clinical information submitted on the OTR/CDMS form and any attached medical records and compare it to the criteria for continued outpatient care. CABH Utilization Managers also monitor the progress toward treatment goals and potential need for changes in treatment strategy. If identified, the CABH Utilization Manager contacts the treating provider by phone or mail to

discuss the treatment plan and/or sends OTR Feedback forms, Best-Practice Intervention Strategies, and other information that will assist the CABH Utilization Manager in making medical necessity determinations on subsequent service requests. Concerns about the quality of care are referred to the Quality Improvement Department for investigation. At any point, CABH Utilization Managers may consult with the Medical Director to discuss specific cases or questions related to the provider's treatment plan:

3.6.1. Meets Criteria:

3.6.1.1. Based on medical necessity determination, the UM will authorize services as appropriate.

3.6.2. Does Not Meet Criteria:

3.6.2.1. If the available information does not meet the medical necessity criteria, the request is forwarded to the Peer Reviewer.

3.6.2.2. The Peer Reviewer consults with qualified board-certified sub-specialty psychiatrists when the Peer Reviewer determines the need, when a request is beyond his/her scope, or when a health care provider provides good cause, in writing.

3.6.3. As a result of the Peer Clinical Review process, CABH makes a decision to approve, partially approve or deny authorization for services.

3.6.3.1. The Peer Reviewer forwards the decision to approve services to the Utilization Manager for generating appropriate approval notifications to providers and members.

3.6.3.2. The Peer Reviewer forwards the decision to deny authorization for services to the Utilization Manager for generating appropriate denial notifications to providers and members.

3.6.3.3. Meets Criteria:

3.6.3.3.1. If the available necessary information meets the medical necessity criteria, the CABH Utilization Manager will approve the requested service within NCQA guidelines or more expeditiously as mandated by state requirements.

3.6.3.3.2. All approval decisions are based on the information available to the treating provider at the time the care is provided.

3.6.3.3.3. Approval notices are provided in writing to the provider of record. The notice includes:

3.6.3.3.3.1. An authorization tracking number;

3.6.3.3.3.2. Number of units and services approved; and

3.6.3.3.3.3. Date of service initiation.

3.6.3.3.4. The CABH Utilization Manager documents the utilization review information, number of certified units, and type of service in the member's record in the clinical document management system.

4. Notice of Action for Untimely Plan Decision

4.1 For service authorization decisions not reached within the timeframes (which constitutes a denial and is thus an adverse benefit determination), notification is made on the date that the timeframe expires.

5. Failure to Follow Filing Procedures

5.1. Failure to follow filing procedures occurs when the member (or the member's authorized representative) does not follow CABH's reasonable filing procedures for requesting preservice or concurrent coverage, CABH notifies the member (or the member's authorized representative) of the failure and informs them of the proper procedures to follow when requesting coverage. Please refer to CC.BH.UM.07 Utilization Management Timeliness and Notification Standards for notification timeframes.

- 5.1.1. CABH may not deny a nonurgent preservice, urgent preservice or urgent concurrent request that requires medical necessity review for failure to follow filing procedures.
- 5.1.2. CABH may deny a post service request if the member (or the member's authorized representative) does not follow the organization's reasonable filing procedures but must provide the reason for the denial.

6. Withdrawal of a request (**Medicare, DSNP & MMP Plans Only**)

- 6.1. The requestor may withdraw the initial request in writing or verbally at any time before the decision is rendered.
- 6.2. CABH will close the authorization and document in a void authorization note the reason for the withdrawal by the provider, member, or member representative.
- 6.3. The provider and member is notified via letter that the Prior Authorization service type request has been withdrawn.
- 6.4. The individual that received the request to withdraw the authorization will send the Notification of Dismissal letter to the member and provider.

REFERENCES:

1. Employee Retirement Income Security Act (ERISA); Final Rule; Volume 65, Number 225
2. Current NCQA Health Plan Standards and Guidelines
3. Current NCQA UM Standards and Guidelines
4. CC.UM.05, Timeliness of UM Decision-making (Medicaid)
5. CC.BH.UM.07 Utilization Management Timeliness and Notification Standards
6. HIM.UM.05, Timeliness of UM Decision-making (Marketplace)
7. CC.UM.07.01 Admin Denials
8. CC.UM.07 Adverse Determination
9. CC.UM.01.07 Concurrent Review
10. CC.UM.01.09 Discharge Planning
11. MCARE.UM.08 Part C Organization Determinations (Medicare)

ATTACHMENTS:

- Attachment A - Tennessee – Ambetter of Tennessee Unique Requirements
- Attachment B - Indiana MHS Unique Requirements
- Attachment C - NH – New Hampshire Healthy Families Plan Unique Requirements
- Attachment D - Nebraska Total Care Unique Requirements
- Addendum E- Illinois Meridian Health Plan Unique Requirements
- Addendum F- Michigan Health Plan
- Addendum G- Ohio Health Plans
- Addendum H- Georgia Peach State Health Plan
- Addendum I- Nevada SilverSummit Health Plan

REGULATORY REPORTING REQUIREMENTS:

NA

REVISION TYPE	REVISION SUMMARY	DATE APPROVED & PUBLISHED
Off Cycle Review	Updated policy to align with corporate policy.	05/18/18
Off Cycle Review	Transferred information for this Policy and Procedure from the EPC.UM.240; EPC.HIM.240 Policy & Procedures to the Centene Policy and Procedure Template and renumbered to CC.BH.UM.240.	02/12/19
Off Cycle Review	Renumbered this P & P from CC.BH.UM.240 to CC.BH.UM.13 per Centene's P & P numbering protocol, removed references to the Company and replaced with CBH, removed State specific language for Louisiana and Texas as they are no longer CBH clients, updated the References and Definitions sections, and fixed formatting issues.	7/16/19
Off Cycle Review	Added MS – Magnolia Health Plan Unique Requirements	1/29/20
Off Cycle Review	Changed "The Peer Reviewer initiates a minimum of one telephonic attempt to contact the treating provider within 24 hours prior to issuing a clinical	3/25/20

REVISION TYPE	REVISION SUMMARY	DATE APPROVED & PUBLISHED
	determination instead of 3 attempts to align with this information contained in the other CBH UM policies.	
Off Cycle Review	Added IN – MHS Plan Unique Requirements	3/25/20
Off Cycle Review	Added Attachment D - NH – New Hampshire Healthy Families Plan Unique Requirements. Consolidated NHHF state specific policy content from CC.BH.UM.19.01.NH, Utilization Review – New Hampshire into CBH policy CC.BH.UM.13, Behavioral Health Utilization Review, Attachment D on 3/25/2020. Retired CC.BH.UM.19.01.NH, Utilization Review – New Hampshire on 5/1/20.	3/25/20
Off Cycle Review	Edited Attachment D – New Hampshire Healthy Families Plan Unique Requirements to include “Concerns About the Appropriateness of a Course of Treatment.”	6/26/20
Off Cycle Review	Ad Hoc Review – Change Needed : Added Attachment E – Nebraska Total Care Unique Requirements to reflect “UM program must comply with Federal utilization control requirements, including the certification of need and recertification of need for continued inpatient settings, including psychiatric residential treatment facilities, and as described in 42 CFR 438. c.”	12/16/20
Annual Review	Annual Review. Reviewed against the 2021 NCQA Standards and Guidelines for all product lines. Reviewed against Corporate Policy CC.UM.02 Critical Decision and Application. Added “NCQA requirements” to Page 3, Section 1.3.2.1. Attachment B - Mississippi – Magnolia Health Plan Unique Requirements regarding PRTF removed as it does not apply to Magnolia Health Plan. Remaining attachments renamed due to reorganization.	3/24/21
Ad Hoc Review	Added Addendum E (Illinois Meridian Health Plan) to policy. Removed Policy Section 2 as it references CC.BH.UM.15 which has been retired due to CC.UM.01 Does not have a retrospective review section and no other PHCO SOP exists, only PS TAT, which is also in TAT SOP	6/28/21
Ad Hoc Review	Added Addendum F, Marketplace Health Plans OON Provider Work Process	9/22/21
Ad Hoc Review	Added Addendum G to address the following unique requirements for Ohio Medicaid and MMP health plans: <ul style="list-style-type: none"> • Ohio Department of Health SUD form • Ohio Medicaid Provider Agreement contract (Appendix B Section 7 (b)(i)) and (Appendix B Section 7 (b)(ii)(4)) 	11/2/21
Ad Hoc Review	Updates made to Addendum E (Illinois Health Plan Unique Requirements) <ul style="list-style-type: none"> • Added unique requirements from House Bill HB2595 (Public Act 102-0579) and (215 ILCS 5/370c) (from Ch. 73, par. 982c) (Text of Section from P.A. 101-81) Sec. 370c. Mental and emotional disorders. 	11/23/21
Ad Hoc Review	Addendum H created to address requirements related to Georgia Medicaid (Peach State Health Plan) from the Georgia Families Medicaid contract and health plan requirements	12/22/21
Ad Hoc Review	Created addendum I to address Nevada specific requirements for the SilverSummit health plan from the Consolidate Nevada Request for Proposal (Section 7.4.7.2) and the Resubmission _Part I Technical Proposal Silver Summit. Replaced ‘contractor’ with CABH.	2/22/22
Annual Review	Removed 2017 revision log history. Created addendum I to address Nevada specific requirements for the SilverSummit health plan from the Consolidate Nevada Request for Proposal (Section 7.4.7.2) and the Resubmission _Part I Technical Proposal Silver Summit. Replaced ‘contractor’ with CABH. Added CC.UM.05, Timeliness of UM Decision-making (Medicaid),	3/29/22

REVISION TYPE	REVISION SUMMARY	DATE APPROVED & PUBLISHED
	<p>CC.BH.UM.07 Utilization Management Timeliness and Notification Standards, HIM.UM.05, Timeliness of UM Decision-making (Marketplace), CC.UM.07.01 Admin Denials, CC.UM.07 Adverse Determination, CC.UM.01.07 Concurrent Review and CC.UM.01.09 Discharge Planning to the Reference section.</p> <p>Replaced “clinical therapist” with “clinician” in Policy section, item 10, per SME recommendation.</p> <p>Removed “telephonically” from Procedure section 1.2 per SME recommendation.</p> <p>Added “physician concurrence” to section 1.3.1.3. Added section 1.3.1.3.1 to include Medicare specific physician concurrence information.</p> <p>Revisions per CC.UM.05, Timeliness of UM Decision-making (Medicaid) and/or CC.BH.UM.07 Utilization Management Timeliness and Notification Standards: Replaced “24 hours or 1 business day” with “72 hours/3 calendar days” in section 1.3.2.1. Added section 4 in Notice of Action for Untimely Plan Decision. Added section 5 Failure to Follow Filing Procedures.</p> <p>Removed section 2.1 Administrative Denials, which is part of CC.BH.UM.08, Adverse Determinations.</p> <p>Addendums A-H reviewed by Compliance. Updated CPS link in Addendums B’s Reference section.</p>	
Ad Hoc Review	<p>Added “Treating”, replaced “requesting” with “attending”, added “after 1 telephonic attempt for peer-to-peer with AP” and replaced “Initial” with “Admission” to Procedure 1.3.1.3.1. Added Procedure 6. “Withdrawal of a request” to align with MCARE.UM.08 Part C Organization Determinations. Replaced “void” with “close” to Procedure 6.2. Replaced “fax or phone” with “letter” to Procedure 6.3. Replaced “Referral Specialist” with “individual that received the request to withdraw the authorization” and Added “Notification of Dismissal” to Procedure 6.4 based on Subject Matter Expert recommendation. Added MCARE.UM.08 Part C Organization Determinations to References.</p>	6/28/22

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, the Company’s P&P management software, is considered equivalent to a signature.

POLICY AND PROCEDURE

DEPARTMENT: Centene Advanced Behavioral Health Utilization Management	REFERENCE NUMBER: CC.BH.UM.19
EFFECTIVE DATE: 9/18/09	P&P NAME: Behavioral Health Emergency Services and Post Stabilization Authorization Subsequent to Emergency Treatment
REVIEWED/REVISED DATE: 04/11/18; 7/29/19; 6/26/20; 6/23/21; 6/28/22;	RETIRED DATE: N/A
BUSINESS UNIT: Centene Advanced Behavioral Health	PRODUCT TYPE: Medicaid, Marketplace, Medicare
REGULATOR MOST RECENT APPROVAL DATE(S):	

SCOPE:

This policy and procedure applies to all Centene Advanced Behavioral Health (CABH), a Centene company, staff involved in the design, implementation, operations, and management of the CABH Utilization Management (UM) Program services for all lines of business and product types. This policy and procedure applies to consultants, and temporary workers who may receive physician/provider calls, contacts, or complaints whether written or verbal regarding our services or staff.

PURPOSE:

Promote timely member access to needed medical/behavioral health emergency services. Appropriate financial reimbursement to providers of emergency services, are handled in an urgent manner.

DEFINITIONS:

Emergency Medical, Behavioral Health, and Substance Use Services: covered inpatient and outpatient services that are (1) furnished by a provider qualified to furnish these services and (2) needed to evaluate or stabilize an emergency medical/behavioral health condition. An emergency medical/behavioral health condition means a medical, mental health, or substance use-related condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

1. Placing the physical or behavioral health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions;
3. Serious dysfunction of any bodily organ or part;
4. Serious harm to self or others due to an alcohol or drug use emergency; Injury to self or bodily harm to
5. others; or
6. With respect to a pregnant woman having contractions: (1) that there is inadequate time to effect a safe transfer to another hospital before delivery, or (2) that transfer may pose a threat to the health or safety of the woman or the unborn child.

Prudent Layperson/ Marketplace Health Plans: a person who is without medical training and who draws on his or her practical experience when making a decision regarding the need to seek emergency medical treatment, as determined by RSMO 376.1350 and the appropriate state statutes.

Stabilization/ Marketplace Health Plans: to provide medical care that is appropriate to prevent a material deterioration of the person's condition, within reasonable medical probability, in accordance with the HCFA (Health Care Financing Administration) interpretative guidelines, policies, and regulations pertaining to responsibilities of hospitals in emergency cases (as provided under the Emergency Medical Treatment and Labor Act, section 1867 of the Social Security Act, 42 U.S.C.S. 1395dd), including medically necessary services and supplies to maintain stabilization until the person is transferred.

PROCEDURE:

1. Emergency services are available 24 hours a day/ 7 days per week. Prior authorization is not required for emergency services and coverage for such is based on the severity of the symptoms at the time of presentation.
2. When a client health plan network practitioner, or CABH representative, instructs a member to seek emergency services, the medical screening examination and other medically necessary emergency services are covered without regard to whether the condition meets the prudent layperson standard.

3. CABH never denies authorization for emergency services based on the practitioner's or the facility's failure to notify CABH of the screening and treatment within the required timeframes, except as related claim filing timeframes managed by the health plan.
4. Health plan members who have an emergency medical condition are not required to pay for subsequent screening and treatment needed to diagnose the specific condition or stabilize the member.
5. Prior authorization is not required for emergency services, and coverage is based on the severity of the symptoms at the time of presentation.
6. Emergency inpatient and outpatient behavioral health services are covered when furnished by a qualified practitioner to evaluate or stabilize an emergency medical/behavioral health condition; and the presenting symptoms are of sufficient severity to constitute an emergency medical/behavioral health condition in the judgment of a prudent layperson.
7. Once the members' emergency condition is stabilized, certification for hospital admission or prior authorization for follow-up care is required.

REFERENCES:

1. Current NCQA UM Standards and Guidelines
2. CC.UM.01, UM Program Description, Emergency Services Section, 3/22

ATTACHMENTS:

- Addendum A – Ohio Buckeye Health Plan Unique Requirements
 Addendum B- Illinois Health Plan Unique Requirements
 Addendum C- Georgia Peach State Health Plan
 Addendum D- North Carolina, Carolina Complete Health

REVISION TYPE	REVISION SUMMARY	DATE APPROVED & PUBLISHED
Ad Hoc Review	Added new table (Attachment B) for state specific payment requirements for emergency services; i.e., Nevada.	03/22/17
Ad Hoc Review	Changed policy number from CCL.244 to EPC.UM.244 and updated company name references	06/16/17
Annual Review	For annual review only: no content changes	04/11/18
Ad Hoc Review	Transferred the information from EPC.UM.244 Emergency Services Policy and Procedure and EPC.UM.248 Post Stabilization Authorization Subsequent to Emergency Treatment Notification Policy and Procedure to the Centene P & P template, and renumbered to CC.BH.UM.19; removed references to Company and replaced with CBH, and updated the References and Definitions sections.	07/19/19
Annual Review	Annual review. Vetted CC.BH.UM.19 Behavioral Health Emergency Services and Post Stabilization Authorization Subsequent to Emergency Treatment with Corporate SOP CC.UM.01 UM Program Description to ensure alignment with Corporate Policy. No applicable 2020 NCQA UM Standard.	06/26/20
Ad Hoc Review	Added verbiage to Page 3, Section 5.2 to align with Corporate SOP CC.UM.01 UM Program Description.	06/26/20
Ad Hoc Review	Unique Requirements Attachment A – Ohio Buckeye Health Plan Unique Requirements developed with content from “Use of ASAM Criteria® for Substance Use Disorder Treatment in Hospitals; Requests for Emergency Hospitalization Under ORC 5122.10 Memo.”	07/20/20
Annual Review	Annual review. Reviewed against CC.UM.01, 2021 UM Program Description, Emergency Services Section, pg. 20, and the CABH SOP was revised to reflect the PHCO emergency services process; Changed title of SOP from Emergency Services and Post-Stabilization to Emergency Services to reflect the PHCO UM PD emergency services section; Deleted revisions prior to 2017; Added Attachment A, Trillium HP requirement, OAR 410-141-3826, Section 12. Updated the policy format to the new template and updated CBH to CABH (Centene Advanced Behavioral Health).	06/23/21

REVISION TYPE	REVISION SUMMARY	DATE APPROVED & PUBLISHED
Ad Hoc Review	Updated formatting for Addendum A (Ohio Buckeye Health Plan Unique Requirements)	8/30/21
Ad Hoc Review	Moved definitions section to beginning of SOP; <u>Marketplace Health Plan Revisions:</u> Included the Prudent Layperson definition section in coordination with MO.HIM.UM.12 Emergency Services – With PLP Process; Included post-stabilization definition in coordination with NC.HIM.UM.12 Emergency Services – No PLP Process	9/22/21
Ad Hoc Review	Addendum B created to address Illinois Medicaid & Marketplace unique requirements from House Bill HB2595 (Public Act 102-0579)	11/23/21
Ad Hoc Review	Addendum C created to address requirements related to Georgia Medicaid (Peach State Health Plan) from the Georgia Families Medicaid contract	12/22/21
Annual Review	Aligned procedure with CC.UM.01, Utilization Management Program Description, 3/22; Addendums reviewed by the compliance team with no edits needed. Addendum D created to address Carolina Complete Health unique requirements based on NC.UM.01.01 Covered Benefits and Services.	6/28/22

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, the Company's P&P management software, is considered equivalent to a signature.

POLICY AND PROCEDURE

DEPARTMENT: Corporate Credentialing and Provider Data Management	DOCUMENT NAME: Practitioner Credentialing & Recredentialing
PAGE: Page 1 of 165	REPLACES DOCUMENTS: See Revisions detail dated 8/6/16.
APPROVED DATE: 08-28-2014	RETIRED:
EFFECTIVE DATE: 08-28-2014	REVIEWED/REVISED: 4/2019; 6/2019; 7/2019; 11/2019; 12/2019; 2/2020; 3/2020; 6/2020; 8/2020; 12/2020; 1/2021; 3/2021; 4/2021; 5/2021; 8/2021; 9/2021; 12/2021; 5/2022; 6/2022; 8/2022; 10/2022
PRODUCT TYPE: All	REFERENCE NUMBER: CC.CRED.01

SCOPE:

Centene Corporate Credentialing (“Credentialing”) and the Provider Data Management Department (“PDM”) on behalf of Centene Health Plans (the “Plan”). Plan Provider Relations, Network Contracting, and Quality Improvement Departments. Plan-specific requirements are included in the Appendices.

PURPOSE:

To ensure the Plan develops and maintains a network of professional practitioners who are qualified to meet the health care needs of covered members in an efficient, compliant, safe, and effective manner.

POLICY:

Centene has established standards for conducting the functions of practitioner selection and retention. These standards include practices for practitioner credentialing, recredentialing, and ongoing monitoring that meet the qualifications of applicable state and federal government regulations, applicable standards of accrediting bodies, including the National Committee for Quality Assurance (NCQA), and Plan requirements to the extent that those standards do not conflict with other laws of the state ¹. Centene recognizes and accepts the credentialing determinations within the Centene Enterprise when available. Additional Credentialing is not required unless and until the practitioner’s credentialing cycle is no longer active.

Network Participation: For consideration to participate in the Plan network, all individual practitioners who have an independent relationship with the Plan must complete an application for participation, submit copies of applicable

¹ Magnolia Health Plan requires the use of credentialing and recredentialing standards set forth by the National Committee for Quality Assurance (NCQA) and EQRO recommendations.

POLICY AND PROCEDURE

DEPARTMENT: Corporate Credentialing and Provider Data Management	DOCUMENT NAME: Practitioner Credentialing & Recredentialing
PAGE: Page 2 of 165	REPLACES DOCUMENTS: See Revisions detail dated 8/6/16.
APPROVED DATE: 08-28-2014	RETIRED:
EFFECTIVE DATE: 08-28-2014	REVIEWED/REVISED: 4/2019; 6/2019; 7/2019; 11/2019; 12/2019; 2/2020; 3/2020; 6/2020; 8/2020; 12/2020; 1/2021; 3/2021; 4/2021; 5/2021; 8/2021; 9/2021; 12/2021; 5/2022; 6/2022; 8/2022; 10/2022
PRODUCT TYPE: All	REFERENCE NUMBER: CC.CRED.01

supporting documentation, meet minimum administrative requirements, and meet the credentialing qualifications of the Plan ².

Exclusion from federal procurement activities is non-compliant with minimum administrative requirements and results in exclusion from payment, any individual or entity that is excluded from participation in any Federal health care program under § 1128 or 1128A of the Act, pursuant to 42 C.F.R. §§ 438.808(a), 438.808(b)(2) 438.610(b) and 1903(i)(2) of the Act, except as permitted under 42 CFR 1001.1801 and 1001.1901. For currently participating practitioners, exclusion results in immediate termination of network participation.^{3 4 5}

It is the sole responsibility of the applicant to produce all necessary information and documentation in a timely manner; as required to conduct a thorough examination. Failure to provide the necessary information within thirty (30) calendar days from the initial application date may result in termination of the process. If the practitioner ever seeks to join Plan in the future once the process has been terminated, he/she must begin the process from inception.

Types of Practitioners: The credentialing/recredentialing processes apply, but are not limited to, the following practitioner types:

² In accordance with IL MCO Model Contract Article 5.9 Uniform Provider Credentialing and Recredentialing, provider enrollment in the Illinois Medicaid Program Advanced Cloud Technology (IMPACT) system constitutes Illinois' Medicaid managed care uniform credentialing and re-credentialing process. To participate in the Next Level Health provider network, Next Level Health will verify that provider is enrolled in IMPACT. As stated in Contract item 5.9.4, Next Level Health is prohibited from requiring providers to undergo additional credentialing processes that are not part of the contract

³ Any excluded individuals and entities discovered as a result of screening for Fraud, Waste and Abuse during the provider application, credentialing and recredentialing processes for Coordinated Care Health Plan must be reported to HCA within five (5) business days of discovery. Credentialing staff will report identified excluded individual/entities to the Compliance Department, who will report to HCA using HCA PIR006- WA Excluded Individual Template.

⁴ Absolute Total Care will report to SC DHHS any excluded individuals and entities discovered as a result of screening for fraud, waste and abuse during the provider application, credentialing or recredentialing process. Credentialing staff will report to the Compliance Department, who will submit the report to the SC DHHS and other regulatory agencies as necessary.

⁵ Louisiana Healthcare Connections will report to LDH those participating providers who have been terminated due to exclusion within three (3) business days.

POLICY AND PROCEDURE

DEPARTMENT: Corporate Credentialing and Provider Data Management	DOCUMENT NAME: Practitioner Credentialing & Recredentialing
PAGE: Page 3 of 165	REPLACES DOCUMENTS: See Revisions detail dated 8/6/16.
APPROVED DATE: 08-28-2014	RETIRED:
EFFECTIVE DATE: 08-28-2014	REVIEWED/REVISED: 4/2019; 6/2019; 7/2019; 11/2019; 12/2019; 2/2020; 3/2020; 6/2020; 8/2020; 12/2020; 1/2021; 3/2021; 4/2021; 5/2021; 8/2021; 9/2021; 12/2021; 5/2022; 6/2022; 8/2022; 10/2022
PRODUCT TYPE: All	REFERENCE NUMBER: CC.CRED.01

- Medical doctors (MD);
- Nurse Practitioners (NP);
- Oral surgeons (DDS/DMD);
- Chiropractors (DC);
- Osteopathic Physicians (DO);
- Podiatrists (DPM);
- Behavioral Health Service Providers ⁶; and
- Mid-level practitioners (non-physician)^{7 8}.
- Telemedicine providers of outpatient services

Completion of the credentialing/recredentialing process is not required when the Plan does not select or direct its members to see a specific practitioner or group of practitioners and for non-participating practitioners. This includes practitioners who practice exclusively within an inpatient setting or freestanding facilities and who provide care for Plan members only as a result of members being directed to the hospital, inpatient setting, or free-standing facility. These practitioners may include, but are not limited to the following specialties:

- Anesthesiology,
- Emergency Medicine,
- Neonatology,

⁶ Licensed Mental Health Practitioners for Louisiana Healthcare Connections for the Healthy Louisiana contract.

⁷ Physician Assistants shall not be approved for credentialing as a primary care physician for CeltiCare Health Plan

⁸ Maryland Physicians Care does not include Physician Assistants in their credentialing program. This mid-level practitioner type must be under the direct supervision of a physician and is not eligible for independent practice.

POLICY AND PROCEDURE

DEPARTMENT: Corporate Credentialing and Provider Data Management	DOCUMENT NAME: Practitioner Credentialing & Recredentialing
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- Pathology,
- Radiology, and
- Telemedicine.

A locum tenens practitioner who does not have an independent relationship with the Plan and who is covering for a participating provider does not require credentialing.

Practitioner Rights: All practitioners are notified of their right to review information obtained by the Plan and/or Credentialing to evaluate their credentialing or recredentialing application upon receipt of a written and signed request submitted to the Credentialing Department. These rights do not include the right to review references, personal recommendations, or other information that is peer review protected.

Practitioners also have the right to receive the status of their credentialing or recredentialing application at any time by contacting the Plan Provider Relations and/or Contracting Department.

Should the practitioner believe any of the credentialing information to be erroneous, or should any information gathered as part of the primary source verification process differ from that submitted by the practitioner, he/she has the right to correct any erroneous information submitted by another party.

New practitioners who are denied participation for non-administrative reasons have the right to request a reconsideration of the decision within thirty (30) calendar days of the date of receipt of the denial letter.

Notification of these rights may occur via individual correspondence, in the provider manual, and/or on Plan's web site.

Provisional Credentialing: Credentialing and the Plan may determine the need to occasionally make practitioners available to members prior to the completion of the entire initial credentialing process. The option for provisional credentialing is only available to practitioners who are applying for the first time to the Plan

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practitioner network. A practitioner may only be provisionally credentialed once and for a time-period no longer than 60 calendar days.^{9 10 11}

Recredentialing: Credentialing formally recredentials practitioners at least every thirty-six (36) months.^{12 13 14} The recredentialing cycle begins with the date of the initial credentialing decision.

Practitioners who are terminated or voluntarily withdraw from the network and subsequently seek to be reinstated must complete the initial credentialing process if the break in service is more than thirty (30) calendar days or if it has been more than thirty-six (36)¹⁵ months since they were last credentialed.

If Credentialing is unable to recredential a practitioner due to military leave, maternity leave or sabbatical, the contract remains in place and the practitioner will be recredentialled upon his/her return. Credentialing will document the reason for this delay in the practitioner's file. At a minimum, the recredentialing

⁹ Louisiana Healthcare Connections utilizes Provisional credentialing to meet the requirement to process expedited and temporary credentials.

¹⁰ Arizona Medicaid Health Plan utilizes the option of Provisional credentialing when necessary to increase the available network of providers in medically underserved areas, whether rural or urban. This also includes providers in a Federally Qualified Health Center (FQHC), FQHC Look-Alike Center, and hospital employed physicians (when appropriate). Providers needed in medically underserved areas, providers joining an existing and contracted oral health provider group, and providers eligible under the SAMHSA Certified Opioid Treatment Program. A decision regarding provisional credentialing is rendered within 14 calendar days from receipt of complete application

¹¹ Maryland Physicians Care does not utilize the provisional credentialing option.

¹² IlliniCare Health Plan requires recredentialing of practitioners at least every 3 years based on the last digit of their social security number. A recredentialing cycle cannot occur more than once in this 3 year cycle.

¹³ Celticare Health Plan requires recredentialing of practitioners every twenty-four (months).

¹⁴ Trillium/HealthNet of Oregon requires recredentialing of practitioners no less than every three years calculated to the month and day of the prior credentialing approval date.

¹⁵ Number of months to align with the Health Plan's required recredentialing timeframe.

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must be completed within 60 calendar days of when the practitioner resumes practice.¹⁶

Professional Competence: For health care practitioners, verification of applicable education and training upon initial credentialing and maintenance of valid professional licensure for practitioner’s field of practice upon recredentialing, which includes requirements for Continuing Medical Education, are accepted as evidence of maintenance of knowledge and ability in practice area(s) for health care practitioner.

Binding Nature of Credentialing Decisions: The Plan has the right to make the final determination about which practitioners may participate within its network. Practitioners who are denied initial participation may reapply for admission into the network no earlier than one (1) year following the initial denial or end of the reconsideration process¹⁷.

PROCEDURES:

I. Application Received

¹⁶ Coordinated Care Health Plan allows active duty military service providers a period of at least one hundred twenty days to complete the recredentialing process after return to civilian status. The one hundred twenty days will begin no earlier than the date the provider’s period of active duty ends.

¹⁷ Practitioners who are denied initial participation for Maryland Physicians Care may reapply for admission into the network at any time following the initial denial.

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- A. Plan contracting secures first-signature contracts, provider applications^{18 19 20 21 22 23 24 25 26 27 28 29 30}, and associated documents from applicant practitioners and forwards to PDM.

¹⁸ CeltaCare Health Plan is required to accept and utilize the Integrated Massachusetts Application for Initial Credentialing and Recredentialing

¹⁹ Magnolia Health Plan is required to accept and utilize the Mississippi Participating Physician Form for the credentialing application.

²⁰ Louisiana Healthcare Connections will accept and utilize the Louisiana Standardized Credentialing Application or the CAQH Application for the credentialing application

²¹ IlliniCare Health Plan will accept and utilize the Illinois Health Care Professional Credentialing and Business Data Gathering Form or the CAQH Application for the credentialing application

²² Home State Health Plan will accept and utilize the CAQH Universal Credentialing Data Source Form (UCDS), pursuant to RSMo 354.442.1 (15) and 20 CSR 400.7.180 (as amended), as the credentialing application for all practitioner credentialing in compliance with section 2.18.8c of the contract.

²³ Coordinated Care will utilize the Washington Practitioner Application to process credentialing for all practitioners that require credentialing

²⁴ Kansas Sunflower State Health Plan will accept and utilize the Kansas Standard Credentialing Application/CAQH to process credentialing for all practitioners that require credentialing

²⁵ Absolute Total Care accepts the SC Uniform Managed Care Provider Credentialing Application or CAQH.

²⁶ Maryland Physicians Care accepts the Maryland Uniform Credentialing form or CAQH. Plan Contracting will return incomplete applications to provider at the address listed on the application within ten (10) days after the date application was received, and will indicate to provider what information is needed to make application complete. Within thirty (30) days of receipt of completed application, Maryland Physicians Care shall send to the provider at the address listed in the application written notice of the intent to continue to process the Provider's application to obtain necessary credentialing information or rejection of the provider for participation in the Maryland Physicians Care provider panel. If Maryland Physicians Care provides notice to the provider of its intent to continue to process the provider's application, Maryland Physicians Care, within 120 days after the date notice is provided, shall: accept or reject the provider for participation; or send written notice of the acceptance or rejection to the provider at the address on the application. Maryland Physicians Care will track the date of the application so that dates of credentialing can be calculated.

²⁷ In accordance with the State Uniform Credentialing and Recredentialing MMIS Policy, Kansas Sunflower State Health Plan will accept and utilize the State of Kansas Standard Credentialing Application/CAQH to process credentialing for all providers/practitioners that require credentialing.

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²⁸ Carolina Complete Health, Inc. accepts only the North Carolina DOI's 'Uniform Application to Participate as a Health Care Practitioner' and does not require an applicant to submit information not required by the application. This is in accordance with North Carolina General Statute 58-3-230. Applications will be processed within the following timelines: **Complete App at time of Receipt:** (b) Within 60 days after receipt of a completed application and all supporting documents, the carrier shall assess and verify the applicant's qualifications and notify the applicant of its decision. If, by the 60th day after receipt of the application, the carrier has not received all of the information or verifications it requires from third parties, or date sensitive information has expired, the carrier shall issue a written notification to the applicant either closing the application and detailing the carrier's attempts to obtain the information or verification, or pending the application and detailing the carrier's attempts to obtain the information or verifications. If the application is held, the carrier shall inform the applicant of the length of time the application will be pending. The notification shall include the name, address and phone number of a credentialing staff person who will serve as a contact person for the applicant. **Incomplete App at time of Receipt:** (c) Within 15 days after receipt of an incomplete application, the carrier shall notify the applicant in writing of all missing or incomplete information or supporting documents, in accordance with the following procedures: (1) The notice to the applicant shall include a complete and detailed description of all of the missing or incomplete information or documents that must be submitted in order for review of the application to continue. The notification shall include the name, address, and telephone number of a credentialing staff person who will serve as a contact person for the applicant. (2) Within 60 days after receipt of all of the missing or incomplete information or documents, the carrier shall assess and verify the applicant's qualifications and notify the applicant of its decision, in accordance with paragraph (b) of this rule. (3) If the missing information or documents have not been received within 60 days after initial receipt of the application or if date-sensitive information has expired, the carrier shall close the application or delay final review, pending receipt of the necessary information. The carrier shall provide written notification to the applicant of the closed or pending status of the application and where applicable, the length of time the application will be pending. The notification shall include the name, address, and telephone number of a credentialing staff person who will serve as a contact person to the applicant.

²⁹ New Hampshire Granite State Health Plan's Contracting team will conduct outreach to prospective Participating Providers within ten (10) business days after receiving notice of the Provider's desire to enroll, and will concurrently work through the Health Plan's and the DHHS contracting and credentialing processes with Providers in an effort to expedite the Provider's network status.

³⁰ Ambetter of Tennessee shall notify the health care provider of the results of the provider's clean CAQH credentialing application and shall notify the health care provider as to whether or not the health insurance entity is willing to contract with that provider within ninety (90) calendar days after receipt of the completed application (this notification is provided by the Contracting Department. A clean CAQH application means an application that has no defect, misstatement of facts, improprieties, including a

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B. PDM verifies existence of sufficient information needed for enrollment:

- i. Completed Provider Data Form or Provider Roster³¹;
- ii. Completed Provider Application signed and dated not more than 150 calendar days prior to enrollment;
- iii. Applicable W-9(s);
- iv. Query of the National Plan & Provider Enumeration System (NPES) to confirm that the practitioner has a current, valid unique National Provider Identifier (NPI) for every provider

lack of any required substantiating documentation, or particular circumstance requiring special treatment that impedes prompt credentialing.

Ambetter of Tennessee shall provide to any medical group practice with which there is an existing contract a list of all information and supporting documentation required for a credentialing application of a new provider applicant to be considered complete pursuant to subsection (f) of the Tenn Code Ann. 56-7-1001. **(A)** Ambetter Contracting Department will notify a new provider applicant in writing of the status of a credentialing application no later than five (5) business days of receipt of the application. The notice shall indicate if the application is complete or incomplete, and, if the application is incomplete, the notice shall indicate the information or documentation that is needed to complete the application. **(B)** If the application is incomplete and the new provider applicant submits additional information or documentation to complete the application, Ambetter shall comply with the requirements of subdivision (f)(2)(A) upon receipt of the additional information or documentation. **(C)** Ambetter shall notify a new provider applicant of the results of the new provider applicant's credentialing application within ninety (90) calendar days after notification from the Ambetter Contracting Department that the application is complete. **(D)** If a new provider applicant fails to submit a complete credentialing application to Ambetter within thirty (30) calendar days of notice of an incomplete application, then the application is deemed incomplete and credentialing is discontinued. If a new provider applicant fails to submit a complete network participation enrollment form, including signature evidencing intent to participate with the group and any other required documentation, to Ambetter within thirty (30) calendar days of notice of an incomplete application, then the new provider applicant is ineligible to receive the payment set out in (f)(3)(A)

³¹ Trillium/HealthNet Oregon requires collection of the OMB CCCE Tracking Form for Cultural Competency Continuing Education Recordkeeping Form, this will be the responsibility of the Health Plan to submit with all provider enrollments at initial credentialing, and will be collected by the credentialing team during recredentialing (starting with those due in late 2021).

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type, to the extent such provider is not an atypical provider as defined by CMS;^{32 33 34}

- v. Current Disclosure of Ownership/Interest Form, signed and dated ^{35 36 37 38}. These forms are not required for WellCare Medicare-only networks;
 - a. PDM provides Disclosure forms to the Corporate Compliance department for monitoring of exclusion checking and ongoing monitoring as specified in CC.COMP.27. ³⁹
 - b. Upon notification from the Corporate Compliance department of a verified exclusion status of an individual or entity with an ownership or controlling interest in the provider or a managing employee of the provider, PDM will initiate the appropriate actions specified in each Health Plan’s contract, up to and including termination of the contracting process or participation status.

³² California Health and Wellness - All providers of Medi-Cal managed care services must have a valid National Provider Identifier (NPI) number.

³³ Home State Health Plan will require each that ordering and referring professional providing services to Home State Health Plan members have a national provider identifier (NPI) in accordance with 45 CSR 162.410 in accordance with Sections 2.2.6 and 3.9.6w of the contract. Home State Health Plan will query the National Plan & Provider Enumeration System at the time of initial and recredentialing to confirm that the practitioner has a current, valid NPI

³⁴ Absolute Total Care recognizes that some ‘atypical’ Provider types may not have NPI.

³⁵ Trillium requires Ownership and Disclosure information to be submitted on OR Form 3974

³⁶ PA Health & Wellness Practitioner and Groups (Single/Multi-Specialty) will no longer require DOO (Disclosure of Ownership/Interest Form) submission with enrollment or at recred.

³⁷ Disclosure of Ownership is not required for submission for any ATC product.

³⁸ Disclosure of Ownership is not required for submission for Arizona

³⁹ ITC follows process outlined in IA.COMP.27

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- vi. In conjunction with the enrollment process, if state requirements specify, PDM also performs additional reviews to ensure compliance to requirements in the provider contract.

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- vii. Eligibility to become a Medicaid provider is verified as part of enrollment, as applicable per Plan requirements^{40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56};

⁴⁰ Magnolia shall ensure that all providers are enrolled as a Medicaid Provider and that all active network providers are enrolled using the same National Provider Identifier (NPI) numbers. Acceptable source for confirmation Medicaid enrollment shall be a review of a file of participating Medicaid providers supplied by the Department of Medicaid.

⁴¹ IlliniCare Health Plan shall ensure all providers are enrolled as a Medicaid Provider. Acceptable source for confirmation shall be a review of a file of participating Medicaid providers supplied by the Department of Medicaid.

⁴² Coordinated Care shall ensure that all providers are enrolled in Washington as a Medicaid Provider. Acceptable source for confirmation shall be a review of the Provider One website.

⁴³ Sunflower Health Plan shall ensure that all providers are Medicaid enrolled.

⁴⁴ Nebraska Total Care will confirm the provider has a valid Medicaid Identification number. Acceptable source for confirmation shall follow MLTC requirements. Providers who have submitted an application as a Medicaid provider but have not yet been approved will be allowed to go through the credentialing process and, if necessary, network participation may be pended until the Medicaid provider application is approved or denied. Once approved, confirmation that a valid Identification number has been issued is performed and the network status may change from pending to participating.

⁴⁵ New Hampshire Healthy Families shall ensure that all providers are enrolled as New Hampshire Medicaid.providers, they must have a NH Medicaid identification number..

⁴⁶ Absolute Total Care shall ensure all providers are enrolled in South Carolina Medicaid.

⁴⁷ Nevada SilverSummit shall ensure all providers are enrolled in Nevada Medicaid (this does not preclude the option to enter into a single case agreement with non-Medicaid providers if needed).

⁴⁸ Trillium Community Health Plan will apply for DMAP when necessary. Practitioners who have submitted a credentialing application for Medicaid participation, but have not yet been approved by Medicaid, will be allowed to go through the credentialing process. Network participation will be pended until the Medicaid approval has been received and confirmed.

⁴⁹ Effective 1/1/2018, all California Health & Wellness network providers must enroll in the Medi-Cal Program. California Health & Wellness relies on the enrollment and screening results conducted by DHCS and will access the California Health and Human Services' (CHHS) Open Data Portal to obtain a list of currently enrolled Medi-Cal FFS providers.

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- C. If any of the required items needed for enrollment are missing or insufficient, PDM notifies Plan Contracting or Provider Relations to secure needed items.
- D. PDM completes enrollment into the Provider Data Management system utilizing the Provider submitted information as referenced above in Section B. This includes but is not limited to demographic information, NPI, licenses, Practice/service location information including accessibility as required by federal, state and local laws, and standards adopted by the Plan, associated groups, education/training, specialty, board certifications, cultural competency training, Panel information, etc. and forwards documentation to Credentialing. Discrepancies identified during the credentialing process regarding licenses, education/training, specialty, board certifications or other information verified by Credentialing is updated by Credentialing prior to completion of the credentialing cycle. Credentialing staff updates the Provider record to reflect the Credentialing Committee decision, PDM staff performs a review of the Provider record for practice/service location and

⁵⁰ PA Health & Wellness reviews applications for the MAID number issued by DHS, however will not delay processing of Provider applications which do not contain the MAID number. Network participation will be pended until the Medicaid approval has been received and confirmed.

⁵¹ Western Sky Community Care, Inc (New Mexico) requires Medicaid product Contract providers to be enrolled with New Mexico Medicaid as a managed care provider.

⁵² In accordance with IL MCO Model Contract Article 5.9 Uniform Provider Credentialing and Recredentialing, provider enrollment in the Illinois Medicaid Program Advanced Cloud Technology (IMPACT) system constitutes Illinois' Medicaid managed care uniform credentialing and re-credentialing process. To participate in the Next Level Health provider network, Next Level Health will verify that provider is enrolled in IMPACT. As stated in Contract item 5.9.4, Next Level Health is prohibited from requiring providers to undergo additional credentialing processes that are not part of the contract.

⁵³ Sunflower Health Plan confirms that the provider has a valid KMAP ID prior to submitting for enrollment.

⁵⁴ Oklahoma Complete Health, Inc. requires providers to be enrolled as contracted providers with SoonerCare

⁵⁵ Managed Health Services – Indiana requires a valid Medicaid ID number

⁵⁶ MHS IN requires a valid Medicaid ID number and IHCP enrollment

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associated group information, and identified discrepancies will be updated prior to changing the status from non-participating to participating in the network. Once made par, the record is fed to both the online directory, the call center system, and the eligibility system for member cards and enrollment.

II. Verification of Items Requiring Primary Source Verification (PSV)

Credentialing verifies using primary sources the elements included in this section. Primary sources may include oral, written, and/or internet sources. Any sources used are NCQA accepted.

Query images and other documentation reviewed (including those retrieved via oral sources) during PSV are saved, date stamped, initialed, and placed in the applicant's file prior to the credentialing decision. For calculating timeliness requirements on Internet and electronic verifications, the date generated by the source when the information is retrieved is used. If the source does not generate a date, the staff person verifying the credential should note the date of receipt of verification in the credentialing file via date stamp.

The minimum verification elements needed for Provisional Credentialing are noted in the section below.

- A. Current, unrestricted state license to practice, if license is required to practice ⁵⁷ ⁵⁸ (*required for Provisional Credentialing*).

⁵⁷ Nebraska Total Care recognizes the licensure for Provisional Licensed Mental Health Practitioners (PLMHP) and Provisional Licensed Alcohol and Drug Abuse Counselors (PLADC) as active and unrestricted.

⁵⁸ New Hampshire Healthy Families requires all practitioners to be licensed or certified in accordance with the laws of New Hampshire.

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- i. Validation that the practitioner has a current and valid license at the time of credentialing decision is required in all states where practitioner provides care to Plan members, and is verified directly from the state license or certification agency (or it's website).
- ii. Verification for state sanctions, restrictions on licensure and limitations on scope of practice is performed for all active state licenses and is performed through a query of the National Practitioner Data Bank or with the applicable State Licensure Board or the applicable State Certification Board or State Agency. Verification of the most recent five year period available through the data source is performed.

B. Education and Training.

- i. Credentialing verifies the highest of the three levels of education and training obtained by the practitioner (graduation from medical school, residency, or board certification).
- ii. Because medical specialty boards verify education and training, verification of board certification fully meets the requirement for verification of education and training, unless otherwise noted.
 - a. Credentialing queries the current version of the ABMS Directory of Medical Specialists via CertiFacts or other NCQA-approved service.
- iii. Other approved primary sources for verifying education and training include:

Practitioner Type	Primary sources for verifying education and training
Physicians	<u>Graduation from Medical School</u>

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Practitioner Type	Primary sources for verifying education and training
	<ul style="list-style-type: none"> • Confirmation from the medical school • Entry in the AMA Physician Master File • Entry in the AOA Official Osteopathic Physician Profile Report or AOA Physician Master File • Confirmation from the Educational Commission for Foreign Medical Graduates for international medical graduates licensed after 1986 (ACFME is not an acceptable substitute). • Confirmation from an association of schools of health professions if the association performs primary-source verification. At least annually, Corporate Credentialing must obtain written confirmation from the association that it performs primary source verification of graduation from medical school. • Confirmation from the state licensing agency, if the state agency performs primary source verification. Corporate Credentialing must maintain a copy of the state statute that requires the licensing board to obtain verification of education and training directly from the institution or must annually obtain a written confirmation from the state licensing agency that it performs primary source verification.. • Sealed transcripts, if submitted in the institution's sealed envelope with an unbroken institution seal. • Confirmation from AMA that the physician's education was completed through the AMA's Fifth Pathway Program. <p><u>Completion of Residency Training</u></p> <ul style="list-style-type: none"> • Confirmation from the Residency training program • Entry in the AMA Physician Masterfile • Entry in the AOA Official Osteopathic Physician Profile Report or AOA Physician Masterfile

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Practitioner Type	Primary sources for verifying education and training
	<ul style="list-style-type: none"> • Confirmation from an association of schools of health professions if the association performs primary-source verification. At least annually, Corporate Credentialing must obtain written confirmation from the association that it performs primary source verification of residency training. • Confirmation from the state licensing agency, if the state agency performs primary source verification of residency training. Corporate Credentialing must maintain a copy of the state statute that requires the licensing board to obtain verification of education and training directly from the institution or must annually obtain a written confirmation from the state licensing agency that it performs primary source verification of residency training. • FCVS for closed residency programs.
Chiropractors	<ul style="list-style-type: none"> • Confirmation from a chiropractic college whose graduates are recognized as candidates for licensure by the regulatory authority issuing the license. • Confirmation from the state licensing agency, if the state agency performs primary source verification of graduation from chiropractic college. Corporate Credentialing must maintain a copy of the state statute that requires the licensing board to obtain verification of education and training directly from the institution or must annually obtain a written confirmation from the state licensing agency that it performs primary source verification of graduation from chiropractic college.
Oral Surgeons	<p>Completion of Residency</p> <ul style="list-style-type: none"> • Training programs in Oral and Maxillofacial Surgery accredited by the Commission on Dental Accreditation (CODA) • Confirmation from the appropriate specialty board if the board performs primary source verification of graduation from a CODA accredited training

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Practitioner Type	Primary sources for verifying education and training
	<p>program. At least annually, Corporate Credentialing must obtain written confirmation from the specialty board that it performs primary source verification of graduation from a CODA accredited training program.</p> <ul style="list-style-type: none"> Confirmation from the state licensing agency, if the state agency performs primary source verification of graduation from a CODA accredited training program. Corporate Credentialing must maintain a copy of the state statute that requires the licensing board to obtain verification of education and training directly from the CODA accredited training program or must annually obtain a written confirmation from the state licensing agency that it performs primary source verification of graduation from a CODA accredited training program.
Mid-level Practitioners	<ul style="list-style-type: none"> Verification from the college or university of the highest level of education. Confirmation from the state licensing agency, if the state agency performs primary source verification of the highest level of education. Corporate Credentialing must maintain a copy of the state statute that requires the licensing board to obtain verification of education and training directly from the institution or must annually obtain a written confirmation from the state licensing agency that it performs primary source verification of the highest level of education. Confirmation from a specialty board or registry, if the board or registry performs primary source verification of professional school training. At least annually, Corporate Credentialing must obtain written confirmation from the specialty board or registry that it performs primary source verification of professional school training.

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Practitioner Type	Primary sources for verifying education and training
Other Non-physician health care professionals	<ul style="list-style-type: none"> • Confirmation from professional school. • Confirmation from the state licensing agency, if the state agency performs primary source verification of professional school training. Corporate Credentialing must maintain a copy of the state statute that requires the licensing board to obtain verification of professional school training directly from the institution or must annually obtain a written confirmation from the state licensing agency that it performs primary source verification of professional school training. • Confirmation from a specialty board or registry, if the board or registry performs primary source verification of professional school training. At least annually, Corporate Credentialing must obtain written confirmation from the specialty board or registry that it performs primary source verification of professional school training.
Podiatrists	<ul style="list-style-type: none"> • Confirmation from the residency training program • Appropriate specialty board, if the board performs primary source verification of completion of residency. At least annually, Corporate Credentialing must obtain written confirmation from the podiatry specialty board that it performs primary source verification of completion of residency. • Confirmation from the state licensing agency, if the state agency performs primary source verification of the completion of residency. Corporate Credentialing must maintain a copy of the state statute that requires the licensing board to obtain verification completion of residency directly from the institution or must annually obtain a written confirmation from the state licensing agency that it performs primary source verification of completion of residency.

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C. Board Certification

- i. Unless specified by Plan requirements^{59 60 61 62}, Board certification is not required for network participation. However, if a physician level practitioner claims to be board certified, Credentialing verifies current board certification.
 - a. The expiration date of the board certification is documented in the credentialing file.
 - b. If the practitioner's board certification does not expire, a lifetime certification status is verified and documented.
 - c. If the medical board does not provide the expiration date, Credentialing verifies that the board certification is current and documents the date of verification.

D. Report(s) of malpractice settlement(s) (*required for Provisional Credentialing*).

- i. National Practitioner Data Bank (NPDB) is queried and reviewed.
- ii. Credentialing reviews the history of all settled malpractice claims against a practitioner within the past five (5) years from

⁵⁹ CultiCare Health Plan requires board certification or alternate educational and clinical pathways as outlined in CC.CRED.10.

⁶⁰ Absolute Total Care Health Plan requires board certification or alternate educational and clinical pathways as outlined in CC.CRED.10.

⁶¹ Granite State Health Plan requires board certification or alternate educational and clinical pathways as outlined in CC.CRED.10

⁶² Louisiana Healthcare Connections requires board certification or alternate educational and clinical pathways as outlined in CC.CRED.10

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date of report, or as defined by the unique Plan look back period.^{63 64}

- E. Medicare/Medicaid-specific exclusions (*required for Provisional Credentialing*).
 - i. OIG LEIE will be queried through the Office of Inspector General's website.
- F. State Specific Exclusion Lists, as applicable.^{65 66 67} (*required for Provisional Credentialing*)
- G. Determination if a practitioner has been debarred, suspended, or otherwise excluded from participating in federal procurement activities (*required for Provisional Credentialing*)
 - i. The System for Awards Management (SAM) website shall be queried.
- H. To ensure practitioner has not opted-out of receiving Medicare funds the regional Medicare administrator must be queried for the applicable state in which the practitioner is providing services to Plan members, as applicable per Plan requirements.⁶⁸

⁶³ CeltiCare Health Plan requires a review of malpractice history for a ten (10) year look back period from the date of presentation to committee for approval.

⁶⁴ Arizona Medicaid Health Plan requires a review of malpractice history for a ten (10) year look back period from the date of presentation to committee for approval.

⁶⁵ The South Carolina (SC) Excluded Providers Listing and the Termination for Cause List on the SC DHHS website shall be queried.

⁶⁶ The Louisiana LDH Adverse Actions List shall be queried

⁶⁷ The Medicaid MS Sanctioned Provider List shall be queried.

⁶⁸ Per requirements applicable to Absolute Total Care, Granite State Health Plan and IlliniCare, to ensure practitioner has not opted-out of receiving Medicare funds the regional Medicare administrator must be queried for the applicable state in which the practitioner is providing services to Plan members.

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- I. Social Security Administration’s Death Master File must be queried for determination if practitioner has deceased, a possible indicator of fraud.
- J. CMS Preclusion list is queried.

III. Verification of Items where PSV is Not Required

The elements below may be verified via secondary sources to support completion of an application and to show eligibility of practitioner to participate in the Plan network. Documentation reviewed during verification is saved, date stamped, initialed, and placed in the applicant’s file prior to the credentialing decision. Secondary sources of information are acceptable for the below credentialing requirements.

The minimum verification elements needed for Provisional Credentialing are noted.

- A. Complete application form is signed and dated by the applicant and must include attestation for correctness and completeness of the application. Attestation elements must include (*required for Provisional Credentialing*):
 - i. Reasons for any inability to perform the essential functions of the position, with or without accommodation;
 - ii. Physical or mental health problems that may affect the provider’s ability to provide health care;
 - iii. Lack of present/current illegal drug use;
 - iv. History of chemical dependency/substance abuse;
 - v. History of loss or limitation of license and/or felony convictions;

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- vi. History of loss or limitation of clinical privileges and/or disciplinary actions; and
 - vii. Current malpractice insurance coverage;
- B. Current valid federal DEA certificate(s) in each state where practitioner provides care to Plan members for those practitioners who are qualified to write prescriptions.)
- i. Credentialing verifies through one of the following methods: Current Certificate, the DEA Diversion website, NTIS, or an AMA or AOA Profile.
 - ii. In cases where a practitioner may not possess a valid DEA certificate, an attestation of DEA Coverage Plan with name of covering practitioner or practice group may be verified ⁶⁹.
 - iii. If the practitioner states in writing that they do not prescribe controlled substances and that in their professional judgement, the patients receiving their care do not require controlled substances, they are therefore not required to have a DEA certificate, but must describe their process for handling instances when a patient requires a controlled substance. The practitioner's statement and process description is included in the credentialing file.
- C. Current valid State Controlled Substance registration in each state where practitioner provides care to Plan members for those practitioners who are qualified to write prescriptions.
- i. Corporate Credentialing verifies through one of the following methods: Current Certificate or through the issuing state agency. For example: CSR, CDS.

⁶⁹ Maryland Physicians Care requires a copy of the DEA certificate, and does not accept a DEA Coverage Plan in lieu of this requirement.

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- ii. Plan-specific requirements may exist and are included in the Appendices.^{70 71 72 73}
- iii. If the practitioner states in writing that they do not prescribe controlled substances and that in their professional judgement, the patients receiving their care do not require controlled substances, they are therefore not required to have a Controlled Substance certificate, but must describe their process for handling instances when a patient requires a controlled substance. The practitioner's statement and process description is included in the credentialing file.

D. Hospital privileges from the primary hospital as indicated on the credentialing application are verified.⁷⁴

- i. This requirement supports patient access to a hospital setting and accurate directory information.

⁷⁰ CeltiCare Health Plan requires verification of the MA CSR, if applicable. A current copy of the certificate is considered a valid source and meeting the requirement. The document does not contain an expiration date. The certificate is valid for three (3) years from date of issuance for physicians and one (1) year for non-physician mid-level practitioners.

⁷¹ Louisiana Healthcare Connections requires verification of the LA controlled dangerous substance certificate, if applicable. A current copy of the certificate is considered a valid source for meeting the requirement or primary source verification.

⁷² Home State Health Plan requires verification of Bureau of Narcotics and Dangerous Drugs issued by the Missouri Department of Health & Human Services, if applicable. A current copy of the certificate is considered a valid source and meeting the requirement. Alternately, this may be verified on line.

⁷³ Maryland Physicians Care requires verification of the MD CDS, if applicable. A current copy of the certificate is considered a valid source and meeting the requirement.

⁷⁴ Absolute Total Care requires hospital privileges or alternate admitting arrangements at an in network hospital.

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- ii. Credentialing may verify using one of the following acceptable sources. Plan-specific requirements may include PSV of hospital admitting privileges.^{75 76 77}
 - a. application attestation;
 - b. letter from facility;
 - c. roster from facility;
 - d. verbal confirmation from the facility; or
 - e. Copy of online directory information provided by the hospital's website specifying admitting privileges.
- iii. If the practitioner does not have privileges, a statement (written or verbal) is obtained regarding the practitioner's alternate admitting arrangements through one of the following acceptable sources:
 - a. the use of a hospitalist program or
 - b. admitting through a colleague.

E. Proof of professional liability coverage

- i. Credentialing verifies existence, currency, and amount using one of the following acceptable sources. Plan-specific requirements may exist.⁷⁸

⁷⁵ CeltiCare Health Plan requires primary source verification of hospital privileges at the practitioner's primary admitting hospital as indicated on the application.

⁷⁶ Magnolia Health Plan requires primary source verification of hospital privileges at the practitioner's primary admitting hospital as indicated on the application, if applicable.

⁷⁷ New Hampshire Granite State Health Plan requires primary source verification of hospital privileges at the practitioner's primary admitting hospital as indicated on the application.

⁷⁸ Magnolia Health Plan verification sources for Malpractice Insurance coverage include current copy of insurance certificate, Federal Tort letter or primary source verification document with the Carrier.

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- a. A current malpractice facesheet, application attestation or primary source verification from the carrier. If the malpractice coverage is current and provided within the application, it must be current as of the date when the practitioner signed the attestation. If the practitioner does not have current malpractice coverage, then it is acceptable to include future coverage with the effective and expiration dates. Coverage must be in an amount not less than \$1,000,000 per occurrence/ \$3,000,000 per aggregate, or as otherwise set forth by the Plan;⁷⁹ ⁸⁰
⁸¹or
 - b. Federal coverage through the Federal Torts Claims Act may be confirmed by a copy of the Federal Tort letter or an attestation from practitioner of Federal Tort coverage. The application does not need to contain the current amount of malpractice insurance coverage; or
 - c. Evidence of compliance with state regulations.
- F. Work history review is performed and the results of the review, including gaps, are documented within the credentialing file.
- i. Relevant work history is obtained through the practitioner's application or Curriculum Vitae (CV). Relevant experience includes work as a health professional.

⁷⁹ Kansas Sunflower State Health Plan accepts the State minimum insurance of \$200,000/\$600,000 per Kansas State Statute.

⁸⁰ Nebraska Total Care accepts the State minimum insurance limits of \$500,000 per occurrence and \$1,000,000 aggregate per policy period. For hospitals the required limits are \$500,000 per incident and \$3,000,000 aggregate per policy period. The Nebraska Excess Liability Fund then provides coverage for any damages exceeding those amounts but falling below the applicable damage cap.

⁸¹ Michigan Health Plans accepts the minimum insurance coverage of \$100,000 per incident, \$300,000 annual aggregate.

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- ii. Work history must be submitted in a month/year format for at least the preceding five (5) years.
 - a. If a practitioner has had continuous employment for five (5) years or more with no gap, providing the year only is acceptable.
- iii. Work history is reviewed for gaps;
 - a. Each gap in employment exceeding six (6) months is clarified either verbally or in writing and documented in the credentialing file.
 - b. Each gap that exceeds one year will be clarified in writing.
- iv. If the practitioner has practiced fewer than five (5) years from the date of verification of work history, the time frame starts at the time of initial licensure. Experience practicing as a non-physician health professional within the five (5) years should be included.

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G. Evidence of CLIA Certificate or Waiver for the provision of laboratory services, as applicable per Plan requirements. ^{82 83 84 85 86 87 88 89 90}

⁸² Magnolia is required to ensure all laboratory testing sites providing services have either a CLIA certificate or waiver of a certificate of registration along with a CLIA identification number. Acceptable formats for review include a current copy of certificate or waiver, or information obtained directly from CLIA.

⁸³ Sunflower State Health Plan shall obtain copies of the valid CLIA certificates from the laboratories and/or all entities providing laboratory services funded by Title XIX and Title XXI of the Social Security Act at credentialing and recredentialing. Per state, when a copy of CLIA is unavailable, a screen shot of CLIA certification via CMS website is acceptable. Sunflower State Health Plan shall provide a listing to the State of all laboratories and/or entities providing laboratory services and shall certify to the State that the laboratories and/or entities providing laboratory services are CLIA certified. Kansas Sunflower State Health Plan shall update the listing and certification as laboratories and/or entities providing laboratory services are added to or dropped from the list.

⁸⁴ New Hampshire Granite State Health Plan is required to ensure all laboratory testing sites providing services have either a CLIA certificate or waiver of a certificate of registration along with a CLIA identification number. Acceptable formats for review include application attestation, current copy of certificate or waiver, or information obtained directly from CLIA.

⁸⁵ California Health and Wellness Plan shall ensure that all contracted laboratory testing sites for use in Medi-Cal managed care have either a Clinical Laboratory Improvement Act (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number.

⁸⁶ Absolute Total Care shall ensure that all offices with laboratory services have Clinical Laboratory Improvement Act (CLIA) certificates or waivers. Certificates or waivers may be primary source verified or a copy of the certificate or waiver is acceptable.

⁸⁷ Nebraska Total Care shall ensure that all clinical laboratories provide verification of CLIA licensure (including the CLIA identification number) or Certificate of Waiver and is a minimum administrative requirement for participation in the network.

⁸⁸ Nevada SilverSummit shall ensure that all laboratory testing sites providing services under this contract have a valid Clinical Laboratory Improvement Amendments (CLIA) certificate or a waiver of certificate of registration, a CLIA identification number, and comply with CLIA regulations as specified by 42 CFR Part 493. Nevada SilverSummit shall provide to the DHCFFP, on request, copies of certificates of any laboratories with which it conducts business.

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H. For non-physician mid-level practitioners, proof of collaborative agreement, protocols, or other written authorization (as required by state law or Plan requirements^{91 92 93 94 95 96 97}) with a licensed

⁸⁹ Trillium/HealthNet Oregon shall and shall ensure that any Laboratories used by Contractor shall comply with the Clinical Laboratory Improvement Amendments (CLIA 1988), 42 CFR Part 493 Laboratory Requirements and ORS 438 (Clinical Laboratories, which require that all laboratory testing sites providing services under this Contract shall have either a Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number. Those Laboratories with certificates of waiver will provide only the eight types of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests.

⁹⁰ MHS is required to ensure all laboratory testing sites providing services have either a CLIA certificate or waiver of a certificate of registration along with a CLIA identification number. Acceptable formats for review include a current copy of certificate or waiver, or information obtained directly from CLIA

⁹¹ For CeltiCare Health Plan non-physician mid-level practitioners a copy of the physician collaborative agreement is obtained for the credentialing file.

⁹² Magnolia Health Plan will verify that Nurse Practitioners acting as PCPs have a formal, written collaborative/consultative relationship with a licensed physician with admitting privileges at a contracted inpatient hospital facility. Nurse Practitioners acting as PCPs shall be held to the same requirements and standards as physicians acting as PCPs.

⁹³ Arizona Medicaid Health Plan will include the name of the Supervising Physician for Physician Assistants in the Committee review materials.

⁹⁴ Absolute Total Care will verify that Nurse Practitioners acting as PCPs have a formal, written collaborative/consultative relationship with a licensed physician with admitting privileges at a contracted inpatient hospital facility.

⁹⁵ PA Health & Wellness will ensure that mid-level practitioners functioning as part of the PCP team are doing so within the scope of his or her license via collection and review of the collaborative agreement, protocols or other written authorization.

⁹⁶ Carolina Complete Health, Inc. requires Nurse Practitioners and Physician Assistants to provide a copy of their physician collaborative agreement.

⁹⁷ Managed Health Services – Indiana requires Mid-Levels to submit proof of collaborative agreement (as required by state law).

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physician who is participating with the Plan, sets forth the manner in which the mid-level practitioner and licensed physician cooperate, coordinate, and consult with each other in the provision of health care to patients and may be secondary source verified utilizing:

- i. Form completed by supervising physician;
 - ii. Copy of authorization or arrangements; or
 - iii. Copy of protocols.
- I. An onsite review may be required of PCPs and OB/GYNs as defined by market-specific requirements. ⁹⁸ ⁹⁹ ¹⁰⁰ Verification process includes review of documentation from Plan staff of completion of assessment with passing score and may be in the form of:
- i. Documented on Provider Data Form;
 - ii. Logged in CRM system;
 - iii. Credentialing staff review of documented site assessment results from the Plan; or
 - iv. Other confirmation communicated verbally or in writing from Plan staff.

⁹⁸ The California Health and Wellness Plan shall conduct Facility Site, Medical Record, and Facility Site Physical Accessibility reviews on all Primary Care and high volume provider sites. These site visits shall consist of initial surveys and subsequent periodic site inspections conducted at least every three (3) years. The initial full scope site review survey can be waived by a plan for a pre-contracted provider site if the provider has documented proof that a current full scope survey with a passing score was completed by another plan within the past three years.

⁹⁹ The Magnolia Health Plan shall conduct site visits for all providers in accordance with the process outlined in Policy and Procedure MS.CONT.03 Site Assessments for New Provider Contracts.

¹⁰⁰ Maryland Physicians Care conducts an initial site visit of primary care practitioners, and primary care obstetricians to ensure that the practitioners' offices and medical record keeping practices meet Maryland Physicians Care standards and compliance with the ADA. Site audits are performed for practitioners with a new location and/or not part of an existing group.

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IV. Recredentialing follows the same process as initial credentialing, with the following differences:

- A. Credentialing team is responsible for collection of the Provider Application¹⁰¹ and associated documentation needed for the recredentialing process (Plan Contracting team is responsible for collection of this documentation for initial credentialing process);
- B. Credentialing secures an updated copy of the Disclosure of Ownership/Interest Form, signed and dated (Plan Contracting team is responsible for collection of this document for initial credentialing process);
- C. Review of work history is not required;
- D. Verification of education and training is not required, unless one of more of the following exceptions exist:
 - i. If additional education has been obtained to change specialty affecting the contractual agreement with the Plan, Credentialing will verify additional education.
 - ii. If a physician level practitioner states he/she is board certified, Credentialing will verify current board certification status from the primary source.
- E. The recredentialing process consider provider-specific performance data such as those collected through the quality improvement program, the utilization management system, the grievance/complaint system, satisfaction surveys, and other activities of the organization, and that includes an attestation to the correctness and completeness of the new information. The

¹⁰¹ Practitioners are allowed to submit the CAQH or the OPRA (Oregon Practitioner Recredentialing Application) for processing.

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credentialing designee gathers applicable performance data from the QI Department designee for inclusion in the recredentialing file.

V. Cases of Information Variance

In cases where information obtained from primary sources varies from information provided by the practitioner, Credentialing contacts the applicant by phone and/or letter to alert the applicant to the variance and request a response.

- A. At least three (3) outreach attempts are made by Credentialing. Each attempt is documented and included in the practitioner's credentialing file.
 - i. Notification sent to the practitioner includes the time frame for submitting a correction or explanation.
 - ii. Notification also includes the contact information for submitting the correction/explanation, including the name and phone number of the Credentialing representative, address, and fax number.
- B. The practitioner must provide a written explanation detailing the error or the difference in information to Credentialing on or before the due date stated on the notification to the practitioner. The Plan Credentialing Committee includes this information as part of the credentialing/recredentialing process.
- C. If requested by the practitioner, a representative of Credentialing contacts the practitioner's office to confirm receipt of the practitioner's written explanation. Credentialing representatives only speak directly to the practitioner, or a designee authorized by the practitioner, to ensure the confidentiality of information.
- D. If no response is received by the stated due date in the notification to the practitioner, Credentialing, on behalf of the Plan, assumes the

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practitioner does not dispute the accuracy of the information collected, and the file is presented to the Credentialing Committee. Information received after the due date, but prior to the next Credentialing Committee meeting, may be accepted at the discretion of Plan.

VI. Complete Application Criteria

A “complete application” contains all of the information needed for credentialing review, including:

- A. the practitioner’s correctly and fully completed application;
- B. submission of all required and current credentialing documents;
- C. current application attestations, aged not more than 180 days from anticipated credentialing decision, and
- D. associated attestation supporting statements.

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State-specific regulations may allow for determination of the “complete application” date to also include verifications obtained from third-party sources.^{102 103 104 105}

The application must be considered complete for credentialing review to occur. The date the application is deemed complete is recorded within the Provider Data Management system.

VII. Process to Secure Missing and/or Expired Information

Missing and/or expired information must be secured before an application can be considered complete.

- A. Credentialing staff and/or the Plan staff contact the practitioner and/or relevant third party to secure missing and/or updated documentation (in cases of expired or soon-to-be-expired)

¹⁰² Applicable to Louisiana Healthcare Connections, per Louisiana State Act 358, complete application is the date on which the managed care organization has received all the information needed for credentialing, including the health care provider's correctly and fully completed application and attestations and all verifications or verification supporting statements required by the managed care organization. "Verification" or "verification supporting statement" means the documentation confirming the information submitted by an applicant for a credentialing application from a specifically named entity or a regional, national, or general data depository providing primary source verification including but not limited to a college, university, medical school, teaching hospital, health care facility or institution, state licensing board, federal agency or department, professional liability insurer, or the National Practitioner Data Bank.

¹⁰³ Per New Hampshire Medicaid Care Management Contract, the complete application start time begins when all necessary credentialing materials have been received by the managed care organization

¹⁰⁴ Per Section 2.2.4 of Kansas Contract - Provider Credentialing and Re-credentialing, the complete application start time begins when all necessary credentialing materials have been received by the managed care organization

¹⁰⁵ South Carolina MCO Contract defines a complete application to include all necessary documentation and attachments, and a signed Provider Agreement.

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information¹⁰⁶ ¹⁰⁷. At least three (3) outreach attempts are made to secure needed information. ¹⁰⁸

B. If information is not secured within twenty one (21) calendar days of first outreach attempt for initial credentialing applications or prior to recredentialing due date for recredentialing applications, Credentialing and the Plan determine course of action up to and including termination of the application process¹⁰⁹.

C. If application is terminated, notification is sent to the practitioner.¹¹⁰

VIII. Minimum Administrative Requirements

Certain minimum requirements must be met for credentialing committee/Medical Director review to occur; if these requirements are not met, termination of the process results and is referred to as “administrative” termination of the application process.

A. Minimum administrative requirements that must be met include:

- i. Contains the minimum elements required for verification as described in Sections II-IV of this document;
- ii. Application is signed and dated not more than 180 calendar days prior to anticipated credentialing decision;

¹⁰⁶ Magnolia Health Plan shall notify a practitioner within five (5) business days of any missing or invalid information that would impede completion of credentialing and/or contracting.

¹⁰⁷ New Hampshire Healthy Families notifies a healthcare provider that a submitted credentialing application is incomplete no later than 15 business days after receipt of the credentialing application.

¹⁰⁸ For any provider submitting new or missing information for its credentialing application, New Hampshire Healthy Families will act upon the new or updated information within ten (10) business days.

¹⁰⁹ For Maryland Physicians Care if missing or expired information can not be secured within 21 calendar days of the first outreach attempt for initial credentialing but the Letter of Intent has gone out the application will proceed through the credentialing process as an Unclean File.

¹¹⁰ Louisiana Healthcare Connections will send termination notice via certified mail, effective fifteen (15) days from the date of the notice. Claims will be paid for services delivered prior to the termination date.

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- iii. Contains primary and/or secondary source verification information collected not more than 120 calendar days prior to placing into the “Ready for Committee” status in the credentialing system of record. And, not more than 180 calendar days at the time of credentialing decision;
 - iv. As applicable to Plan requirements,¹¹¹ does not contain information that practitioner has opted-out of receiving Medicare funds;
 - v. Does not contain information that the practitioner has been excluded from participation in the Medicare and/or Medicaid program or state-specific exclusions; and
 - vi. Does not contain information that the practitioner has been identified as being included on the Social Security Administration’s Death Master File.
 - vii. Does not contain information that the practitioner has been excluded from participation in the federal health care programs under either Section 1128 or Section 1128A of the Social Security Act.
- B. Credentialing notifies the practitioner via certified mail of the administrative termination of the application process.
- i. A copy of the letter is retained in the practitioner’s closed file and maintained in the Credentialing Department for future reference.

¹¹¹ Per requirements applicable to Absolute Total Care, New Hampshire Healthy Families, and IlliniCare, to ensure practitioner has not opted-out of receiving Medicare funds the regional Medicare administrator must be queried for the applicable state in which the practitioner is providing services to Plan members.

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C. When administrative requirements (iv), (v) and/or (vi) are not met, Credentialing notifies the Plan and PDM to ensure appropriate actions are taken:

- i. As applicable, PDM modifies Provider Data Management system to prohibit payment to practitioners under these programs.
- ii. If practitioner is found listed on the Social Security Administration’s Death Master File and Credentialing reasonably suspects potential fraud, Credentialing engages Centene’s Special Investigations Unit (SIU).
- iii. Plan Compliance ensures applicable State notifications are completed.^{112 113 114 115}

IX. Determination and Review of Clean Files

Applicants who meet the participation criteria and are determined to have a “clean file” are approved for Plan participation following review by the Corporate or Plan Medical Director or chair of the Credentialing Committee.

¹¹² Magnolia Health Plan shall notify the Division within ten (10) calendar days of the denial of a Provider credentialing application either for program integrity-related reasons or due to limitations placed on the Provider's ability to participate for program integrity-related reasons

¹¹³ Effective 2/1/2015, Louisiana Healthcare Connections shall notify DHH of denial of a Provider credentialing application for program integrity-related reasons or otherwise limits the ability of Providers to participate for program integrity-related reasons

¹¹⁴ Any type of provider who is denied credentialing or recredentialing by Absolute Total Care, regardless of the reason, will be reported to the SC Division of Program Integrity/SUR and SC DHHS. Credentialing staff will notify the Compliance Department, who will provide the notification.

¹¹⁵ If Nevada Silver Summit decredentials, terminates or disenrolls a provider, Nevada Silver Summit will inform DHCFP Provider Enrollment Unit within five (5) business days.

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- A. Plan defines a “clean file” as one that meets the following criteria, unless otherwise noted in Plan-specific attachments to this policy:
- i. No past or present suspensions or limitations of state licensure within a five (5) year look back period;
 - ii. No past or present suspensions or limitations of DEA or state controlled substance registration within a five (5) year look back period;
 - iii. Current Malpractice coverage in the amount required by Plan;
 - iv. No past or present Federal or State sanction activity including Medicare/Medicaid sanctions;
 - a. At the discretion of the Credentialing Manager or Medical Director, sanctions over the five (5) year look back period may be presented to the Committee if the practitioner has recent sanctions and the older history may provide more information regarding an appropriate decision
 - v. Absence of information that practitioner has opted-out of receiving Medicare funds, as applicable to Plan requirements¹¹⁶;
 - vi. Any malpractice claim that resulted in a settlement under or equal to \$500,000.00 (any \$501,000.00 and over must go to full Committee for review) in favor of the plaintiff (claims ruled in favor of the defendant or dismissed are acceptable for a clean file) in a five (5) year look back period for new applicants

¹¹⁶ Per requirements applicable to Absolute Total Care, Granite State Health Plan, and IlliniCare, to ensure practitioner has not opted-out of receiving Medicare funds the regional Medicare administrator must be queried for the applicable state in which the practitioner is providing services to Plan members.

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or a three (3) year lookback period for re-applicants¹¹⁷ from date of settlement;^{118 119 120}

- a. At the discretion of the Credentialing Manager or Medical Director, malpractice claims over the three (3) year lookback period for reapplicants or five (5) year lookback period for intial applicant may be presented to the Committee if the practitioner has recent aberrant malpractice claims and the older history may provide more information regarding an appropriate decision.
- vii. No current hospital membership or privilege restrictions and no history of hospital membership or privilege restrictions within a five (5) year look back period for initial applicants and within a three (3) year look back period for re-applicants;
- viii. No history of or current use of illegal drugs or alcoholism;
- ix. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field.
- x. No criminal/felony convictions, including a plea of no contest.
- xi. No involuntary terminations from an HMO or PPO.

¹¹⁷ CeltiCare Health Plan requires a review of malpractice history for a ten (10) year look back period from the date of presentation to committee for approval.

¹¹⁸ Pennsylvania Health and Wellness Clean File eligibility criteria is expanded to include a defined threshold for applicants with previous history of limitation of licensure, malpractice claims, or privilege actions based upon an expanded level of review and determination by the Medical Director.

¹¹⁹ Maryland Physicians Care Clean File eligibility criteria is expanded to include malpractice claims with settlement amount under \$49,999.99.

¹²⁰ Meridian IL and Meridian MI Clean File eligibility criteria is expanded to include malpractice cases settled for no greater than \$200,000.

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- xii. For those practitioners for whom site visit is required, site visit score meets appropriate threshold for passage.
- xiii. No “yes” answers on attestation/disclosure questions, with exceptions of the following which do not trigger a full Committee review:
 - a. Investment or business interest in ancillary services, equipment or supplies;
 - b. Voluntary resignation from a hospital or organization related to practice relocation or facility utilization;
 - c. Voluntary surrender of state license related to relocation or nonuse of said license;
 - d. A report of a malpractice judgement or settlement under or equal to \$500,000.00 or a report of a malpractice settlement that is over five (5) years old for initial applicants and three (3) years old for re-applicants from date of report, or as defined by the unique Plan look back period;
 - e. Nonrenewal of malpractice coverage or change in malpractice carrier related to changes in the carrier’s business practices (no longer offering coverage in a state or no longer in business);
 - f. Previous failure of a certification exam in a provider who is currently board certified or who remains in the five (5) year post residency training window;
 - g. Actions taken by a hospital against a practitioner’s privileges related solely to the failure to complete medical records in a timely fashion; and/or

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h. History of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction.

B. In cases of recredentialing:

- i. Issues, judgments, or settlements previously reviewed do not have to be resubmitted during the current phase of recredentialing; and
- ii. Issues, judgments, or settlements since prior credentialing may be considered in the determination of whether a file is considered clean.

C. If a file is determined to be clean, the practitioner is presented to the Corporate or Plan Medical Director or chair of the Credentialing Committee on a summary listing containing, at minimum, practitioner name, NPI and specialty.

- i. Information is typically presented via email, but may also be presented in person.
- ii. Approvals received via email are from a secure system with a unique electronic identifier with appropriate controls to ensure that only the designated medical director or qualified physician can access and use as an electronic signature.

D. If approved for network participation, a letter of acceptance is mailed to the applicant within sixty (60) calendar days of the determination, unless otherwise specified by Plan requirements.^{121 122}

¹²¹ CeltaCare Health Plan applicants must be notified of the credentialing committee decision on an initial application within four (4) business days. The notice shall include the committee decision and the decision date.

¹²² Arizona Complete Health requires notification within ten (10) days of Credentialing Committee decision.

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- i. Notification of acceptance is not provided for recredentialing applications.

X. Committee Review of Unclean Files

Credentialing and/or recredentialing application files that do not meet criteria for clean file review are brought to the Credentialing Committee for review. The Credentialing Committee has been delegated the responsibility from the Plan Quality Improvement Committee to review the qualifications of each applicant presented and make approval or rejection determinations¹²³

- A. The following grid summarizes file criteria and when Credentialing Committee review is required:

Credentials	Criteria	Committee Review
NPDB Profiles	NPDB Reports within five (5) years of the resolution date, <u>per report</u> to the committee decision/date.	Yes
	<i>Example: Committee Date 01/2007 NPDB Report 1 Resolution 1/2009</i>	Yes
	<i>NPDB Report 2 Resolution 10/1991</i>	No
Restricted License Adverse Activity Disciplinary Limited Supervision	State Licensure documentation within five (5) years of <u>date of final action/order</u> to the committee decision/date. <i>Please see the NPDB example for date compliance.</i>	Yes
	All Open, Pending, Discovery Claims	No ¹²⁴

¹²³ MPC Credentialing Committee determinations for Unclean Files are presented to the MPC Board of Directors who hold the authority for making final determinations.

¹²⁴ Files with History of Malpractice claims settled for over \$50,000.00, and all Open, Pending and Discovery Claims are designated as unclean and require review by Maryland Physicians Care Credentialing Committee and Board of Directors.

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Credentials	Criteria	Committee Review
Malpractice History	<i>Committee cannot make a recommendation on these types of issues until a final judicial outcome. The Credentialing Committee will review the final outcome during the recredentialing or ongoing monitoring process.</i>	
	All Closed or Dismissed Claims	No
	Claims that resulted in a settlement or judgement for the plaintiff	Yes
Federal, State Sanctions, Financial	State, Medicare/Medicare Sanctions, Fines, Discipline activity within five (5) years. Review dates for determination.	Yes
	<u>Current Medicare/Medicaid Exclusions</u> File will be administratively declined for participation.	No
Work History Gap	Gaps over 1 year in work history must be documented in writing and reviewed by committee.	No
Specialty Issues Board Certification Clinical Education Training Program	If Board Certification has been revoked by the Certifying Board, file should go to Committee for review.	Yes
Relinquish privileges, licensure, certification	Voluntary Relinquishment of state clinical license or certificates, malpractice insurance coverage, clinical or staff privileges, appointments, board status etc.	No
	*If under Investigation or involuntary relinquishment for any of the above	Yes

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Credentials	Criteria	Committee Review
Quality Indicators Recredentialing Only	During recredentialing the practitioner or facility have unsatisfactory Quality indicators, which can be one or more of the following: quality of care, over/under utilization, inadequate medical records, accessibility issues, and inappropriate volume of member complaints.	Yes

* It is expected that these findings will be discovered for currently participating practitioners through ongoing sanction monitoring. Practitioners with such findings will be individually reviewed and considered by the Credentialing Committee at the time the findings are identified. These practitioners will be identified (off cycle) when they are presented to the Credentialing Committee.

C. The Credentialing Committee may utilize an exception process should it be necessary to credential certain practitioners given the needs of its membership ¹²⁵.

- i. When there are extenuating circumstances that preclude the practitioner from meeting minimum participation criteria, but do not preclude the practitioner from providing quality care and service for Plan members, the Medical Director/Credentialing Committee Chair /Credentialing Committee may decide to utilize an exception process to extend an offer of participation.
- ii. A complete discussion of this decision is reflected in the Credentialing Committee meeting minutes.
- iii. If such a need exists, each criterion for selection is examined on an individual basis taking into account the following:
 - a. If there is a history of drug or alcohol abuse, the applicant must be involved in a credible program to correct impairment with concurrent and present

¹²⁵ Maryland Physicians Care Credentialing Committee/Board of Directors doesn't utilize an exception process.

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monitoring by the medical society or state board. There should be no evidence of recidivism.

- b. Previous sanction activity: the nature of the sanction and remedy.
 - c. Office site visit: a plan to remedy any deficiencies with provisional approval until the remedy is achieved, if Plan requires site visits.
 - d. Additional exceptions are granted and reviewed on an individual basis by the Credentialing Committee.
- D. The Credentialing Committee and/or Quality Improvement Committee has the authority to require an applicant to undergo an evaluation of his/her physical and/or mental status prior to further consideration of the application or in order to retain active status within Plan.
- E. If the Credentialing Committee requires additional information prior to making a determination, application may be pended and information is obtained and file presented to Credentialing Committee at a future meeting.
- F. The Credentialing Committee may determine that corrective action is necessary in order to credential a practitioner. The Committee decision includes a description of the steps necessary to fulfill compliance with the required action. If necessary, a work process will be created to document the specific step-by-step detail of how to complete the required tasks. Provider application should be pended and a future date set for re-review.

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G. The applicant is sent notice of his/her status in writing within sixty (60) calendar days of the Credentialing Committee decision, unless otherwise required by Plan.¹²⁶

XI. Denial of Initial Credentialing/Recredentialing Application

- A. Corporate or Plan Medical Director or Credentialing Committee may decide not to extend or continue to extend participation status to a practitioner.
- B. The Credentialing Committee Chair or designee notifies the practitioner via certified mail of the Credentialing Committee denial decision within sixty (60) calendar days of the Credentialing Committee’s decision.^{127 128}
 - i. A letter of denial includes the reason and information on the practitioner’s right to view and/or correct erroneous information.^{129 130 131}

¹²⁶ CeltiCare Health Plan applicants must be notified of the credentialing committee decision on an initial application within four (4) business days. The notice shall include the committee decision and the decision date.

¹²⁷ For those practitioners reviewed by Committee for recredentialing and denied continued participation, Louisiana Healthcare Connections will send a termination notice effective fifteen (15) days from the date of the notice via certified to the last mailing and email address submitted by the provider.

¹²⁸ Arizona Complete Health requires notification within ten (10) days of Credentialing Committee decision.

¹²⁹ Nebraska Total Care will include a description of appeal rights in the denial letter for Initial credentialing applications.

¹³⁰ Maryland Physicians Care letter of denial includes reason and right to view and/or correct for currently participating providers only.

¹³¹ When an adverse credentialing decision is rendered, PA Health & Wellness will provide written notice which will include a clear and complete explanation of the rationale and factual basis for the determination. The notice shall include any utilization profiles used as a basis for the decision and explain the methodology for adjusting profiles for non-clinical management factors.

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- ii. A copy of the letter is retained in the practitioner’s closed file and maintained in the Credentialing Department for future reference.
- iii. If the practitioner’s current participation status is being suspended, restricted or terminated based on issue of quality of care or service, Plan offers and informs the practitioner of the appeal process in accordance with the associated policies, CC.CRED.07 - Practitioner Disciplinary Action and Reporting, and CC.CRED.08 - Practitioner Appeal Hearing Process.

C. In order to support compliance with specific Plan requirements, Credentialing notifies Plan Compliance of Credentialing Committee denials as soon as reasonably possible after the committee proceedings conclude. ^{132 133 134 135}

XII. Practitioner Requests for Status of Credentialing/ Recredentialing Application

- A. Practitioner contacts Plan Provider Relations Department to request status.
- B. Upon receiving such request, the Plan Provider Relations Representative obtains information from Credentialing as needed,

¹³² Per South Carolina Managed Care Policy and Procedure Guide, any type provider who is denied credentialing or recredentialing, regardless of the reason(s), must be reported to the MCO’s Program Manager the same day (or within 24 hours) of the denial

¹³³ Magnolia Health Plan shall notify the Division within ten (10) calendar days of the denial of a Provider credentialing application either for program integrity-related reasons or due to limitations placed on the Provider’s ability to participate for program integrity-related reasons

¹³⁴ Home State Health Plan will notify the state agency of any denial of provider credentialing or re-credentialing in a timely manner and will report provider terminations as part of its quarterly fraud and abuse report following the State provided forms

¹³⁵ Arizona Medicaid Health Plan will report adverse credentialing actions to the AHCCCS Clinical Quality Management Unit within one business day.

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and provides practitioner with information such as the application approval date, status of any requests for additional information, the expected date the practitioner's file will go to the Credentialing Committee, etc.

C. Plan Provider Relations Department relays status information to requesting Practitioner.

XIII. Practitioner Requests to Review Information Obtained During Credentials Verification

- A. Practitioner submits a written and signed request for access to information obtained during the credentialing and/or recredentialing process.
- B. Requested information is secured and sent to the practitioner via Restricted Delivery Certified Mail within fourteen (14) days of the receipt of the request from the practitioner.
 - i. If Credentialing is unsure of the type of information that can be released, Corporate Counsel is immediately notified.
- C. The written request from the practitioner and the information provided by Credentialing is documented in the provider's credentialing file.

XIV. New Practitioner Requests Reconsideration

- A. A practitioner who is denied participation for non-administrative reasons requests a reconsideration of the decision ¹³⁶ ¹³⁷.

¹³⁶ Request for reconsideration of non-administrative denials by new (non-participating) practitioners is not applicable to Maryland Physicians Care.

¹³⁷ Meridian of MI and Meridian of IL recognize that those new applicants (those not currently participating in the network) who do not meet the established standards and are declined may initiate an 'appeal process', this process follows the same timeline and additional investigative activity as the core language criteria in this policy, but, which is termed the 'reconsideration process'.

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- i. If the request is received within thirty (30) calendar days of the date of receipt of the denial letter and includes additional supporting documentation in favor of the applicant's consideration for network participation, reconsideration will occur.
- ii. The request is presented to the Credentialing Committee at the next regularly scheduled meeting but in no case later than sixty (60) calendar days from the receipt of additional information. The Credentialing Committee may recommend:
 - a. Support of the original denial recommendation by the Credentialing Committee and closure of the file; OR
 - b. Support of the applicant's ability to meet the Plan minimum participation criteria and approval of the applicant for inclusion in the Plan practitioner network.
- iii. The Medical Director/Credentialing Committee Chair, or designee, notifies the applicant in writing within sixty (60) calendar days of the Credentialing Committee decision.

XV. Once credentialing is complete, PDM performs a quality check and makes the provider "par" (i.e. participating) in the Provider Data Management system¹³⁸. Once made par, the record is fed to both the online directory, the call center system, the claims system¹³⁹ ¹⁴⁰, and the eligibility system for member cards and enrollment.

¹³⁸ Arizona Medicaid Health Plan will ensure the practitioner is listed as participating within thirty (30) calendar days of Credentialing Committee approval.

¹³⁹ Magnolia Health Plan will load provider information into it's claims processing system within thirty (30) calendar days of provider contract approval.

¹⁴⁰ Western Sky Community Care will ensure that for Behavioral Health Providers, the provider specific contract information entered into the claims system must recognize the provider as a network provider with accuracy sufficient to pay claims no later than fifteen (15) calendar days after a provider is credentialed.

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REFERENCES:
<p>Current NCQA Health Plan CR Standards and Guidelines</p> <p>CMS Medicare Managed Care Manual Chapter 6 “Relationships with Providers”</p> <p>State and Federal regulations for Credentialing and Recredentialing including: 42 C.F.R. § 438.214, 455.104, 455.105, 455.106, 455.107, 1001.1801, 1001.1901, 1002.3(b)</p> <p>Current South Carolina Medicaid Managed Care Program- Policy and Procedure Guide for MCOs</p> <p>Arizona Health Care Cost Containment System (AHCCCS)</p> <p>Mississippi Department of Insurance Regulation 98-1</p> <p>State of Oregon: OAR 410-120-1280 and OAR 410-141-3510</p>
ATTACHMENTS:
<ul style="list-style-type: none"> A. CeltiCareHealth Plan Unique Credentialing Requirements B. Mississippi - Magnolia Health Plan/WellCare of Mississippi Unique Credentialing Requirements C. Louisiana Healthcare Connections/WellCare of Louisiana Unique Requirements for Credentialing D. Ambetter of Illinois Health Plan/MeridianComplete of Illinois and WellCare of Illinois Unique Requirements for Credentialing E. Home State Health Plan/WellCare of Missouri Unique Requirements for Credentialing F. Coordinated Care/WellCare of Washington Unique Requirements for Credentialing G. Kansas Sunflower State Health Plan Unique Requirements for Credentialing

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<p>H. New Hampshire Healthy Families/WellCare of New Hampshire Health Plans Unique Requirements for Credentialing</p> <p>I. California Health and Wellness/WellCare of California Health Plans Unique Requirements for Credentialing</p> <p>J. Absolute Total Care Plan Unique Requirements for Credentialing</p> <p>K. Michigan Complete Health/Meridian Complete Michigan/Meridian Health of Michigan/WellCare of Michigan Unique Requirements for Credentialing</p> <p>L. Trillium/HealthNet Oregon Unique Requirements for Credentialing</p> <p>M. Arizona Complete Health/WellCare of Arizona Unique Requirements for Credentialing</p> <p>N. PA Health and Wellness Unique Requirements for Credentialing</p> <p>O. Nebraska Total Care Unique Requirements for Credentialing</p> <p>P. Maryland Physicians Care (MPC) Unique Requirements for Credentialing</p> <p>Q. Nevada SilverSummit Unique Requirements for Credentialing</p> <p>R. Arkansas Health and Wellness/Arkansas Total Care/WellCare of Arkansas Unique Requirements for Credentialing</p> <p>S. Western Sky Community Care, Inc (New Mexico); and Ambetter of Western Sky Community Care Unique Requirements for Credentialing</p> <p>T. Carolina Complete Health, Inc. NC (Medicaid)/WellCare of North Carolina (Medicaid) Unique Requirements for Credentialing</p> <p>U. Illinois Medicaid Health Plans Unique Requirements for Credentialing</p> <p>V. Iowa Total Care Unique Requirements for Credentialing</p> <p>W. Ambetter of Tennessee/WellCare of Tennessee Unique Requirements for Credentialing</p> <p>X. Ambetter of Virginia Unique Requirements for Credentialing</p> <p>Y. MHS Health Wisconsin/Allwell from MHS Health Wisconsin (Medicare) Unique Requirements for Credentialing</p> <p>Z. Ascension Joint Venture Unique Requirements for Credentialing</p> <p>AA. Healthsmart Complete Unique Requirements for Credentialing</p> <p>BB. Oklahoma Complete Health, Inc. Unique Requirements for Credentialing</p> <p>CC. Managed Health Services (MHS) Indiana (includes Medicaid, Ambetter and Allwell)/WellCare of Indiana Unique Requirements for Credentialing</p> <p>DD. WellCare of Alabama – Unique Requirements for Credentialing</p> <p>EE. WellCare of Connecticut – Unique Requirements for Credentialing</p> <p>FF. WellCare of Vermont – Unique Requirements for Credentialing</p> <p>GG. WellCare of Rhode Island – Unique Requirements for Credentialing</p> <p>HH. WellCare of Maine – Unique Requirements for Credentialing</p> <p>II. WellCare of Massachusetts – Unique Requirements for Credentialing</p> <p>JJ. Ohana Health Plan QI and CCS - Hawaii – Unique Requirements for Credentialing</p> <p>KK. WellCare of Kentucky – Unique Requirements for Credentialing</p> <p>LL. WellCare of North Carolina (Medicare) – Unique Requirements for Credentialing</p>
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<p>MM. WellCare of New York – Unique Requirements for Credentialing NN. WellCare of Ohio – Unique Requirements for Credentialing OO. WellCare of Texas – Unique Requirement for Credentialing PP. WellCare of Georgia– Unique Requirements for Credentialing QQ. WellCare of Florida Medicare Unique Requirements for Credentialing RR. WellCare of New Jersey Medicare Unique Requirements for Credentialing SS. Delaware First Health Unique Requirements for Credentialing TT. Ohio Buckeye Health Plan Unique Requirements for Credentialing</p>

DEFINITIONS:

REVISION LOG

REVISIONS	DATE
Added provisions for Louisiana Healthcare Connections RFP effective 2/1/2015, including – 30-day turnaround time to completely process a provider application and that MCO must notify DHH upon denials or limitations for program integrity reasons	09/15/2014
Revised language for Magnolia Health Plan Site Visit requirements.	10/31/14
Revised language for Kansas Sunflower Health Plan Unique Requirements to specify CLIA validation at credentialing and recredentialing. Revised language for Louisiana Healthcare Connections Unique Requirements to include query of Louisiana Exclusion Database (LED)	12/4/14
Revised language for New Hampshire Granite State Health Plan Unique Requirements to include primary source verification of hospital privileges.	12/10/2014
Revised language for Louisiana Healthcare Connections Unique Requirements to clarify that Provisional credentialing process is used for expedited and temporary credentials.	2/27/2015
Revised language for South Carolina Absolute Total Care Unique Requirements to include detail on site visit documentation.	3/23/2015
Kansas Sunflower State Health Plan Unique Requirement language was updated to include acceptance of the Kansas state minimum malpractice coverage amount.	3/30/2015
WA Coordinated Care Health Plan Unique Requirement language was updated to include reporting for screening of excluded individuals.	7/15/2015
Revised language to clarify that reference to Board Certification is most applicable to physician level practitioners. Revised language in Section V.B that practitioner must reply regarding discrepancies in accordance with the due date stated on the request. Revised language in Section VII.B from thirty (30) days to twenty one (21) days. Kansas Sunflower State Health Plan Unique Requirement language was updated to include information specific to HCBS/Autism waiver providers.	10/7/2015

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<ul style="list-style-type: none"> Revised Attachment M Absolute Total Care Health Plan Unique Requirement to meet SCDHHS MCO Policy and Procedure Guide, revised November 2015. 	11/9/2015
<ul style="list-style-type: none"> Revised title of Procedure IV on page 22 to provide clarity 	1/6/2016
<ul style="list-style-type: none"> Revised Attachment F Coordinated Care Unique Requirements for Credentialing to include language allowing 120 days after return to civilian status to complete the recredentialing process for active duty military service providers. 	3/9/2016
<ul style="list-style-type: none"> Added 'current' to the section regarding Disclosure of Ownership form in section I.B.v (page 7) Slight revision of language in Procedure IV (page 22) to provide clarification that the disclosure of ownership form is collected at both initial and recredentialing, however, the team member responsible for the collection is different for the separate process type. Updated reference to NCQA Standards year; and updated reference to SC MCP policy and procedure year. 	3/28/2016
<ul style="list-style-type: none"> Added Attachment L - Pennsylvania Health and Wellness Unique Requirements for Credentialing 	5/4/2016
<ul style="list-style-type: none"> Revised Attachment L title – from Pennsylvania Health and Wellness Unique Requirement for Credentialing to Trillium Unique Requirements for Credentialing. Added Attachment M – Arizona Medicaid Health Plan Unique Requirements for Credentialing Added Attachment N - Pennsylvania Health and Wellness Unique Requirements for Credentialing (pasted previous information and included additional language) Added Attachment O – Nebraska Total Care Unique Requirements 	6/2/2016
<ul style="list-style-type: none"> Added additional Pennsylvania Department of Health's requirements Added language to ATC – SC Unique requirements that SCDHHS Form 1514 is the required format for DOO. Also added to page 7, as footnote 16. Clarified Celticare 24 month recredentialing requirement in Unique Requirement section and in footnote 6. 	7/7/2016
<ul style="list-style-type: none"> Removed the requirement for Site visit at initial credentialing for PCP and OB/GYN from ATC – SC Unique Requirement section and footnote section. Updated sources in References section to 2016 as applicable. 	8/6/2016

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<ul style="list-style-type: none"> Removed the following items from the “Replaces Documents: section of the header, and added notation to review the comment on this date: CC.CRED.01 Credentialing Program Description; CC.CRED.03 Primary Source Verification; CC.CRED.04 Initial Credentialing Process; CC.CRED.04.01 Practitioner Rights to Review and Correct; CC.CRED.04.02 Provisional Credentialing; CC.CRED.05 Initial Sanction Information; CC.CRED.07 Recredentialing Policy 	
<ul style="list-style-type: none"> Added language which requires provider participation in NH Medicaid to the Unique Requirement list for New Hampshire Healthy Families. 	10/12/2016
<ul style="list-style-type: none"> Added “LEIE” after OIG to help specify source on page 17 item E (OIG). Revised the titles for items listed in the Reference section to notate ‘current’ standards. <p>Louisiana Healthcare Connections Unique requirements (and footnotes) revisions:</p> <ul style="list-style-type: none"> processing of complete applications from 30 days to 60 days. Revised name of query database from LA Exclusion List (LED) to LA DHHS Adverse Action List. <p>ATC – SC Unique requirements (and footnotes) revisions/additions:</p> <ul style="list-style-type: none"> to report any excluded individuals and entities discovered to SC DHHS. to specify acceptable application form. To clarify acceptance that ‘atypical’ provider types may not have NPI. Clarified SC DHHS Form 1514 is specific to ATC Added requirement for validating enrollment in SC Medicaid Added reference to SC.CRED.13 in footnote for Board Certification. Added requirement for hospital privileges or admitting arrangements are at an in network hospital. Added requirement to verify NPs acting as PCP have formal collaborative relationship with in network licensed physician with admitting privileges at a contracted inpatient hospital facility. Added requirement to completely process credentialing applications within 60 days of receipt of complete application. 	11/16/16

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<ul style="list-style-type: none"> Tweaked language for notification to SC regulatory agencies of providers denied credentialing or recredentialing. 	
<ul style="list-style-type: none"> Minor changes made to page 9, section E and added section XV to clarify PDM and Credentialing responsibilities. 	2/2/2017
<ul style="list-style-type: none"> Added Maryland Physicians Care (MPC) Unique Requirements Attachment 	2/22/2017
<ul style="list-style-type: none"> Added Nevada SilverSummit Unique Requirements Attachment 	3/9/2017
<ul style="list-style-type: none"> Added clarifying language to IX.C.ii – to note that clean file approvals received via email are from a secure system. 	3/22/2017
<ul style="list-style-type: none"> Added Arkansas Health and Wellness Unique Requirements Attachment 	5/16/2017
<ul style="list-style-type: none"> Revised Trillium unique requirements to specify DMAP review, recredentialing application type, and verification of nonlicensed behavioral health practitioners through CCO Document Bank. Revised Maryland Physicians Care unique requirements with 10 year lookback period for malpractice settlements. 	8/18/2017
<ul style="list-style-type: none"> Add Western Sky Community Care, Inc (New Mexico) Attachment. 	10/18/2017
<ul style="list-style-type: none"> Added clarifying language to Magnolia Unique Requirement Attachment – all active network providers are enrolled (in Medicaid) using the same NPI numbers; and Nurse Practitioners acting as PCPs are held to the same requirements and standards as physicians acting as PCPs. Added language to Nebraska Total Care Unique Requirements Attachment – acceptance of a lower coverage amounts in accordance with the State Excess Liability Fund. 	11/10/2017
<ul style="list-style-type: none"> Added language to California Health & Wellness Unique Requirement Attachment: Effective 1/1/2018, all California Health & Wellness network providers must enroll in the Medi-Cal Program. California Health & Wellness relies on the enrollment and screening results conducted by DHCS and will access the California Health and Human Services' (CHHS) Open Data Portal to obtain a list of currently enrolled Medi-Cal FFS providers. 	12/8/2017

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<ul style="list-style-type: none"> Added language to PA Health & Wellness Unique Requirement Attachment – added review of MAID number; review of mid-level supervisory agreement; and specific language requirements in letters of denial. 	12/20/2017
<ul style="list-style-type: none"> Added language to KS Sunflower Unique Requirement Attachment to clarify that the State Uniform Credentialing application is used. And, clarification on CLIA collection: Per state, when a copy of CLIA is unavailable, a screen shot of CLIA certification via CMS website is acceptable 	12/23/2017
<ul style="list-style-type: none"> Added Carolina Complete Health, Inc. Unique Requirement Attachment. 	12/2017
<ul style="list-style-type: none"> Revised Carolina Complete Health, Inc Unique Requirement Attachment to clarify that only the NC DOI Uniform Credentialing application is accepted and no other information is required. Updated first sentence (bolded) of section IV in an effort to provide better clarity regarding recred process. 	1/22/2018
<ul style="list-style-type: none"> Updated Magnolia Health Plan Unique Requirements language to specify that the Health Plan follows credentialing and recredentialing standards of NCQA and EQRO recommendations; Credentialing must be completed before final execution of the contract with the Provider; notification to practitioner within five (5) business days of any missing or invalid information that would impede completion of credentialing and/or contracting; added footnote and unique requirement to state that Magnolia Health Plan will load provider information into it’s claims processing system within thirty (30) calendar days of provider contract approval. Updated core policy section XV to include reference to ‘the claims system’. Updated references to Board Certification policy (formerly state specific and number 13) to the current/active policy CC.CRED.10. 	2/5/2018
<ul style="list-style-type: none"> Added Next Level Health (IL Medicaid) Unique Requirement Attachment. Clarified ‘make par’ timeline for Arizona Medicaid Health Plan. 	2/5/2018
<ul style="list-style-type: none"> Added ATC South Carolina requirement to query the SC DHHS Termination for Cause List query during cred/recred. 	4/2018
<ul style="list-style-type: none"> Added clarifying language to Trillium Unique Requirement Policy in accordance with OHA/CCO contract. 	5/2018

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<ul style="list-style-type: none"> Added language to Procedure I.Biv - to the extent such provider is not an atypical provider as defined by CMS. Added 'Behavioral Health Service Providers' in the Policy 'Types of Providers' section. 	6/2018
<ul style="list-style-type: none"> Updated Sunflower Health Plan requirements to include validation of KMAP ID prior to enrollment. Updated Nebraska Total Care Unique Requirement to note that the Health Plan recognizes the licensure for Provisional Licensed Mental Health Practitioners (PLMHP) and Provisional Licensed Alcohol and Drug Abuse Counselors (PLADC) as active and unrestricted. 	8/18
<ul style="list-style-type: none"> Added Iowa Total Care Unique Requirement Attachment. 	9/18
<ul style="list-style-type: none"> Updated Magnolia Health Plan Unique Requirement to include query of Medicaid MS Sanctions Provider List. 	11/18
<ul style="list-style-type: none"> Added following item to the Minimum Administrative Requirements section: does not contain information that the practitioner is excluded from participation in the federal health care programs under either Section 1128 or Section 1128A of the Social Security Act.; Added item 6 regarding Autism providers to the California H&W Unique Requirement attachment; Added items 7 & 8 regarding Addictions Counselor Act and non-clinical BH types to submit supervising clinician statement.; Added item 6 regarding SUD providers and item 7 regarding LADC supervision to the New Hampshire Healthy Families Unique Requirement Attachment.; Added item 5 regarding ABA providers to the Coordinated Care Unique Requirement Attachment. Added Ambetter of Tennessee Unique Requirement Attachment Added Ambetter of Virginia Unique Requirement Attachment 	12/18
<ul style="list-style-type: none"> Added language to Unique Requirements for Iowa regarding PCP eligibility. Added language to Unique Requirements for Kansas to clarify requirements for Autism service providers. 	1/19
<ul style="list-style-type: none"> Updated Procedures I.D (which details how the enrollment team enters demographic and other information into the system based upon the application) to include reference to Panel Size. 	2/19

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<ul style="list-style-type: none"> Added language in Unique Requirements for Home State Health Plan regarding Medicaid Enrollment requirements. Revised Unique Attachment M from Arizona Medicaid Health Plan to Arizona Complete Health Updated Unique Requirement for Iowa Total Care item #2 for timeliness, removed duplicate item. 	
<ul style="list-style-type: none"> Updated ATC Unique Requirement Attachment language to include: SC List of Suspended Providers, Behavioral Health Actions and any other databases as the Department or Secretary of Health and Human Services may prescribe. Removed the following previous revision dates from header: 9/14; 09/14; 10/14; 12/14; 12/14; 3/15; 7/15; 10/15; 1/16; 3/16; 3/16; 5/16; 6/16; 7/16; 8/16; 10/16; 11/16; 2/17; 2/17; 3/17; 3/17; 5/17; 8/17; 10/17; 11/17; 12/17; 12/17; 1/18; 2/18; 4/18; 5/18; 8/18; 9/18; 11/18; 12/18; 1/19; 2/19 Updated Coordinated Care Unique Requirements with 10 calendar day notification requirement. Removed Requirement for Supervising Clinician document or statement for LADC. Updated Louisiana Healthcare Connections Unique Requirements attachment with additional detail on the restriction on contracting with excluded providers – particularly as related to HCBS; no payment for services to providers located outside fo the United States; additional language to accreditation requirements for BH organizations; acknowledgement that state may contract with a single CVO and we will agree to utilize with at least 90 days notice before implementation. Added Attachment Y: MHS Health Wisconsin Unique Credentialing Requirements Added query of CMS Preclusion list to core policy 	4/2019
<ul style="list-style-type: none"> Updated New Hampshire Healthy Families Unique Requirement Grid to clarify time frame and liquidated damages requirements. 	6/2019
<ul style="list-style-type: none"> Updated Trillium Unique Requirement grid with regulatory citation for exclusion monitoring, and CLIA. Removed requirement for supervising/collaborative agreement for LADC (it is not applicable). 	7/2019
<ul style="list-style-type: none"> Revised language in Core section of Policy IX. A. vii – review of work history. The language added doesn't change our current process, but helps to clarify and align with guidance in other sections of the policy. 	11/2019

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<ul style="list-style-type: none"> In section III.B.ii – (DEA Coverage Plan) replaced the word ‘physician’ with ‘practitioner’. This is not a change in policy, instead we updated the word for clarification as it is understood that DEA is not limited to physician only, and neither is the coverage plan. 	
<ul style="list-style-type: none"> Updated Trillium/HealthNet Oregon Unique Requirements to comply with Contract requirements. Notably, requirement to verify licensure expiration and non-renewal; and specific language regarding not applying licensure for Indian Health Services. Updated Ambetter TN Unique Requirements with numbers 1-4 	12/2019
<ul style="list-style-type: none"> Updated Louisiana Healthcare Connections Unique Requirements with the following: report to LDH within 3 days those participating providers terminated due to exclusions; added footnote denoting that behavioral health providers are LMHPs for Healthy Louisiana Contract; updated the reference entity of the LA State Exclusion list site from DHHS to LDH; removed the requirement that providers must be enrolled in LA Medicaid to participate; practitioners who do not meet timeliness for recredentialing requirements are sent notice of termination effective 15 days from date of the notice, claims for services provided prior to the termination date will be paid; If participating provider is presented to Credentialing Committee for recredentialing and is denied – letter is sent effective 15 days from the date of the notice; removed older/duplicative item related to compliance with Act 358, the item removed referenced completion of cred within 90 days, the correct item remains with a completion within 60 days; added requirement to send a minimum of 3 written notices with the first issued no later than 6 months prior the expiration of current credentialing. Updated Core policy Process III.B (page 20) to clarify DEA covering plan to align with NCQA language which requires Name of the covering provider, but, does not require the DEA number of the covering provider; updated Process II.A (page 12) with clarifying language for the requirements for license review. Verification of active/valid license in all states where practitioner sees our members, and review for sanctions, license disciplinary actions, and scope of practice restrictions for all active state licenses even in those states which the practitioner may not see members. Clarified sources for each. Updated reference section for OR slightly. Changed the former OAR 410-141-3420 to OAR 410-141-3120 	2/2020

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<ul style="list-style-type: none"> Updated Core policy language for query of NPPES to clarify that the NPI must be unique for every provider type Update New Hampshire Healthy Families Unique Requirements attachment to clarify that providers submitting new or missing information will be acted upon within 10 business days. Updated New Hampshire Healthy Families Unique Requirement attachment to clarify that Medicaid ID is required. 	3/2020
<ul style="list-style-type: none"> Updated Western Sky Community Care, Inc (New Mexico) Unique Requirement attachment to clarify requirement for Medicaid participation is for the Medicaid product; added language to note that contract shall not include a clause relieving either party (contractor or health carrier) of liability for actions or inactions; added clarification that the credentialing verification program will be provided to the regulator/superintendent upon request. Updated Absolute Total Care Unique Requirement attachment – Requirement to collect Disclosure of Ownership is no longer required for any product. Added Unique Requirement Attachment for Ascension Joint Venture network. Added Unique Requirement Attachment for ICNF network. 	6/2020
<ul style="list-style-type: none"> Updated Coordinated Care Unique Requirement attachment with updated language regarding timeliness for credentialing and specification of reimbursement to occur upon receipt of complete credentialing application. Clarified ‘References’ sections to include reference to State and Federal Regulations for credentialing and recredentialing. Clarified Unique Requirement for Western Sky Community Care, Inc. are inclusive of Ambetter from Western Sky Community Care. 	8/2020
<ul style="list-style-type: none"> Updated New Hampshire Healthy Families Unique requirement attachment to include requirement to notify healthcare provider that a submitted credentialing application is incomplete no later than 15 business days after receiving the credentialing application. Updated Kansas Sunflower State Health Plan Unique Requirement language to include information specific to HCBS/Autism waiver providers and updated options for enrollment requirements. Updated Ascension Joint Venture Unique Requirement with clarification to follow the applicable state Health Plan Unique Requirement per AJ state. 	9/2020

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PRODUCT TYPE: All	REFERENCE NUMBER: CC.CRED.01

<ul style="list-style-type: none"> Updated Home State Health Plan Unique Requirements to include detail on workflow to ensure compliance with Missouri Statute 376.1578 Updated Arizona Complete Health Attachment M and document to update provisional credentialing requirement, change timeliness for notifications to 10 days from date of decision based on ACOM 950 updates. 	
<ul style="list-style-type: none"> Added language to Unique Requirement Attachment for Carolina Complete Care regarding indemnification for claims or actions related to the credentialing information provided by NC DHHS. Updated PA Health & Wellness Unique Requirement Attachment removing the requirement to collect DOO at initial and recred. (also cleaned up Health Plan name in all entries from Pennsylvania Health and Wellness to PA Health & Wellness) Updated Iowa Total Care Unique Requirement Attachment to include the check against the SING registry 5 years from enrollment and every 5 years thereafter. Updated Ambetter of Tennessee Unique Requirement Attachment with language that clarifies reimbursement will not be denied based solely on non-maintenance of certification. Added clarifying information to Core policy to include Telemedicine (outpatient services). This is not new to our process, however, adding the type of specialty to our cred required type section is prudent. Added to Core policy: Centene recognizes and accepts the credentialing determinations within the Centene Enterprise when available. Additional Credentialing is not required unless and until the practitioner's credentialing cycle is no longer active. 	12/2020
<ul style="list-style-type: none"> Updated Arizona Complete Care Unique Requirement Attachment to include the requirement to conduct timely verification of information as evidenced by approval (or denial) of verification within 75 days of receipt of complete application. Added HealthSmart Unique Requirement Attachment Updated Core Policy DEA language to align with NCQA Standard 	1/2021
<ul style="list-style-type: none"> Updated Core language for Malpractice coverage which aligns with updated NCQA guidelines, coverage effective at date of attestation of application, and future coverage with effective and expiration dates. 	3/2021

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<ul style="list-style-type: none"> • Updated Core language to include additional references to regulatory requirements related to exclusions (these processes are not new, just simply adding the reference. • Added language noting that DOO is no longer required for Arizona • Added language to Western Sky NM Unique Requirements to clarify that credentialing should be completed within 30 days for Behavioral Health providers vs 45 days for all others. • Removed Unique Requirement Attachment for Integrated Health Network (FL) • Added Unique Requirement Attachment for HealthSmart • Added Unique Requirement Attachment for Oklahoma Complete Health, Inc. • Removed the following language from the Iowa Total Care Unique Requirement attachment “include the check against the SING registry 5 years from enrollment and every 5 years thereafter”. And removed the language prohibiting Physician Assistants from acting as a PCP. • Updated reference from Compliance 360 to Archer 	
<ul style="list-style-type: none"> • Added language to Western Sky Unique Requirement attachment clarifying that Behavioral Health Provider data will be entered into claims system with sufficient accuracy to pay claims no later than 15 calendar days after a provider is credentialed. 	4/2021
<ul style="list-style-type: none"> • Added Meridian Illinois into the Ambetter Illinicare Unique Requirement Attachment. • Removed requirement for validation of Medicaid ID from the Ambetter IL and Meridian IL Unique Requirement Attachment. • Updated Next Level Health Unique Requirement Attachment name to Illinois Medicaid Health Plans. • Added Meridian Michigan into the Michigan Complete Care Unique Requirement Attachments • Added Managed Health Services - Indiana Unique Requirement Attachment • Updated Arkansas Unique Requirement Attachment with changes requested from Arkansas Cred Department; also added Arkansas Total Care 	5/2021
<ul style="list-style-type: none"> • Updated Trillium/HealthNet Oregon Unique Requirements to include collection of the Cultural Competency Recordkeeping Form (responsibility for initials is Health Plan; responsibility for recreds is with Credentialing team). 	8/2021

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<ul style="list-style-type: none"> Updated Wisconsin Unique Requirements to clarify that NCQA guidelines are followed and applications must be signed and dated 180 days prior to enrollment. 	
<ul style="list-style-type: none"> Added Unique Requirements Attachment for WellCare of Alabama. Added WellCare of Arkansas to the Unique Requirement of Attachment for Arkansas Health Plans. Added WellCare of California to the Unique Requirement Attachment for California Health and Wellness Plan. Added WellCare of New Hampshire to the Unique Requirement Attachment for New Hampshire Healthy Families. Added WellCare of Connecticut, Vermont, Rhode Island, and Maine Unique Requirement Attachments Added WellCare of Illinois to Ambetter of Illinicare, etc... Unique Requirement Attachment Added WellCare of Indiana to Managed Health Services- Indiana Unique Requirement Attachment. Added WellCare of Louisiana to Louisiana Healthcare Connections Unique Requirement Grid. Updated Michigan Complete Health/Meridian Complete Michigan/Meridian Health of Michigan/WellCare of Michigan Unique Requirements for Credentialing Updated Magnolia Health Unique Requirement Attachment to include WellCare of Mississippi Added WellCare of Tennessee to Ambetter of Tennessee to Unique Requirement Attachment. Added WellCare of Massachusetts Unique Requirement Attachment Added WellCare of Hawaii Unique Requirement Attachment Added Wellcare of Kentucky Unique Requirement Attachment 	9/2021
<ul style="list-style-type: none"> Updated OK Unique Requirements to clarify timelines for clean file and adverse file completion. PSV shall be requested within 7 days of receipt of a complete application. Those files deemed 'clean' must be completed within 45 days, those 	12/2021

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<p>deemed unclear may have the process extended in 60 day increments, not to exceed 180 calendar days. And, Plan must refrain from solely basing a denial for lack of board certification or board eligibility and from adding new requirements solely for the purpose of delaying an application.</p> <ul style="list-style-type: none"> Updated Arizona Unique Requirements to include language ensuring 95% of practitioners/providers are loaded into the claim system within 30 calendar days of credentialing approval. Added language to the Unique Requirement attachment for WC of Florida Updated Unique Requirements attachment for Home State Health Plan 	
<ul style="list-style-type: none"> Corrected Name on the Unique Provider Attachment for Ambetter and WellCare of Illinois Added language to Unique Requirements attachment for Meridian MI to include provider's right to request retroactive effective date back to date of receipt of complete credentialing application. 	5/2022
<ul style="list-style-type: none"> Added language to Meridian MI Unique Requirement Attachment to include timeline to review/process credentialing and recredentialing requests. Added language to OR Trillium Unique Requirement Attachment to clarify that recredentialing is calculated to occur every three years to the day, not the end of the month of the prior credentialing approval date. 	6/2022
<ul style="list-style-type: none"> Added language to Managed Health Services – IN Unique Requirement Attachment to include ensuring credentialing is completed within 30 days (including monitoring) and IN Medicaid requires IHCP enrollment; Also added CLIA certificate or waiver requirement. Updated Iowa Unique Requirements – changing the 45-day timeliness requirement from 100% to 98% for completing credentialing. Updated Arizona Unique Requirements for notification and verification of credentialing approval and denial. Added language to Home State Health Unique Requirements regarding Provisional Licensed Psychologists and Professional Counselors as active and unrestricted providers in the network. 	8/2022
<ul style="list-style-type: none"> Added Delaware First Health Unique Requirement Attachment. 	10/2022

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<ul style="list-style-type: none"> • Updated NH Health Families/WellCare of New Hampshire Unique Requirements to show providers excluded from federal health care programs cannot be employed or contracted with the plans. • Added Buckeye Health Plan Unique Requirement Attachment 	
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POLICY AND PROCEDURE APPROVAL

The electronic approval retained in Archer, Centene's P&P management software, is considered equivalent to an actual signature on paper.

Corporate Credentialing: __Approval on file_____

Attachment A

CeltiCare Health Plan Unique Requirements for Credentialing

1. Celticare Health Plan requires recredentialing of practitioners every twenty-four (months).
2. CeltiCare Health Plan requires primary source verification of hospital privileges at the practitioner's primary admitting hospital as indicated on the application.
3. CeltiCare Health Plan requires a review of malpractice history for a ten (10) year look back period from the date of presentation to committee for approval.
4. CeltiCare Health Plan requires verification of the MA CSR, if applicable. A current copy of the certificate is considered a valid source and meeting the requirement. The document does not contain an expiration date. The certificate is valid for three (3) years from date of issuance for physicians and one (1) year for non-physician mid-level practitioners.
5. CeltiCare Health Plan requires board certification or alternate educational and clinical pathways as outlined in CC.CRED.10.
6. For CeltiCare Health Plan non-physician mid-level practitioners a copy of the physician collaborative agreement is obtained for the credentialing file.
7. CeltiCare Health Plan applicants must be notified of the credentialing committee decision on an initial application within four (4) business days. The notice shall include the committee decision and the decision date.
8. CeltiCare Health Plan is required to accept and utilize the Integrated Massachusetts Application for Initial Credentialing and the Integrated Massachusetts Application for Recredentialing
9. Physician Assistants shall not be approved for credentialing as a primary care physician for CeltiCare Health Plan.

Attachment B

Mississippi - Magnolia Health Plan/WellCare of Mississippi Unique Requirements for Credentialing

1. Magnolia Health Plan requires primary source verification of hospital privileges at the practitioner's primary admitting hospital as indicated on the application, if applicable.
2. Magnolia Health Plan is required to accept and utilize the Mississippi Participating Physician Form for the credentialing application.
3. Magnolia Health Plan verification sources for Malpractice Insurance coverage include current copy of insurance certificate, Federal Tort letter or primary source verification document with the Carrier.
4. Magnolia is required to ensure that all laboratory testing sites providing services have either a CLIA certificate or waiver of a certificate of registration along with a CLIA identification number. Acceptable formats for review include a current copy of certificate or waiver, or information obtained directly from CLIA. If the Laboratory Services section of the application is blank, Magnolia Health Plan will consult the Provider Data Form submitted with the contract to confirm whether CLIA verification is appropriate.
5. Magnolia shall ensure that all providers are enrolled as a Medicaid Provider and that all active network providers are enrolled using the same National Provider Identifier (NPI) numbers. Acceptable source for confirmation Medicaid enrollment shall be a review of a file of participating Medicaid providers supplied by the Department of Medicaid.
6. Magnolia Health Plan will verify that Nurse Practitioners acting as PCPs have a formal, written collaborative/consultative relationship with a licensed physician with admitting privileges at a contracted inpatient hospital facility. Nurse Practitioners acting as PCPs shall be held to the same requirements and standards as physicians acting as PCPs.
7. Magnolia Health Plan shall credential all completed application packets within ninety (90) calendar days of receipt. In cases of network inadequacy, Magnolia Health Plan shall credential all completed application packets within forty-five (45) calendar days of receipt. Magnolia Health Plan shall notify the Division of any Provider applications requiring longer than ninety (90) calendar days via monthly report. Credentialing must be completed before final execution of the contract with the Provider.
8. Magnolia Health Plan shall notify the Division within ten (10) calendar days of the denial of a Provider credentialing application either for

program integrity-related reasons or due to limitations placed on the Provider's ability to participate for program integrity-related reasons.

9. The Magnolia Health Plan shall conduct site visits for all providers in accordance with the process outlined in Policy and Procedure MS.CONT.03 Site Assessments for New Provider Contracts.
10. Magnolia Health Plan requires the use of credentialing and recredentialing standards set forth by the National Committee for Quality Assurance (NCQA) and EQRO recommendations
11. Magnolia Health Plan shall notify a practitioner within five (5) business days of any missing or invalid information that would impede completion of credentialing and/or contracting.
12. Magnolia Health Plan will load provider information into its claims processing system within thirty (30) calendar days of provider contract approval.
13. The Medicaid MS Sanctioned Provider List shall be queried at initial and recredentialing and proof of query will be included in the files.
14. Magnolia Health Plan LPC's are not eligible to enroll into Medicaid; therefore, a Medicaid number is not required for this particular state.

Attachment C

Louisiana Healthcare Connections (LHC)/WellCare of Louisiana Unique Requirements for Credentialing

1. Louisiana Healthcare Connections will accept and utilize the Louisiana Standardized Credentialing Application or the CAQH Application for the credentialing application.
2. Louisiana Healthcare Connections requires verification of the LA controlled dangerous substance certificate, if applicable. A current copy of the certificate is considered a valid source for meeting the requirement or primary source verification.
3. LHC - All changes to this Policy & Procedure shall be submitted to the DHH when a change is made and annually thereafter.
4. Louisiana Healthcare Connections requires board certification or alternate educational and clinical pathways as outlined in CC.CRED.10
5. Louisiana Healthcare Connections shall notify LDH of denial of a Provider credentialing application for program integrity-related reasons or otherwise limits the ability of Providers to participate for program integrity-related reasons.
6. Per Louisiana – Act 358. Interim credentialing requirements: Under certain circumstances and contingent upon the provisions of this Subsection being met, a managed care organization contracting with a group of physicians that bills a managed care organization utilizing a group identification number, such as the group federal tax identification number or the group National Provider Identifier as set forth in 45 CFR 162.402 et seq., shall pay the contracted reimbursement rate of the physician group for covered health care services rendered by a new physician to the group, without health care provider credentialing as described in this Subpart. This provision shall apply in each of the following circumstances:
 - a. When the new physician has already been credentialed by the managed care organization and the physician's credentialing is still active with the managed care organization.
 - b. When the managed care organization has received the required credentialing application and information, including proof of active hospital privileges, from the new physician and the managed care organization has not notified the physician group that credentialing of the new physician has been denied.

- c. A managed care organization shall comply with the provisions of Subsection A of this Section no later than thirty days after receipt of a written request from the physician group.
7. Louisiana Healthcare Connections shall completely process credentialing applications from all types of providers within sixty (60) calendar days of receipt of a completed credentialing application, including all necessary documents and attachments, and a signed provider agreement. “Completely process” shall mean that LHC shall:
 - a. Provide written confirmation, electronically or by mail, of receipt to the provider within five (5) business days of receipt of the application;
 - b. Review, approve, and load approved applicants to its provider files in its claims processing system;
 - c. Submit on the weekly electronic Provider Directory to the LDH or LDH’s designee, or
 - d. Deny the application and assure the provider is not used by the MCO.
8. Louisiana Healthcare Connections utilizes Provisional credentialing to meet the requirement to process expedited and temporary credentials.
9. LHC - Louisiana LDH Adverse Action List shall be queried.
10. LHC shall not contract or shall terminate contracts with providers who have been excluded from participation in the Medicare and/or Medicaid program pursuant to Section 1128 (42 U.S.C. §1320a-7) or Section 1156 (42 U.S.C. §1320c- 5) of the Social Security Act or who are otherwise barred from participation in the Medicaid and/or Medicare program. This includes providers undergoing any of the following conditions identified through LDH proceedings:
 - a. Revocation of the provider’s home and community-based services license or behavioral health service license;
 - b. Exclusion from the Medicaid program;
 - c. Termination from the Medicaid program;
 - d. Withholding of Medicaid reimbursement as authorized by the Department’s Surveillance and utilization Review (SURS) Rule (LAC 50:I.Chapter 41);
 - e. Provider fails to timely renew its home and community-based services license as required by the Home and Community-Based Services providers Licensing Standards Rule (LAC 48:I.Chapter 50); or
 - f. The Louisiana Attorney General’s Office has seized the assets of the service provider.

11. LHC shall not remit payment for services provided under this contract to providers located outside of the United States. The term “United States” means the fifty (50) states, the District of Columbia, and any U.S. territories.
12. Louisiana Healthcare Connections understands that the State reserves the right to contract with a single Credential Verification Organization (CVO). If this option is pursued, LHC and our subcontractors shall agree to use the CVO for the credentialing and recredentialing of all participating providers. LCH will be given at least 90 days’ notice before implementation of any CVO contract.
13. Louisiana Healthcare Connections will report to LDH those participating providers who have been terminated due to exclusion within three (3) business days.
14. Behavioral Health Services Providers - Licensed Mental Health Practitioners for Louisiana Healthcare Connections for the Healthy Louisiana contract.
15. Louisiana Healthcare Connections will provide a minimum of three (3) written notices to a contracted provider with information regarding the recredentialing process, including requirements and deadline for compliance. The first notice shall be issued no later than six (6) months prior to the expiration of the provider’s current credentialing. The notice shall include the effective date of termination if the provider fails to meet the requirements and deadlines of the recredentialing process.
16. For those practitioners who fail to meet timely recredentialing requirements, Louisiana Healthcare Connections will send termination notice via certified mail, effective fifteen (15) days from the date of the notice. Claims will be paid for services delivered prior to the termination date.
17. For those practitioners reviewed by Committee for recredentialing and denied continued participation, Louisiana Healthcare Connections will send a termination notice effective fifteen (15) days from the date of the notice via certified to the last mailing and email address submitted by the provider.
18. Health plan(s) operating in the State of Louisiana require individual providers to meet professional liability insurance in the minimum limits of: \$100,000 per occurrence \$300,000 aggregate OR Enrollment in the Louisiana Patients’ Compensation Fund.

Attachment D

Ambetter of Illinois Health Plan and Meridian Complete of Illinois and WellCare of Illinois Unique Requirements for Credentialing

1. The Health Plan will accept and utilize the Illinois Health Care Professional Credentialing and Business Data Gathering Form or the CAQH Application for the credentialing application.

2. Meridian IL Clean File eligibility criteria is expanded to include malpractice cases settled for no greater than \$200,000.

3. Meridian of IL recognize that those new applicants (those not currently participating in the network) who do not meet the established standards and are declined may initiate an 'appeal process', this process follows the same timeline and additional investigative activity as the core language criteria in this policy, but, which is termed the 'reconsideration process'.

4. To ensure practitioner has not opted-out of receiving Medicare funds the regional Medicare administrator must be queried for the applicable state in which the practitioner is providing services to Plan members.

5. The Health Plan requires recredentialing of practitioners at least every 3 years based on the last digit of their social security number. A recredentialing cycle cannot occur more than once in this 3 year cycle.

6. Meridian Illinois ensures that approved practitioner sites and their staff are scheduled for the Practitioner orientation at which time they receive their Provider Manual.

Attachment E

Home State Health Plan/WellCare of Missouri Unique Requirements for Credentialing

- Home State Health Plan will accept and utilize the CAQH Universal Credentialing Data Source Form (UCDS), pursuant to RSMo 354.442.1 (15) and 20 CSR 400.7.180 (as amended), as the credentialing application for all practitioner credentialing in compliance with section 2.18.8c of the contract.
- Home State Health Plan will require each that ordering and referring professional providing services to Home State Health Plan members have a national provider identifier (NPI) in accordance with 45 CSR 162.410 in accordance with Sections 2.2.6 and 3.9.6w of the contract. Home State Health Plan will query the National Plan & Provider Enumeration System <https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do> at the time of initial and recredentialing to confirm that the practitioner has a current, valid NPI.
- Home State Health Plan requires verification of Bureau of Narcotics and Dangerous Drugs issued by the Missouri Department of Health & Human Services, if applicable. A current copy of the certificate is considered a valid source and meeting the requirement. Alternately, this may be verified on line:
<https://webapp01.dhss.mo.gov/mohworx/RegistrantSearch.aspx>
- As per Missouri 376.1578: A health carrier shall assess a health care practitioner's credentialing information and make a decision as to whether to approve or deny the practitioner's credentialing application within sixty business days of the date of receipt of the completed application. A completed application is a practitioner's application to a health carrier that seeks the health carrier's authorization for the practitioner to provide patient care services as a member of the health carrier's network and does not omit any information which is clearly required by the application form and the accompanying instructions. The sixty-day deadline established in this section shall not apply if the application or subsequent verification of information indicates that the practitioner has:
 - a. A history of behavioral disorders or other impairments affecting the practitioner's ability to practice, including but not limited to substance abuse;
 - b. Licensure disciplinary actions against the practitioner's license to practice imposed by any state or territory or foreign jurisdiction;
 - c. Had the practitioner's hospital admitting or surgical privileges or other organizational credentials or authority to practice revoked,

restricted, or suspended based on the practitioner's clinical performance; or

- d. A judgment or judicial award against the practitioner arising from a medical malpractice liability lawsuit.
- Home State Health Plan will notify the state agency of any denial of provider credentialing or re-credentialing in a timely manner and will report provider terminations as part of its quarterly fraud and abuse report following the State provided forms.
 - Home State Health Plan will initially submit Credentialing Policies & procedures to MO HealthNet for approval in compliance with section 2.18.8c, 2.18.8c5, 3.9, 3.9.6 of the contract and thereafter as changes are made.
 - Home State Health Plan may execute network provider agreements pending the outcome of Medicaid enrollment of up to 120 days, but must terminate a network provider immediately upon notification from the State that the network provider cannot be enrolled, or the expiration of one 120 day period without enrollment of the provider, and notify affected enrollees as of January 1, 2018 per 42 CFR 438.602(b) and 438.608(b).
 - Home State Health Plan recognizes the licensure for Provisional Licensed Psychologists and Provisional Licensed Professional Counselors as active and unrestricted providers in the network.

Home State Health Plan Work Flow and Requirements for adding New Practitioners

Home State Health Contracting will follow the procedures outlined below in the initial credentialing process for all non-delegated practitioners in conjunction with Centene Credentialing in order to ensure compliance with Missouri Statute 376.1578. Although credentialing procedures employed by delegated IPAs/medical groups may vary somewhat from those outlined herein, such procedures shall at all times be consistent with state requirements.

Adding New Practitioner to New Contract

Application Receipt Process

Practitioner completes the application request (includes credentialing info, contract, W9, DOO, etc.), and forwards it, along with requested supporting documentation, as instructed, to the Contracting Inbox.

Within **2 working days of application receipt**, Lead Contract Coordinator will enter date request was received into CenPoint, and attach the application request that was sent to our email

inbox. Lead Contract Coordinator will also enter date request was received into the Contracting Share Point site for tracking purposes.

Additionally, the Lead Contract Coordinator will send an email to the requesting practitioner out of CenPoint acknowledging receipt within **2 working days of application receipt** and enter that date into the Contracting Share Point. This email will inform the practitioner that a Contract Negotiator has been assigned to their application.

If the initial application is not complete, additional information will be requested by the Contract Negotiator within **10 working days of receipt in the Inbox**. Negotiator will specifically outline missing information and send the email from the Inbox. The date of email request will be logged in the Contracting Share Point.

Once additional information is received in the Inbox, Negotiator will review for completeness and, if incomplete, repeat the process noted in the above paragraph.

If complete, the completed information needed is documented in CenPoint within **2 working days of receipt in the Inbox**. At this point, Corporate Credentialing follows procedures outlined in CC.CRED.01 within **30 calendar days of receipt in CenPoint**.

Concurrent to CenPoint entry, Negotiator also logs the date of receipt of additional information in the Contracting Share Point and within **2 working days of receipt** emails the practitioner to acknowledge that the additional information has been received. The date of this email is entered into the Contracting Share Point.

Credentialing Completion

After Corporate Credentialing completes the process outlined in CC.CRED.01, practitioner goes to the HSH Credentialing Committee for approval. After approval is received, the Contracting Coordinator will send a Welcome Letter to the practitioner within 2 days of Credentialing Committee approval.

Adding New Practitioner to Existing Contract

Application Receipt Process

Practitioner completes a Home State Health Plan non-delegate roster or Provider Data Form and forwards it, along with requested supporting documentation, as instructed, to the PDM email box, CHHS_PROVIDER_ROSTER@CENTENE.COM.

Within **2 working days of application receipt**, the Quality Business Analyst will enter date request was received into the PDM Sharepoint site and attach the application request that was sent to our email inbox.

Additionally, the Quality Business Analyst will send an email to the submitter of the request from the CHHS_PROVIDER_ROSTER email address acknowledging receipt within **2 working days of application receipt** and enter that date into the PDM Share Point. This email will inform the submitter of the request that Home State PDM is in receipt of their request to add the practitioner(s).

If the initial application is not complete, additional information will be requested by the PDM Business Analyst within **10 working days of receipt in the Inbox**. Business Analyst will specifically outline missing information and send the email from the Inbox or their personal Centene email address. The date of email request will be logged in the PDM Share Point.

Once additional information is received in the Inbox, Business Analyst will review for completeness and, if incomplete, repeat the process noted in the above paragraph.

If complete, the completed information needed is documented in the Sharepoint site within **2 working days of receipt in the Inbox**. The enrollment case is submitted to CenProv. At this point, Corporate Credentialing follows procedures outlined in CC.CRED.01 within **30 calendar days of receipt in CenPoint**.

Concurrent to CenProv entry, Business Analyst also logs the date of receipt of additional information in the PDM Share Point and within **2 working days of receipt** emails the submitter of the request to acknowledge that the additional information has been received. The date of this email is entered into the PDM Share Point.

Roles and Responsibilities

- Home State Health Contracting is responsible for initial receipt of new practitioner information and delivering a completed set of information to Corporate Credentialing within the outlined timeframes. Once approved by the Credentialing Committee, Contracting will send the welcome letter.
- Corporate Credentialing is responsible for all core credentialing processes outlined in CC.CRED.01 within 30 days of receipt in CenPoint.
- Home State Health Provider Data Management is responsible for operational oversight of the entire process within the 60 day requirement (completed application to committee approval) outlined in Missouri Statute 376.1578.
- Home State Health Compliance is responsible for ongoing monitoring of compliance with Missouri Statute 376.1578 and documentation of any disclosures that are required as the result of non-compliance.
- As part of re-credentialing, Home State Health shall audit records of primary care providers, hospitals, home health agencies, personal care providers, and hospices to determine whether the provider is following the policies and procedures related to advance directives.

- As part of credentialing and re-credentialing, Home State Health shall collect from providers directly contracted with Home State Health, full and complete information, as described herein, regarding ownership and control, financial transactions and persons convicted of criminal activity related to Medicare, Medicaid, CHIP, or any other Federal health care program, including Public Chapter 379 of the Acts of 1999 and 42 CFR 455.104-106 and 42 CFR 1001.1001-1051. Home State Health shall collect and provide this information to the state agency in the format and frequency specified by the state agency in “Ownership or Controlling Interest Disclosure”, “Transaction Disclosure”, and “Provider and Subcontractor Disclosure” located and periodically updated on the MO HealthNet website at Health Plan Reporting Schedule and Templates (<http://dss.mo.gov/business-processes/managed-care-2017/health-plan-reporting-schedules-templates/>).

Home State Health shall collect the information from the provider and retain evidence of having done so to produce to the state agency upon request; or if Home State Health has verifying documentation that the Missouri Medicaid Audit & Compliance (MMAC) has collected the required disclosures from the provider, then Home State Health may utilize the collected disclosures from MMAC:

 - At the stage of provider credentialing and re-credentialing;
 - Upon execution of the provider agreement;
 - Within thirty-five (35) days of any change in ownership of the provider; and
 - At any time upon the request of the state agency for any or all of the information described in this section.
- Home State Health shall promptly forward such disclosures or documentation of the disclosures to the state agency, in accordance with prescribed timeframes. Per the subcontracting requirements specified herein, Home State Health shall include provisions in its subcontracts for health care services notifying the provider or benefit management organization to provide the disclosures to Home State Health. The state agency will, in accordance with 42 CFR 455.106(b), notify the HHS Office of the Inspector General (HHS-OIG) within twenty (20) business days from the date it receives the information, of any disclosures made by providers under 42 CFR 455.106 (relating to criminal convictions of the provider, or of a person who has an ownership or control interest in the provider, or is an agent or managing employee of the provider) that result in a subcontractor being ineligible for participation. Home State Health must retain evidence that it received the proper disclosures or documentation of the disclosures as outlined in the Records Retention Section and produce the same for the State upon request.
- Home State Health shall promptly notify the state agency of any denial of enrollment due to the results of the provider credentialing or re-credentialing process. This requirement is in addition to the requirement herein for Home State Health to report provider terminations as part of its quarterly fraud, waste, and abuse report. The state agency shall, pursuant to 42 CFR 1002.3(b), promptly notify HHS-OIG of the denial of credentialing or re-credentialing where that denial is based on a determination that the provider has been excluded from participation in Medicare, Medicaid, CHIP, or any other Federal health care program; has failed to renew its license or certification registration, or has a revoked professional license or certification; has been terminated by the state

agency for cause; or has been excluded by OIG under 42 CFR 1001.1001 or 1001.1051. In making such disclosures, Home State Health shall use the template provided in Provider and Subcontractor Disclosure located and periodically updated on the MO HealthNet website at Home State Health Reporting Schedule and Templates (<http://dss.mo.gov/business-processes/managed-care-2017/health-plan-reporting-schedules-templates/>) or provide documentation of the disclosures.

- As part of credentialing and re-credentialing, Home State Health shall screen all health care service subcontractors to determine whether the subcontractor or any of its employees or subcontractors has been excluded from participation in Medicare, Medicaid, CHIP, or any Federal health care program (as defined in Section 1128B(f) of the Act); has failed to renew license or certification registration; has revoked professional license or certification; or has been terminated by the state agency. The screening shall consist of, at a minimum, consulting the following databases on at least a monthly basis: the List of Excluded Individuals/Entities (LEIE) and the Excluded Parties List System (EPLS). The LEIE is located at https://oig.hhs.gov/exclusions/exclusions_list.asp and the EPLS is located at <https://www.sam.gov/portal/public/SAM/>. The screening shall also consist of consulting the following additional databases, consistent with State and Federal requirements: the National Plan and Provider Enumeration System (NPPES), located online at <https://nppes.cms.hhs.gov/NPPES/Welcome.do>, the Missouri Professional Registration Boards website, and any such other State or Federal required databases. If Home State Health has verifying documentation that the Missouri Medicaid Audit & Compliance (MMAC) conducted a required screening, then Home State Health may utilize the collected screenings from MMAC. Home State Health may use the template provided in Provider and Subcontractor Disclosure located and periodically updated on the MO HealthNet website at Health Plan Reporting Schedule and Templates (<http://dss.mo.gov/business-processes/managed-care-2017/health-plan-reporting-schedules-templates/>) to memorialize these screenings. Home State Health shall deny credentialing or re-credentialing to any subcontractor that falls within this section. In addition, Home State Health shall terminate the provider contract of any subcontractor for which a check reveals that the subcontractor falls within this section.
- Home State Health shall accurately and timely load into Home State Health's claim adjudication and payment systems those new subcontracting contracts, subcontracted provider demographic information, changes in subcontracting contract terms, changes in subcontracted provider demographic information, updated prior authorization requirements, and changes to the provider directory.
 - Unless otherwise written in the subcontract, Home State Health shall load credentialed providers into the claim adjudication and payment system within the following time frames in order to ensure timely denial or payment for a health care service or item already provided to a participant and billed to Home State Health by the provider:
 - Newly credentialed provider attached to a new contract within ten (10) business days after completing credentialing;
 - Newly credentialed hospital or facility attached to a new contract within fifteen (15) business days after completing credentialing;

- Newly credentialed provider attached to an existing contract within five (5) business days after completing credentialing;
- Changes for a re-credentialed provider, hospital, or facility attached to an existing contract within five (5) business days after completing re-credentialing;
- Change in existing contract terms within ten (10) business days of the effective date after the change.
- Changes in provider service location or demographic data or other information related to member's access to services must be updated no later than thirty (30) calendar days after Home State Health receives updated provider information.
- Payment should be made on the next payment cycle following the requirement outlined above.
- In no case shall a provider be loaded into the provider directory which cannot receive payment on Home State Health's current payment cycle.
- Upon request by the state agency, Home State Health shall provide a report demonstrating the following:
 - Compliance with the credentialing requirements herein including but not limited to the average number of days taken to complete credentialing by provider type, and the number of providers who were not credentialed according to the requirements by provider type; and
 - Compliance with the required timeframes for loading credentialed providers.

Attachment F

Coordinated Care/WellCare of Washington Unique Requirements for Credentialing

1. Coordinated Care will utilize the Washington Practitioner Application to process credentialing for all practitioners that require credentialing. The database selected pursuant to RCW 48.165.035 must be used to manage credentialing applications from health care providers. Coordinated Care will not require a health care provider to submit credentialing information in any format other than through the database selected pursuant to RCW 48.165.035
2. Coordinated Care shall ensure that all providers are enrolled in Washington as a Medicaid Provider. Acceptable source for confirmation of Medicaid enrollment shall be a review of the Provider One website.
3. Coordinated Care will ensure any excluded individuals and entities discovered as a result of screening for Fraud, Waste and Abuse during the provider application, credentialing and recredentialing processes, must be reported to HCA within five (5) business days of discovery. Credentialing staff will report identified excluded individual/entities to the Compliance Department, who will report to HCA using HCA PIR006-WA Excluded Individual Template.
4. Coordinated Care Health Plan allows active duty military service providers a period of at least one hundred twenty days to complete the recredentialing process after return to civilian status. The one hundred twenty days will begin no earlier than the date the provider's period of active duty ends.
5. Coordinated Care recognizes and credentials Centers of Excellence (COE) and Applied Behavior Analysis (ABA) therapy providers that provide ABA therapy services under the Applied Behavior Analysis Program and in accordance with WAC 182-531A-0900
6. Coordinated Care will will a determination approving or denying a credentialing application no later than ninety (90) days after receiving a complete application from a health care provider. All determination made in approving or denying credentialing applications must average no more than sixty (60) days. This criteria does not apply to health care entities that utilize credentialing delegation arrangements. Credentialing means the collection, verification, and assessment of whether a health care provider meets relevant licensing, education, and training requirements.

7. Coordinated Care will provide notification of Committee Decision within 10 calendar days.

8. When credentialing a new health care provider through a new provider contract, Coordinated Care reimburses the health care provider for covered services provided to members retroactively to the date of contract effectiveness if the credentialing process extends beyond the effective date of the new contract. When credentialing a provider to be added to an approved and in use provider contract where a relationship already existed between Coordinated Care and the healthcare provider or entity for whom the health care provider is employed or engaged at the time health care provider submitted the completed credentialing application, Coordinated Care will reimburse the health care provider for covered services provided to members during the credentialing process beginning when the health care provider submitted a completed credentialing application. Coordinated Care will reimburse the health care provider at the contracted rate for the applicable health benefit plan that the health care provider would have been paid at the time the services were provided if the health care provider were fully credentialed.

Attachment G

Kansas Sunflower State Health Plan Unique Requirements for Credentialing

1. In accordance with the State Uniform Credentialing and Recredentialing MMIS Policy, Kansas Sunflower State Health Plan will accept and utilize the State of Kansas Standard Credentialing Application/CAQH to process credentialing for all providers/practitioners that require credentialing.
2. Kansas Sunflower State Health Plan shall obtain copies of the valid CLIA certificates from the laboratories and/or all entities providing laboratory services funded by Title XIX and Title XXI of the Social Security Act at credentialing and recredentialing. Per state, when a copy of CLIA is unavailable, a screen shot of CLIA certification via CMS website is acceptable. Kansas Sunflower State Health Plan shall provide a listing to the State of all laboratories and/or entities providing laboratory services and shall certify to the State that the laboratories and/or entities providing laboratory services are CLIA certified. Kansas Sunflower State Health Plan shall update the listing and certification as laboratories and/or entities providing laboratory services are added to or dropped from the list.
3. Kansas Sunflower State Health Plan shall ensure that credentialing of all service providers applying for network provider status shall be completed as follows: 90% within 30 days; 100% within 45 days. The start time begins when all necessary credentialing materials have been received. Completion time ends when written communication is mailed or faxed to the provider notifying them of the Credentialing Committee's decision.
4. Sunflower Health Plan shall ensure that all providers are Medicaid enrolled.
5. Kansas Sunflower State Health Plan accepts the State minimum insurance of \$200,000/\$600,000 per Kansas State Statute.
6. Sunflower Health Plan accepts HCBS Autism and/or State Plan Autism Service providers who are Medicaid enrolled, meet the criteria as an Autism Specialist (CCTS) or IIS. The CCTS Provider will be either a 1) Board Certified Behavior Analyst (BCBA) or Assistant Behavior Analyst licensed through the Kansas Behavioral Sciences Regulatory Board (KS BSRB) or 2) Board Certified Behavior Analyst – Doctoral (BCBA-D) or Board Certified Assistant Behavior Analyst (BCaBA) or 3) an individual with a Master's degree, preferably in Human Services or Education, and completion of state approved training curriculum.

7. The IIS worker can be 1) Certification as a Registered Behavior Technician (RBT) under the supervision of a BCBA, or 2) An individual at least eighteen years of age with a high school diploma or equivalent; And 40 hours of successfully applied behavioral analysis training following the Autism Center of Excellence (ACE) Program guidelines which would include: 8 hours – supervised intervention work; 3 hours – ethics. And, at least 1 hour of: criterion reference; social skills training; parent training; program development; successful completion of an initial competency assessment. This provider will work under the direction of the BCBA or other qualified CCTS practitioner and meet all annual training requirements as specified by certification.
8. Additionally for both CCTS and ISS, the individual must have a clean background, as evidenced through background checks of records maintained by the Kansas Bureau of Investigation (KBI), Adult Protective Services (APS), Child Protective Services (CPS), Nurse Aide Registry and Motor Vehicle Screen.
9. If a provider is KMAP approved, Sunflower Health Plan will not require documentation in excess of the requirements in the state contract.
10. In accordance with the Addictions Counselor Licensure Act, the Company must provide assurance that addiction counselors are licensed by the Behavioral Sciences Regulatory Board (BSRB). The Company must ensure that any provider of Substance Use Disorder (SUD) treatment services in a facility setting be licensed by the Kansas Social & Rehabilitation Services (SRS) to provide SUD treatment services. Any provider determining the medical necessity of such services according to the Kansas definition must be a BSRB-licensed practitioner practicing within their scope as defined by the BSRB. Omnibus Health Bill – HB 2182, 2011: Expands independent practice, as applied to addiction counseling and licensed clinical addiction counselors, to include not only the diagnosis and treatment of substance abuse disorders but to allow for both independent practice and diagnosis and treatment of substance abuse disorders; and allows a licensed addiction counselor, on and after July 1, 2011, to practice in treatment facilities exempted under KSA 59-29b46.

Attachment H

New Hampshire Healthy Families/WellCare of New Hampshire Health Plans Unique Requirements for Credentialing

1. New Hampshire Healthy Families/WellCare of New Hampshire will credential all service providers applying for network provider status in the following timelines: primary care providers within 30 calendar days of receipt of clean and complete credentialing applications; Specialists within 45 days of receipt of clean and complete credentialing applications. The start time begins when New Hampshire Healthy Families/WellCare of New Hampshire has received a Provider's clean and complete application, and ends on the date of the Provider's written notice of network status. In the event the Provider's credentialing application is not processed within the these time frames, the Provider will be paid retroactive to thirty (30) calendar days or forty five (45) calendar days after receipt of the Provider's clean and complete application. For each day an application is delayed beyond the prescribed timeframe, the Health Plan will be fined in accordance with Exhibit N (Liquidated Damages Matrix) in the New Hampshire Medicaid Care Management Services Model Contract.
2. New Hampshire Healthy Families/WellCare of New Hampshire's Contracting team will conduct outreach to prospective Participating Providers within ten (10) business days after receiving notice of the Provider's desire to enroll, and will concurrently work through the Health Plan's and the DHHS contracting and credentialing processes with Providers in an effort to expedite the Provider's network status.
3. New Hampshire Healthy Families/WellCare of New Hampshire is required to ensure that all laboratory testing sites providing services have either a CLIA certificate or waiver of a certificate of registration along with a CLIA identification number. Acceptable formats for review include application attestation, current copy of certificate or waiver, or information obtained directly from CLIA.
4. To ensure practitioner has not opted-out of receiving Medicare funds the regional Medicare administrator must be queried for the applicable state in which the practitioner is providing services to Plan members.
5. New Hampshire Healthy Families/WellCare of New Hampshire requires primary source verification of hospital privileges at the practitioner's primary admitting hospital as indicated on the application.

6. New Hampshire Healthy Families/WellCare of New Hampshire shall ensure that all providers are enrolled as New Hampshire Medicaid providers, they must have a NH Medicaid identification number.
7. New Hampshire Healthy Families/WellCare of New Hampshire requires all practitioners to be licensed or certified in accordance with the laws of New Hampshire.
8. New Hampshire Healthy Families/WellCare of New Hampshire shall offer contracts to Medicaid enrolled SUD providers who meet the Health Plan's credentialing standards.
9. New Hampshire Healthy Families/WellCare of New Hampshire notifies a healthcare provider that a submitted credentialing application is incomplete no later than 15 business days after receipt of the credentialing application.
10. For any provider submitting new or missing information for its credentialing application, New Hampshire Healthy Families/WellCare of New Hampshire will act upon the new or updated information within ten (10) business days.
11. New Hampshire Healthy Families/WellCare of New Hampshire will not employ or contract with Providers excluded from participation in federal health care programs [42 CFR 438.214(d)(1); 42 455.101; Section 1932(d)(5) of the Act].

Attachment I

California Health and Wellness/WellCare of California Health Plans Unique Requirements for Credentialing

1. All providers of Covered Services must be qualified in accordance with current applicable legal, professional, and technical standards and are appropriately licensed, certified or registered. All providers of Medi-Cal managed care services must have good standing in the Medicare and Medicaid/Medi-Cal programs. Providers that have been terminated from either Medicare or Medicaid/Medi-Cal cannot participate in California Health and Wellness Plan's provider network for Medi-Cal managed care.
2. All providers of Medi-Cal managed care services must have a valid National Provider Identifier (NPI) number.
3. California Health and Wellness Plan shall ensure that all contracted laboratory testing sites for use in Medi-Cal managed care have either a Clinical Laboratory Improvement Act (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number.
4. The California Health and Wellness Plan shall conduct Facility Site, Medical Record, and Facility Site Physical Accessibility reviews on all Primary Care and high volume provider sites by reviewers who are appropriately trained, monitored, and evaluated. These site visits shall consist of initial surveys and subsequent periodic site inspections conducted at least every three (3) years. The California Health and Wellness Plan shall use Med-Cal Managed Care Division survey criteria and scoring methodology for site and medical record audits. The initial full scope site review survey can be waived by a plan for a pre-contracted provider site if the provider has documented proof that a current full scope survey with a passing score was completed by another plan within the past three years. This is not a requirement for practitioners in the WellCare of California Medicare Health Plan network.
5. Effective 1/1/2018, all California Health & Wellness network providers must enroll in the Medi-Cal Program. California Health & Wellness relies on the enrollment and screening results conducted by DHCS and will access the California Health and Human Services' (CHHS) Open Data Portal to obtain a list of currently enrolled Medi-Cal FFS providers. This is not a requirement for practitioners in the WellCare of California Medicare Health Plan network.
6. The California Health and Wellness Plan recognizes and credentials Qualified Autism Service (QAS) providers, professionals, and paraprofessionals that provide Behavioral Health Therapy (BHT) services in accordance with Section 1374.73 of the California Health and Safety Code.

7. Disclosure of Ownership form is not required for WellCare of California Medicare Health Plan.

Attachment J

Absolute Total Care Plan Unique Requirements for Credentialing

1. Absolute Total Care will report to SC DHHS any excluded individuals and entities discovered as a result of screening for fraud, waste and abuse during the provider application, credentialing or recredentialing process. Credentialing staff will report to the Compliance Department, who will submit the report to the SC DHHS and other regulatory agencies as necessary.
2. For the state of South Carolina's (SC) report of exclusions based on fraud, convictions, loss of license, patient abuse and other reasons, the SC Excluded Providers Listing and the Termination for Cause List on the SC DHHS website, SC List of Suspended Providers, Behavioral Health Actions and any other databases as the Department or Secretary of Health and Human Services may prescribe shall be queried during the credentialing/recredentialing process.
3. To ensure practitioner has not opted-out of receiving Medicare funds the regional Medicare administrator must be queried for the applicable state in which the practitioner is providing services to Plan members.
4. Absolute Total Care shall ensure that all offices with laboratory services have Clinical Laboratory Improvement Act (CLIA) certificates or waivers. Certificates or waivers may be primary source verified or a copy of the certificate or waiver is acceptable.
5. Credentialing or recredentialing policies and procedures must be submitted to SCDHHS for approval prior to implementing the changes. The changes must be submitted to SCDHHS prior to implementation and follow the same submission process as changes outlined in the contract submission process.
6. Any type of provider who is denied credentialing or recredentialing by Absolute Total Care, regardless of the reason, will be reported to the SC Division of Program Integrity/SUR and SC DHHS. Credentialing staff will notify the Compliance Department, who will provide the notification.
7. Medical professionals to include, but not limited to physicians, physician's assistants, certified nurse midwives/ licensed midwives, certified registered nurse anesthetists (CRNAs)/ anesthesiologist assistants (AAs), nurse practitioners/ clinical nurse specialists,

podiatrists, chiropractors, private therapists and audiologists must all be licensed and certified to practice by the appropriate Board/ Licensing body (i.e., Board of Medical Examiners, Board of Nursing, Council on Certification of Nurse Anesthetists, Board of Podiatry Examiners, Board of Chiropractic Examiners, Board of Occupational Therapy, Board of Physical Therapy, Board of Examiners in Speech Language Pathology and Audiology).

8. For all other state agencies and organizations, including the Department of Alcohol and Other Drug Abuse, The South Carolina Department of Mental Health, The Department of Social Services, The Department of Health and Environmental Control, local education agencies, Rehabilitative Behavioral Health providers (public and private) and The Department of Disabilities and Special Needs, the MCO will credential the state agency/organization rather than the individual providers in the agency/organization. The state agency/organization is responsible for screening and exclusions for any employees utilized for service provision.
9. Absolute Total Care recognizes that some 'atypical' Provider types may not have NPI.
10. Disclosure of Ownership form is not required for submission for any ATC product.
11. Absolute Total Care shall ensure all providers are enrolled in South Carolina Medicaid.
12. Absolute Total Care requires hospital privileges or alternate admitting arrangements at an in network hospital.
13. Absolute Total Care will ensure that Nurse Practitioners are able to perform those services allowed within the parameters of the SC Nurse Practice Act (State Statute Section 40-33) by verifying NP license status, review of formal, written protocols as evidence of a collaborative/consultative relationship with a licensed physician participating in the network;
14. Contract section 2.8.2.4.2, Absolute Total Care (ATC) will completely process credentialing applications within sixty (60) calendar days of receipt of a completed credentialing application. Complete application is defined as all necessary documentation and attachments, and a verify that there is a process in place to accommodate medically necessary hospital admissions.
15. In accordance with South Carolina model MCO contract, completely process means the ATC shall review, approve, and load approved applicants to it's Provider files in it's claims processing system or deny the application and assure that the Provider is not used by ATC.

Attachment K

Michigan Health Plans (Michigan Complete Health/Meridian Complete/Meridian Health/WellCare of Michigan) Unique Requirements for Credentialing

1. All Health Plans shall ensure that all offices with laboratory services have Clinical Laboratory Improvement Act (CLIA) certificates or waivers. Certificates or waivers may be primary source verified or a copy of the certificate or waiver is acceptable.
2. To ensure practitioner has not opted-out of receiving Medicare funds the regional Medicare administrator must be queried for the applicable state in which the practitioner is providing services to Plan members.
3. If there are any substantial discrepancies noted during the credentialing process, the applicant is notified in writing or verbally by the credentialing department within thirty (30) calendar days and has thirty (30) calendar days to respond in writing regarding the discrepancies and correct any erroneous information.
4. Michigan Complete Care must have a formal process by which a health professional may submit supplemental or corrected information to the Plan's Credentialing Committee and request a reconsideration of the health professional's credentialing verification application if the health professional feels that the Plan's Credentialing Committee received information that is incorrect or misleading.
5. Upon written request to the Credentialing Department, an applicant may obtain all policies related to the credentialing and recredentialing process.
6. Completed Disclosure of Ownership form will be collected during the enrollment process and at time of recredentialing (not applicable for Medicare).
7. Michigan Health Plans accepts the minimum insurance coverage of \$100,000 per incident, \$300,000 annual aggregate.
8. Meridian MI Clean File eligibility criteria is expanded to include malpractice cases settled for no greater than \$200,000.
9. Meridian of MI recognize that those new applicants (those not currently participating in the network) who do not meet the established standards

and are declined may initiate an ‘appeal process’, this process follows the same timeline and additional investigative activity as the core language criteria in this policy, but, which is termed the ‘reconsideration process’.

10. Medicaid lines of business perform validation of Community Health Automated Medicaid Processing System (CHAMPS) prior to enrollment.
11. Meridian Michigan ensures that approved practitioner sites and their staff are scheduled for the Practitioner orientation at which time they receive their Provider Manual.
12. Providers that choose to provide Home and Community Based Services (HCBS) shall maintain certification as a Community Care Provider. All providers will show proof of this certification prior to the performance of any HCBS services. Health Plan will ensure that all providers are credentialed prior to becoming network providers and that a site visit is conducted as appropriate to all providers following recognized managed care industry standards and relevant state regulations.
13. Once provider is approved by Credentialing Committee, Providers may request a retroactive effective date which goes back to the date of receipt of a complete credentialing application.
14. Once the Credentialing Specialist verifies the credentialing application is complete, there is an approximate turnaround time of 30 to 60 calendar days for Committee approval.
15. Applicants have the right to be notified of the credentialing decision within 60 calendar days of the Credentialing Committee’s decision and re-credentialing denials within 60 days of decision date, notwithstanding this provision, credentialing timeframes and notification will not exceed timelines required by state or federal regulations.

Attachment L

Trillium/HealthNet Oregon Unique Requirements for Credentialing

1. Trillium Community Health Plan will apply for DMAP when necessary. Practitioners who have submitted a credentialing application for Medicaid participation, but have not yet been approved by Medicaid, will be allowed to go through the credentialing process. Network participation may be pended up to 120 days until the Medicaid approval has been received and confirmed. If after 120 days the provider cannot be enrolled with OHA, Contract team will terminate the contract immediately.
2. Trillium shall ensure that individuals or programs have a letter of approval or license from OHA for the Substance Use Disorders services they provide and meet all other applicable requirements of the Medicaid contract, except that Providers under The Drug Addiction Treatment Act of 2000, Title 42 Section 3502 Waiver may treat and prescribe Buprenorphine for opioid addiction in any appropriate practice setting in which they are otherwise credentialed to practice and in which such treatment would be Medically Appropriate.
3. Trillium will not refer Members to or use Providers who have been terminated from OHA or excluded as Medicare, CHIP or Medicaid Providers by CMS or who are subject to exclusion for any lawful conviction by a court for which the Provider could be excluded under 42 CFR 1001.101 and 42 CFR 455.3(b). Trillium will not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act and in accordance with 42 CFR 438.214(d). Trillium will not accept billings for services to Members provided after the date of the Provider's exclusion, conviction, or termination. If Trillium knows or has reason to know that a Provider has been convicted of a felony or misdemeanor related to a crime, or violation of federal or state laws under Medicare, Medicaid, or Title XIX (including a plea of "nolo contendere"), Trillium will immediately notify OHA's Provider Services Unit.
4. If Participating Providers (whether employees or Subcontractors) are not required to be licensed or certified by a State of Oregon board or licensing agency, Trillium will document, certify and report on Exhibit G the date that the person's education, experience, competence, and supervision are adequate to permit the person to perform his or her specific assigned duties.
 - (1) If Participating Providers are not required to be licensed or certified by a State of Oregon board or licensing agency, then, in accordance with:
Coordinated Care Organization – Amended and Restated Effective:

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(a) Participating Providers must meet the definitions for QMHA (qualified mental health associate) or QMHP (qualified mental health professional) as described in Exhibit A, Definitions and provide services under the supervision of a LMP (licensed medical practitioner) as defined in Exhibit A, Definitions; or

(b) For Participating Providers not meeting either the QMHP or QMHA definition, Trillium shall document and certify that the person's education, experience, competence, and supervision are adequate to permit the person to perform his or her specific assigned duties.

*The State of Oregon monitors the agencies and provides oversight for non-licensed behavioral health practitioners. Access to verification information is with the State of Oregon CCO Document Bank.

5. Trillium will ensure that its employees, Subcontractors and facilities are prepared to meet the special needs of Members who require accommodations because of a disability or limited English proficiency. Trillium will include in its Grievance and Appeal procedures, described in Exhibit I, a process for Grievances and Appeals concerning communication or access to Covered Services or facilities.
6. Trillium will only use psychiatric inpatient facilities and non-inpatient facilities certified by OHA under OAR 309-033-0200 through 309-033-0340
7. In addition to access and Continuity of Care standards specified in the rules cited in Subsection a, of the OHA contract section, Trillium will establish standards for access to Covered Services and Continuity of Care which are consistent with the Accessibility requirements in OAR 410-141-3515.
8. Practitioners are allowed to submit the CAQH or the Oregon Practitioner Credentialing Application and the Oregon Practitioner Recredentialing Application.
9. Trillium will screen providers for compliance with 42 CFR 455 Subpart E (42 CFR 455.410 through 42 CFR 455.470) and retain all resulting documentation for audit purposes
10. Trillium shall ensure that data received from providers, either directly or through a third party, is accurate, truthful, and complete in accordance with OAR 410-120-1280 and OAR 410-141-3565 by:
 - a. Verifying the accuracy and timeliness of data reported
 - b. Screening the data for completeness, logic, and consistency
 - c. Collecting data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for State Medicaid quality improvement and care coordination efforts in accordance with OHA Electronic Data Transmission (EDT) procedures in OAR Chapter 943 Division 120.

11. Ownership and Disclosure information to be submitted on OR Form 3974
12. Trillium/HealthNet Oregon shall and shall ensure that any Laboratories used by Contractor shall comply with the Clinical Laboratory Improvement Amendments (CLIA 1988), 42 CFR Part 493 Laboratory Requirements and ORS 438 (Clinical Laboratories, which require that all laboratory testing sites providing services under this Contract shall have either a Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number. Those Laboratories with certificates of waiver will provide only the eight types of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests.
13. Trillium/HealthNet Oregon shall provide accurate and timely information to the Authority about License or Certification expiration and renewal dates; whether a provider's license or certification is expired or not renewed or is subject to licensing termination, suspension or certification sanction.
14. Trillium/HealthNet Oregon shall not apply any requirement that an entity operated by the HIS, an Indian tribe, tribal organization or urban Indian organization be licensed or recognized under the State or local law where the entity is located to furnish health care services, if the entity meets all the applicable standards for such licensure or recognition. This requirement is pursuant to 25 USC 1621t and 1647a. Trillium/HealthNet Oregon shall not require the licensure of a health professional employed by such an entity under the State or local law where the entity is located, if the professional is licensed in another state. Contracts will be offered to all Medicaid eligible IHCPs and to provide timely access to specialty and primary care within their networks to enrolled IHS beneficiaries seen and referred by IHCPs, regardless of the IHCPs status as contracted provider within the network.
15. Each atypical provider is required to be enrolled with the Authority and shall obtain and use registered National Provider Identifiers (NPIs) and taxonomy codes reported to the Authority in the Provider Capacity Report for purposes of encounter data submission prior to submitting encounter data in connection with services by the provider. Each qualified provider is required to have and use an NPI as enumerated by the National Plan and Provider Enumeration System (NPPES).
16. The provider enrollment request (for encounter purposes) and credentialing documents require the disclosure of taxpayer identification numbers. The Authority shall use taxpayer identification numbers for the administration of this program including provider enrollment, internal verification, and administrative purposes for the medical assistance program for administration of tax laws. The Authority may use taxpayer identification numbers to confirm whether the individual or entity is subject

to exclusion from participation in the medical assistance program. Taxpayer identification number includes Employer Identification Number (EIN), Social Security Number (SSN), and Individual Tax Identification Number (ITIN) used to identify the individual or entity on the enrollment request form or disclosure statement. Disclosure of all tax identification numbers for these purposes is mandatory. Failure to submit the requested taxpayer identification numbers may result in denial of enrollment as a provider and denial of a provider number for encounter purposes or denial of continued enrollment as a provider and deactivation of all provider numbers used by the provider for encounters.

17. Trillium/HealthNet Oregon requires collection of the OMB CCCE Tracking Form for Cultural Competency Continuing Education Recordkeeping Form, this will be the responsibility of the Health Plan to submit with all provider enrollments at initial credentialing, and will be collected by the credentialing team during recredentialing (starting with those due in late 2021).
18. Trillium/HealthNet of Oregon requires recredentialing of practitioners no less than every three years calculated to the month and day of the prior credentialing approval date.

Attachment M

Arizona Complete Health/WellCare of Arizona Unique Requirements for Credentialing

1. Arizona Complete Health Medicaid ACC and RBHA Plans follow all standards and elements outlined in AMPM 950 as updated from time to time and published by AHCCCS at the following internet link:
<https://azahcccs.gov/shared/MedicalPolicyManual/>.
2. Arizona Complete Health utilizes the option of Provisional credentialing when necessary to increase the available network of providers in medically underserved areas, whether rural or urban. This also includes providers in a Federally Qualified Health Center (FQHC), FQHC Look-Alike Organization, Rural Health Clinic (RHC) and hospital employed physicians (when appropriate). Providers needed in medically underserved areas, providers joining an existing and contracted oral health provider group, and providers eligible under the SAMHSA Certified Opioid Treatment Program, and providers as directed by AHCCCS during a federal and/or state declared emergency. A decision regarding provisional credentialing is rendered within 14 calendar days from receipt of complete application.
3. Arizona Complete Health will include the name of the Supervising Physician for Physician Assistants in the Committee review materials.
4. Arizona Complete Health will report adverse credentialing actions to the AHCCCS Clinical Quality Management Unit within one business day.
5. Arizona Complete Health requires a review of malpractice history for a ten (10) year look back period from the date of presentation to committee for approval.
6. Arizona Complete Health will ensure 95% of practitioners/providers are loaded into the claims system within thirty (30) calendar days of Credentialing Committee approval. Effective dates are assigned based upon the date the provider joined the group or the contract effective date, whichever is later. Regardless of effective date, the provider will not appear active in the provider directory until approved by the Credentialing Committee.
7. Arizona Complete Health requires notification within ten (10) days of Credentialing Committee decision based on AMPM 950 for Medicaid and seven(7) days based on ARS Title 20.3453 for Ambetter.

8. Arizona Complete Health will conduct timely verification of information, as evidenced by approval (or denial) of a provider within 60 days of receipt of a complete application.
9. Disclosure of Ownership is not required for submission for Arizona

Attachment N

PA Health & Wellness Unique Requirements for Credentialing

1. PA Health & Wellness will initially submit Credentialing Policies & procedures to Pennsylvania Department of Health for approval and changes shall be submitted for approval before implementation.
2. PA Health & Wellness will submit a report at least two (2) years regarding its credentialing process to include:
 - a. The number of applications made to the plan
 - b. The number of applications approved by the Plan
 - c. The number of applications rejected by the Plan
 - d. The number of providers terminated for reasons of quality
3. PA Health & Wellness reviews applications for the MAID number issued by Department of Human Services, however will not delay processing of Provider applications which do not contain the MAID number. Network participation will be pended until the Medicaid approval has been received and confirmed.
4. PA Health & Wellness does not require DOO submission with enrollment or at time of recredentialing
5. PA Health & Wellness will ensure that mid-level practitioners functioning as part of the PCP team are doing so within the scope of his or her license via collection and review of the collaborative agreement, protocols or other written authorization.
6. When an adverse credentialing decision is rendered, PA Health & Wellness will provide written notice which will include a clear and complete explanation of the rationale and factual basis for the determination. The notice shall include any utilization profiles used as a basis for the decision and explain the methodology for adjusting profiles for non-clinical management factors.
7. PA Health & Wellness Clean File eligibility criteria is expanded to include a defined threshold for applicants with previous history of limitation of licensure, malpractice claims, or privilege actions based upon an expanded level of review and determination by the Medical Director.

Standard:

No past or present suspensions or limitations of state licensure within a five (5) year look back period.

Expanded:

Past restrictions which have been lifted and were not related to alleged moral turpitude violations

Voluntary surrender of license or privileges not due to avoidance of an investigation

Medical Board reprimand(s) involving resolved fines and penalties due to CMEs (Continuing

Medical Education) can be resolved at the Medical Director's level regardless of the time frame. The Medical Director can forward case(s) to the Credentialing Committee if the Medical Director desires.

Medical Board reprimand(s) involving resolved fines and penalties due to documentation and/or records can be resolved at the Medical Director's level, if events took place over 5 years ago.

The Medical Director can forward case(s) to the Credentialing Committee if the Medical Director desires.

Standard:

No malpractice claims that resulted in a settlement or a verdict in favor of the plaintiff (claims ruled in favor of the defendant are acceptable for a clean file) in a five (5) year look back period¹⁴¹ from date of settlement.

Expanded:

Less than or equal to four (4) unrelated cases for initial applications; less than or equal to two (2) unrelated cases for recredentialing applications.

Death or complication with indirect provider involvement.

Less than \$2 Million per case or \$5 Million total payment or settlement

Complication common to procedure or treatment not directly due to malpractice

Standard:

No current hospital membership or privilege restrictions and no history of hospital membership or privilege restrictions within a five (5) year look back period;

Expanded:

Resolved investigations at a facility that occurred over five years. Clinical privileges must have been restored. Medical Director can forward to the Credentialing Committee if deemed necessary

No additional actions or involvement occurring within the past 5 years for initial applicants and 3 years for recredentialing applicants.

Standard:

No history of or current use of illegal drugs or alcoholism

Expanded:

When the substance abuse treatment is beyond 5 years for initial applications and 3 years for recredentialing applications

Standard:

No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field.

Expanded:

Health issues not limiting full scope of practice or access to services for Health Plan or a customer/client.

Standard:

No criminal/felony convictions, including a plea of no contest

Expanded:

Civil or Criminal Convictions (Misdemeanor) not related to violations of moral turpitude.

Attachment O

Nebraska Total Care Unique Requirements for Credentialing

1. Nebraska Total Care Health Plan shall ensure that credentialing of all service providers applying for network provider status shall be completed within 30 days; from the-time when all necessary credentialing materials have been received. Completion time ends when written communication is mailed or faxed to the provider notifying them of the Credentialing Committee's decision.
2. Nebraska Total Care will review, approve, and load approved providers to its provider files in its system and submit the information in the weekly electronic provider file to MLTC or MLTC's designee, or deny the application and ensure that the provider is not included in the Nebraska Total Care network. A provider whose application is denied must receive written notification of the decision, with a description of his/her/its appeal rights.
3. Nebraska Total Care will accept provider credentialing information submitted via the Council for Affordable Quality Healthcare system. Nebraska Total Care will also accept any standardized provider credentialing form and/or process for applicable providers within 60 calendar days of its development and/or approval by the administrative simplification committee and MLTC.
4. A provider whose credentialing/re-credentialing application is denied will receive written notification of the decision, with a description of his/her/its appeal rights.
5. Nebraska Total Care shall ensure that all clinical laboratories provide verification of CLIA licensure (including the CLIA identification number) or Certificate of Waiver and is a minimum administrative requirement for participation in the network.
6. Nebraska Total Care will confirm the provider has a valid Medicaid Identification number. Acceptable source for confirmation shall follow MLTC requirements. Providers who have submitted an application as a Medicaid provider but have not yet been approved will be allowed to go through the credentialing process and, if necessary, network participation may be pended until the Medicaid provider application is

approved or denied. Once approved, confirmation that a valid Identification number has been issued is performed and the network status may change from pending to participating.

7. Nebraska Total Care accepts the State minimum insurance limits of \$500,000 per occurrence and \$1,000,000 aggregate per policy period. For hospitals the required limits are \$500,000 per incident and \$3,000,000 aggregate per policy period. The Nebraska Excess Liability Fund then provides coverage for any damages exceeding those amounts but falling below the applicable damage cap.
8. Nebraska Total Care recognizes the licensure for Provisional Licensed Mental Health Practitioners (PLMHP) and Provisional Licensed Alcohol and Drug Abuse Counselors (PLADC) as active and unrestricted.

Attachment P

Maryland Physicians Care (MPC) Unique Requirements for Credentialing

1. For Maryland Physicians Care, Centene Health Plan refers to management services provided by Envolve, Inc
2. Practitioner credentialing and recredentialing files are maintained by the Envolve/Centene Credentialing Department and are made available upon request to the Maryland Physicians Care Quality Management Oversight Committee, accreditation agencies, state regulators, CMS and/or an External Quality Review Organization (EQRO) and to the extent required by law as determined by the appropriate regional general counsel. The Envolve/Centene Credentialing Department is responsible for monitoring the activities performed by the MPC Credentialing Committee and preparing summary reports of credentialing and recredentialing decisions for the MPC Quality Management Oversight Committee and MPC Board of Directors.
3. Maryland Physicians Care does not include Physician Assistants in their credentialing program. This mid-level practitioner type must be under the direct supervision of a physician and is not eligible for independent practice.
4. Maryland Physicians Care does not utilize the provisional credentialing option.
5. Practitioners who are denied initial participation for Maryland Physicians Care may reapply for admission into the network at any time following the initial denial.
6. Maryland Physicians Care requires a copy of the DEA certificate, and does not accept a DEA Coverage Plan in lieu of this requirement.
7. Maryland Physicians Care accepts the Maryland Uniform Credentialing form or CAQH. MPC accepts the Maryland Uniform Credentialing form or CAQH. Plan Contracting will return incomplete applications to provider at the address listed on the application within ten (10) days after the date application was received, and will indicate to provider what information is needed to make application complete. Within thirty (30) days of receipt of completed application, MPC shall send to the provider at the address listed in the application written

- notice of MPC's intent to continue to process the Provider's application to obtain necessary credentialing information or rejection of the provider for participation in the MPC provider panel. If MPC provides notice to the provider of its intent to continue to process the provider's application, MPC, within 120 days after the date notice is provided, shall: accept or reject the provider for participation; or send written notice of the acceptance or rejection to the provider at the address on the application. MPC will track the date of the application so that dates of credentialing can be calculated.
8. Maryland Physicians Care conducts an initial site visit of primary care practitioners, and primary care obstetricians to ensure that the practitioners' offices and medical record keeping practices meet MPC standards and compliance with the ADA. Site audits are performed for practitioners with a new location and/or not part of an existing group.
 9. Maryland Physicians Care conducts a re-assessment of Provider Site for ADA compliance when the provider has relocated to a site that has not been previously evaluated and approved as being ADA compliant, or there is evidence of ADA non-compliance issues with a particular site of care delivery. Documentation of performance indicators provided by the Quality team to the Credentialing team for recredentialing review includes a notation regarding the results of the review for ADA compliance.
 10. Maryland Physicians Care requires verification of the MD CDS, if applicable. A current copy of the certificate is considered a valid source and meeting the requirement.
 11. Maryland Physicians Care will include a review of EPSDT certification as part of the credentialing and recredentialing process for those PCPs who deliver preventive health care services to enrollees less than 21 years of age.
 12. For Maryland Physicians Care if missing or expired information can not be secured within 21 calendar days of the first outreach attempt for initial credentialing but the Letter of Intent has gone out the application will proceed through the credentialing process as an Unclean File.
 13. MPC Credentialing Committee determinations for Unclean Files are presented to the MPC Board of Directors who hold the authority for making final determinations

14. Maryland Physicians Care Clean File eligibility criteria is expanded to include malpractice claims with settlement amount under \$49,999.99.
15. Files with History of Malpractice claims settled for over \$50,000.00, within ten (10) year lookback period, which have been and all Open, Pending and Discovery Claims are designated as unclean and require review by Maryland Physicians Care Credentialing Committee and Board of Directors.
16. Maryland Physicians Care letter of denial includes reason and right to view and/or correct for currently participating providers only.
17. Request for reconsideration of non-administrative denials by new (non-participating) practitioners is not applicable to Maryland Physicians Care.
18. If a practitioner's credentials are terminated Maryland Physicians Care notifies appropriate regulatory boards or agencies. If appropriate, law enforcement is also notified.

Attachment Q

Nevada Silver Summit Unique Requirements for Credentialing

1. Nevada SilverSummit shall ensure all providers are enrolled in Nevada Medicaid (this does not preclude the option to enter into a single case agreement with non-Medicaid providers if needed).
2. If Nevada Silver Summit decredentials, terminates or disenrolls a provider, Nevada Silver Summit will inform DHCFP Provider Enrollment Unit within five (5) business days.
3. Nevada SilverSummit shall ensure that all laboratory testing sites providing services under this contract have a valid Clinical Laboratory Improvement Amendments (CLIA) certificate or a waiver of certificate of registration, a CLIA identification number, and comply with CLIA regulations as specified by 42 CFR Part 493. Nevada SilverSummit shall provide to the DHCFP, on request, copies of certificates of any laboratories with which it conducts business.
4. Nevada SilverSummit recognizes the following additional provider licensure types as QMHPs:
 - a. Licensed Clinical Social Worker (LCSW) Interns meet the requirements under a program of internship and are licensed as an intern pursuant to the State of Nevada, Board of Examiners for Social Workers (Nevada Administrative Code (NAC) 641B).
 - b. Licensed Marriage and Family Therapist (LMFT) and Licensed Clinical Professional Counselor Interns who meet the requirements under a program of internship and are licensed as an intern pursuant to the State of Nevada Board of Examiners for Marriage and Family Therapists and Clinical Professional Counselors.
 - c. Psychological Assistants who hold a doctorate degree in psychology, is registered with the State of Nevada Board of Psychological Examiners (NAC 641.151) and is an applicant for licensure as a Licensed Clinical Psychologist who has not yet completed the required supervised postdoctoral experience approved by the Board.
Reimbursement for Interns/Psychological Assistants is based upon the rate of a QMHP, which includes the clinical and direct supervision of services by a licensed supervisor.

5. Nevada SilverSummit will have written policies and procedures that include a uniform documented process for credentialing, which include the vendor's initial credentialing of practitioners, as well as its subsequent recredentialing, recertifying and/or reappointment of practitioners. Nevada SilverSummit will comply with NAC 679B.0405 which requires the use of Form NDOI-901 for use in credentialing providers. The DHCFP reserves the right to request and inspect the credentialing process and supporting documentation. Nevada SilverSummit agrees to allow the DHCFP and/or its contracted EQRO to inspect its credentialing process and supporting documentation.
6. Nevada SilverSummit may not employ or contract with providers excluded from participation in the federal health care programs under Section 1128 of the Social Security Act.
7. Nevada SilverSummit retains the right to approve new practitioners and sites, and to terminate or suspend individual practitioners. Nevada SilverSummit has policies and procedures for the suspension, reduction or termination of practitioner privileges
8. Changes to the credentialing process will need to be provided in writing to the DHCFP's Provider Enrollment unit thirty (30) calendar days prior to the change. If the change is unanticipated, the vendor will notify the DHCFP's Provider Enrollment unit within five (5) calendar days of the change.
9. All credentialing policies will be reviewed and approved by the Governing Body or their delegate.

Attachment R

Arkansas Health and Wellness (AHW)/Arkansas Total Care/WellCare of Arkansas Unique Requirements for Credentialing Pursuant to ACA §17-95-107 and ACA §17-95-210

1. Primary Source Verification

Arkansas state law requires that Primary Source Verification credentialing information for MD/DOs -be requested from the Arkansas State Medical Board's Centralized Credentials Verification Service (CCVS). Information acquired from CCVS may not be requested of the physician by Arkansas Credentialing. The CCVS Authorization and Release Form and the attestation form is faxed to the CCVS which will initiate primary source verifications. CCVS has 15 days to provide an initial profile, the Arkansas credentialing team has 60 days to complete credentialing.

When CCVS completes verification on a practitioner, an email is generated by CCVS to advise the Credentialing Specialist that the report is available on the Arkansas State Medical Board website. The credentialing/recredentialing report from the Arkansas State Medical Board Centralized Credentials Verification Service is printed and will be maintained in the credentialing file for MDs and DOs. Initial credentialing reports should verify the following information:

- a. Current Arkansas state medical license
- b. Current DEA certificate
- c. Current malpractice insurance with minimum limits of \$1 million/\$3 million
- d. Current clinical privileges in a participating network facility or documentation that such is not needed for practice.
- e. Verification of education (medical school, residency, fellowship)
- f. Work history from completion of the highest level of medical education with no unexplainable gaps of thirty (30) days or more. A written explanation of any work gap over thirty (30) days is provided by the Arkansas State Medical Board.
- g. Medicare and Medicaid verification, if applicable.
- h. Verification of board certification, if applicable
- i. Criminal conviction information
- j. Attestation signed and dated by applicant with questions regarding any physical or mental condition, illegal drug use, history of loss of license or DEA certificate, misdemeanor or felony charges or convictions, and privileges at hospitals or healthcare organizations

2. Processing of Credentialing Applications/Documents

Arkansas plans utilize the credentialing team to secure applications and associated documents, as well as verifying all requested documentation. The PDM team updates Portico with information after credentialing is completed.

3. Disclosure of Ownership/Interest Forms

Disclosure of Ownership/Interest forms are required for practitioners providing services for all product lines associated with the Arkansas Total Care Health Plans. This form is not required for WellCare of Arkansas Medicare Health Plan.

4. Primary Source Verification for Recredentialing

Recredentialing files are pended until receipt of the CCVS report. The CCVS recredentialing report verifies all the elements of the initial credentialing report with the exception of education. Recredentialing reports will be printed and maintained in the provider file. CCVS has a thirty (30) day window in which recredentialing information may be requested.

5. Delegation to Cenpatico

Arkansas plans access the NovaSys Health provider network. NovaSys Health does not delegate credentialing or re-credentialing of behavioral health practitioners and providers to Cenpatico. NovaSys Health is responsible for this process for all behavioral health practitioners and providers.

6. Provider Notification Requirements

The following notices must be sent to Practitioners within designated timeframes:

- Acknowledgement of application within 10 days of receipt
- Notice of incomplete application within 15 days of receipt
- Notice within 90 days to submit recredentialing application
- Notification of termination within 45 days which includes reason for termination

7. Allied Credentialing

Initial Allied credentialing applications must be completed within 180 days of receipt. All other steps follow regular procedure. Allied practitioners includes, but is not limited to the following:

- Doctor of Chiropractic
- Doctor of Podiatry Medicine
- Doctor of Dental Surgery specializing in Maxillofacial
- Licensed Certified Social Worker
- Licensed Professional Counselor
- Doctor of Philosophy (Ph.D.)

- Doctor of Education (Ed.D.)
- Doctor of Optometry
- Nurse Practitioner

8. Cases of Information Variance

In cases where information obtained from CCVS varies from information provided by the practitioner, Credentialing contacts the applicant by phone, e-mail and/or letter to alert the applicant to the variance. It should be clearly communicated to the applicant that all updated information must be submitted to CCVS and not the Arkansas Credentialing team. After the requested information is submitted to CCVS, a new profile will be available to the Arkansas Credentialing team.

Arkansas will submit credentialing information in its possession to the board in order to complete the primary source verification procedure, upon the board's request and upon the boards providing proof that the physician has authorized the release of the information.

9. Arkansas Prescription Monitoring Program

In order to encourage legitimate use; help curtail misuse and abuse; and assist in combating illegal trade in and diversion of controlled substances, an enrolled Arkansas practitioner that holds an active DEA certificate and licensure issued to provide healthcare services in Arkansas must attest that they are enrolled in the Arkansas Prescription Monitoring Program ("AR PMP"). The enrolled consents to the Arkansas Department of Health confirming enrollment in AR PMP to Arkansas.

10. Conditional Credentialing Approval

If it is determined a practitioner has an active license and is allowed to practice, but has certain stipulations that must be met within a specific timeframe, the credentialing committee can approve credentialing for a period shorter than the standard 36 months. The practitioner would then be required to recredential at the end of that credentialing period to determine if all stipulations have been met.

11. Other Arkansas Specific Requirements

- a. Arkansas Credentialing does not charge fees as part of the credentialing of practitioners or providers.
- b. Telemedicine practitioners are credentialed using the same process referenced in this policy.
- c. Arkansas Credentialing uses information received from CCVS for credentialing of practitioners only. This information is not used for any

other purpose or shared with any other organization outside of Centene Corporation.

Attachment S

Western Sky Community Care, Inc (New Mexico); and Ambetter from Western Sky Community Care Unique Requirements for Credentialing

1. Because practitioners may participate in multiple products (Medicare, Medicaid, Exchange/Marketplace, Commercial), the unique requirements for Western Sky Community Care, Inc (New Mexico) and Ambetter from Western Sky Community Care are the same except where noted as product specific requirements.
2. Western Sky Community Care, Inc. will participate and collaborate with any statewide initiatives to standardize the credentialing/re-credentialing process, including the usage of one entity for primary source verification and collection and storage of provider credentialing/re-credentialing application information.
3. Western Sky Community Care, Inc (New Mexico) requires Contract providers within the Medicaid product to be enrolled with New Mexico Medicaid as a managed care provider.
4. Western Sky Community Care will ensure that for Behavioral Health Providers, the provider specific contract information entered into the claims system must recognize the provider as a network provider with accuracy sufficient to pay claims no later than fifteen (15) calendar days after a provider is credentialed.
5. The credentialing verification plan shall include a process to assess and verify the qualifications of providers applying to become participating providers within 45 calendar days (30 days for Behavioral Health providers) of receipt of a provider's request for credentialing or a provider's completed uniform credentialing form, whichever is earlier. The plan shall allow for the following to take place within this 45 (30 for BH) calendar days:
 - (a) time required to obtain the completed uniform credentialing form in electronic format, if necessary;
 - (b) time to request and obtain primary source verifications and other information that must be obtained from third parties in order to authenticate the applicant's credentials;
 - (c) a final decision by a credentialing committee if the health carrier's plan requires such review; and
 - (d) time to notify the provider of the health carrier's decision.

6. Western Sky Community Care, Inc shall not use any provider credentialing application form other than uniform credentialing forms, as that term is defined in 13.10.28.7 NMAC. Exceptions are made if the provider is licensed and practices in a state other than New Mexico. Western Sky Community Care, Inc shall not require an applicant to submit information not required by the uniform credentialing or re-credentialing forms other than information or documentation that is reasonably related to information on the application.
7. Upon receiving a provider's request for credentialing or a provider's completed credentialing form, Western Sky Community Care, Inc and/or our agent shall review the application to verify that the application includes all necessary information and documentation that is reasonably related to the information in the application. We may initially attempt to obtain additional or missing information by informal means including but not limited to fax, telephone, or e-mail.
8. Western Sky Community Care, Inc and/or our agent shall notify the applicant by US certified mail within 10 days of receipt that the request for credentialing has been received, but that if the application is incomplete that the 45-day time period set forth in Subsection C of 13.10.28.11 NMAC shall not commence until the applicant provides all requested information or documentation. Except as may otherwise be required by a health carrier's accreditation organization a health carrier may not require a participating provider to be re-credentialed based on: a change in the provider's federal tax identification number; a change in the federal tax identification number of a provider's employer; or a change in the provider's employer, if the new employer: is a participating provider; or also employs other participating providers.
9. Reporting requirements. Each health carrier shall submit a report to the superintendent regarding its credentialing process for the prior two-year period beginning December 31, 2018, and on December 31 for all even numbered years thereafter, or as otherwise directed by the superintendent. The report shall include the following:
 - the number of applications made to the plan for each type of provider;
 - the number of applications approved by the plan for each type of provider;
 - the number of applications rejected by the plan for each type of provider;
 - the number of providers terminated for reasons of quality; and
 - the amount of time taken to review and reach a determination on an application.

10. A copy of the Western Sky Community Care, Inc Credentialing verification plan (policies) will be provided to the Regulator - NM Office of Superintendent of Insurance upon request.
11. No contract between Western Sky Community Care, Inc and a participating provider shall include a clause that has the effect of relieving either party of liability for its actions or inactions.
12. Western Sky Community Care, Inc shall reimburse a provider, subject to co-payments, co-insurance, deductibles, or other cost-sharing provisions, for any clean claims for covered services, provided that:
 - the date of service is more than 45 calendar days after the date the provider requested credentialing from the health carrier and either the provider supplied a completed uniform credentialing application or made the completed uniform credentialing application available for electronic access, including submission of any supporting documentation requested in writing during the initial 10-day review period;
 - has approved, or has failed to approve or deny the applicant's completed uniform credentialing application within the timeframe established pursuant to Subsection C of 13.10.28.11 NMAC;
 - the provider has no past or current license sanctions or limitations, as reported by the New Mexico medical board or another pertinent licensing and regulatory agency, or by a similar out-of-state licensing and regulatory entity for a provider licensed in another state; and
 - the provider has professional liability insurance or is covered under the Medical Malpractice Act.

Sole practitioner. A provider who, at the time services were rendered has been approved for credentialing or who has been awaiting a credentialing decision pursuant to Subsection C of 13.10.28.11 NMAC and was not in a practice or group that has contracted to provide services at specified rates of reimbursement, shall be paid in accordance with the standard reimbursement rate or at an agreed upon rate.

Provider group reimbursement. A provider who, at the time services were rendered, has been approved for credentialing or who has been awaiting a credentialing decision pursuant to Subsection C of 13.10.28.11 NMAC and was in a provider group that has contracted to provide services at specified rates of reimbursement, shall be paid in accordance with the terms of the provider group contract.

Reimbursement period. Western Sky Community Care, Inc shall reimburse a provider pursuant to Subsections A, B, and C of 13.10.28.12 NMAC until the earlier of the following occurs: denial of the provider's credentialing application; approval of the provider's credentialing application and the provider enters a contract to replace a previously agreed upon rate, or the passage of three years from the date of receipt of the provider's completed uniform credentialing application.

13. **Credentialing and Payment Dispute Resolution Internal review process.**

Western Sky Community, Inc will establish an internal process for resolving disputes regarding payment of claims for providers arising when a credentialing decision is delayed beyond the timeline found in Subsection C of 13.10.28.11 NMAC, the prompt payment deadline described in Paragraph (2) of Subsection A of 13.10.28.9 NMAC has passed, and payment has not been made. The internal process shall include required notification regarding pending claims and calculation and payment of interest on overdue claims, as described in Subsections C and D of 13.10.28.9 NMAC. The internal process shall provide for resolution of disputes regarding reimbursement rates as described in 13.10.28.12 NMAC. At a minimum, the internal review process shall provide for the following:

To initiate a payment dispute, the provider shall contact Western Sky Community Care, Inc in writing to determine the status of a claim, to ensure that sufficient documentation supporting the claim has been provided, and to determine whether the claim is considered to be a clean claim.

Western Sky Community Care, Inc shall respond in writing to a provider's inquiry regarding the status of an unpaid claim within 15 days of receiving the inquiry. The response shall explain its failure or refusal to pay, and the expected date of payment if payment is pending.

The internal review process may provide specific procedures for resolving payment disputes, including by not limited to, the use of mediation.

Attachment T

Carolina Complete Health, Inc.(Medicaid)/WellCare of North Carolina (Medicaid) Unique Requirements for Credentialing

1. Carolina Complete Health, Inc. accepts only the North Carolina DOI's 'Uniform Application to Participate as a Health Care Practitioner' and does not require an applicant to submit information not required by the application. This is in accordance with North Carolina General Statute 58-3-230.
2. Application processing timelines.
 - a. **Complete App at time of Receipt:** (b) Within 60 days after receipt of a completed application and all supporting documents, the carrier shall assess and verify the applicant's qualifications and notify the applicant of its decision. If, by the 60th day after receipt of the application, the carrier has not received all of the information or verifications it requires from third parties, or date sensitive information has expired, the carrier shall issue a written notification to the applicant either closing the application and detailing the carrier's attempts to obtain the information or verification, or pending the application and detailing the carrier's attempts to obtain the information or verifications. If the application is held, the carrier shall inform the applicant of the length of time the application will be pending. The notification shall include the name, address and phone number of a credentialing staff person who will serve as a contact person for the applicant.
 - b. **Incomplete App at time of Receipt:** (c) Within 15 days after receipt of an incomplete application, the carrier shall notify the applicant in writing of all missing or incomplete information or supporting documents, in accordance with the following procedures: (1) The notice to the applicant shall include a complete and detailed description of all of the missing or incomplete information or documents that must be submitted in order for review of the application to continue. The notification shall include the name, address, and telephone number of a credentialing staff person who will serve as a contact person for the applicant. (2) Within 60 days after receipt of all of the missing or incomplete information or documents, the carrier shall assess and verify the applicant's qualifications and notify the applicant of its decision, in accordance with paragraph (b) of this rule. (3) If the missing information or documents have not

been received within 60 days after initial receipt of the application or if date-sensitive information has expired, the carrier shall close the application or delay final review, pending receipt of the necessary information. The carrier shall provide written notification to the applicant of the closed or pending status of the application and where applicable, the length of time the application will be pending. The notification shall include the name, address, and telephone number of a credentialing staff person who will serve as a contact person to the applicant.

3. Nurse Practitioners and Physician Assistants must provide a copy of their physician collaborative agreement.
4. ix. Without waiving any sovereign immunities, and to the extent permitted by law, including the NC Tort Claims Act, and subject to Section III.D.5. Availability of Funds, DHHS shall indemnify, defend, and hold harmless the PHP, its officers, agents, and employees from liability of any kind, including but not limited to claims and losses accruing or resulting to any other person, firm, or corporation that may be injured or damaged, arising out of or resulting from incomplete and/or inaccurate credentialing information provided to the PHP by the Department or its Provider Data Contract, Contract Verification Organization, or other Department vendor providing such information to the PHP and relied upon by the PHP in credentialing a provider for participation in the PHP's network. The obligations set forth in the preceding sentence shall survive termination or expiration of the Contract. The PHP shall have the option to participate at its own expense in the defense of such claims or actions filed and the PHP shall be responsible for its own litigation expenses if it exercises this option. In no event shall the PHP be deemed to be in breach of this Contract as a result of it having relied and/or acted upon the credentialing information provided to it by DHHS. The PHP shall have no liability to DHHS in respect to any act or omission arising under, resulting from, or relating to the PHP's use of and reliance on such credentialing information.

Attachment U

Illinois Medicaid Health Plans (Meridian Health and Meridian Complete) Unique Requirements for Credentialing

1. In accordance with IL MCO Model Contract Article 5.9 Uniform Provider Credentialing and Recredentialing, provider enrollment in the Illinois Medicaid Program Advanced Cloud Technology (IMPACT) system constitutes Illinois' Medicaid managed care uniform credentialing and re-credentialing process. To participate in the Illinois Medicaid Health Plan provider network, verification that provider is enrolled in IMPACT will occur prior to submission for enrollment into the system. As stated in Contract item 5.9.4, Illinois Medicaid Health Plan is prohibited from requiring providers to undergo additional credentialing processes that are not part of the contract.
2. Contractor shall ensure that only those Providers that are approved and authorized by the Department are providing Covered Services under HCBS Waivers, and that those Providers are providing to Enrollees only Covered Services for which they are approved and authorized. The Department will provide Contractor with a weekly Department extract file containing the list of such approved and authorized Providers.
3. In accordance with IL MCO Model Contract Article 5.9 Uniform Provider Credentialing and Recredentialing, Illinois Medicaid Health Plans do not have a Credentialing Committee.

Attachment V
Iowa Total Care
Unique Requirements for Credentialing

1. Iowa Total Care (ITC) shall submit provider network information via electronic file to the Department of Human Services (DHS) in the timeframe and manner defined by DHS. ITC shall keep provider enrollment and disenrollment information up-to-date.
2. The Provider Credentialing Report details the timeliness and effectiveness of the provider credentialing processes, including but not limited to credentialing committee and onsite provider reviews. Credentialing of all providers applying for network provider status shall be completed as follows: (i) eighty-five percent (85%) within thirty (30) calendar days; and (ii) ninety-eight percent (98%) within forty-five (45) calendar days. The start time begins when Iowa Total Care has received all necessary credentialing materials from the provider. If a request for additional materials, not already submitted by the provider, as a result of committee review, the time shall not be measured while waiting for the requested materials. Completion time ends when written communication is mailed or faxed to the provider notifying them of the credentialing decision.
3. Credentialing and re-credentialing process for all contracted providers shall meet the guidelines and standards of the accrediting entity through which ITC attains accreditation and in compliance with 441 Iowa Administrative Code Chapter 88 as well as all State and Federal rules and regulations.
4. When individuals providing covered services under the Contract are not required to be licensed or certified, ITC shall ensure, based on applicable state licensure rules and/or program standards, that they are appropriately educated, trained, qualified and competent to perform their job responsibilities.
5. ITC shall not permit the provider into the provider network if the Agency or Contractor determines that any person who has ownership or control interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or CHIP, or if DHS or ITC determine that the provider did not fully and accurately make any disclosure required pursuant to 42 C.F.R. § 1001.1001(a)(1).

6. For monitoring of Disclosure of Ownership forms, ITC follows process outlined in CC.COMP.27

Attachment W
Ambetter of Tennessee/WellCare of Tennessee
Unique Requirements for Credentialing

1. Ambetter of Tennessee shall accept, in addition to its own credentialing and recredentialing applications, the credentialing and recredentialing applications from the Council on Affordable Quality Healthcare (CAQH). Ambetter is a participating organization of CAQH, and shall accept the application from either CAQH by electronic means or from the provider by electronic means or by a paper copy. The provider shall complete and submit the attestation clause of Ambetter of Tennessee before an application is considered complete.
2. Ambetter of Tennessee shall notify the health care provider of the results of the provider's clean CAQH credentialing application and shall notify the health care provider as to whether or not the health insurance entity is willing to contract with that provider within ninety (90) calendar days after receipt of the completed application (this notification is provided by the Contracting Department).
3. A clean CAQH application means an application that has no defect, misstatement of facts, improprieties, including a lack of any required substantiating documentation, or particular circumstance requiring special treatment that impedes prompt credentialing.
4. Ambetter of Tennessee shall provide to any medical group practice with which there is an existing contract a list of all information and supporting documentation required for a credentialing application of a new provider applicant to be considered complete pursuant to subsection (f) of the Tenn Code Ann. 56-7-1001. **(A)** Ambetter Contracting Department will notify a new provider applicant in writing of the status of a credentialing application no later than five (5) business days of receipt of the application. The notice shall indicate if the application is complete or incomplete, and, if the application is incomplete, the notice shall indicate the information or documentation that is needed to complete the application. **(B)** If the application is incomplete and the new provider applicant submits additional information or documentation to complete the application, Ambetter shall comply with the requirements of subdivision (f)(2)(A) upon receipt of the additional information or documentation. **(C)** Ambetter shall notify a new provider applicant of the results of the new provider applicant's credentialing application within ninety (90) calendar days after notification from the Ambetter Contracting Department that the application is complete. **(D)** If a new provider applicant fails to submit a complete credentialing application to Ambetter within thirty (30) calendar days of notice of an incomplete application, then the application is deemed incomplete and

- credentialing is discontinued. If a new provider applicant fails to submit a complete network participation enrollment form, including signature evidencing intent to participate with the group and any other required documentation, to Ambetter within thirty (30) calendar days of notice of an incomplete application, then the new provider applicant is ineligible to receive the payment set out in (f)(3)(A).
5. Ambetter of Tennessee shall not deny reimbursement to or prevent a physician licensed pursuant to title 63, chapter 6 or 9 from participating in any of the insurance entity's provider networks based solely on a physician's decision not to participate in any form of maintenance of licensure or maintenance of certification, including basing a physician's network participation on any form of maintenance of licensure tied to maintenance of certification.
 6. Ambetter of Tennessee shall not discriminate with respect to reimbursement levels based solely on a physician's decision not to participate in any form of maintenance of licensure or maintenance of certification, including basing a physician's reimbursement level on any form of maintenance of licensure tied to maintenance of certification.

Attachment X
Ambetter of Virginia
Unique Requirements for Credentialing

1. None

Attachment Y
MHS Health Wisconsin
Unique Requirements for Credentialing

1. MHS Health Wisconsin requires credentialing for locum tenens
2. MHS Health Wisconsin does not utilize the provisional credentialing option
3. MHS Health Wisconsin will accept and utilize CAQH or the Wisconsin Universal Application to process credentialing for all practitioners that require credentialing
4. MHS Health Wisconsin follows NCQA guidelines – Completed provider applications must be signed and dated not more than 180 calendar days prior to enrollment.
5. MHS Health Wisconsin Ownership and Disclosure information is not required when providers are Wisconsin Medicaid enrolled as outlined in WI policy WI.CRED.19
6. MHS Health Wisconsin adds queries only for surrounding states, IA, IL, MI and MN
7. MHS Health Wisconsin does not perform provisional credentialing
8. MHS Health Wisconsin requires a copy of the DEA certificate, and does not accept a DEA Coverage Plan in lieu of this requirement
9. MHS Health Wisconsin requires primary source verification of hospital privileges at the practitioner’s primary admitting hospital as indicated on the application

10. MHS Health Wisconsin requires clarification in writing for gaps exceeding six (6) months

11. MHS Health Wisconsin Ownership and Disclosure information is not required when providers are Wisconsin Medicaid enrolled as outlined in WI policy WI.CRED.19

12. MHS Health Wisconsin primary source verification criteria is expanded to include malpractice claims with settlement amounts under \$250,000 and any claim resulting in a death

13. MHS Health Wisconsin applicants must be notified of the Credentialing Committee decision on an initial and re-credentialing application within thirty (30) calendar days. The notice shall include the committee decision and the decision date

Attachment Z
Ascension Joint Venture
Unique Requirements for Credentialing

1. Follow Unique Requirements of the applicable state Health Plan if listed in other attachments.

Attachment AA
HealthSmart Complete
Unique Requirements for Credentialing

1. Follow Unique Requirements of the applicable state Health Plan if listed in other attachments.

Attachment BB
Oklahoma Complete Health, Inc.
Unique Requirements for Credentialing

1. Practitioner credentialing and recredentialing is based on criteria established by OHCA or the State, in accordance with 42 C.F.R. §§ 438.12(a)(2) and 42 C.F.R. 438.214(e). This shall include all requirements included in the MCO Contract and any amendments thereto, along with all other OHCA guidance on Participating Provider selection along with any applicable state law during the term of the Model Contract, including criteria provided in the uniform credentialing application required by Section 1-106.2 of Title 63 of the Oklahoma Statutes.
2. Physicians or other health care providers under consideration to provide health care services for Oklahoma Complete Health shall apply for credentialing and recredentialing on the uniform credentialing application and provide the documentation as outlined by the plan's checklist of materials required in the application process.
3. Oklahoma Complete Health shall ensure all applications are credentialed within forty-five (45) calendar days of receipt of a complete application which meets clean file criteria. Once an application is deemed complete, requests for primary source verification and malpractice history will be initiated within seven (7) calendar days. . Definition of a complete application means an application that has no defect, misstatement of facts, improprieties, including a lack of any required substantiating documentation, or particular circumstance requiring special treatment that impedes prompt credentialing. If plan is unable to credential or recredential a physician or other health care provider due to an application's not being clean, plan may extend the credentialing or recredentialing process for sixty (60) calendar days. At the end of sixty (60) calendar days, if the plan is awaiting documentation to complete the application, the physician or other health care provider shall be notified of the reason for the delay by certified mail. The physician or other health care provider may extend the sixty-day period upon written notice to the plan within ten (10) calendar days; otherwise the application shall be deemed withdrawn. In no event shall the entire credentialing or recredentialing process exceed one hundred eighty (180) calendar days. Oklahoma Complete Health, Inc, will refrain from solely basing a denial of an application for credentialing or recredentialing

on the lack of board certification or board eligibility and from adding new requirements solely for the purpose of delaying an application. Providers are enrolled into our systems within seven (7) business days of credentialing approval.

4. Oklahoma Complete Health, Inc. requires providers to be enrolled as contracted providers with SoonerCare in accordance with provider disclosure, screening and enrollment requirements at 42 C.F.R. §§438.608(b), 455.100-107 and 455.400-470 .

5. Oklahoma Complete Health, Inc. will honor the current contracting and credentialing process established by OSDE for School-Based providers. A copy of appropriate credentials and OSDE contracts will be provided by OSDE during audits of the Health Plan. License requirements currently outlined by OSDE will be accepted; No additional paperwork will be required.

6. Oklahoma Complete Health, Inc. will support the use of a centralized credentialing agency if established in Oklahoma.

7. Provider Agreements for Behavioral Health providers require Participating Providers to complete OHCA Customer Data Core (CDC) form located at http://www.odmhsas.org/picis/CDCPAForms/arc_CDCPA_Forms.htm as a condition of payment for services provided under the Model Contract.

Attachment CC

Managed Health Services (MHS)– Indiana (Medicaid, Ambetter,
Allwell)/WellCare of Indiana
Unique Requirements for Credentialing

1. Managed Health Services – Indiana shall ensure that credentialing of all service providers applying for network provider status shall be completed within 30 days from the time when all necessary credentialing materials, including primary source verification documentation, is received, as long as no adverse information is included. Completion time ends upon the date of the Credentialing Committee decision. Monitoring of this metric is performed through review of reports and inventory management processes.
2. Managed Health Services – Indiana (Medicaid) requires a valid Medicaid ID number and IHCP enrollment.
3. Managed Health Services – Indiana requires Mid-Levels to submit proof of collaborative agreement (as required by state law).
4. Managed Health Services- Indiana requires as part of the initial credentialing decision, the Credentialing Committee shall include the results of a site visit for primary care and all OB/GYN practitioners who are applying for participation in the IHCP programs. If the score is less than 80%, the Credentialing Committee will develop an action plan for improvement and will revisit the site at least every six months until performance standards are met. This process is explained in detail in CC.CRED.05. The following practitioners can be considered primary medical providers (PMP) under the Indiana Medicaid program: Family Practice; Pediatrician; General Practitioner; Internal Medicine; OB (HHW only); Gynecologist; Endocrinologist (if primarily engaged in Internal Medicine); Nurse Practitioner; and Physician Assistant (Nurse practitioners may hold a panel only under IHCP programs. Whereas Physician Assistant may hold a panel with both Ambetter and IHCP programs. Holding a panel does not allow Nurse Practitioners and Physician Assistants to practice independently in Indiana and they must still have a collaborating agreement with a PMP Physician).
5. Managed Health Services - Indiana recognizes the Indiana Licensing Bureau uses a status of “Valid to Practice while Under Review”. While the expiration date of the license may indicate that the license has expired, the Attorney General’s Office has the authority to put the renewal on hold while review various actions. As the license remains unrestricted and non-probationary during the review, MHS considers the license as clean and in effect until the review is completed, thus meeting minimum standards. However for this license status, the

- credentialing specialist will monitor the license each month until the status is updated. Appropriate action will be taken at that time.
6. Managed Health Services - Indiana will notify FSSA of any practitioner denied participation for quality or program integrity reasons
 7. All health plan(s) operating in the State of Indiana require individual providers to meet professional liability insurance in the minimum limits of: \$250,000 per occurrence \$750,000 aggregate.
 8. MHS is required to ensure all laboratory testing sites providing services have either a CLIA certificate or waiver of a certificate of registration along with a CLIA identification number. Acceptable formats for review include application attestation, current copy of certificate or waiver, or information obtained directly from CLIA.

Attachment DD
WellCare of Alabama
Unique Requirements for Credentialing

1. None

Attachment EE
WellCare of Connecticut
Unique Requirements for Credentialing

1. None

Attachment FF
WellCare of Vermont
Unique Requirements for Credentialing

1. None

Attachment GG
WellCare of Rhode Island
Unique Requirements for Credentialing

1. None

Attachment HH
WellCare of Maine
Unique Requirements for Credentialing

1. None

Attachment II
WellCare of Massachusetts
Unique Requirements for Credentialing

1. None

Attachment JJ
Ohana Health Plan – Hawaii – QI and CCS
Unique Requirements for Credentialing

Quest Integration (QI)

1. The Health Plan shall not include in its network any Providers when a person with an ownership or controlling interest in the Provider, an owner including the Provider himself or herself, or an agent or managing employee of the Provider, has been excluded from participation by the DOH and Human Services, Office of Inspector General (OIG) under Section 1128 of the Social Security Act, or has been excluded by DHS from participating in the Hawaii Medicaid program.
2. The Health Plan shall conduct a monthly check with DHS to identify any Providers excluded from the Hawaii Medicaid program. On a monthly basis, the Health Plan shall check the federal exclusion lists, including but not limited to the Social Security Administration's Death Master File, the National Plan and Provider Enumeration System, List of Excluded Individuals and Entities (LEIE) maintained by the OIG, and System for Award Management.
3. The Health Plan shall demonstrate that its network providers are credentialed as required under 42 CFR §438.214. The Health Plan will follow the most current NCQA credentialing and re-credentialing standards including delegation and provider monitoring/oversight.
4. The Health Plan shall reserve the right to require approval of providers, with regard to standards and thresholds set by the Health Plan and/or DHS (e.g., with regards to performance standards, office site criteria, medical record keeping, complaints triggering on-site visits). The Health Plan shall also meet requirements of the RFP related to appointment availability and medical record keeping.
5. The Health Plan shall ensure each PCP meets all applicable requirements of law and has the necessary and current license/certification/accreditation/designation approvals per State requirements.
6. The Health Plan shall ensure that each acute care provider meets all applicable requirements of law and has the necessary and current

- license/certification/accreditation/designation approvals per State requirements.
7. The Health Plan shall ensure that all facilities and organizational providers including, but not limited to, hospitals, are certified or licensed as required by the State.
 8. The Health Plan shall ensure that each service delivery site of each behavioral health provider meets all applicable requirements of federal and state law and has the necessary and current license, certification, accreditation, or designation approvals per State requirements. When individuals providing behavioral health treatment services are not required to be licensed or certified, it is the responsibility of the Health Plan to ensure, based upon applicable state licensure rules and/or program standards, that those individuals are appropriately educated, trained, qualified, and competent to perform said services and job responsibilities.
 9. The Health Plan shall ensure that each service and service delivery site of each LTSS provider meets all applicable requirements of Federal and State law and has the necessary and current license, certification, accreditation, or designation approvals per State requirements. When individuals providing LTSS services are not required to be licensed or certified, it is the responsibility of the Health Plan to ensure, based upon applicable state licensure rules and/or program standards, that those individuals are appropriately educated, trained, qualified, and competent to perform said services and job responsibilities.
 10. Health Plans shall ensure all criminal history record check requirements are conducted for all high-risk providers determined by the State.
 11. The Health Plan shall ensure that all providers including, but not limited to, therapists, meet state licensure requirements.
 12. The Health Plan shall comply with the provisions of the CLIA. The Health Plan shall require that all laboratory testing sites providing services under this RFP have either a current CLIA certificate of waiver, or a certificate of registration along with a CLIA identification number. Laboratories with certificates of waiver, shall provide only their types of tests permitted under the terms of the waiver. Laboratories with certificates of registration, may perform a full range of laboratory tests.

13. The Health Plan shall submit its credentialing, recredentialing and other certification policies and procedures to DHS for review and approval in accordance with §13.3.
14. The Health Plan shall participate along with DHS' centralized credentialing initiative should it occur.

Community Care Services (CCS)

1. The Health Plan shall not include in its network any Providers when a person with an ownership or controlling interest in the Provider, an owner including the Provider himself or herself, or an agent or managing employee of the Provider, has been excluded from participation by the DOH and Human Services, Office of Inspector General (OIG) under Section 1128 of the Social Security Act, or has been excluded by DHS from participating in the Hawaii Medicaid program.
2. The Health Plan shall conduct a monthly check with DHS to identify any Providers excluded from the Hawaii Medicaid program. On a monthly basis, the Health Plan shall check the federal exclusion lists, including but not limited to the Social Security Administration's Death Master File, the National Plan and Provider Enumeration System, List of Excluded Individuals and Entities (LEIE) maintained by the OIG, and System for Award Management.
3. The Health Plan shall demonstrate that its network providers are credentialed as required under 42 CFR §438.214. The Health Plan will follow the most current NCQA credentialing and re-credentialing standards including delegation and provider monitoring/oversight. The Health Plan will also meet requirements of the RFP related to appointment availability and medical record keeping.
4. The Health Plan shall ensure that all facilities and organizational providers including, but not limited to, hospitals, are certified or licensed as required by the State.
5. The Health Plan shall ensure that each service delivery site of each behavioral health provider meets all applicable requirements of federal and state law and has the necessary and current license, certification, accreditation, or designation approvals per State requirements. When individuals providing behavioral health treatment services are not required to be licensed or certified, it is the responsibility of the Health Plan to ensure, based upon applicable state licensure rules

and/or program standards, that those individuals are appropriately educated, trained, qualified, and competent to perform said services and job responsibilities.

6. The Health Plan shall ensure that all providers including, but not limited to, therapists, meet state licensure requirements.
7. The Health Plan shall comply with the provisions of the CLIA. The Health Plan shall require that all laboratory testing sites providing services under this RFP have either a current CLIA certificate of waiver, or a certificate of registration along with a CLIA identification number. Laboratories with certificates of waiver, shall provide only their types of tests permitted under the terms of the waiver. Laboratories with certificates of registration, may perform a full range of laboratory tests.
8. The BHO shall ensure that its providers submit full disclosures as identified in 42 CFR Part 455, Subpart B. Disclosures shall include:
 - (i) The name and address of any person (individual or corporation) with an ownership or control interest in the disclosing entity. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address;
 - (ii) Date of birth and Social Security Number of each person with an ownership or control interest in the disclosing entity; and
 - (iii) Other tax identification number of each corporation with an ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity has a five (5) percent or more interest.
 - Whether the person (individual or corporation) with an ownership or control interest in the disclosing entity is related to another person with ownership or control interest in the
 - disclosing entity as a spouse, parent, child, or sibling; or whether the person with an ownership or control interest in any subcontractor in which the disclosing entity has a five (5) percent or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling.
 - The name of any other disclosing entity in which an owner of the disclosing entity has an ownership or control interest.
 - The name, address, date of birth, and Social Security Number of any managing employee of the disclosing entity.

- The identity of any individual who has an ownership or control interest in the provider, or is an agent or managing employee of the provider, and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the title XX services program since the inception of those programs.

The BHO shall obtain with on-going efforts, disclosures from its providers at the following times:

- When the provider submits a provider application for initial credentialing;
- Upon execution of the provider agreement;
- During recredentialing;
- Upon request from the health plan or DHS; and
- Within thirty-five (35) days after any change in ownership of the disclosing entity information to the health plan.

The provider shall submit, within thirty-five (35) days of the date on a request by the health plan, the DHS, or the Secretary full and complete information about:

- The ownership of any subcontractor with whom the provider has had business transactions totaling more than \$25,000 during the 12-month period ending on the date of the request; and
- Any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request.

The health plan may refuse to enter into or renew an agreement with a provider if any person who has an ownership or control interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the Title XX Services Program. In addition, the health plan may refuse to enter into or may terminate a provider agreement if it determines that the provider did not fully and accurately make any disclosure required above.

Initial Credentialing

- 1) The Provider Relations Department will ensure an Ownership Disclosure & Control Interest Form is completed by all new providers and submit to the Credentialing Department along with the providers Credentialing Application.
- 2) The Credentialing Department shall review the Disclosure Form and data enter any disclosure data into the tracking database.

Re-Credentialing

- 1) The Credentialing Department will mail Ownership Disclosure and Control Interest Forms to all providers entering the Re-Credentialing process
- 2) Disclosure information received will be data entered into the tracking database.
- 3) If a provider does not submit a complete Ownership Disclosure and Control Interest Form at the time, and for the purpose, of recredentialing (Re-Credentialing Ownership Disclosure Form), the following will occur:
 - a. A follow-up letter will be sent to the provider. (To be repeated (2) additional times should the provider fail to submit a complete Re-Credentialing Ownership Disclosure Form)
 - b. Upon preparation of a third follow-up letter to a provider, the provider's name will be submitted to Market staff.
 - c. Upon receipt of a provider's name, Market staff will make follow-up phone calls to the provider.
 - d. If a provider fails to submit a complete Re-Credentialing Ownership Disclosure Form, after receiving follow-up phone calls from the Market staff, the health plan will continue to take steps to obtain a complete Re-Credentialing Ownership Disclosure Form from the provider.
9. The BHO shall notify DHS through its Provider Suspension and Termination report identified in Section 6.3 of any providers that the health plan refuses to enter into or renew an agreement.
10. The BHO shall submit its credentialing, recredentialing and other certification policies and procedures to MQD for review and approval by the due date identified in Section 13.3.B, Readiness Review.

Attachment KK
WellCare of Kentucky
Unique Requirements for Credentialing

REQUIREMENTS IN KENTUCKY REVISED STATUTE (KRS) 304.17A-576

WellCare of Kentucky shall comply with the requirements established in KRS 304.17A-576.

KRS 304.17A-576 states:

(1) An insurer issuing a managed care plan shall notify an applicant of its determination regarding a properly submitted application for credentialing within forty-five (45) days of receipt of an application containing all information required by the most recent version of the Council for Affordable Quality Healthcare (CAQH) credentialing form. Nothing in this section shall prevent an insurer from requiring information beyond that contained in the credentialing form to make a determination regarding the application.

(2) The forty-five (45) day requirement set forth in subsection (1) of this section shall not apply if the failure to notify is due to or results from, in whole or in part, acts or events beyond the control of the insurer issuing a managed care plan, including but not limited to acts of God, natural disasters, epidemics, strikes or other labor disruptions, war, civil disturbances, riots, or complete or partial disruptions of facilities.

(3) Following credentialing, the applicant and, upon the applicant's signing of a contract with the managed care plan, the insurer shall make payments to the applicant for services rendered during the credentialing process in accordance with procedures for reimbursement for participating providers.

(4) An applicant for which an application for credentialing is denied shall be reimbursed, if the enrollee is enrolled in a plan which provides for out-of-network benefits, by the insurer issuing a managed care plan in accordance with procedures for reimbursement to nonparticipating providers.

REQUIREMENTS IN KRS 205.560(12)

WellCare shall comply with the requirements established in KRS 205.560(12) except that WellCare shall comply with the shorter credentialing timeframe (forty-five days) established in KRS 304.17A-576 rather than the ninety (90) day timeframe allowed in KRS 205.560(12)(c).

Pursuant to KRS 205.560(12)(c), within 45 days of receipt of a correct and

complete application for credentialing by a behavioral health provider providing substance use disorder services, a Medicaid managed care organization shall complete its contracting and credentialing process, unless the Medicaid managed care organization notifies the provider that additional time is needed to render a decision. If additional time is needed, the MCO shall not take any longer than ninety (90) days from receipt of the credentialing application to deny or approve and contract with the provider.

Pursuant to KRS 205.560(12)(d), a MCO shall adjudicate any clean claims submitted for a substance use disorder service from an enrolled and credentialed behavioral health provider who provides substance use disorder services in accordance with KRS 304.17A-700 to 304 17A-730.

Pursuant to KRS 205.560(12)(e), the Kentucky Department of Insurance may impose a civil penalty of one hundred dollars (\$100) per violation when a MCO fails to comply with this section. Each day that a MCO fails to pay a claim may count as a separate violation.

Pursuant to KRS 205.560(12)(a), a MCO shall use the forms and guidelines established under KRS 304.17A-545(5) to credential a provider. For any provider who contracts with and is credentialed by a MCO prior to enrollment, the Cabinet for Health and Family Services shall complete the enrollment process and deny, or approve and issue a Provider Identification Number (PID) within fifteen business days from the time all necessary completed enrollment forms have been submitted and all outstanding accounts receivable have been satisfied.

KENTUCKY CONTRACTUAL REQUIREMENTS

Contract Section 28.2 – Provider Credentialing and Recredentialing

Pursuant to Kentucky Managed Care Organization (MCO) Contract Section 28.2, “Provider Credentialing and Recredentialing”, WellCare shall conduct Credentialing and Recredentialing in compliance with National Committee for Quality Assurance standards (NCQA), KRS 205.560(12), 907 KAR 1:672 or other applicable state regulations and federal law. WellCare shall document the procedure, which shall comply with the Department’s current policies and procedures, for credentialing and recredentialing of providers with whom it contracts or employs to treat Enrollees. Detailed documentation and scope of the Credentialing and Recredentialing process is contained in **Appendix J. “Credentialing Process.”**

WellCare shall complete the Credentialing or Recredentialing of a Provider within ninety (90) calendar days of receipt of all relative information from the Provider, or within forty-five (45) days if the Provider is providing substance use disorder services. The status of pending requests for credentialing or recredentialing shall be submitted as required in **Appendix J. “Credentialing Process.”**

Unless prohibited by NCQA standards, if WellCare allows the Provider to provide covered services to its Enrollees before the credentialing or recredentialing process is completed and the Provider is credentialed, WellCare shall allow the Provider to be paid for the period from the date of its application for credentials to completion of the credentialing or recredentialing process.

If WellCare accepts the Medicaid enrollment application on behalf of the provider, WellCare will use the format provided in **Appendix J. “Credentialing Process”** to transmit the listed provider enrollment data elements to the Department. A Provider Enrollment Coversheet will be generated per provider. The Provider Enrollment Coversheet will be submitted electronically to the Department.

WellCare shall establish ongoing monitoring of provider sanctions, complaints and quality issues between recredentialing cycles, and take appropriate action.

WellCare shall provide a credentialing process whereby the Provider is only required to go through one credentialing process that applies to WellCare and any or all of its Subcontractors, if one credentialing process meets NCQA requirements.

Pursuant to Kentucky MCO Contract Section 28.3, “Implementation of a Credentialing Verification Organization (CVO)”, WellCare shall comply with and take all necessary actions to implement the requirements of 2018 Ky.Acts Ch. 69 and all other applicable Federal and State laws. The Contractor shall work with any identified CVO designated by the Department.

Pursuant to Kentucky MCO Contract Section 28.4, “Provider Credentialing and Recredentialing”, WellCare shall conduct Credentialing and Recredentialing in compliance with NCQA, KRS 205.560(12), 907 KAR 1:672 and other applicable state regulations and federal law. WellCare shall document the procedure, which shall comply with the Department’s current policies and procedures, for credentialing and recredentialing of providers with whom it contracts or employs to treat Enrollees. Detailed documentation and scope of the Credentialing and Recredentialing process is contained in **Appendix J. “Credentialing Process.”** WellCare shall complete the Credentialing or

Recredentialing of a Provider within forty-five (45) calendar days of receipt of all relative information from the Provider. The status of pending requests for credentialing or recredentialing shall be submitted as required in **Appendix J. “Credentialing Process.”** Unless prohibited by NCQA standards, if WellCare allows the Provider to provide covered services to its Enrollees before the credentialing or recredentialing process is completed and the Provider is credentialed, WellCare shall allow the Provider to be paid for the period from the date of its application for credentials to completion of the credentialing or recredentialing process. If WellCare accepts the Medicaid enrollment application on behalf of the provider, WellCare will use the format provided in **Appendix J. “Credentialing Process”** to transmit the listed provider enrollment data elements to the Department. A Provider Enrollment Coversheet will be generated per provider. The Provider Enrollment Coversheet will be submitted electronically to the Department. WellCare shall establish ongoing monitoring of provider sanctions, complaints and quality issues between recredentialing cycles, and take appropriate action. WellCare shall provide a credentialing process whereby the Provider is only required to go through one credentialing process that applies to WellCare and any or all of its Subcontractors, if one credentialing process meets NCQA requirements.

Contract Section 29.3 – Contractor’s Provider Network

In accordance with Kentucky MCO Contract Section 29.3, Contractor’s Provider Network”, Providers shall meet the credentialing standards described in Section 28.2 **“Provider Credentialing and Re-Credentialing** of this Contract and be eligible to enroll with the Kentucky Medicaid Program. A provider joining WellCare’s Network shall meet the Medicaid provider enrollment requirements set forth in the Kentucky Administrative Regulations and in the Medicaid policy and procedures manual for fee-for-service providers of the appropriate provider type.

WellCare shall provide written notice to Providers not accepted into the network along with the reasons for the non-acceptance. A provider cannot enroll or continue participation in WellCare’s Network if the provider has active sanctions imposed by Medicare or Medicaid or SCHIP, if required licenses and certifications are not current, if money is owed to the Medicaid Program, or if the Office of the Attorney General has an active fraud investigation involving the Provider or the Provider otherwise fails to satisfactorily complete the credentialing process. The Contractor shall obtain access to the National Practitioner Database as part of their credentialing process in order to verify the Provider’s eligibility for network participation. Federal Financial Participation is not available for amounts expended for providers excluded by Medicare, Medicaid, or SCHIP, except for Emergency Medical Services.

Appendix J. Credentialing Process

Pursuant to the section titled “Credentialing and Recredentialing Requirements” of Appendix J., “Credentialing Process”, of the Kentucky MCO Contract, This documentation shall include, but not be limited to, defining the scope of providers covered, the criteria and the primary source verification of information used to meet the criteria, the process used to make decisions and the extent of delegated credentialing and recredentialing arrangements. The Contractor shall have a process for receiving input from participating providers regarding credentialing and recredentialing of providers. Those providers accountable to a formal governing body for review of credentials shall include physicians, dentists, advanced registered nurse practitioners, audiologist, CRNA, optometrist, podiatrist, chiropractor, physician assistant and other licensed or certified practitioners. Providers required to be recredentialled by WellCare per Department policy are physicians, audiologists, certified registered nurse anesthetists, advanced registered nurse practitioners, podiatrists, chiropractors and physician assistants. However, if any of these providers are hospital-based, credentialing will be performed by the Department. WellCare shall be responsible for the ongoing review of provider performance and credentialing as specified below:

- A. WellCare shall verify that its enrolled network Providers to whom Members may be referred are properly licensed in accordance with all applicable Commonwealth law and regulations and have in effect such current policies of malpractice insurance as may be required by WellCare.
- B. The process for verification of Provider credentials and insurance, and any additional facts for further verification and periodic review of Provider performance, shall be embodied in written policies and procedures, approved in writing by the Department.
- C. WellCare shall maintain a file for each Provider containing a copy of the Provider’s current license issued by the Commonwealth and such additional information as may be specified by the Department.
- D. The process for verification of Provider credentials and insurance shall be in conformance with the Department’s policies and procedures. WellCare shall meet requirements under KRS 205.560(12) related to credentialing. WellCare’s enrolled providers shall complete a credentialing application in accordance with the Department’s policies and procedures.

The process for verification of Provider credentials and insurance shall include the following:

- A. Written policies and procedures that include WellCare’s initial process for credentialing as well as its re-credentialing process that must occur, at a

minimum, every three (3) years;

- B. A governing body, or the groups or individuals to whom the governing body has formally delegated the credentialing function;
- C. A review of the credentialing policies and procedures by the formal body;
- D. A credentialing committee which makes recommendations regarding credentialing;
- E. Written procedures, if WellCare delegates the credentialing function, as well as evidence that the effectiveness is monitored;
- F. Written procedures for the termination or suspension of Providers; and
- G. Written procedures for, and implementation of, reporting to the appropriate authorities serious quality deficiencies resulting in suspension or termination of a provider.

WellCare shall meet requirements under KRS 205.560(12) related to credentialing. Verification of Provider's credentials shall include the following:

- A. A current valid license or certificate to practice in the Commonwealth of Kentucky;
- B. A Drug Enforcement Administration (DEA) certificate and number, if applicable;
- C. Primary source of graduation from medical school and completion of an appropriate residency, or accredited nursing, dental, physician assistant or vision program as applicable; if provider is not board certified.
- D. Board certification if the practitioner states on the application that the practitioner is board certified in a specialty;
- E. Professional board certification, eligibility for certification, or graduation from a training program to serve children with special health care needs under twenty-one (21) years of age;
- F. Previous five (5) years' work history;
- G. Professional liability claims history;
- H. Clinical privileges and performance in good standing at the hospital designated by the Provider as the primary admitting facility, for all providers whose practice requires access to a hospital, as verified through attestation;
- I. Current, adequate malpractice insurance, as verified through attestation;
- J. Documentation of revocation, suspension or probation of a state license or DEA/BNDD number;

- K. Documentation of curtailment or suspension of medical staff privileges;
- L. Documentation of sanctions or penalties imposed by Medicare or Medicaid;
- M. Documentation of censure by the State or County professional association; and
- N. Most recent information available from the National Practitioner Data Bank.
- O. Health and Human Services Office of Inspector General (HHS OIG)
- P. System for Award Management (SAM)

The provider shall complete a credentialing application that includes a statement by the applicant regarding:

- A. The ability to perform the essential functions of the positions, with or without accommodation;
- B. Lack of present illegal drug use;
- C. History of loss of license and felony convictions;
- D. History of loss or limitation of privileges or disciplinary activity;
- E. Sanctions, suspensions or terminations imposed by Medicare or Medicaid; and
- F. Applicants attest to the correctness and completeness of the application.

Before a practitioner is credentialed, WellCare shall verify information from the following organizations and shall include the information in the credentialing files:

- A. National practitioner data bank, if applicable;
- B. Information about sanctions or limitations on licensure from the appropriate state boards applicable to the practitioner type; and
- C. Other recognized monitoring organizations appropriate to the practitioner's discipline.

At the time of credentialing, WellCare shall perform an initial visit to providers as it deems necessary and as required by law. (See 42 CFR Part 455 Subpart E.). WellCare shall document a structured review to evaluate the site against WellCare's organizational standards and those specified by this contract. WellCare shall document an evaluation of the medical record documentation

and keeping practices at each site for conformity with WellCare's organizational standards and this contract.

WellCare shall have formalized recredentialing procedures. WellCare shall formally recredential its providers at least every three (3) years. WellCare shall comply with the Department's recredentialing policies and procedures. There shall be evidence that before making a recredentialing decision, WellCare has verified information about sanctions or limitations on practitioner from:

- A. A current license to practice;
- B. The status of clinical privileges at the hospital designated by the practitioner as the primary admitting facility;
- C. A valid DEA number, if applicable;
- D. Board certification, if the practitioner was due to be recertified or become board certified since last credentialed or recredentialled;
- E. Five (5) year history of professional liability claims that resulted in settlement or judgment paid by or on behalf of the practitioner; and
- F. A current signed attestation statement by the applicant regarding:
 - (1) The ability to perform the essential functions of the position, with or without accommodation;
 - (2) The lack of current illegal drug use;
 - (3) A history of loss, limitation of privileges or any disciplinary action; and
 - (4) Current malpractice insurance.
 - (5) Health and Human Services Office of Inspector General (HHS OIG)
 - (6) System for Award Management (SAM)

There shall be evidence that before making a recredentialing decision, WellCare has verified information about sanctions or limitations on practitioner from:

- A. The national practitioner data bank;
- B. Medicare and Medicaid;
- C. State boards of practice, as applicable; and
- D. Other recognized monitoring organizations appropriate to the practitioner's specialty.

WellCare shall have written policies and procedures for the initial and on-going

assessment of organizational providers with whom it intends to contract or which it is contracted. Providers include, but are not limited to, hospitals, home health agencies, free-standing surgical centers, residential treatment centers, and clinics. At least every three (3) years, WellCare shall confirm that the provider is in good standing with state and federal regulatory bodies, including the Department, and, has been accredited or certified by the appropriate accrediting body and state certification agency or has met standards of participation required by WellCare.

WellCare shall have policies and procedures for altering conditions of the practitioners participation with WellCare based on issues of quality of care and services. WellCare shall have procedures for reporting to the appropriate authorities, including the Department, serious quality deficiencies that could result in a practitioner's suspension or termination.

If a provider requires review by WellCare's credentialing Committee, based on WellCare's quality criteria, WellCare will notify the Department regarding the facts and outcomes of the review in support of the State Medicaid credentialing process.

WellCare shall use the provider type summaries listed at

<https://chfs.ky.gov/agencies/dms/dpi/pe/Pages/prov-summaries.aspx>

Attachment LL
WellCare of North Carolina Medicare
Unique Requirements for Credentialing

1. None

Attachment MM
WellCare of New York
Unique Requirements for Credentialing

1. None

Attachment NN
WellCare of Ohio
Unique Requirements for Credentialing

1. None

Attachment 00
WellCare of Texas/Texan Plus
Unique Requirements for Credentialing

1. None

Attachment PP
WellCare of Georgia
Unique Requirements for Credentialing

1. None

Attachment QQ
WellCare of Florida
Unique Requirements for Credentialing

1. Staywell shall be responsible for the credentialing and recredentialing of its provider network.
2. If Staywell has delegated credentialing and/or recredentialing to a subcontractor, the agreement must ensure that all providers are credentialed in accordance with Staywell's and the Agency's credentialing requirements.
3. Staywell may be required to contract with an SMMC single credentialing vendor, managed by the Agency
4. Staywell agrees to participate in workgroups with other Managed Care Plans, the Agency, and additional stakeholders to focus on reducing SMMC program redundancies in the provider on-boarding process.
5. Staywell agrees to fully enroll/on-board all providers it chooses to contract within 60-days. The 60-day metric will be measured by the number of days between the day Staywell receives a full and complete provider enrollment application and the day the Agency successfully receives the provider on Staywell's Provider Network Verification (PNV) file. Staywell agrees to submit the date it receives full and complete provider applications to the Agency on the PNV file when requested.
6. Staywell agrees to allow the Agency to procure a provider enrollment and/or credentialing vendor for the entire Medicaid program, including Managed Care Plan onboarding and credentialing, as determined by the Agency.
7. On at least a monthly basis check current staff, subcontractors and providers against the federal LEIE and the federal SAM (includes the former EPLS) or their equivalent, to identify excluded parties. Staywell shall also check monthly the Agency's listing of suspended and terminated providers at the Agency website below, to ensure Staywell does not include any non-Medicaid eligible providers in its network:
http://apps.ahca.myflorida.com/dm_web
8. If a provider is currently suspended or terminated from the Florida Medicaid program whether by contract or sanction, other than for purposes of inactivity, that provider is not considered an eligible Medicaid provider. Suspension and termination are described further in Rule 59G-9.070, F.A.C.

9. Staywell shall report suspected unlicensed ALF's and AFCH's to the Agency, and shall require its providers to do the same pursuant to 408.812 F.S.
10. For Staywell's MMA and CMS product, attestation that the total active patient load (all populations, including but not limited to Medicaid FFS, Children's Medical Services, SMMC plans, Medicare, KidCare, and commercial coverage) is no more than three thousand (3,000) patients per physician. An active patient is one that is seen by the provider a minimum of two (2) times per year.
11. A good standing report on a site visit survey. For each provider, documentation in Staywell's credentialing files regarding the site survey shall include the following: (a)
Evidence that Staywell has evaluated the provider's facilities using Staywell's organizational standards; Evidence that the provider's office meets criteria for access for persons with disabilities and that adequate space, supplies, proper sanitation, smoke-free facilities, and proper fire and safety procedures are in place; and Evidence that Staywell has evaluated the provider's enrollee record keeping practices at each site to ensure conformity with Staywell's organizational standards

Attachment RR
WellCare of New Jersey Medicare
Unique Requirements for Credentialing

1. None

Attachment SS
Delaware First Health
Unique Requirements for Credentialing

1. In accordance with 42 CFR 438.214, Delaware First Health must have and follow a documented process for credentialing and recredentialing acute, behavioral, substance use disorders, and LTSS participating providers before they provide services to members.
2. The credentialing and recredentialing process or participation criteria shall ensure that all participating providers, including, but not limited to, licensed independent practitioners, licensed organizational providers, and non-licensed independent and organizational providers such as certain HCBS providers and certain behavioral health providers, are qualified to perform their services.
3. Delaware First Health shall, at a minimum, comply with the current NCQA Standards and Guidelines for the Accreditation of MCOs for the credentialing and recredentialing of providers (NCQA credentialing standards).
4. Delaware First Health shall ensure that all HCBS and behavioral health providers, including those credentialed/recruited in accordance with NCQA credentialing standards, meet applicable state requirements.
5. Per the Clinical Laboratory Improvement Act of 1998 (CLIA), Delaware First Health shall ensure that all participating laboratory testing sites have either a CLIA certification or waiver of certification with a CLIA identification number. Delaware First Health shall further ensure that laboratories with a certificate of waiver only provide those tests that are CLIA-waived.
6. Delaware First Health shall have a process that permits providers to apply for credentialing and recredentialing online.
7. Delaware First Health shall ensure that applicants for credentialing have not been excluded from participation in Federal health care programs under either Section 1128 or 1128A of the Social Security Act.
8. Delaware First Health shall refer any provider who notifies the plan of a change in location, licensure, certification, specialty, or status to the DMAP provider web portal for updating the provider's enrollment information/status with DMAP.
9. Delaware First Health shall complete the initial credentialing process for a provider in accordance with this Contract before the effective date of the provider's participation agreement for services under this Contract.
10. Delaware First Health shall completely process credentialing applications from all types of participating providers (physical health, behavioral health and LTSS providers) within 45 calendar days of receipt of a completed credentialing application, including all necessary documentation and attachments. Completely process shall mean that the plan shall review, approve and load approved applicants to its provider files in its claims

processing system or deny the application, notify the provider, and ensure that the provider is not used by Delaware First Health for services under this Contract.

11. Delaware First Health shall notify the State when the plan denies a provider credentialing/recredentialing application for program integrity-related reasons (see Section 3.16, Program Integrity).
12. Consistent with 42 CFR 455.436, Delaware First Health shall screen all participating providers against the Social Security Administration's Death Master File (DMF), the National Plan and Provider Enumeration System (NPPES), the LEIE, and the System for Award Management (SAM) and any other databases specified by the State or the Federal government as part of initial credentialing and then monthly to ensure providers are not excluded.
13. Delaware First Health must monitor its providers and take appropriate action against providers who are found to be out-of-compliance with the plan's credentialing standards.
14. Delaware First Health shall recredential all participating providers other than HCBS providers every three years. The plan shall recredential or verify participation criteria for HCBS providers annually.
15. Delaware First Health's recredentialing process shall take into consideration provider performance data, including, but not limited to, member Grievances and Appeals, provider audits, and quality of care and/or quality of service issues.
16. Delaware First Health's credentialing and recredentialing process for HCBS providers shall include assessment of each provider setting to ensure that all applicable HCB settings requirements are met. The plan shall use the process prescribed by DMMA.
17. Delaware First Health's credentialing and recredentialing process for Home Visiting providers shall be limited to confirming the provider is enrolled with DMAP and reviewing evidence that the provider meets all national and State standards (set by DPH) for Home Visiting under the Nurse Family Partnership or Healthy Families America model. check of the national and the Delaware sex offender registry and a check of the excluded provider list.
18. Delaware First Health shall verify that potential Self-Directed HCBS Employees meet all applicable qualifications prior to delivering services including the following minimum qualifications: are at least 18 years of age, have the skills necessary to perform the required services, possess a valid Social Security number and are willing to submit to a criminal background check. For each potential Self-Directed HCBS Employee Delaware First Health shall conduct a State and Federal criminal background check through the Delaware State Bureau of Identification, a check of the Delaware's Adult Abuse Registry (see 11 DE Code 8564; registry is available on the DHSS website), a check of the national and the Delaware sex offender registry and a check of the excluded provider list.

Delaware First health shall secure and pay for background checks on prospective Self-Directed HCBS Employees on behalf of members.

19. Delaware First Health shall conduct criminal and other background checks and credentialing activities as required by State or Federal law and regulation on all participating providers before entering into any participation agreement with such provider.

Attachment TT
Ohio Buckeye Health Plan
Unique Requirements for Credentialing

1. None

POLICY AND PROCEDURE

POLICY NAME: Prior Authorization Policy Development	POLICY ID: CC.PHARM.55
BUSINESS UNIT: Corporate	FUNCTIONAL AREA: Pharmacy
EFFECTIVE DATE: 09/15/2017	PRODUCT(S): All
REVIEWED/REVISED DATE: 09/07/18, 09/12/18, 08/22/19, 07/28/20, 05/27/21, 04/08/2022, 06/21/22, 12/07/2022	
REGULATOR MOST RECENT APPROVAL DATE(S): N/A	

POLICY STATEMENT:

The purpose of this policy is to establish a standardized approach for PA policy development and maintenance.

PURPOSE:

The purpose of this policy is to establish a standardized approach for PA policy development and maintenance.

SCOPE:

All prior authorization (PA) policies that are created or revised by the Drug Information team.

DEFINITIONS: N/A

POLICY:

Pharmacy services is a subsidiary of Centene Corporation®. Centene® does not discriminate on the basis of race, color, national origin, sex, age or disability, nor exclude from participation in, deny the benefits of, or otherwise subject to discrimination under any applicable Company health program or activity (see reference CC.COMP.42_ACA 1557 Nondiscrimination in Health Programs Activities).

When a new drug is approved by the Food and Drug Administration (FDA), pharmacy services Drug Information (DI) team will create a PA policy as part of the new drug review. For drugs that were previously FDA-approved, a policy will be created when a new indication is given to a new dosage form of an existing molecular entity. When there is not a new dosage form of an existing agent, pharmacy services DI team will revise an existing PA policy as part of the new indication review. PA policies may also be revised when clinically significant changes are needed that alter the coverage criteria due to updates to evidence-based national treatment guidelines or publication of new study information. Additionally, PA policies may be revised due to updates to the FDA-approved labeling, such as newly approved dosage forms and changes to the safety information.

PA policies are created based on published, peer-reviewed, medical and scientific information, as well as national compendia, other recognized sources, non-profit criteria, and input from appropriate practitioners including specialists. For instance, for drugs used to treat mental health or substance use disorders, appropriate specialists (e.g., psychiatrists, addiction specialists) who have knowledge and/or experience in treating patients with the specific disease state will be consulted for their input.

PROCEDURE:

- 1) A request to create or update a PA policy may come from internal as well as external stakeholders. A clinical pharmacist assigned as the author to complete the new drug review is responsible for creating a PA policy as part of the review. The author creates the PA policy using the practices and principles of evidence-based medicine as well as procedures described in CC.PHARM.31 – Creating and Revising Drug Prior Authorization Policies. When evidence is lacking or is equivocal, reviews, recommendations, and opinions from evidence-based medicine resources, national professional organizations, government agencies, medical experts, and other recognized sources may be used.
- 2) An author assigned to complete the new indication review will revise a PA policy as part of the review. The author will revise the PA policy using the practices and principles of evidence-based medicine and following the procedures described in CC.PHARM.31 – Creating and Revising Drug Prior Authorization policies. When evidence is lacking or is equivocal, reviews, recommendations and opinions from evidence-based medicine resources, national professional organizations, government agencies, medical experts, and other recognized sources can be used.
- 3) At the time of PA policy creation or revision, the review shall:
 - a) Be based on applicable nationally recognized medical standards,
 - b) Be consistent with applicable governmental guidelines,
 - c) Provide for the delivery of a health care service in a clinically appropriate type, frequency and setting and for a clinically appropriate duration,

- d) Reflect the current medical and scientific evidence regarding emerging procedures, clinical guidelines and best practices as articulated in independent, peer-reviewed medical literature.
- 4) The author may review the following sources of evidence, recommendations, and opinions:
 - a) The American Hospital Formulary Service (AHFS) Drug Information
 - b) Truven Health Analytics Micromedex DrugDex
 - c) National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium
 - d) Clinical Pharmacology
 - e) Lexi-Comp
 - f) The most recent manufacturer's Prescribing Information document and formulary dossier
 - g) Peer reviewed medical literature
 - h) Other reviews and monographs (e.g., The Formulary Monograph Service Inc.)
 - i) Evidence-based medicine resources (e.g., HAYES, EBMS)
 - j) Evidence-based clinical practice guidelines
 - k) Peer-reviewed medical literature appearing in the regular editions for off-label use of drugs and biologicals in an anti-cancer chemotherapeutic regimen
 - 5) The author must review the following sources of evidence if the conditions are met:
 - a) If the drug(s) of interest are used for mental health or substance use disorder, then the author must follow Substance Abuse and Mental Health Services Administration (SAMHSA) guidelines
 - b) If the drug(s) of interest are used for transgender health, then the author must follow the World Professional Association for Transgender Health (WPATH) guidelines
 - 6) The author will consider the following when creating or revising the PA policy:
 - a) The abuse potential of the drug
 - b) Whether the molecular entity of the drug is new to the market
 - c) The possibility for off-label use of the drug
 - d) Any safety or efficacy concerns
 - e) The place in therapy of the drug with respect to standard of care
 - 7) The author will create a draft policy, which will be sent to at least two external physician specialists representing the area of specialty and preferably certified by a Board of various American medical specialties (i.e. American Board of Medical Specialties [ABMS], American Board of Physician Specialties (ABPS), and American Osteopathic Association Bureau of Osteopathic Specialists [AOABOS]) for review and feedback.
 - a) For plans situated in Oklahoma other than those in connection with a contract with the federal or state government of Oklahoma for utilization review of patients eligible under the Social Security Act, the two external physician specialists will be Board certified.
 - 8) The author will revise the PA policy, if necessary, based on input from specialists.
 - 9) The author will present the PA policy to the Clinical Pharmacy Advisory Committee (CPAC), a subcommittee of the pharmacy services and Therapeutics (P&T) Committee.
 - 10) When CPAC approves the PA policy, the status will be changed from a draft PA policy to an interim PA policy. Prior authorization pharmacists will use the interim criteria as a reference when evaluating coverage requests until the criteria are reviewed and approved at the pharmacy services P&T Committee meeting.
 - 11) The PA policy will be presented at the pharmacy services P&T Committee meeting. When the policy is approved by the pharmacy services P&T meeting, it will be considered a final version.

REFERENCES: N/A

ATTACHMENTS: N/A

ROLES & RESPONSIBILITIES: N/A

REGULATORY REPORTING REQUIREMENTS: N/A

REVISION LOG

REVISION TYPE	REVISION SUMMARY	DATE APPROVED & PUBLISHED
New Policy	Removed posting to Envolve site as interim criteria	9/7/18
Annual Review	Added, "4) The author will consider the following when creating the prior authorization policy..." to support NH 9421 2018.	9/12/18
Annual Review	No significant changes.	8/22/19
Annual Review	Added process of abbreviated reviews resulting in PA policy revisions due to updates to the FDA-approved labeling; added that place in therapy with respect to standard of care will be considered in PA policy creation/revision.	8/27/20
Annual Review	Revised product type to "ALL." Added WPATH and SAMHSA guidelines as required references for PA policy development, when applicable, to ensure compliance with California SB855. Added disclaimer language for Nondiscrimination in Health Programs Activities. Added an example of specialist input for MH/SUD.	5/27/21
Ad hoc update	Revised minor wording from must "review" to "follow" SAMHSA and WPATH guidelines, and added "non-profit" criteria as part of resources used to develop PA policies per request from HNCA Compliance.	06/15/21
Annual Review	Added reference to Centene P&T.	01/19/22
Ad Hoc	Replaced all EPS references with 'pharmacy services'. Changed policy ID from EPS.PHARM.55 to CC.PHARM.PHARM.55	04/08/2022
Annual Review	Clarified scope to those policies created or revised by the DI team.	6/21/22
Ad Hoc	To support 2022 PA S 225 - PBM 8, added that at the time of PA policy creation or revision, the review shall: a) Be based on applicable nationally recognized medical standards, b) Be consistent with applicable governmental guidelines, c) Provide for the delivery of a health care service in a clinically appropriate type, frequency and setting and for a clinically appropriate duration, d) Reflect the current medical and scientific evidence regarding emerging procedures, clinical guidelines and best practices as articulated in independent, peer-reviewed medical literature	12/07/2022

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, the Company's P&P management software, is considered equivalent to a signature.

Manager, Formulary Development: Approval on file

Director, Drug Information: Approval on file

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PRODUCT TYPE: All	REFERENCE NUMBER: CC.QI.CLAS.29

SCOPE: This policy applies to Centene Corporate (“the Company”), all Company subsidiaries and departments, contracted providers, major subcontractors, and subcontractors.

PURPOSE:

To provide clarity regarding the provision of cultural and linguistic services in accordance with regulatory and managed care contract requirements. This includes the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (The National CLAS Standards), as developed by the U.S. Department of Health and Human Services Office of Minority Health and Section 1557 of the Affordable Care Act. The scope of this policy covers:

- Health literacy and plain communication
- Language services
- Reduction of health disparities
- Cultural competency capabilities
- Support for members with disabilities

Centene is committed to developing, strengthening and sustaining healthy provider/member relationships. Members are entitled to dignified, appropriate and quality care. When healthcare services are delivered without regard for cultural differences, members are at risk for sub-optimal care. Members may be unable or unwilling to communicate their healthcare needs in an insensitive environment, reducing effectiveness of the entire healthcare process. Providers should note that the experience of a member begins with their first interaction with the health plan. Failure to use culturally competent and linguistically competent practices could result in the following:

- Feelings of being insulted or treated rudely
- Reluctance and fear of making future contact with the office
- Confusion and misunderstanding
- Treatment non-compliance and poor health outcomes
- Feelings of being uncared for, looked down upon, or devalued
- Parents resisting to seek help for their children
- Unfilled prescriptions
- Missed appointments
- Misdiagnosis due to lack of information sharing
- Inefficient use of resources
- Increased grievances or complaint
- Litigation

POLICY: The Company provides culturally appropriate health care. Services are provided in an accessible and responsive manner to all beneficiaries, including those with diverse cultural and ethnic backgrounds, diverse health beliefs and practices, limited English proficiency, disabilities, and

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differential abilities, regardless of race, color, national origin, sex, sexual orientation, gender identity, preferred language, or limited health literacy, free of charge. The Company implements processes that assure the health care services provided have the flexibility to meet the unique needs of members.

Cultural competency within Centene is defined as the willingness and ability of a system to value the importance of culture in the delivery of services to all segments of the population. It is the use of a systems perspective which values differences and is responsive to diversity at all levels in an organization. Cultural competency is developmental, community focused, and family oriented. In particular, it is the valuing of differences and integration of cultural attitudes, beliefs and practices into diagnostic and treatment methods throughout the system to support the delivery of culturally relevant and competent care. It is also the development of skills and practices sensitive to cross-cultural interactions, and encouragement of practices that ensure services delivered in a culturally competent manner.

STANDARDS:

The Company accomplishes culturally appropriate services through the following standards:

I. Identifying the cultural, linguistic, disparity and accessibility needs of members

The Company will:

- a. Collect and Maintain *Member Demographic Information*: maintain a membership database to capture member demographic information including race, ethnicity, preferred language, alternate format preferences, and disability status from various sources (e.g., enrollment forms, membership files, etc.). In the event member demographic information conflicts, the enrollment file from the state or federal government is treated as the source of truth if self-reported data has not been validated with the member at point-of-contact. Reconciliation of disparate member demographic data will be recorded, and time stamped within the membership database for prioritization of data from sources that use different levels of granularity.
- b. Data collected using these methods has the ability to be aggregated to The Executive Office of the President of the United States: Office of Budget and Management (OMB) race and ethnicity classifications, unless state or federal enrollment data is submitted using a different classification process. Data is uploaded into membership records with the ability to generate member level reporting. Members may be informed of the need to collect demographic information through newsletters, annual or targeted mailings, contact with Member Services and/or member websites. Members will be informed at the point of data

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collection of the permissible and impermissible uses of race, ethnicity, and language data.

- c. A demographic analysis of member composition by race, ethnicity, preferred language, age group, and sex is conducted annually. The Company uses census data, indirect race/ethnicity estimations and local data sources to create a demographic profile when member reported data is not sufficient. The Company analyzes provider linguistic and cultural concordance with member demographics.
- d. Conduct *Disparity Assessments* – The Company annually assesses its quality improvement program to identify targeted Healthcare Effectiveness Data and Information Set (HEDIS) measures with a focus on population size and disparities that if addressed, will have the ability to improve metrics such as minimum performance levels and STAR ratings. Data sources for disparity analysis can include publicly available aggregate data identifying health outcome disparities or health plan member data. Identified targets are presented to quality committees for discussion on the development of tailored interventions to support disparity reduction. Selected metrics are tracked and monitored, and outcomes of disparity reduction projects are reported to quality committees.
- e. Produce a *Cultural Competency Work Plan* – the Company develops and annually updates a Cultural Competency Plan (CCP), in consultation with representatives from diverse cultural communities. The CCP includes, at a minimum:
 - a. An organizational commitment to deliver culturally appropriate health care services.
 - b. A work plan that establishes goals and objectives and covers the areas of health literacy, cultural competency, language services, health disparities and disability accessibility.
 - c. A timetable for implementation and accomplishment of the goals and objectives.
 - d. An organizational chart clearly identifying the key staff titles with overall responsibility for cultural services and activities. Qualifications of staff, including appropriate education, experience, and training shall also be described.
 - e. Standards and performance requirements for the delivery of culturally appropriate health care services based on federal/state standards with delineation as needed by product (i.e., Medicare, Medicaid, Exchange)
 - f. Committee Reporting: Cultural and linguistic reporting is provided annually to Quality and Care Management committees to ensure integration of C&L into organization functions and support resolution of C&L barriers.

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II. Ensuring members fully understand the health care and services available to them, that they have the opportunity to participate in their own care, and have the right information to make informed decisions

I. The Company will:

- a. *Document Cultural/Linguistic/Disability Provider Access Capabilities – Update Provider Directories* in accordance with state contract and regulatory requirements, to reflect the cultural, linguistic, and/or disability access capabilities of contracted providers including:
 - i. *Disability Access* – the Company has a system to document disability access of contracted providers and information on provider access capabilities are made available in the provider directory, and/or assessment is completed regarding which network practitioners have completed cultural competency training.
 - a. Refer to policy MCARE.PRVS.10 Access and Availability for provider accessibility requirements pertaining to physical accessibility and Centene’s Provider Accessibility Initiative.
 - ii. *Cultural Competency* – Contracted providers confirm completion of ongoing cultural competency training, and this information is uploaded into the Company’s provider directory
 - iii. *Linguistic capabilities* – Contracted providers document office staff and provider non-English language capabilities. Providers documenting non-English language capabilities are attesting to meeting the standards for “qualified” bilingual staff per Section 1557 of the Affordable Care Act (ACA). Providers are required to attest that they and their staff have the appropriate skills, knowledge and qualifications to provide bilingual services in accordance with state and federal guidelines. Providers must retain documentation demonstrating compliance with these requirements and furnish this information upon request.
 - iv. *Provide Medical Care and Information on Treatment Options* – Contracted providers are expected to provide medical care, information, and treatment options in a manner that is respectful of diverse cultural beliefs, health literacy levels, and disability access needs, as well as preferred language choices. This includes, but is not limited to, a member’s ability to obtain, process, and understand information.
- b. *Maintain compliant provider directories and provide appropriate support services*
 - i. *Update Provider Directories* in accordance with state contract and regulatory requirements, to reflect any changes in the cultural, linguistic, and/or disability access capabilities of contracted providers.
 - ii. *Offer Support Services* to connect members with cultural, linguistic, and disability-responsive community health and social service resources.

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- c. *Meet the needs of members for language support and appropriate member materials*
- i. *Provide High Quality Interpreter and Linguistic Services:* free of charge, in a timely manner, for limited English proficient (LEP) members or potential members in all languages, including American Sign Language, at all key points of contact through a variety of formats. Services will be provided accurately and protect the privacy and independence of members with LEP.
 - a. Policy Statements
 - i. The Company evaluates and arranges for qualified interpreter services at the time of the appointment that is appropriate to the patient and the situation. Methods of interpreter services include telephonic, video, and in-person.
 - ii. The Company provides communication services in support of members who are visually impaired and deaf or hard of hearing.
 1. The Company Call Centers provide access to video relay or TTY lines to deaf or hard of hearing members/enrollees, their support person(s), and potential members/enrollees upon request.
 2. The Company provides American Sign Language for in-person communication for members who are deaf or hard of hearing.
 - iii. Bilingual staff: Only Company staff who have passed a bilingual assessment are eligible to use their bilingual skills to facilitate non-clinical communication. The Company ensures bilingual staff English proficiency through interview, hiring and annual training/evaluation requirements. For clinical interpretation, the Company only uses contracted interpreter vendors who meet interpreter quality standards.
 - iv. The Company and participating providers facilitate access to language services and documents a request and/or refusal of services in the plan or the provider's member data system.
 1. Use of family, friends and minors for interpreters: Federal law prohibits Providers and Company staff from requiring or recommending that members provide an interpreter, including ASL, or use friends or family to provider interpreter services.
 2. Minors: A minor child can only be used as an interpreter in an emergency involving an imminent threat to the safety or welfare of the individual or the public where there is no qualified interpreter for the individual with limited English proficiency immediately available.

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- 3. Adults: An accompanying adult may be used to interpret or facilitate communication in an emergency involving imminent threat to the safety and welfare of an individual or the public where there is no qualified interpreter available or, when the individual with limited English proficiency specifically requests that the accompanying adult interpret, the accompanying adult agrees to provide such assistance, and reliance on that adult for such assistance is appropriate under the circumstances.

- b. Quality standards for interpreter services are included in each interpreter vendor contract. Interpreter quality standards include:
 - i. Standards to adhere to generally accepted interpreter ethics principles, such as those published by the National Council for Interpreting in Health Care, including patient confidentiality;
 - ii. Demonstrated proficiency in speaking and understanding both spoken English and at least one other spoken language;
 - iii. Demonstrated ability to interpret effectively, accurately, and impartially, both receptively and expressly, to and from such language(s) and English, using any necessary specialized vocabulary, terminology and phraseology.

- c. Quality Standards for Bilingual Staff
 - i. Bilingual providers and staff are considered qualified to provide language services if they have a demonstrated proficiency in speaking and understanding both English and at least one other language, including any necessary specialized vocabulary, terminology, and phraseology; are able to effectively, accurately, and impartially communicate directly with individuals with limited English proficiency in their primary language. The Company will verify language capability of providers and staff who provide bilingual services and will document the languages spoken in the provider directory.

- d. Interpreter Services are available as required by contract or regulation.

- e. Interpreter services are coordinated with the scheduling of appointments in a manner that ensures that interpreter services are available at the time of the appointment.

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- f. Interpreter services must be provided to facilitate communication between the Company and the member/enrollee.
 - i. Interpreter services must be provided at all applicable points of contact
 - 1. Points of contact include but are not limited to medical care settings such as patient encounters, interactions with pharmacists, diagnosticians, laboratory technicians.
 - 2. Points of contact include non-medical care settings such as member services, appointment scheduling or orientations.
 - ii. Interpreter services are provided without imposing an undue delay on the scheduling of the appointment.

- g. Informing members of the availability of language services, including interpreter services and alternate formats.
 - i. The Company notifies all new and renewing members/enrollees of the availability of language services through methods such as websites, annual mailings, and member handbooks.
 - 1. The organization's member handbook:
 - a. Informs members how to access auxiliary aids and services.
 - b. Is available upon request.
 - c. Is available free of charge.
 - ii. The Company includes a notice of Non-Discrimination with all significant communications sent to members. The significant communication includes all Non-Discrimination elements required by federal rules or regulations.
 - iii. All significant communications that include Non-Discrimination information also include a Notice of Language Assistance advising the member of the availability of language assistance services. Other communications should include language assistance taglines when possible or as required by state or federal regulations.
 - iv. The Company notifies members/enrollees of the following:
 - 1. The availability of qualified interpreters.
 - 2. Their right to request or refuse interpreter services.
 - 3. Members/enrollees may request interpreter services without compromising the effectiveness of services.
 - 4. The provider may not request or require that the member bring their own interpreter.
 - 5. Minors can only be used as interpreters when there is an emergency.

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6. The availability of sign language interpreters.
 7. The use of family and friends as interpreters is permitted if it is appropriate to the situation and both the patient and the accompanying adult agree to act as interpreters.
- h. Provider language services notification
- i. The Company notifies contracted providers, including specialty plans, of the availability of no-cost interpreter services and oral translation services through Company Provider Operations Manual and other methods as determined by the Company. Notification will include:
 1. The types of interpreter services available at no cost from the Company.
 2. Information on how to arrange for interpreter services.
 3. The limitations on the use of bilingual staff, minors or accompanying adults as interpreters.
 - i. Monitoring of interpreter services
 - i. The Company monitors interpreter and oral translation services provided for effectiveness.
 - ii. The Company requires that interpreter, sign language, video remote interpretation and oral translation services meet the standards of quality necessary to each point of contact as required by law, regulatory agency, contract, or oversight agency.
 - iii. The Company requires that contracted interpreters and oral translators have received education and training in interpreter ethics, conduct and confidentiality.
 - iv. The Company conducts, at minimum, every other year business reviews of contracted interpretation service vendors that include performance review to determine if quality standards were met.
 - v. The Company reviews member/enrollee complaints and grievances related to the delivery of interpreter services.
 - ii. *Provide Translated Member Materials in non-English Threshold Language and Alternate Formats:*
 - a. *Threshold/prevalent languages*
 - i. The Company establishes and publishes prevalent languages for all lines of business annually, inclusive of identification of emerging languages that are trending toward becoming a threshold language. The Company

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coordinates any new prevalent/emerging languages with impacted departments to ensure coordination of material development.

- b. *Requirements for Translations and Alternate Formats*
- i. *Non-English languages:* The Company provides required translated materials in threshold/prevalent languages in accordance with state and federal requirements for mailed materials and materials available electronically. At a minimum, these materials are provided upon request by the member. The Company follows all State, MMP and Medicare regulations related to the requirements of standing requests as applicable. MMP and Medicare plans provide materials in non-English prevalent languages as a standing request. A standing request is a process that is used to make materials available to the member in threshold languages at the time of request and on an ongoing basis thereafter.
 - ii. *Alternative Formats:* Under Section 1557 of the Affordable Care Act, Title II of the Americans with Disabilities Act and Section 504 of the Rehabilitation Act of 1973, federally conducted and assisted programs along with programs of state and local government are required to make their programs accessible to people with disabilities as well as provide effective communication. Effective communication means to communicate with people with disabilities as effectively as communicating with others. Any documents sent by the Company or our delegate(s) are made available upon request in an alternate format. Once a member's alternate format preference is known, MMP and Medicare members receive their materials in their preferred alternate format as a standing request.
 - iii. *Oral Translations:* To ensure timeliness for access to medical information and/or for languages and/or materials that do not meet state and federal requirements for written translations, the Company, at a minimum, provides oral translations in all languages (including members who have visual impairments) by facilitating a reading of the material to the member in their preferred language through use of qualified bilingual staff and/or Company interpreter vendors. Written translation in any language is provided following oral translation, upon member request.
- c. *Quality requirements:* The Company ensures that all non-English translations and alternate formats meet the standards of quality required by law, regulatory

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agency, contract, or oversight agency. The Company uses contracted vendors for all non-English translations and braille. Translation vendors provide an attestation of quality for all materials CMS requires an attestation for all translations including alternate formats for materials provided to Medicare and MMP members. Document owners are responsible for requesting this from the vendor fulfilling this request.

1. Monitoring of the translation and alternate format process is conducted by the Company and includes:
 - a. Monitoring grievances that are related to alternate formats, taking corrective actions to address the grievance issues, tracking of grievances to identify trends, and collecting information on the performance of alternate format vendors.
 - b. Oversight of the vendors for quality standards, turn-around times and monitoring vendor performance.
 - c. Monitoring of workbaskets and workgroups with Centene line of business Project Managers to identify barriers and develop solutions to support quality translation processes.
 - d. *Ensure Website Accessibility:* The Company's website and content posted to the website meets the accessibility guidelines published by the Web Accessibility Initiative and outlined in Section 508 of the Rehabilitation Act of 1973.
- iii. *Develop information on community resources* that support the ethnic and diverse make-up of the member community with a focus on resources that support the social determinants of health.
- iv. *Written materials in plain language:* the Company ensures that all member materials are written in plain language and are culturally sensitive taking into consideration language proficiencies, type of disabilities, literacy levels, cultural variation, age-specific targeted learning skills and ability to access and use technology. Materials will be written in Sans Serif font using a font size of 12 or larger. When requested, or as required by regulators, materials in Large Print text are produced in font size 18 or larger. Unless otherwise specified in state contracts, plain language is determined as no greater than an 8th grade reading level for Medicare and Marketplace and 6th grade reading level for Medicaid/MMP. The Company uses readability testing on all materials to ensure plain language standards are met.

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III. Create a safe, accessible, and welcoming environment at key points of contact.

The Company and contracted providers share responsibility for:

- i. *Education and Training* – Staff, leadership (individuals with managerial authority and executive roles such as managers, directors, vice presidents or chief officers), governance bodies, including the organization’s board of directors, committees, providers and ancillary services such as home health, receive ongoing education and training to ensure cultural competency. The Company offers training, education, information and/or consultation on cultural and linguistic services to contracted providers and internal departments on a regular basis.

- ii. *Workforce Development* – The Company supports workforce development by recruiting, hiring, developing and promoting a culturally, linguistically, and disability-diverse workforce that reflects the diversity of the membership and has a familiarity with the service area, cultural norms, and how people access health care. This is accomplished in a variety of ways, including but not limited to:
 - Talent Attraction actively partners with all hiring leaders to encourage diverse hiring while also providing guides and resources (see resources available on Manager Central including the Partnership Guide and Interview Structure Best Practices: Selecting a Diverse Interview Panel).
 - Having Certified Diversity Recruiters on staff - Talent Advisors complete diversity training and receive Certified Diversity Recruiter (CDR) certification
 - A diverse executive hiring commitment, with specific goals surrounding Diversity of Slate (DoS) to ensure the company reflects the communities it serves
 - Workforce monitoring for potential underrepresentation
 - Professional development partnerships such as the St. Louis Business Diversity Initiative Fellows Program, Executive Immersion Program: RISE, and The Hispanic Leadership Institute (HLI)
 - Centene University – an award-winning training program that offers a plethora of trainings focused on diversity, equity, and inclusion
 - Equitable benefits for LGBTQ employees and their families
 - Non-discrimination policies across our business entities
 - Employee Inclusion Groups (EIGs)
 - Series of “Real Talk” sessions with Centene leadership as well as employee-led “Courageous Conversations”, focused on racial equity, justice, and allyship
 - Promote diverse hiring externally through Careers Site, Job Postings (member of DirectEmployers Association which then aggregates to diversity job hiring boards)
 - DEI Hiring Champion Pledge for all hiring managers (coming soon)

POLICY AND PROCEDURE

DEPARTMENT: Enterprise Quality & Performance Improvement (QPI)	DOCUMENT NAME: Cultural Competency and Linguistic Assistance Policy (C&L)
PAGE: 12 of 17	REPLACES DOCUMENT: N/A
APPROVED DATE: 01/05/2021	RETIRED: N/A
EFFECTIVE DATE: 12/19	REVIEWED/REVISED: 10/1/20, 01/05/2021, 1/28/2022, 10/2022
PRODUCT TYPE: All	REFERENCE NUMBER: CC.QI.CLAS.29

- iii. Hiring and recruitment practices for internal and external positions (temporary and permanent) including promotions and reclassifications are evaluated annually to track and measure the inclusiveness of the workforce (e.g., race, ethnicity, and sex). Entities that are subject to the recordkeeping and reporting requirements of the Equal Employment Opportunity Commission (EEOC) and the Office of Federal Contract Compliance Programs currently collect and maintain data and supporting documentation that may assist in evaluating and assessing their policies and practices related to workforce diversity and inclusion, monitoring and evaluating performance on an ongoing basis.
- iv. *Monitoring and Evaluation* – the Company uses the annual assessment to identify opportunities to improve diversity, equity, inclusion, and cultural humility within primary workforce groups (i.e., staff, leadership, governance bodies committees, etc.) coordinate interventions in partnership with quality improvement, utilization management and care coordination.

IV. Holding the Company and contracted providers, vendors and ancillary plans accountable to provide high quality health care and services that are accessible and culturally and linguistically responsive.

- a. Contracted providers will, as previously noted, *Document Cultural/Linguistic/Disability Access Capabilities*, as described in section II (a) (i) above.
- b. The Company will:
 - i. *Establish and Maintain community linkages* and provide documentation of community partnership.
 - ii. *Document Cultural/Linguistic/Disability Access Capabilities*, as described in section II (a) (i) above.
 - iii. *Develop Quality Assurance Standards* for cultural, linguistic, and disability access services to ensure the quality, accuracy, and timely delivery of these services at all points of contact for emergency, urgent, and routine health care services.
 - iv. *Evaluate* the Cultural, Linguistic, Disparity and Disability outcomes annually.
 - v. *Conduct audits* of vendors and ancillary plans for compliance with cultural and linguistic requirements.
 - i. Submission of annual reports that document language services provided, member demographic analysis of members served, P&Ps, training and bilingual staff certification. Reporting is aligned to ensure that quality interpreter standards are met through all vendors and ancillary plans that are not using Company language services.

POLICY AND PROCEDURE

DEPARTMENT: Enterprise Quality & Performance Improvement (QPI)	DOCUMENT NAME: Cultural Competency and Linguistic Assistance Policy (C&L)
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- ii. Internal review of vendor and ancillary plan P&Ps to ensure compliance with federal and state standards for C&L, as often as required per policy CC.COMP.21 Third Party Oversight Program Description.
 - iii. Participate in recurring Joint Oversight Committees (JOCs) with vendors who provide C&L services and review monthly or quarterly metrics and barriers. JOCs will also produce CAPs and support resolution of identified issues.
 - iv. Provision of Corrective Action Plan when vendors and ancillary plans are not in compliance with identified standards.

- vi. *Perform Quality Assurance Oversight for providers* – Perform quality assurance oversight of contracted providers to ensure compliance with the regulatory requirements related to cultural, linguistic, and disability access, on a regular basis. Activities may include: desktop review of policies and procedures and on-site review. The Company monitors member satisfaction and access to C&L services through Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey and appeals and grievances.

- vii. Both the Company and Contracted Providers will: *Inform Members of Right to File Grievance* – Ensure members receive information regarding a member’s right to file a grievance and seek an independent medical review in threshold, concentration standard languages, and in alternative formats and other languages, upon request.

- c. The Company will additionally:
 - i. *Provide Access to Grievance System* – Ensure members have access to and can participate in the grievance system. By participating in the grievance system, members receive, at a minimum, written translations and/or oral interpretation of grievance procedures, materials written in plain language. Easily understandable notification includes a complete explanation of the reason for the denial in plain language that does not include abbreviations or acronyms that are not defined, health care codes that are not explained, or medical jargon that a layperson would not understand), as well as access to auxiliary aids & services that assist members with disabilities.

 - ii. *Track and Report Grievances* – Track members’ complaints and grievances, including reporting related to discrimination, cultural, linguistic, and disability access.

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PRODUCT TYPE: All	REFERENCE NUMBER: CC.QI.CLAS.29

REFERENCES:

External References: Culturally and Linguistically Appropriate Standards (CLAS), Office of Minority Health; Americans with Disabilities Act (ADA), Title II and Title III; Civil Rights Act of 1964; Section 1557 of the Affordable Care Act (ACA); National Association of Social Workers (NASW) Practice Standards & Guidelines; Medicare Marketing Guidelines; Medicaid Managed Care Rules; NCQA Health Plan Standards and Guidelines 2020; NCQA Distinction in Multicultural Health Care (MHC) Standards and Guidelines (2021); NCQA Health Equity Accreditation Standards and Guidelines (2022); NCQA Population Health Management (PHM) Guidelines; Centers for Medicare and Medicaid Services (CMS) Code of Federal Regulations (CFR), CMS Criteria for Medicaid Managed Care Contract Review and Approval, Plain Writing Act of 2010; U.S. Code § 18031 Affordable choices of health benefit plans.

Internal References: CC.COMP.42 Section 1557 Nondiscrimination in Centene Health Care Programs and Activities, CC.COMP.21.02 Third Party Corrective Action Process, Found Policy, CC.MRKT.14 Web 508 Compliance, MCARE.PRVS.10 Access and Availability, CC.HUMR.75 Disability Accommodation, CC.HUMR.02 Equal Employment Opportunity & Affirmative Action, CC.COMP.21 Third Party Oversight Program Description

DEFINITIONS:

Alternate Formats — auxiliary aids used to effectively communicate printed information to people who are blind or have low vision or people who have other functional impairments. Text produced in audio formats, electronic formats, large print, braille and accessible PDFs.

Ancillary Plan — an additional health insurance plan entity that may provide extra “ancillary” services including services including vision, dental care, behavioral health care, etc.

Auxiliary aids and services — include, as defined in 45 CFR 92.4, (2) Qualified readers; taped texts; audio recordings; Braille materials and displays; screen reader software; magnification software; optical readers; secondary auditory programs; large print materials; accessible electronic and information technology; or other effective methods of making visually delivered materials available to individuals who are blind or have low vision; (3) Acquisition or modification of equipment and devices; and (4) Other similar services and actions.

Qualified bilingual/multilingual staff — a member of a covered entity’s workforce who is designated by the covered entity to provide oral language assistance as part of the individual’s current, assigned job responsibilities and who has demonstrated to the covered entity that he or she: (1) is proficient in speaking and understanding both spoken English and at least one other spoken language, including any necessary specialized

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vocabulary, terminology and phraseology, and (2) is able to effectively, accurately, and impartially communicate directly with individuals with limited English proficiency in their primary languages.

Braille — a tactile system of print in which the characters are represented by tangible points or dots.

Contract Provider — an individual provider, clinic, group, association, vendor or facility employed by or under a provider agreement with the contractor to furnish physical health, behavioral health or long-term care covered services to the contractor’s members under the provisions of this agreement.

Culture — includes, but is not limited to, history, traditions, values, family systems, and artistic expressions of client groups served in the different cultures related to race and ethnicity, immigration and refugee status, tribal status, religion and spirituality, sexual orientation, gender identity and expression.

Cultural Competence — a set of congruent behaviors, attitudes and policies that come together in a system or agency or among professionals that enables them to work effectively in cross-cultural situations. Cultural competency involves integrating and transforming knowledge, information and data about individuals and groups of people into specific clinical standards, service approaches, techniques and Marketing programs that match an individual’s culture to increase the quality and appropriateness of health care and outcomes.

Electronic Format — text that is produced for use with digital equipment such as email, computer programs, screen readers or electronic players such as MP3 players.

Grievance — an expression of dissatisfaction about any matter or aspect of the contractor or its operation, other than a contractor adverse benefit determination.

Health literacy — a person’s ability to read, understand, communicate, and act upon health information.

Health literacy level — the degree to which members are able to obtain, process, communicate, understand basic health information and services needed to make appropriate health decisions.

Large Print — text produced in Times New Roman or similar font style in font size 14 or larger as required by regulator.

Limited English Proficient (LEP) — an inability or limited ability to speak, read, write, or understand the English language at a level that permits effective Interaction with health care providers or plan employees.

Linguistic Competence (Capabilities) — providing readily available, culturally appropriate oral and written language services to limited English proficiency (LEP) (with the exception of Native American languages for which there are not written forms and/or for which the State has not obtained consent from Tribal leadership

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to use the language) members through such means as bilingual/bicultural staff, trained medical interpreters, and qualified translators.

Major subcontractors — an entity with which the contractor has, or intends to have, an executed agreement to deliver or arrange for the delivery of any of the covered services under the agreement.

Marketing materials — materials that are produced in any medium, by or on behalf of the contractor that can reasonably be interpreted as intended to market to a recipient or potential member.

Member — a person who has been determined eligible for the Company’s plan and who has enrolled in the contractor’s managed care organization (MCO).

Oral Interpretation — the process of understanding and analyzing a written text in one language and re-expressing that message faithfully, accurately, and objectively in a spoken or signed language, taking cultural and social context into account.

People-first language — a type of linguistic prescription to avoid marginalization or dehumanization (either conscious or subconscious) when discussing people with a health issue or disability. It can be applied to any group that would otherwise be defined or mentally categorized by a condition or trait (for example, disease, age, disability, or appearance).

Plain language — information focused on readers. It is also referred to as “plain English”. Materials written in plain language allow the readers to quickly and easily find what they need, understand what they find, and act appropriately on that understanding.

Points of contact — instances in which a member accesses the services covered under a plan contract, health insurer’s policy or certificate, including administrative and clinical services, telephonic and in-person contacts where the need for language assistance may be reasonably anticipated.

Provider — an institution, facility, agency, physician, health care practitioner, or other entity that is licensed or otherwise authorized to provide any of the covered services in the state in which they are furnished. Providers include individuals and vendors providing services to members through the self-directed community benefit.

Qualified interpreter for an individual with limited English proficiency — an interpreter who via a remote interpreting service or an on-site appearance: (1) adheres to generally accepted interpreter ethics principles, including client confidentiality; (2) has demonstrated proficiency in speaking and understanding both spoken English and at least one other spoken language; and (3) is able to interpret effectively, accurately, and impartially, both receptively and expressly, to and from such language(s) and English, using any necessary specialized vocabulary, terminology and phraseology.

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Source language — the language in which the statement or conversation originated. For the purposes of bilingual assessment, the source language is English.

Standing Request — a process that is used to make materials available to the member in threshold languages at the time of request and on an ongoing basis thereafter.

Subcontractors — an entity with which the contractor has, or intends to have, an executed agreement to perform any functions required under the agreement and does not include a provider or contract provider.

Target language — the language into which the statements are converted.

Threshold language — a language spoken by a minimum number or percentage of members.

Translation — the conversion of a written text in one language (source language) into a written text in a second language (target language) corresponding to and equivalent in meaning to the text in the first language.

Tribal — denoting an Indian or Alaska Native tribe, band, nation, pueblo, village, or community that the Secretary of the Interior acknowledges to exist as an Indian tribe pursuant to the Federally Recognized Indian Tribe List Act of 1994, 25 U.S.C.

REVISION LOG

REVISION:	DATE:
Addition of addenda - NE and KS	10/1/2020
Revision of Member Handbook Information	01/05/2021
Addition of updated KS addendum	11/12/2021
Annual review	1/28/22
Minor grammatical and formatting revisions	10/1/2022

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in our P&P management software is considered equivalent to a physical signature.

Vice President QI/QM _____ Date _____

POLICY AND PROCEDURE

POLICY NAME: Utilization Management Program Description	POLICY ID: CC.UM.01
BUSINESS UNIT: Please refer to system of record – Archer	FUNCTIONAL AREA: Utilization Management
EFFECTIVE DATE: 06/2002	PRODUCT: Marketplace, Medicare
REVIEWED/REVISED DATE: 07/17; 10/17; 01/18; 04/18; 01/19; 01/20; 07/20; 11/20; 12/20; 02/21; 06/21; 10/21; 02/22; 03/22; 07/22	
REGULATOR MOST RECENT APPROVAL DATE: N/A	

POLICY STATEMENT:

This policy outlines the Utilization Management program description.

PURPOSE:

To describe the Utilization Management Program.

SCOPE:

Population Health and Clinical Operations (PHCO)

DEFINITIONS: N/A

POLICY:

The Population Health and Clinical Operations Department maintains a Utilization Management Program Description which encompasses the functions of pre-authorization, care management, concurrent review, and disease management. The program description is consistent with all regulatory and accrediting guidelines. The document is reviewed and revised at least annually and more frequently as needed.

REFERENCES:

NCQA Health Plan Standards and Guidelines
 CM.01 - Care Management Program Description
 CP.CPC.01 - Clinical Policy Committee
 CP.CPC.03 - Preventive Health and Clinical Practice Guideline Policy
 CC.UM.27- Member Appeals System Description
 CC.QI.14 - Oversight of Delegated Activities
 EPC.CL.01 - Crisis Assessment, Triage, and Crisis Resolution

ATTACHMENTS:

Nebraska Total Care Addendum
 Managed Health Services WI Addendum
 Peach State Health Plan Addendum
 Celtic Insurance Company - Tennessee Addendum
 Arizona Complete Health Addendum
 Superior Health Plan Addendum
 Western Sky Community Care Addendum

ROLES & RESPONSIBILITIES: N/A

REGULATORY REPORTING REQUIREMENTS: N/A

REVISION LOG

REVISION TYPE	REVISION SUMMARY	DATE APPROVED & PUBLISHED
Annual Review	Annual review; updated document to 2017; removed revision history prior to 2014; no substantive changes	07/17
Ad Hoc Review	Added language to support Medicaid Final Rule for MHPAEA as applicable (81 FR 18389) pg. 28, paragraph 1 under Behavioral Health Management	10/17
Ad Hoc Review	Minor changes to the BH Management section to reflect changes in delegation of some BH UM activities.	01/18
Ad Hoc Review	• Minor grammatical changes throughout policy	04/18

	<ul style="list-style-type: none"> • Authority section – revised to note the UM Program may be reviewed/ approved by the QIC, or the BOD directly • UMSC section – revised to note the UMSC meets a minimum of four times a year (versus six times a year) • UM Process section – added verbiage regarding requests for LTSS services • Qualifications and Training/Chief Medical Director section – added verbiage noting all appropriate practitioners who can made medical necessity denials • Qualifications and Training section – added references to BH professionals where applicable, and minor changes to UM staff descriptions • Added BH detail throughout policy where appropriate, including BH services under covered benefits listing, BH criteria, BH specific clinical information, etc. • Prior authorization/clinical information section – removed references to requests for coding • Appeal of UM Decisions section – revised appeal filing timeframe to 60 days (from 90 days) to reflect NCQA and federal requirement for Medicaid • Behavioral Health Management section – removed reference to delegation, as this is addressed in the delegation section • Triage and Referral for Behavioral Health section – added definitive statement clarifying that health plans do not have a centralized triage and referral process • Added Behavioral Health Levels of Care section, describing each behavioral health level of care in detail • Removed detail in Disease Management section as detail is addressed in other policies <p>Removed detail in Case Management section as detail is addressed in other policies</p>	
Annual Review	Removed revision history prior to 2016, no substantive changes.	01/19
Annual Review	<p>Removed revision history prior to 2017. Changed “<i>Utilization Management Subcommittee</i>” to “<i>Medical Management Committee</i>.”</p> <ul style="list-style-type: none"> • Added “<i>The services include medical, behavioral and pharmacy services</i>” under Scope section. • Added “<i>Staff who are not qualified healthcare professionals, who are under the supervision of appropriately licensed healthcare professionals may approve services when there are explicit UM criteria and no clinical judgment is required</i>” to QUALIFICATIONS AND TRAINING section. • Added “<i>Plan regularly monitors and reports on timeliness of UM decision making</i>” under TIMELINESS OF UTILIZATION MANAGEMENT DECISIONS section. • Added “<i>The Plan implements any IRO, State Fair Hearing, External Review appeal overturn decision as applicable</i>” under Independent/External Appeals section. <p>Updated REFERENCES section by adding policies:</p> <ul style="list-style-type: none"> • CP.CPC.01 - Clinical Policy Committee • CP.CPC.03 Preventive Health and Clinical Practice Guideline Policy • QI.11 - Appeals and Grievance Process <p>Minor grammatical and formatting changes.</p>	01/20
Ad Hoc Review	Updated addendum for Nebraska Total Care.	07/20
Ad Hoc Review	Updated Implementation section to include telemedicine. Added <i>Marketplace</i> under Product Type in header. Added <i>EPC.CL.01 - Crisis Assessment, Triage, and Crisis Resolution</i> to REFERENCES section.	11/20

Annual Review	Removed revision history prior to 2016, no substantive changes.	01/19
Annual Review	<p>Removed revision history prior to 2017. Changed “<i>Utilization Management Subcommittee</i>” to “<i>Medical Management Committee</i>.”</p> <ul style="list-style-type: none"> Added “<i>The services include medical, behavioral and pharmacy services</i>” under Scope section. Added “<i>Staff who are not qualified healthcare professionals, who are under the supervision of appropriately licensed healthcare professionals may approve services when there are explicit UM criteria, and no clinical judgment is required</i>” to QUALIFICATIONS AND TRAINING section. Added “<i>Plan regularly monitors and reports on timeliness of UM decision making</i>” under TIMELINESS OF UTILIZATION MANAGEMENT DECISIONS section. Added “<i>The Plan implements any IRO, State Fair Hearing, External Review appeal overturn decision as applicable</i>” under Independent/External Appeals section. <p>Updated REFERENCES section by adding policies:</p> <ul style="list-style-type: none"> CP.CPC.01 - Clinical Policy Committee CP.CPC.03 - Preventive Health and Clinical Practice Guideline Policy QI.11 - Appeals and Grievance Process <p>Minor grammatical and formatting changes.</p>	01/20
Ad Hoc Review	Updated addendum for Nebraska Total Care.	07/20
Ad Hoc Review	Updated Implementation section to include telemedicine. Added <i>Marketplace</i> under Product Type in header. Added <i>EPC.CL.01 - Crisis Assessment, Triage, and Crisis Resolution</i> to REFERENCES section.	11/20
Ad Hoc Review	Added addendum for Managed Health Services of Wisconsin .	12/20
Annual Review	<p>Replaced MM with PHCO and updated REFERENCES section:</p> <p>Added policies:</p> <ul style="list-style-type: none"> <i>CC.UM.27-Member Appeals System Description</i> <i>QI.14- Oversight of Delegated Activities</i> <p>Deleted policy:</p> <ul style="list-style-type: none"> <i>QI.11 - Appeals and Grievance Process.</i> <p>Minor verbiage changes made throughout policy for clarity. Added addendum for Peach State Health Plan.</p>	02/21
Ad Hoc Review	Updates for references to associated P&Ps; grammatical updates for clarity and tense.	06/21
Ad Hoc Review	Added addendum for Celtic Insurance Company – Tennessee.	10/21
Annual Review	Added addendum for Ascension Complete and updated addendum for TN.	02/22
Ad Hoc Review	No content change to policy. Updated addendum for Nebraska Total Care.	03/22
Ad Hoc Review	Added addendum for Superior Health Plan and updated addendum for Arizona Complete Health.	07/22
Ad Hoc Review	Added addendum for Western Sky Community Care.	11/22

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, the Company’s P&P management software, is considered equivalent to a signature.

2022
Utilization Management
Program Description

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Purpose

The purpose of the Utilization Management (UM) Program Description is to define the structures and processes within Population Health and Clinical Operations, including assignment of responsibility to appropriate individuals, to promote fair, impartial, and consistent utilization management decisions and coordination of care for the health plan members.

Scope

The scope of the UM Program is comprehensive and applies to all eligible members across all product types, age categories, and range of diagnoses. The UM Program incorporates all care settings including preventive care, emergency care, primary care, specialty care, acute care, short-term care, long term care, and ancillary care services. The services include medical, behavioral, and pharmacy services.

Goals

The goals of the UM Program are to optimize members' health status, sense of well-being, productivity, and access to quality health care, while at the same time actively managing cost trends. The UM Program aims to provide services that are covered benefits, medically necessary, appropriate to the patient's condition, rendered in the appropriate setting, and meet professionally recognized standards of care.

Implementation

The UM Program seeks to advocate the appropriate utilization of resources using the following program components: 24-hr nurse triage, telemedicine, prior authorization/precertification, second opinion, concurrent review, ambulatory review, and retrospective review for both medical and behavioral health care services, and discharge planning activities. Additional program components implemented to achieve the program's goals include tracking utilization of services to guard against over- and under-utilization of services and interactive relationships with practitioners to promote appropriate practice standards. Referrals to hospital discharge planners and dialogue with the primary care provider (PCP) regarding long-term needs are initiated promptly. The PCP is responsible for assuring appropriate utilization of services along the continuum of care.

Confidentiality

Confidential information is defined as any data or information that can directly or indirectly identify a patient or physician. The Plan adheres to the following:

- Staff and consultants are required to sign a confidentiality statement.
- All members of the UM Committee are required to sign a confidentiality waiver.
- All employees and practitioners can access and disclose confidential information only as necessary to fulfill assigned duties and responsibilities.
- Medical information sent by mail or fax to the attention of the recipient is clearly marked "personal and confidential".
- All medical information is secured in a locked location with access limited to essential personnel only.
- Medical information stored in the software system is protected under multiple levels of security by system configuration, which includes user access passwords.
- Confidential information is destroyed by a method that induces complete destruction when no longer needed.
- The Plan abides by all federal and state laws governing the issue of confidentiality.

Authority

The Plan Board of Directors (BOD) has ultimate authority and accountability for the oversight of the quality of care and services provided to members. The BOD oversees development, implementation and evaluation of the Quality Improvement Program. The Plan BOD delegates the daily oversight and operating authority of UM activities to the Plan's Quality Improvement Committee (QIC), which, in turn, delegates responsibility for the UM Program to the Population Health and Clinical Operations Committee (PHCOC), including the review and appropriate approval of medical necessity criteria and protocols and utilization management policies and procedures. The PHCOC is responsible for reviewing all utilization management issues and related information and making recommendations to the Plan's QIC or the BOD as necessary. The UM Program is reviewed and approved by the Plan's BOD or the QIC on an annual basis.

The Chief Medical Director has operational responsibility for and provides support to the Plan's UM Program. The Plan Chief Medical Director, Vice President of Population Health and Clinical Operations (VPPHCO), and/or any designee as assigned by the Plan President and CEO are the senior executives responsible for implementing the UM Program including cost containment; review activities pertaining to utilization review, complex, controversial or experimental services; and successful operation of the PHCOC. A designated behavioral health practitioner is involved in the implementation, monitoring, and directing of behavioral health aspects of the UM Program. Appropriate specialists are involved in the implementation, monitoring, and directing of specialty health and service aspects of the UM Program. A

pharmacist oversees the implementation, monitoring, and directing of pharmacy services. In addition to the Chief Medical Director, the Plan may have one or more other Medical Directors.

The Chief Medical Director's responsibilities include, but are not limited to, coordination and oversight of the following activities:

- Development/revision of UM policies and procedures as necessary to meet state and federal statutes and regulations and accrediting body requirements.
- Monitor compliance of the UM Program.
- Provide clinical support to the UM staff in the performance of their UM responsibilities.
- Assure medical necessity criteria used in the UM process are appropriate and reviewed by physicians and other practitioners according to policy.
- Assure the medical necessity criteria are applied in a consistent manner.
- Assure review of cases that do not meet medical necessity criteria are conducted by physicians or other healthcare professional as appropriate, in a manner that meets all pertinent statutes, regulations and Plan policy, and takes into consideration the individual needs of the involved members and assessment of the local delivery system.
- Review, approve, and sign (if required) denial letters for cases that do not meet medical necessity criteria after appropriate review has occurred.
- Assure the medical necessity appeal process is carried out in a manner that meets all applicable contractual requirements, as well as all federal and state statutes and regulations, is consistent with all applicable accreditation standards, and is done in a consistent and efficient manner.
- Provide a point of contact for practitioners calling with questions about the UM process.
- Communicate/consult with practitioners in the field as necessary to discuss UM issues.
- Coordinate and oversee the delegation of UM activity as appropriate and monitor each delegated arrangement assuring all applicable contractual requirements and accreditation standards are met.
- Assure there is appropriate integration of physical, behavioral, and social health services for all Plan members.
- Participate in and provide oversight to the PHCOC and all other physician committees or subcommittees.
- Recommend and help monitor corrective action as appropriate for practitioners with identified deficiencies related to UM.
- Serve as a liaison between UM and other Plan departments.
- Educate practitioners regarding UM issues, activities, reports, requirements, etc.
- Report UM activities to the QIC as needed.

Integration With Other Programs

The UM, Pharmacy and Therapeutics (P&T), Quality Improvement (QI), Credentialing, and Fraud, Waste, and Abuse Programs are closely linked in function and process.

The UM process utilizes quality indicators as a part of the review process and provides the results to the Plan's QI Department. As care managers perform the functions of utilization management, quality indicators (including those prescribed by the Plan as part of the patient safety plan) are identified. The required information is documented appropriately and forwarded to the QI Department for review and resolution. As a result, the utilization of services is inter-related with the quality and outcome of the services.

Any adverse information that is gathered through interaction between the Plan UM staff and the practitioner or facility staff is also vital to the recredentialing process. Such information may relate, for example, to specific care management decisions, discharge planning, precertification of non-covered benefits, etc. The information is forwarded to the QI Department in the format prescribed by the Plan for review and resolution as needed. The Chief Medical Director or Medical Director determines if the information warrants additional review by the Plan Peer Review or Credentialing Committee. If committee review is not warranted, the information is documented in the practitioner's record and may be used for trending or reviewed at the time of the practitioner's recredentialing.

UM policies and processes serve as integral components in preventing, detecting, and responding to fraud, waste, and abuse among practitioners and members. The Department works closely with the Compliance Officer and the Special Investigations Unit to resolve any potential issues that may be identified.

In addition, the Plan coordinates utilization/care management activities with local community practitioners for activities that include, but are not limited to:

- Early childhood intervention

- State protective and regulatory services
- Women, Infant, and Children Services (WIC)
- EPSDT services/Health Check
- Services provided by local public health departments

Population Health and Clinical Operations Committee (PHCOC)

Daily oversight and operating authority of UM activities are delegated to the PHCOC, which reports to the Plan's QIC and ultimately to the Plan BOD. The PHCOC is responsible for the review and appropriate approval of medical necessity criteria and protocols and UM policies and procedures. The PHCOC coordinates annual review and revision of the UM Program Description, Work Plan, and the Annual UM Program Evaluation. These documents are presented annually to the BOD or QIC for review and approval. The PHCOC monitors and analyzes relevant data to detect and correct patterns of potential or actual inappropriate over- or under-utilization, which may impact health care services, coordination of care, and appropriate use of services and resources as well as member and practitioner experience with the UM process. Analysis of the above tracking and monitoring processes, as well as status of corrective action plans, as applicable, are reported to the Plan's QIC.

In addition to the above, the PHCOC also provides ongoing evaluation of the appropriateness and effectiveness of practitioner quality incentive payments and assists in modifying and designing an appropriate quality incentive program.

PHCOC Scope

- Oversees the UM activities of the Plan regarding compliance with contractual requirements, federal and state statutes and regulations, and requirements of accrediting bodies such as the National Committee for Quality Assurance (NCQA).
- Develops and annually reviews/approves the UM Program Description, guidelines, policies and procedures, and the list of services requiring prior authorization.
- Monitors reports for timeliness of behavioral, non-behavioral, and pharmacy UM decisions and notification.
- Reviews practitioner-specific UM reports to identify trends and/or utilization patterns and makes recommendations to the QIC for further review.
- Reviews reports specific to facility and/or geographic areas for trends and/or patterns.
- Examines appropriateness of care reports to identify trends and/or patterns of over- and under-utilization; refers identified practitioners to the QIC for performance improvement and/or corrective action.
- Examines results of annual member and practitioner satisfaction surveys to determine overall experience with the UM Program and identify areas for performance improvement.
- Provides a feedback mechanism to the QIC for communicating findings, recommendations, and a plan for implementing corrective actions related to UM issues.
- Identifies those opportunities whereby the UM data can be utilized in the development of quality improvement activities and submitted to the QIC for recommendations.
- Reports findings of UM studies and activities to the QIC.
- Liaisons with the QIC for ongoing review of quality indicators.

PHCOC Members

The Plan actively involves participating network practitioners in utilization review activities as available and to the extent that there is not a conflict of interest. The Plan's UM Program Description and policies define when such a conflict may exist and describe the remedy when conflicts occur. Participation in the Plan's PHCOC is one of the primary ways in which network practitioners participate in Plan utilization review activities.

Plan's PHCOC is comprised of the following members:

- Network practitioners representing the range within the network and across the service area
- Plan Chief Medical Director/Medical Director
- Plan VPPHCO
- Plan executive leadership, UM, and QI staff
- Other operational staff as requested, e.g., Network/Contracting, Member/Provider Services, Compliance/Regulatory, Pharmacy

The PHCOC is chaired by a Plan Medical Director and may be co-chaired by a network physician; this activity may be delegated to another physician member or the VPPHCO for a specific meeting as needed.

Meeting Frequency and Documentation of Proceedings

The PHCOC meets at least four (4) times per year and the VPPHCO maintains detailed records of all PHCOC meeting minutes, UM activities, care management program statistics, and recommendations for UM improvement activities made by the PHCOC. The PHCOC submits to the QIC meeting minutes and reports regarding UM studies and activities.

Utilization Management Process

The UM process encompasses the following program components: 24-hr nurse triage, referrals, second opinions, prior authorization, pre-certification, concurrent review, ambulatory review, retrospective review, discharge planning and care coordination. All approved services must be medically necessary or in the case of long-term services and supports (LTSS), be supported by an assessment of needs of the designated program benefits. The clinical or service decision process begins when a request for authorization of service or determination of service need for member receiving LTSS is received at the Plan. Request types may include authorization of specialty services, second opinions, outpatient services, ancillary services, scheduled inpatient services, or emergent/urgent inpatient services, including obstetrical deliveries. The process is complete when the requesting practitioner and member (when applicable) have been notified of the determination.

Qualifications and Training

Appropriately licensed, qualified health professionals supervise the UM process and all medical necessity decisions. A physician or other appropriately licensed health care professional (as indicated by case type) reviews all medical necessity denials of healthcare services offered under the Plan's benefits. Personnel employed by or under contract to perform utilization review are appropriately qualified, trained, and hold current professional licensure. This licensure is specific to the state of contract if required by state regulations. Staff who are not qualified healthcare professionals, who are under the supervision of appropriately licensed healthcare professionals may approve services when there are explicit UM criteria, and no clinical judgment is required.

UM employee compensation includes hourly fees and salaried positions. All staff completing UM reviews and decisions are required to sign an affirmative statement regarding compensation annually. Compensation or incentives to staff or agents based on the amount or volume of adverse determinations; reductions or limitations on lengths of stay, benefits, services; or frequency of telephone calls or other contacts with health care practitioners or patients is prohibited. The Plan and its delegated Utilization Review agents do not permit or provide compensation or anything of value to its employees, agents, or contractors based on:

- The percentage of the amount by which a claim is reduced for payment, the number of claims or the cost of services for which the person has denied authorization or payment, decisions that result in under-utilization; or
- Any other method that encourages the rendering of an adverse determination.

The Plan determines appropriate staffing based on Plan need and contract requirements that may include, but is not limited to the following:

Chief Medical Director/Medical Director

As previously stated, the Chief Medical Director oversees the UM Program. The Chief Medical Director/Medical Director(s) is a physician currently licensed (without restrictions) to practice medicine in the state. The Chief Medical Director and Medical Director(s) are hereafter collectively referred to as 'Medical Director'.

The Medical Director is required to supervise all medical necessity decisions and conducts level II medical necessity reviews. Persons authorized to make a clinical denial based on medical necessity include licensed MDs, DOs, doctoral-level clinical psychologists, certified addition-medicine specialists, chiropractors, physical therapists, dentists (DDSs), and pharmacists (RPhs) (as allowed by state contract).

Behavioral Health Practitioner

A behavioral health practitioner is involved in implementing, monitoring, and directing the behavioral health care aspects of the Plan's UM program. A behavioral health practitioner may participate in UM rounds to assist in identifying behavioral health care needs and integrating behavioral and physical care. Behavioral health practitioners also participate on various Plan committees. The behavioral health practitioner may be a Medical Director, a clinical director, or a Plan network practitioner and must be a physician or appropriate behavioral health practitioner (i.e., behavioral health practitioner with a clinical PhD or PsyD).

Vice President of Pharmacy Operations (as applicable)

The Vice President of Pharmacy Operations is a registered pharmacist with experience in UM activities. The VPPO is responsible for overseeing the day-to-day operational activities of the Plan's Pharmacy Program. The VPPO reports to the Plan Chief Medical Director. The VPPO, in collaboration with the Pharmacy Benefit Manager (PBM), assists

with the development of the Pharmacy UM strategic vision in alignment with the corporate and Plan objectives, policies and procedures.

Plan Pharmacist/Pharmacy Director

The Plan Pharmacist is a licensed (without restrictions) pharmacist in the state of contract. Plan Pharmacists report directly to the Plan Medical Director, or Vice President of Pharmacy Operations. The Plan Pharmacist monitors and analyzes pharmacy utilization and reports findings to the Plan PHCOC and/or QIC. The Plan Pharmacist is a member of the Plan's Pharmacy and Therapeutics (P&T) Committee.

Pharmacy Manager (if Plan has one – otherwise refer up to Pharmacy Director)

The Plan Pharmacy Manager is a licensed pharmacist in the state of contract. The Plan Pharmacy Manager reports directly to the Plan Pharmacist/Pharmacy Director. The Pharmacy Manager is the point of contact for Plan physicians regarding concerns with the preferred drug list. Where applicable, the Pharmacy Manager reviews all pharmacy prior authorization requests that do not meet criteria and makes an appropriate determination in conjunction with the Plan Medical Director, if needed. Plan Pharmacy Manager and the Plan Pharmacist monitor pharmacy utilization and report findings to Plan PHCOC and/or QIC.

Pharmacy Technicians

Pharmacy Technicians are individuals with experience working in a pharmacy and have a minimum of a high school diploma. Where applicable, Pharmacy Technicians review information submitted for pharmacy preauthorization and may have the authority to approve specific services for which there are explicit criteria. Pharmacy Technicians cannot make clinical determinations and must refer all clinical decisions to the Plan Pharmacist. Pharmacy technicians report to and are supervised by the Plan Pharmacist.

Board-Certified Clinical Consultants

In some cases, the clinical judgment needed for a UM decision is specialized. In these instances, the Medical Director may utilize a board-certified consultant from the appropriate specialty for additional or clarifying information when making medical necessity determinations or denial decisions. Clinical experts outside the Plan may be contacted when necessary to avoid a conflict of interest. The Plan defines conflict of interest to include situations in which the practitioner who would normally advise on a UM decision made the original request for authorization or determination or is in, or affiliated with, the same practice group as the practitioner who made the original request or determination.

Service Consultants

UM staff call upon service experts outside the Plan to assist in making authorization determinations for specialty services in certain cases. In these instances, a licensed/certified service consultant specializing in the area of service in question is contacted. Specialty service consultants may include but are not limited to: Occupational Therapist, Physical Therapist, Speech Therapist, Physician Assistant, Certified Nurse Practitioner, etc.

Vice President of Population Health and Clinical Operations (VPPHCO)

The VPPHCO is a registered nurse with experience in UM and Care Management (CM) activities. The VPPHCO is responsible for overseeing the day-to-day operational activities of the Plan's UM Program. The VPPHCO reports to the Plan President and CEO or Chief Operating Officer (COO). The VPPHCO, in collaboration with the Chief Medical Director, assists with the development of the UM strategic vision in alignment with the corporate and Plan objectives, policies and procedures.

Utilization Management Director/ Manager

The UM Director/Manager is a registered nurse or appropriate licensed behavioral health professional. The UM Director/Manager directs and coordinates the activities of the department including supervision of the referral specialist staff, prior authorization and concurrent review nurses, and denial/appeals staff as applicable. The UM Director/Manager reports to the VPPHCO. They work in conjunction with the VPPHCO and CM Director/Manager to execute the strategic vision in conjunction with corporate and Plan objectives, policies and procedures and state contractual responsibilities.

Care Management Director/ Manager

The Director/Manager of CM is a registered nurse or other appropriately licensed healthcare professional. The CM Director/ Manager directs and coordinates the activities of the department including supervision of the Care Managers, Program Specialists and Program Coordinators. The CM Director/Manager reports to the VPPHCO. They

work in conjunction with the VPPHCO and the UM Director/Manager to execute the strategic vision in conjunction with corporate plan objectives and attendant policies and procedures and state contractual responsibilities.

Care Managers

Care Managers are nurses or appropriate licensed behavioral health professionals with clinical and preferably UM and/or CM experience. There are several levels or types of CMs within the organization and as such may be referenced with alternate titles such as: Prior Auth Nurse, Concurrent Review Nurse, Discharge Planning Nurse, Hospital Care Manager, Complex Care Manager, Catastrophic Care Manager, Disease Care Manager, Care Manager I, Care Manager II, etc., hereinafter collectively referred to as Care Managers.

Care Managers who coordinate discharge planning and apply approved UM medical necessity criteria to new or continued service requests and for concurrent review and requests for discharge report to and are supervised by the Director/Manager of UM. Care Managers who are responsible for the daily coordination of care management and similar specialty programs report to the Director/Manager of Care Management. Care Managers are prohibited from making adverse medical necessity determinations. When a request for authorization of services does not meet the standard UM criteria, the case is referred to the Medical Director for a medical necessity review.

Program (Social Service) Specialists

Program Specialists (also known as Social Service Specialists) are individuals with background in social services or other applicable health related field, who may or may not be licensed. Program Specialists work with Care Managers and other members of the team to coordinate psychosocial and community resources for members. They assist members with utilization of medical resources related to care management, disease management and discharge planning. Program Specialists are authorized to approve specific services for which there are explicit criteria, develop service plans (as applicable for members in LTSS or other service-oriented benefit programs) and coordinate care plans. They are required to refer all potential adverse determinations to the designated Plan Medical Director. Program Specialists report to the Director/Manager of Care Management.

Program Coordinators

Program Coordinators are highly trained clinical or non-clinical staff with significant experience as a health service professional. This experience may be from a variety of settings of care: lab, hospital, clinic, or other community-based entity. This staff assists the care team with administrative duties such as member or provider follow-up calls, data collection for screening assessments, obtaining test results, coordinating home health services, and obtaining transportation. They may attend marketing and outreach meetings and coordinate services with community-based organizations. They work in collaboration with the interdisciplinary care team and refer all clinical decisions to the Care Manager.

Referral Specialists

Referral Specialists are individuals with significant administrative experience in the health care setting. Experience with diagnosis and procedural coding is preferred. Referral Specialists work with providers to collect demographic and other data necessary for preauthorization and may have the authority to approve services for which there are explicit criteria or algorithms. Referral Specialists cannot make clinical determinations, referring all clinical decisions to a Care Manager. Referral Specialists report to and are supervised by the UM Director/Manager or qualified designee.

Medical Necessity Review

Covered services are those medically necessary health care services provided to members as outlined in the Plan's contract with the State and/or CMS, or member's evidence of coverage. Medical necessity means the covered services prescribed are based on generally accepted medical practices considering conditions at the time of treatment. Medically necessary services are those that are:

- Appropriate and consistent with the diagnosis of the treating practitioner and the omission of which could adversely affect the member's medical or behavioral health (BH) condition;
- Compatible with the standards of acceptable medical practice in the community;
- Provided in a safe, appropriate, and cost-effective setting given the nature of the diagnosis and the severity of the symptoms;
- Not provided solely for the convenience of the member, the practitioner, or the facility providing the care;
- Not primarily custodial care unless custodial care is a covered service or benefit under the member's evidence of coverage and appropriate; and
- There must be no other effective and more conservative or substantially less costly treatment, service, and setting available.

Medical necessity determinations are made by appropriate professionals and include decisions about covered benefits defined by the Plan, including inpatient and outpatient services, as listed in the summary of benefits and care or services that could be considered either covered or non-covered, depending on the circumstances.

Covered benefits vary by Plan contract and may include any or all the following with associated coverage limitations:

- ambulatory surgical services
- audiology services
- BH crisis stabilization
- BH day treatment
- BH acute inpatient care
- BH intensive outpatient treatment
- BH outpatient services
- BH partial hospitalization
- childbirth education services
- dental services
- durable medical equipment
- early and periodic screening, diagnostic and treatment services
- emergency transportation services
- family planning services
- federally qualified health center services
- home health services
- hospice services
- inpatient hospital services
- laboratory and radiological services
- nurse midwife services
- nurse practitioner services
- nursing facility services
- obstetrical services
- occupational therapy services
- optometric services
- orthotic and prosthetic services
- oral surgery
- outpatient hospital services
- pharmacy services
- physical therapy services
- physician services
- podiatric services
- pregnancy-related services
- private duty nursing services
- psychiatric residential treatment
- rural health clinic services
- speech therapy services
- substance abuse services
- swing bed services
- targeted care management
- transplants

Two levels of UM medical necessity review are available for all authorization requests:

Level I review is conducted on covered medical benefits by a Care Manager who has been appropriately trained in the principles, procedures, and standards of utilization and medical necessity review. A Level I review is conducted utilizing Change Healthcare's InterQual®, the American Society of Addiction Medicine's (ASAM) criteria, or applicable state or company developed clinical policy, while taking into consideration the individual member needs and complications at the time of the request, in addition to the local delivery system available for care. Other factors that must be considered when applying criteria to a given individual situation includes the member's age, co-morbidities, complications, progress of treatment, psychosocial situation, and home environment, when applicable. At no time does a Level I review result in a reduction, denial, or termination of service. Adverse determinations can only be made by a Medical Director, or other healthcare professional as appropriate, during a Level II review.

Level II review is conducted on a case-by-case basis by an appropriate practitioner with a current license to practice without restriction, or other healthcare professional as appropriate. For instance, if the request is for a behavioral health service, a qualified behavioral health practitioner conducts the Level II review or is consulted during the review. If the request is for dental services, a qualified dental practitioner conducts the Level II review. Automatic referral for Level II review includes requests for services or procedures that require benefit determination, services that do not have existing medical necessity criteria, or are potentially experimental or new in practice. A Level II review is also indicated when the request does not meet the existing medical necessity criteria following a Level 1 review. All Level II reviews are conducted with consideration given to continuity of care, individual member needs at the time of the request, and the local delivery system available for care. A board-certified consultant may be used or consulted in making a medical necessity determination.

Clinical Criteria

The goal in utilization management is to help guide best practice medicine in the most efficient and economical manner while addressing patient-specific needs. To that end, the clinical decision criteria utilized aligns the interests of the health plan, the practitioner, and the member. The UM criteria are nationally

recognized, evidence-based standards of care and include input from recognized medical experts. UM criteria and the policies for application are reviewed and approved at least annually and updated as appropriate. Through the PHCOC, appropriate practitioners are involved in developing, adopting, and reviewing criteria. Utilization review criteria are utilized as an objective screening guide and are not intended to be a substitute for physician judgment. Utilization review decisions are made in accordance with currently accepted medical or health care practices, while taking into consideration the individual member needs and complications at the time of the request, in addition to the local delivery system available for care. The Medical Director (or other appropriate practitioner as defined in this program description), reviews all potential medical necessity denials for medical appropriateness and has authority to implement an adverse determination which results in reduction, suspension, denial, or termination of services.

In general, the Plan uses InterQual guidelines to determine medical necessity and appropriateness of physical and/or behavioral health care. Change Healthcare plays an integral role in healthcare, serving more than 50% of America's hospitals, 20% of U.S. physicians and 96% of the top health plans. InterQual is developed by generalist and specialist physicians representing a national panel from academic as well as community-based practice, both within and outside the managed care industry. InterQual provides a clear, consistent, evidence-based platform for care decisions that promote appropriate use of services, enhance quality, and improve health outcomes. The Plan uses InterQual's Level of Care and Care Planning Criteria for Pediatric Acute, Adult Acute, Home Care, Durable Medical Equipment, and Procedures to determine medical necessity and appropriateness of care. The Plan may also use the Subacute/SNF guidelines to assist in determining medical necessity for subacute or skilled nursing care for members with catastrophic conditions or special health care needs. The Plan utilizes InterQual guidelines for behavioral health inpatient, residential/PRTF, partial hospitalization, intensive outpatient and outpatient therapy services. The Plan may also use ASAM criteria for substance abuse.

New Technology Review

In instances of determining benefit coverage and medical necessity of new and emerging technologies, the new application of existing technologies, or application of technologies for which no InterQual Criteria exists, the Plan's Medical Director consults available Clinical Policies. The Clinical Policy Committee (CPC) develops these statements.

The CPC is responsible for evaluating new technologies or new applications of existing technologies for inclusion as medical necessity criteria. The CPC develops, disseminates and at least annually updates clinical policies related to medical procedures, behavioral health procedures, devices, and pharmaceuticals. The CPC or assigned designee reviews appropriate information including published scientific evidence, applicable government regulatory body information, CMS's National and Local Coverage Decisions database/manual, and input from relevant specialists and professionals who have expertise in the technology. Practitioners are notified in writing through the provider newsletters and the practitioner web portal (as applicable) of new technology determinations made by the Plan.

Preventive and Clinical Practice Guidelines

While practice guidelines are not used as criteria for medical necessity determinations, the Medical Director and UM staff make UM decisions that are consistent with national evidence-based guidelines distributed to network practitioners. Such guidelines include, but are not limited to, Adult and Child Preventive Health, Asthma, Prenatal Care, Diabetes, Lead Screening, Sickle Cell, Immunizations, and ADHD/ADD Guidelines for both adults and children.

Practitioner Access to Criteria

At any time, treating practitioners may request UM criteria, including internal clinical policy, pertinent to a specific authorization request by contacting the Population Health and Clinical Operation department or may discuss the UM decision with the Plan Medical Director. Each contracted practitioner receives a Provider Manual, a quick reference guide, and a comprehensive orientation that contains critical information about how and when to interact with the department. The manual also outlines the Plan's policies and procedures.

Interrater Reliability

At least annually, the Chief Medical Director and VPPHCO assess the consistency with which Medical Directors and UM staff making clinical decisions apply UM criteria in decision-making. The assessment is

performed as a periodic review by the VPPHCO or designee to compare how staff members manage the same case, a forum in which the staff members and physicians evaluate determinations, or periodic reviews/audits of cases against criteria. When an opportunity for improvement is identified through this process, the Plan's leadership takes corrective action. New UM staff is required to successfully complete interrater reliability testing prior to being released from training oversight.

Submission of Clinical Information

UM requests and supporting clinical information for review may be submitted to the department by phone, facsimile or web portal (as available) from the servicing/managing practitioner or facility. Although a health care practitioner may designate one or more individuals as the contact for the staff, in no event does this preclude the Plan from contacting a health care practitioner or others in his or her employment when there is unreasonable delay or when the designated individual is unable to provide the necessary information or data requested.

Prior Authorization

Prior authorization requires the provider or practitioner to make a formal request to the Plan prior to the service being rendered. Upon receipt, the prior authorization request is screened for eligibility and benefit coverage and assessed for medical necessity and appropriateness of the health services proposed, including the setting in which the proposed care takes place.

Prior authorization is required for only those procedures and services for which the quality of care or financial impact can be favorably influenced by medical necessity or appropriateness of care review, such as non-emergent inpatient admissions (other than normal newborn deliveries), all out-of-network services and certain outpatient services, ancillary services and specialty injectables as described on the prior authorization list. Prior authorization is never required for emergency services or urgent care services.

The department reviews the prior authorization list regularly, in conjunction with the Plan's Medical Director and VPPHCO, to determine if any services should be added or removed from the list. The Provider Services, Member Services, and Network Management departments are also consulted on proposed revisions to the prior authorization list. Such decisions are based on Plan program requirements, or to meet federal or state statutory or regulatory requirements. Practitioners are appropriately notified when such modifications occur.

Clinical Information

For medical services that the Plan has determined require prior authorization and/or certification, only the minimally necessary information is obtained. The information required is not overly burdensome for the member, the practitioner/staff, or the health care facility staff. Only information necessary to certify the admission, procedure or treatment, length of stay, or frequency or duration of services is collected. Information needed to perform the review may include, as applicable, but is not limited to, the following information:

- Office and hospital records
- A history of the presenting problem
- Clinical or mental status exam notes
- Diagnostic testing results
- Treatment plans and progress notes
- Patient psychosocial history or assessments
- Information on consultations with the treating practitioner
- Evaluations from other healthcare practitioners and providers
- Photographs
- Operative and pathological reports
- Rehabilitation evaluations
- Printed copy of criteria related to the request
- Information regarding benefits for service or procedure
- Information regarding the local delivery system
- Patient characteristics and information
- Information from responsible family members
- LOCUS, CALOCUS, or other level of care assessment
- Physical or behavioral health screenings and results

Clinical information received, as well as rationale for the medical necessity determination and/or leveling of care is documented and maintained in the clinical documentation system.

Referrals

PCPs are not required to issue *paper* referrals but are expected to direct the member's care and assist with obtaining prior authorization for referrals to certain services and all non-emergent out-of-network practitioners as noted on the Plan prior authorization list.

Second Opinions

A second opinion may be requested when there is a question concerning diagnosis, options for surgery, or other treatment of a health condition, or when requested by a member of the member's health care team, including the member, parent, guardian or others with custodial responsibilities. Authorization for a second opinion is granted to a network practitioner or an out-of-network practitioner if there is no in-network practitioner available. The second opinion is provided at no cost to the member.

Extended Specialist Services

Established processes are in place by which a member requiring ongoing care from a specialist may request a standing authorization. Additionally, the policies include guidance on how members with life-threatening conditions or diseases which require specialized medical care over a prolonged period can request and obtain access to specialty care centers.

Out-of-Network Practitioner

If a member requires services that are not available from a qualified network practitioner, the Plan adequately and timely (i.e., according to the Plan's practitioner availability and accessibility standards) covers services out-of-network for members. The decision to authorize use of an out-of-network practitioner is based on continuity of care, availability and location of an in-network practitioner of the same specialty and expertise, and complexity of the case. Network practitioners are prohibited from making referrals for designated health services to health care entities with which the practitioner or a member of the practitioner's family has a financial relationship.

Specialty Injectables

The Plan establishes clinical criteria for coverage of specialty injectables. Prior authorization requests that do not meet criteria are referred to the Plan Pharmacist for review and determination in collaboration with the Plan Medical Director, if needed.

Concurrent Review

The concurrent review process assesses the clinical status of the member, verifies the need and level of continued hospitalization or ongoing ambulatory care, facilitates the implementation of the practitioner's plan of care, promotes timely care, determines the appropriateness of treatment rendered, and monitors the quality of care to verify professional standards of care are met. Information assessed during the review includes:

- Clinical information to support the appropriateness and level of service proposed,
- Member status, including any diagnosis change during stay, to determine special requirements to facilitate a safe discharge to another level of care,
- Additional days/service/procedures proposed, and
- Reasons for extension of the treatment or service.

Concurrent review for inpatient hospitalization is conducted throughout the inpatient stay, with each hospital day approved based on review of the patient's condition and evaluation of medical necessity. Concurrent review can occur on-site or telephonic. The frequency of reviews is based on the severity/complexity of the member's condition and/or necessary treatment and discharge planning activity and are not routinely conducted daily. If, at any time, services cease to meet inpatient or ambulatory criteria, discharge criteria are met and/or alternative care options exist, the care manager contacts the facility and obtains additional information to justify the continuation of services. When medical necessity for the case cannot be determined, the case is referred to the Medical Director or appropriate behavioral health

professional for review. The need for care management or discharge planning services is assessed during the admission review and each concurrent review, meeting the objective of planning for the most appropriate and cost-effective alternative to inpatient care. If at any time the UM staff become aware of potential quality of care issues, the concern is referred to the Plan QI Department for investigation and resolution.

Discharge Planning

Discharge planning is a method of coordinating care, controlling costs, and arranging for the appropriate services upon discharge from the hospital. For members who have not fully recovered or do not require the highly specialized and intensive services of acute hospital care, discharge planning assists the member in receiving the most timely, appropriate, safe, and cost-effective discharge with additional health care services such as home health care or appropriate placement in an extended care facility.

Discharge planning occurs as early as possible in a member's hospital stay. The Care Manager reviews the post-hospital needs of the member with the member, the member's family, the PCP, and other practitioners as appropriate. The Care Manager works with the UM staff of the hospital, PCP, and managing physician to arrange for services needed before the member is discharged from the hospital. Community-based agencies are included in the discharge planning as appropriate.

Coordination of Services

Coordination of services and benefits is a key function of care management both during inpatient acute episodes of care as well as for complex or special needs cases. Coordination of care encompasses synchronization of medical, behavioral health, social, and financial services and may include management across payer sources. The Care Manager must promote continuity of care by ensuring appropriate referrals and linkages are made for the member to the applicable provider or community resource, even if these services are outside of the required core benefits of the health plan or the member has met the benefit limitation. Because Medicaid is always the payer of last resort, the Plan must coordinate benefits with other payers including Medicare, Worker's Compensation, commercial insurance, etc. to maintain access to appropriate services.

Other attempts to promote continuity and coordination of care include member notifications of the termination of a PCP or other practitioner (with whom the member is in an active course of treatment) from the Plan. The Plan assists the member as needed to choose a new PCP (or other practitioner) and transfer the medical records to the new practitioner, as appropriate. If the provider is not termed due to a quality issue, the Plan may also authorize continued treatment with the practitioner under certain situations. The Plan also coordinates continuity of care with other Medicaid health plans when a new member comes onto the Plan or a member transition from the Plan to a new health plan.

Retrospective Review

Retrospective review is an initial review of services that have already been rendered. This process encompasses services performed by a participating or non-participating practitioner without Plan notification and/or authorization and when there was no opportunity for concurrent review. The Director or designee reviews the request for retrospective authorization. If supporting documentation satisfies the administrative waiver of notification, the request is reviewed utilizing the standard medical necessity review process. If the supplied documentation meets medical necessity criteria, the request is authorized. If the supporting documentation is questionable, the Director or designee requests a Medical Director review.

Significant Lack of Agreement

When there is significant lack of agreement between the Plan's staff and the health care practitioner regarding the appropriateness of certification during the initial review or appeal process, additional information may be requested. "Significant lack of agreement" means the employee has:

- Tentatively determined a service cannot be certified;
- Referred the case to the Medical Director for review; and
- Spoken to or attempted to speak to the health care practitioner regarding additional information.

Timeliness of Utilization Management Decisions

Utilization management decisions are made in a timely manner to accommodate the clinical urgency of the situation and to minimize any disruption in the provision of health care. Established timelines are in place for practitioners to notify the Plan of a service request and for the health plan to make UM decisions and subsequent notifications to the member and practitioner. Plan regularly monitors and reports on timeliness of UM decision making.

For all pre-scheduled services requiring prior authorization, the provider must notify the Plan within five (5) days prior to the requested service date. Prior authorization is never required for emergent or urgent care services. Facilities are required to notify the Plan of all inpatient admissions and long-term care facility admissions within one (1) business day following the admission. Once the member's emergency medical condition is stabilized, certification for hospital admission or authorization for follow-up care is required as stated above. All decisions and notifications are provided within the timeframes as noted in the *Timeliness of UM Decisions and Notifications* policy.

Denial Notices

A denial of services, also called an adverse determination, is a reduction, suspension, denial or termination of any service based on medical necessity or benefit limitations. The Medical Director may approve an alternative to the service being requested. If the requesting provider and/or member do not agree to the alternative, the originally requested service may be denied. However, if the requesting provider and/or member agree with the alternative and the care is authorized, the requesting provider has essentially withdrawn his or her initial request and this is not considered a denial.

Upon any adverse determination made by the Plan Medical Director or other appropriately licensed health care professional (as indicated by case type) a written notification, at a minimum, is communicated to the member and requesting practitioner. Verbal notification of any adverse determination is also provided when applicable. All notifications are provided within the timeframes as noted in the *Timeliness of UM Decisions and Notifications* policy. The written notification is easily understandable and includes the member-specific reason/rationale for the determination, specific criteria and availability of the criteria used to make the decision as well as the availability, process, and timeframes for appeal of the decision.

Requesting practitioners are provided with the opportunity to discuss any UM denial decisions with a physician or other appropriate reviewer. The Plan Medical Director or appropriate practitioner reviewer (behavioral health practitioner, dentist, pharmacist, etc.) serves as the point of contact for the peer-to-peer discussion. This is communicated to the practitioner at the time of verbal notification of the denial, as applicable, and is included in the standard denial letter template.

Access to Physician Reviewer

The Plan Medical Director or appropriate practitioner reviewer (behavioral health practitioner, dentist, pharmacist, etc.) serves as the point of contact for practitioners calling in with questions about the UM process and/or case determinations. Requesting practitioners are notified of availability of an appropriate practitioner reviewer to discuss any UM denial decisions through the Provider Manual, new practitioner orientation, and/or the provider newsletter. Notification of the availability of an appropriate practitioner reviewer to discuss any UM denial decision, and how to contact a reviewer for specific cases, is also provided verbally and/or in the written notification at the time of an adverse determination. The Plan Medical Director may be contacted by calling the Plan's main toll-free phone number and asking for the Plan Medical Director. A Plan Care Manager may also coordinate communication between the Plan Medical Director and requesting practitioner.

Appeal of Utilization Management Decision

A request to change or reverse a previous adverse clinical decision is considered an appeal. Appeals may be requested for benefit and/or medical necessity adverse determinations. Members, their authorized representatives (with written consent from the member as dictated by CMS or State contract), or legal representatives of a deceased member's estate may appeal adverse determinations regarding their care. A healthcare practitioner with knowledge of the member's condition, acting on behalf of the member and with the member's written consent, may file an appeal. Expedited appeals are available to members for any urgent care requests and do not require written member consent for a healthcare

practitioner to act on the member's behalf. Punitive action is not taken against a practitioner who requests an expedited resolution or supports a member's appeal.

Members are provided a reasonable timeframe to file an appeal. The content of an appeal including all clinical care aspects involved are fully investigated and documented. Members, or their authorized representatives, have the right to submit comments, records, documentation, and other information relevant to the appeal in person or in writing. A physician or other appropriate clinical peer of a same-or-similar specialty, not supervised by the individual, nor involved in the original determination, evaluates medical necessity decisions for adverse appeal decisions. The Plan receives, reviews, resolves, and provides the member with written or electronic notification of the decision as noted in the *Member Appeals System Description* policy.

Independent/External Appeals

The Plan's appeal process includes a level of independent, external review (State Fair Hearing, External Review Agency etc.) of final determinations. The Plan provides an explanation of the appeals process and the right to an independent review of adverse determination according to the requirements of the state to all members upon enrollment and annually thereafter. This process is explained in the Member Handbook, member newsletters, member educational flyers, adverse determination notifications, and may be posted at network provider offices. All materials are produced in English, Spanish, and additional languages as needed. Members and practitioners, who appeal on behalf of members, are also made aware that once the grievance/appeal process has been exhausted, they may request an independent external review as defined in the state and/or federal administrative code. The Plan implements independent external review appeal decisions as applicable.

Experience With Utilization Management Process

Annually, the Plan evaluates both member and provider experience with the UM process. Mechanisms of information gathering may include but are not limited to member satisfaction survey results (e.g., CAHPS), member/provider grievances/complaints and appeals that relate specifically to UM, provider satisfaction surveys with specific questions about the UM process and soliciting feedback from members/providers who have been involved in appeals related to UM. When analysis of the information gathered indicates that there are areas of dissatisfaction, the Plan develops an action plan and interventions to improve on the areas of concern that may include staff retraining and member/provider education.

Communication

Members and practitioners can access UM staff through a toll-free number at least eight hours a day during normal business hours for inbound or outbound calls regarding UM issues or questions about the UM process. TDD/TTY services for deaf, hard of hearing, or speech-impaired members are available. The phone numbers are included in the Member Handbook, on the web and in all member letters. Additionally, language assistance for members to discuss UM issues is provided either by bilingual staff or through language line services.

Inbound and outbound communications may include directly speaking with practitioners and members; or fax, electronic or telephone communications (e.g., sending email messages or leaving voicemail messages). Staff identifies them self by name, title, and organization name when initiating or returning calls regarding UM issues. After normal business hours and on holidays, calls to the UM Department are automatically routed to the 24-hour nurse line. 24-hour nurse line is not a delegated UM entity and therefore does not make authorization decisions. 24-hour nurse line staff accepts authorization information for next business day response by the Plan or notifies the Plan on-call staff in cases requiring immediate response.

The department is available to coordinate services for members with urgent and emergent care, including ambulance services, to promote timely access to and delivery of necessary health services. As part of the triage process, staff may direct the member, as appropriate, to their PCP or an emergency department. Under no circumstances does the staff offer medical advice. At any time, members may also contact 24-hour nurse line, the medical triage phone service which provides 24-hour healthcare assistance and advice.

Requesting Copies of Medical Records

The Plan's staff does not routinely request copies of medical records on all patients reviewed. During prospective and concurrent telephonic review, copies of medical records are only required when difficulty develops in certifying the medical necessity or appropriateness of the admission or extension of stay. In those cases, only the necessary or pertinent sections of the record are required. Medical records may also be requested to complete an investigation of a member complaint/grievance/appeal or when a potential quality of care issue is identified through the UM process. Confidentiality of information necessary to conduct UM activities is always maintained. Unless modified by state code and or federal regulations, health care practitioners are not reimbursed for the reasonable costs for providing medical information in writing including copying and transmitting any requested patient records or other documents. Members requesting a copy of the Plan's designated record set are not charged for the copy.

Sharing Information

The Plan's staff share all clinical and demographic information on individual patients among various divisions (e.g., certification, discharge planning, care management) via the clinical documentation system to avoid duplicate requests for information from members or practitioners.

Practitioner – Member Communication

The Plan's UM Program in no way prohibits or otherwise restricts a healthcare professional acting within the lawful scope of practice from advising or advocating on behalf of a member, who is his or her patient, for the following:

- The member's health status, medical or behavioral care or treatment options, including any alternative treatments that may be self-administered;
- Any information the member needs to decide among all relevant treatment options;
- The risks, benefits and consequences of treatment or absence of treatment;
- The member's right to participate in decision regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

Emergency Services

Emergency department services are available 24 hours day/7days week. Prior authorization is not required for emergency services and coverage for such is based on the severity of the symptoms at the time of presentation. Emergency services are covered inpatient and outpatient services furnished by a qualified practitioner that are needed to evaluate or stabilize an emergency medical condition. The Plan covers emergency services when the presenting symptoms are of sufficient severity to constitute an emergency medical condition in the judgment of a prudent layperson.

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairments of bodily functions, or serious dysfunction of any bodily organ or part. An emergency medical condition is not defined based on lists of diagnoses or symptoms.

Emergency services are covered when furnished by a qualified practitioner, including non-network practitioners, and are covered until the member is stabilized. The Plan also covers any screening examination services conducted to determine whether an emergency medical condition exists.

If a Plan network practitioner, or Plan representative, instructs a member to seek emergency services, the medical screening examination and other medically necessary emergency services are covered without regard to whether the condition meets the prudent layperson standard. Once the member's emergency medical condition is stabilized, certification for hospital admission or prior authorization for follow-up care is required as previously stated.

Although the Plan may establish guidelines and timelines for submittal of notification regarding the provision of emergency services, including emergent admissions, the Plan does not refuse to cover an emergency service based on the practitioner's or the facility's failure to notify the Plan of the screening and treatment within the required timeframes, except as related to any claim filing timeframes. Members who have an emergency medical condition are not required to pay for subsequent screening and treatment needed to diagnose the specific condition or stabilize the member.

Pharmaceutical Management

The Pharmacy Management Program is overseen by the Chief Medical Director, VPPHCO, Vice President of Pharmacy Operations, or the Plan Pharmacist. All policies and procedures utilized by the Plan related to pharmaceutical management include the criteria used to adopt the procedure as well as a process that includes pharmacists and appropriate practitioners and uses clinical evidence from appropriate external organizations in the development of such policies and procedures. The program is reviewed at least annually and updated as new pharmaceutical information becomes available. Pharmacy policies and procedures are made available, annually and after updates, to members and prescribing practitioners via newsletter or another mailer and/or the Plan website.

Preferred Drug List

The corporate preferred drug list (PDL) was created to offer a core list of preferred medications to all health plans. The corporate PDL serves as a basis for the Plan PDL. The corporate PDL is developed and maintained by the corporate Pharmacy and Therapeutics (P&T) Committee. The Plan P&T Committee determines which drugs from the corporate PDL are incorporated into the Plan PDL. The Plan PDL is available on the Plan website or in hard copy upon request.

Pharmacy Benefit Manager

The Pharmacy Benefit Manager is responsible for pharmaceutical administrative and clinical operations, including pharmacy network contracting and credentialing; pharmacy claims processing system and data operations; and pharmacy-related customer service, help desk, prior authorization (where state law allows), clinical services, and quality improvement functions. The PBM may accomplish those tasks either internally or through contracted vendors. The PBM follows and maintains compliance with Plan policies and all pertinent state and federal statutes and regulations. As a delegated entity, Envolve Pharmacy Solutions is monitored according to the delegation policies and processes as discussed later in this document.

The pharmacy prior authorization (PA) process promotes the most appropriate utilization of selected high risk and/or high-cost medications, and those with a high potential for abuse. This process is delegated to the PBM and administered in accordance with applicable state and federal requirements, accreditation standards, and recognized high quality practice standards. The PA criteria for approval of drug coverage are developed, reviewed, and approved by the Plan P&T Committees in conjunction with the PBM. In addition, PA criteria are consistent with current pharmaceutical and medical literature, peer reviewed journals, and professional standards of practice.

Behavioral Health Management

The Plan complies with the Mental Health Parity and Addiction Equity Act (MHPAEA) as it applies to its Medicaid Managed Care Organizations as described in section 1903(m) of the Social Security Act (the Act); Medicaid Alternative Benefit Plans (ABPs) as described in the Act; and Children's Health Insurance Programs (CHIP) under title XXI of the Act. The Plan ensures that any benefit limitations for mental health or substance use disorder (MH/SUD) are comparable to those for medical/surgical benefits and do not impose less favorable limitations on MH/SUD benefits compared to medical/surgical benefits, including with respect to annual and lifetime dollar limits, financial requirements, or treatment limits (see COMP.46).

Accessing Behavioral Health

The Plan does not have a centralized triage and referral process; members accessing care with contracted providers *do not* require a referral from their PCP nor an assessment. Plan staff assists members with locating a network behavioral health provider to meet their clinical needs as needed. Plan members calling for assistance in accessing behavioral health or substance abuse services are referred with appropriate urgency to the applicable care setting and treatment resources.

Behavioral Health Levels of Care

The Plan ensures members receive high quality behavioral health care services, in the least restrictive setting to meet their individualized needs. The Plan has defined the following levels of care and described the minimum services associated with each level of care. Each level of care includes individualized treatment planning that addresses the member's behavioral health (i.e., mental health and/or substance abuse) needs. Levels of care may be available as a covered benefit; covered benefits vary by Plan contract and may have associated coverage limitations.

Acute Psychiatric Inpatient Hospitalization

Acute hospitalization is the highest level of care for psychiatric and substance abuse services; this facility-based care may occur in a psychiatric or detoxification unit of a general hospital or at a freestanding psychiatric facility. Key elements include: the facility is licensed as a hospital, 24-hour medical and nursing care is provided, and care is supervised by behavioral health specialists. This level of care also includes 23-hour observation beds or beds that provide an equivalent or greater intensity of nursing and medical care.

Crisis Stabilization

Crisis stabilization services provide 24-hour medical and nursing care, serving as a diversion to acute psychiatric inpatient services. Crisis stabilization services are provided by behavioral health specialists at facilities that are not licensed as hospitals.

Residential Treatment

Residential treatment describes a longer term 24-hour program for severe MH/SUD. Care at a Residential Treatment Center (RTC) or Psychiatric Residential Treatment (PRTF) is medically monitored, with 24-hour onsite nursing services and medical provider availability. This level of care is expected to provide a range and intensity of diagnostic, therapeutic, life skills, rehabilitation and milieu-behavioral health services that cannot be provided by a combination of outpatient or community-based services. Each member's treatment plan should address their specific MH/SUD needs, set discharge criteria, barriers to discharge, and ensure the treatment is the least restrictive option. Family therapy should occur 2-3 times a week to ensure the member can successfully reintegrate back to their home and community unless there is an identified valid reason why this is not clinically appropriate or feasible.

Partial Hospitalization

Partial hospital programs provide services at least 4 hours a day/3 days a week. These facility-based services are of similar intensity to acute hospital services (e.g., on-site nursing, psychiatric, and behavioral health services are available as needed by the member) but are provided less than 24 hours a day. A specific treatment goal for this level of care is improving symptoms and level of functioning sufficiently for the member to return to a lesser level of care. Partial hospital programs for children and adolescents are expected to have family therapy sessions at least once a week.

Day Treatment

Day treatment programs can be either free-standing or hospital-based and provide frequent behavioral monitoring, and intervention and access to frequent medication management by a behavioral health specialist when necessary. Individuals in this level of care are unable to be treated by or have not responded to behavioral health services such as individual/ family/group therapy, medication management, etc. and are experiencing an exacerbation of a longstanding psychiatric disorder, are at risk of deteriorating, or cannot reach identified goals due to significant functional impairments associated with the mental health diagnosis. The program must provide an integrated program of rehabilitation counseling, education, therapeutic, and/or family services at least 25 hours in a week to address an individual's MH/SUD needs, with a specific treatment goal of reduction in severity of symptoms and improvement in level of functioning sufficient to return the member to a lower level of care.

Intensive Outpatient

Intensive outpatient programs must provide an integrated program of rehabilitation, counseling, education, therapeutic, and/or family services preferably 9 hours in a week (minimum of 6 hours a week) to address an individual's behavioral health needs. A specific treatment goal of this level of care is reduction in severity of symptoms and improvement in level of functioning sufficient to return the member to outpatient treatment follow-up and/or self-help support groups.

Community Based Services

Community-based services, where available, should be utilized when traditional services, such as therapy and/or medication management have been attempted and are inadequate to prevent a member from deteriorating and requiring a higher level of care. For children and adolescents,

requests for this level of care must clearly document that the child is at imminent risk of out-of-home placement due to functional impairments associated with a behavioral health diagnosis. In all cases, the treatment plan should use techniques that are time-limited and support the goal of enhanced autonomy and the least restrictive environment possible. The treatment plan should be updated monthly and reflect efforts to reduce the frequency of service or clinical documentation for inability to decrease the usage of community-based services.

Outpatient Treatment

Outpatient treatment may be comprised of evaluation services, individual, group, and/or family therapy, and medication management services provided by behavioral health specialists. The treatment plan should be updated monthly (every 30 days) and reflect efforts at targeting symptom reduction, increase community tenure, and enhance independence.

Disease Management

Disease management is a multidisciplinary, continuum-based approach to healthcare delivery that proactively identifies populations with, or at risk for, chronic medical conditions. Disease management is a system of coordinated healthcare interventions and communications for populations with conditions in which patient self-care efforts are significant. Disease management programs generally are offered telephonically, involving interaction with a trained nursing professional, and require an extended series of interactions, including a strong educational element. The Plan's disease management programs emphasize prevention and members are expected to play an active role in managing their diseases. The Plan may delegate management of specific disease management programs. The Plan's Disease Management programs are described in detail in associated policies or individual Disease Management Program Descriptions.

Care Management

Care management or care coordination is a collaborative process of assessment, planning, coordinating, monitoring, and evaluating the services required to meet an individual's needs. Care management serves as a means for achieving member wellness and autonomy through advocacy, education, communication, identification of service resources and service facilitation. The goal of care management is provision of quality health care along a continuum, decreased fragmentation of care across settings, enhancement of the member's quality of life, and efficient utilization of patient care resources. The Care Manager helps identify appropriate providers and facilities throughout the continuum of services, while ensuring available resources are being used in a timely and cost-effective manner. To optimize the outcome for all concerned, care management services are best offered in a climate that allows direct communication between the Care Manager, the member, and appropriate service personnel, while maintaining the member's privacy, confidentiality, health, and safety through advocacy and adherence to ethical, legal, accreditation, certification, and regulatory standards or guidelines. The Care Management Program is described in detail in the Care Management Program Description.

Program Evaluation

The UM Program is evaluated at least annually, and modifications to the program made as necessary. The Chief Medical Director and VPPHCO may use the following to evaluate the impact of the UM Program along with other sources:

- Member complaint, grievance, and appeal data
- The results of member satisfaction surveys
- Practitioner complaints and satisfaction surveys
- Relevant UM data
- Practitioner profiles
- Drug Utilization Review (DUR) profiles (where applicable)

The evaluation covers all aspects of the UM Program. Problems and/or concerns are identified and recommendations for removing barriers to improvement are provided. The evaluation and recommendations are submitted to the PHCOC for review, action and follow-up. The final document is then submitted to the Board of Directors and/or QIC for approval.

Delegation

The Plan may elect to delegate various UM activities to entities that demonstrate the ability to meet the Plan's UM standards and standards for delegation, as outlined in the UM work plan and policies and procedures. The Plan conducts ongoing oversight and annual review of each delegate's UM program as outlined in the associated policy. Delegation is dependent upon the following factors:

- A pre-delegation review is necessary to determine the ability to accept delegation.
- Once the delegate is determined to be capable of fulfilling the responsibilities of delegation, a delegation agreement is executed with the organization to which the UM activities have been delegated, clarifying the responsibilities of the delegated group and the Plan. The agreement also specifies reporting requirements, and the standards of performance to which the contracted group has agreed.
- The delegated group must conform to the Plan's UM standards; including timeframes outlined in the Plan's policy and procedure *Timeliness of UM Decisions and Notifications*.
- The delegated group is responsible for providing the Plan with a written UM Program Description/Plan for annual review and approval by the Plan's QIC.
- The delegated group is responsible for submitting utilization reports, to include monthly utilization summaries, high-cost days, and quality assurance/improvement issues, as applicable.

The Plan retains accountability for any functions and services delegated and as such monitors the performance of the delegated entity through the following vehicles:

- Annual approval of the delegate's UM program (or portions of the program that are delegated), as well as any significant program changes that occur in between.
- Routine reporting of key performance metrics that are required and/or developed by Plan's Chief Medical Director and the PHCOC.
- Annual or more frequent evaluation to determine whether the delegated activities are being carried out according to Plan standards and state program requirements.

In the instance where the delegate is NCQA accredited, the Plan may assume that the delegate is carrying out responsibilities in accordance with NCQA standards and revise the annual audit or evaluation, per state or CMS contract requirements. At the time of pre-delegation, the Plan must evaluate the compatibility of the delegate's UM Program with the Plan's UM Program. Once delegation is approved, the Plan requires that the delegate provide the appropriate reports as determined by the Plan to monitor the delegate's continued compliance with the needs of the Plan. The Plan annually reviews the delegate's ongoing accreditation status.

POLICY AND PROCEDURE

POLICY NAME: Clinical Decision Criteria and Application	POLICY ID: CC.UM.02
BUSINESS UNIT: Please refer to system of record – Archer	FUNCTIONAL AREA: Utilization Management
EFFECTIVE DATE: 03/16/2006	PRODUCTS: Commercial, Marketplace, Medicaid, Medicare
REVIEWED/REVISED DATE: 08/16; 06/17; 07/17; 10/18; 05/19; 09/19, 12/19; 12/20; 02/22; 05/22	
REGULATOR MOST RECENT APPROVAL DATES: N/A	

POLICY STATEMENT:

This policy outlines how clinical support criteria is used in determining medical necessity.

PURPOSE:

To ensure clinical decisions made utilize all relevant clinical information and are based on objective and evidence-based criteria considering individual circumstances and local delivery systems.

SCOPE:

This policy applies to Population Health and Clinical Operations

DEFINITIONS:

Medical Director: As used in this policy is a collective term for the Chief Medical Officer, Chief Medical Director or Associate Medical Director(s).

UM Designee: Member of the UM department who has been appropriately trained in the principles, procedures, and standards of utilization and medical necessity review. See *UM.04 Appropriate UM Professionals* for UM department staff titles, qualifications, and reporting structure.

POLICY:

The Plan and delegated vendors (as applicable) use written clinical support criteria to evaluate medical necessity, level of care, and/or clinical appropriateness of medical, behavioral healthcare, and pharmacy services that require approval. They work collaboratively to ensure members have timely access to high quality healthcare and appropriate healthcare resources. The medical necessity criteria and the procedures for applying them are reviewed annually and updated as appropriate.

PROCEDURE:

I. Clinical Criteria

A. Objective, evidence-based clinical criteria:

UM staff consult the following criteria sets when determining medical necessity, level of care, and appropriateness of health care. Refer to *CP.CPC.05 – Medical Necessity Criteria* for appropriate hierarchy in selecting criteria:

1. Clinical policies include medical, behavioral health, pharmacy (including drugs covered under both the pharmacy benefit and the medical benefit), and durable medical equipment and devices. The policies are developed based on current scientific medical evidence and clinical practice.
2. The Clinical Policy Committee (CPC) reviews and approves all clinical policies, which includes policies for new and emerging technologies and new uses for existing technologies.
3. The Clinical Pharmacy Advisory Committee (CPAC) and Pharmacy and Therapeutics (P&T) Committee review and approve all pharmacy policies for pharmaceuticals covered under both the pharmacy and medical benefits.
4. Clinical policies are available to all staff on the Clinical Policy SharePoint page and external providers on the Plan website, provider portal, or upon request (see *CP.CPC.01 Clinical Policy Committee and EPS.PHARM.72 Clinical Pharmacy Advisory Committee Evaluation of New Drug Products and Indications*). Most clinical policies are also available as custom content integrated into InterQual® custom content, designated as “CCO” in the title of the subset in TruCare.
5. The adopted nationally recognized decision support tool is Change Healthcare’s InterQual (InterQual) Level of Care and Care Planning Criteria including Acute Adult, Acute Pediatric, Long-Term Acute Care, Rehabilitation, Subacute/SNF, Home Care, Outpatient Rehabilitation and Chiropractic, Durable Medical Equipment, Imaging, Procedures, Molecular Diagnostics. Also available are InterQual Criteria for behavioral health inpatient, residential/PRTF, partial hospitalization, intensive outpatient and outpatient therapy, American Society of Addiction Medicine (ASAM) criteria for substance use services, and state specific medical necessity criteria for community based behavioral health services or MCG® as appropriate.
6. Local state and/or regulatory guidelines are also used in making UM decisions where applicable, including Local Coverage Determinations (LCD) and National Coverage Determinations (NCD).
7. While clinical practice guidelines are not used as criteria for medical necessity determinations, the Medical Director and UM staff ensure UM decisions are consistent with guidelines adopted by Plan. Such guidelines

include, but are not limited to, preventive health (adult and child), asthma, prenatal care, diabetes, psychiatric, substance abuse, and certain medications.

8. Other nationally recognized support and reference tools such as Hayes Knowledge Center, Up-To-Date, Cochrane Reviews, Agency for Healthcare Research and Quality (AHRQ), etc., are available to medical director(s).

B. Annual Review of Criteria

Updates and revisions to InterQual, MCG, ASAM, other applicable criteria, state specific service definitions, clinical and pharmacy policies, as well as the procedures for applying such criteria, are reviewed annually by the Utilization Management Committee (UMC) and/or Quality Improvement Committee (QIC) that involves local practitioners. All clinical policies are reviewed, updated, and approved by the CPC on an annual basis. All pharmacy policies are reviewed and approved by the CPAC and P&T committees. Practitioners with professional knowledge or clinical expertise in the criteria reviewed are involved in the development, review, and adoption of all clinical policies.

C. Availability of Criteria

Providers are notified through provider orientation, the provider manual, Plan website, and provider newsletters of the criteria utilized for medical necessity determinations. The provider manual, newsletters, clinical policies, and other provider information are also available in the provider tool kit on the Plan website. These communications include notification that treating providers may, at any time, request UM criteria pertinent to a specific authorization by contacting the Population Health and Clinical Operations or may discuss the UM decision with the Medical Director.

II. Clinical Criteria Application

A. Levels of Clinical Review

Clinical criteria is applied to determine medical necessity and/or appropriate level of care for the service being requested. Two levels of UM clinical review are available for all authorization requests, Level I and Level II (UM.02.01 - *Medical Necessity Review*).

1. **Level I** review is conducted by a clinical UM designee (prior authorization nurse, behavioral health licensed clinician, care manager, etc.) who has been appropriately trained in the principles, procedures, and standards of utilization and medical necessity review. At no time does a Level I review result in a reduction, denial, or termination of a service. A Level I review is conducted based on all the following:
 - a. InterQual, MCG, ASAM criteria, clinical policy, or other applicable criteria including but not limited to LCD and NCD.
 - b. Individual member needs and characteristics at the time of the request including age, co-morbidities, complications, progress of treatment, psychosocial situation, and home environment, when applicable.
 - c. The local delivery system availability and ability to meet the specific member's health care needs is also considered.
2. **Level II** review is conducted by an appropriately licensed practitioner or other health care professional. Adverse determinations can only be made by a Medical Director, or qualified designee, during a Level II review
 - a. If the request is for behavioral health service, a qualified behavioral health practitioner conducts the review.
 - b. If the request is for dental services, a qualified dental practitioner conducts the Level II review.
 - c. A board-certified specialist may also be consulted in making a medical necessity determination.
 - d. InterQual, MCG, ASAM criteria, clinical policy, or other applicable criteria including but not limited to LCDs and NCDs are used with consideration given to continuity of care, individual member complexities (as described above) and needs at the time of the request, and the local delivery system available for care.

B. Consistency in Applying Criteria

Annual Interrater Reliability (IRR) testing is performed by all staff involved in UM decision making to ensure consistency in determinations and documentation (refer to *UM.02.05 – Interrater Reliability*).

1. IRR testing occurs at least annually. This includes all medical directors, pharmacists, registered nurses, licensed practical nurses, therapists, and appropriately licensed behavioral health clinicians.
2. All new employees are tested after training, and before the end of their 90-day orientation, regardless of any pre-employment test. If this testing coincides with the annual testing, it may be used for both. If there are more than 30 days separating the new employee and annual testing, it is repeated.
3. Temporary staff required to use decision-making criteria are tested prior to working in the live authorization system. Temporary employees who do not pass the applicable IRR testing are ineligible for assignment.
4. Staff are updated related to any changes in the criteria set on an as needed basis when changes occur.

REFERENCES:

UM.02.01 – Medical Necessity Review
 UM.02.05 – Interrater Reliability
 UM.04 - Appropriate UM Professionals
 CP.CPC.01 - Clinical Policy Committee
 EPS.PHARM.72 - Clinical Pharmacy Advisory Committee Evaluation of New Drug Products and Indications
 CP.CPC.05 – Medical Necessity Criteria
 NCQA Health Plan Standards and Guidelines

ATTACHMENTS:

Arkansas Health and Wellness Addendum

ROLES & RESPONSIBILITIES: N/A**REGULATORY REPORTING REQUIREMENTS: N/A****REVISION LOG**

REVISION TYPE	REVISION SUMMARY	DATE APPROVED & PUBLISHED
Annual Review	Annual review: NCQA updated to reflect current; removed revision history prior to 2013; removed reference to MCG guidelines used by Indiana under "Procedures"; updated approver titles.	08/16
Annual Review	Annual review: updated section I. C. to reflect the availability of the Provider Toolkit on the Plan web site. Removed reference to UM.01 from References list.	06/17
Ad Hoc Review	Removed third bullet in Procedure I., Section A, ("Centene's Medical Management Guidelines for therapies and rehabilitation") as reference is duplicative. Guidelines for therapies and rehabilitation are covered under clinical policies, InterQual, or local state and/or regulatory guidelines and thus already covered in this section.	07/17
Annual Review	Annual review: NCQA updated to reflect current; removed revision history prior to 2013; removed reference to MCG guidelines used by Indiana under "Procedures"; updated approver titles.	08/16
Annual Review	Updated sections 1.A and REFERENCES by changing name of P&P from " <i>CP.MP.68 Medical Necessity Criteria</i> " to " <i>CP.CPC.05 Medical Necessity Criteria</i> " changed all instances of <i>McKesson</i> to <i>Change Healthcare</i> , added " <i>Commercial</i> " to product type, and removed revision history prior to 2016. Under Purpose, changed "written, nationally recognized clinical decision support criteria" to "objective and evidence-based criteria....delivery systems." In the "clinical criteria" section on clinical policies: for portion detailing that medical necessity decisions are based on scientific research and clinical thinking, changed "clinical thinking" to "clinical practice and judgment; added that clinical policies are available on SharePoint, and most are available as custom content in InterQual. Under Policy, changed "select services including inpatient hospitalization and outpatient referrals" to "medical, behavioral....requiring approval" Under Procedure, changed "nationally recognized clinical support tools" to Objective, evidenced-based clinical criteria. Rewording for clarity in I.A.1 and I.A.2. Under Annual Review of Criteria, clarified that local practitioners are involved in the UMC/QIC and that Practitioners with appropriate expertise are involved in the development, review and adoption of all clinical policies. Under II.A.1, re-ordered the section into bullet points	05/19
	Added Addendum for Managed Health Services WI Plan. No other changes.	09/19
Ad Hoc Review	Inclusion of drugs covered under the medical benefit and Clinical Pharmacy Advisory Committee. Removed Addendum for Managed Health Services WI Plan from Archer due to changes to policy.	12/19

Annual Review	Annual Review: Updated minor formatting and acronym change; added MCG throughout document.	12/20
Annual Review	Added addendum for Arkansas Health and Wellness and Arkansas Total Care.	02/22
Ad Hoc Review	Updated addendum for Arkansas Health and Wellness.	05/22

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, the Company's P&P management software, is considered equivalent to a signature.

POLICY AND PROCEDURE

POLICY NAME: Appropriate UM Professionals	POLICY ID: CC.UM.04
BUSINESS UNIT: Please refer to system of record – Archer	FUNCTIONAL AREA: Utilization Management
EFFECTIVE DATE: 03/2006	PRODUCTS: Commercial, Medicare, Marketplace, Medicaid
REVIEWED/REVISED DATE: 11/16; 09/17; 11/18; 07/19; 07/20; 10/20; 10/21; 10/22; 12/22	
REGULATOR MOST RECENT APPROVAL DATE: N/A	

POLICY STATEMENT:

This policy details the company’s requirements for utilization management staffing.

PURPOSE:

To ensure qualified licensed health professionals assess the clinical information used to support utilization management (UM) decisions.

SCOPE:

This policy applies to Population Health and Clinical Operations

DEFINITIONS: N/A

POLICY:

Appropriately licensed, qualified health professionals supervise the utilization management process and all medical necessity decisions. A physician or other appropriately licensed health care professional (as indicated by case type) reviews all medical necessity denials of healthcare services offered under the medical benefits. Appropriate practitioners include:

- Physicians – for all types of denials
- Behavioral health practitioners, including psychiatrists, doctoral level clinical psychologists or certified addiction medicine specialists – for behavioral healthcare denials
- Chiropractors – for chiropractic denials
- Dentists – for dental denials
- Pharmacists – for pharmaceutical denials
- Physical therapists – for physical therapy denials

Qualified licensed health professionals, who are appropriately trained in the principles, procedures, and standards of utilization management and medical necessity review, conduct authorization and/or concurrent reviews utilizing generally accepted evidenced-based clinical criteria and may approve services. Licensed supervisory staff such as the Vice President of Population Health and Clinical Operations or UM Directors/Managers/Supervisors:

- Provide supervision of assigned UM staff
- Participate in staff training
- Monitor for consistent application of criteria by UM staff for each level and type of UM decision
- Monitor documentation for accuracy and appropriateness
- Are available to UM staff on site or via telephone

Non-licensed staff may collect non-clinical data and structured clinical data for preauthorization and concurrent review, under the supervision of appropriately licensed health professionals. They may also have the authority to approve (but not to deny) services for which there are explicit criteria. Non-licensed staff do not conduct any activities requiring evaluation or interpretation of clinical information. All non-licensed staff are supervised by licensed staff and have qualified licensed staff available to them for assistance at all times.

PROCEDURE:

Appropriate staffing is determined based on membership and requirements. Personnel employed by or under contract to perform utilization review are appropriately trained, qualified, and currently licensed in the State as applicable.

Licensed Health Professionals

Chief Medical Officer/Medical Director

The Chief Medical Officer (CMO) oversees clinical aspects of the Utilization Management Program and provides direct support to the UM staff in performance of their UM responsibilities. Based on need, a Medical Director or associate Medical Director(s) may also be involved in medical review. CMO, Medical Directors, and Associate Medical Directors, hereafter are collectively referred to as “Medical Director”.

The Medical Director supervises all medical necessity decisions and conducts Level II medical necessity reviews. Delegate (including wholly-owned sister organizations and external delegates) staff who are appropriate practitioners (i.e. as listed above and described below) may also make denial decisions based on medical necessity as applicable to their scope of practice. Practitioners who review potential denials of care based on medical necessity must meet the following requirements of the CMO or Medical Director's job description which include, but are not limited to:

- Education, training, or professional experience in medical or clinical practice.
- A current, unrestricted license to practice medicine in the state unless otherwise allowed by state statutory requirements.

The Medical Directors' job descriptions are held by the Human Resource Department.

Behavioral Health Provider

A behavioral health provider is involved in implementing, monitoring, and directing the behavioral health care aspects of the UM program. The behavioral health provider may be a clinical director, a network practitioner, or a behavioral health delegate.

A physician, appropriate behavioral health practitioner (i.e., doctoral-level clinical psychologist or certified addiction-medicine specialist), or pharmacist, as appropriate, reviews any behavioral health care denial of care based on medical necessity.

Pharmacists

The Pharmacist is a licensed pharmacist in the state of contract. The Pharmacist is the point of contact for physicians regarding concerns with the preferred drug list. They review pharmacy prior authorization requests that do not meet criteria and make an appropriate determination; determinations may be made in conjunction with the Medical Director as needed.

Board-Certified Clinical Consultants

In some cases, the clinical judgment needed for UM decisions is narrowly specialized. In these instances, the Medical Director may consult with a board-certified physician from the appropriate specialty for additional or clarifying information when making medical necessity determinations/ denials. Appropriate documentation of their clinical judgment is provided (*UM.52 – Use of Board Certified Consultants*).

Service Consultants

In some cases, UM staff must call upon service experts to assist in making authorization determinations for specialty services. In these instances, a licensed/certified service consultant specializing in the area of service in question is contacted. Specialty service consultants may include but are not limited to: Chiropractors, Dentists, Occupational Therapists, Physical Therapists, Speech Therapists, Physician Assistants, Certified Nurse Practitioners, etc., (*UM.52 – Use of Board Certified Consultants*). As noted above, only appropriate practitioner types specified in this policy can assign denials of care based on medical necessity applicable to their scope of practice.

Vice President of Population Health and Clinical Operations (VP of PHCO) (or Director of PHCO)

The VP of PHCO is a registered nurse with experience in utilization management activities. The VP of PHCO is responsible for overseeing the day-to-day operational activities of the UM Program.

Utilization Management Unit Head

The Utilization Management (UM) unit head is a registered nurse. The UM unit head (e.g. Utilization Management Director/Manager, Care Management Director/Manager, etc.) directs and coordinates the daily activities of the department, including supervision of the Referral Specialists, Program Specialists, Program Coordinators, and Care Managers. The UM unit head, in conjunction with the VP of PHCO, assists with the development of the UM strategic vision in conjunction with the company objectives, policies, and procedures.

Care Managers

Care Managers (CM) are nurses with clinical and preferably utilization management experience. There are several levels or types of CMs within the organization and as such may be referenced with alternate titles such as: Prior Authorization Nurse, Concurrent Review Nurse, Concurrent Review Care Manager, Hospital Care Manager, Complex Care Manager, Catastrophic Care Manager, Disease Care Manager, Care Manager I, Care Manager II, Utilization Manager, etc. Care Managers report to and are supervised by the UM unit head or a qualified designee.

Care Managers conduct Level I reviews for medical necessity and have access to an appropriate licensed health care professional for consultation if needed. They apply approved UM criteria and perform reviews for requested services and for concurrent review. Care Managers are prohibited from making adverse medical necessity determinations. When a request for authorization of services does not meet the standard UM criteria, the case is referred to the Medical Director for a Level II medical necessity review. Care Managers are also responsible for the daily coordination of the care management and specialty programs including high-risk conditions and disease specific cases.

Non-Licensed UM Staff

Referral Specialists / Marketplace Coordinator - for Ambetter

Referral Specialists (RS) are individuals with administrative experience in the health care setting. Experience with diagnosis and procedure coding is preferred. The RS are responsible for reviewing service requests for completeness of information, collecting demographic data necessary for pre-certification, and authorizing referrals to specialty providers. RS cannot make clinical determinations and are required to refer all clinical decisions to a Care Manager. They report to and are supervised by the UM unit head, or qualified designee.

Program Coordinators / Marketplace Coordinator - for Ambetter

Program Coordinators (PC) are trained non-clinical staff with significant experience in a health care setting such as lab technician or medical office assistant. PCs assist the Care Manager with administrative duties such as follow-up calls, screening assessments, obtaining tests results, coordinating home health services, and arranging transportation. They may attend marketing and outreach meetings, and coordinate services with community based organizations. They work under the direction of the Care Manager and refer all clinical decisions to the Care Manager.

Program Specialists

Program Specialists (PS) (also known as Social Service Specialists - SSS) are staff with background in social services, who may or may not be licensed social workers. The PS/SSS is responsible for coordinating psychosocial services for members identified as having special needs. They assist the members with utilization of medical resources related to care management, disease management, and discharge planning. Program Specialists are authorized to make referrals and coordinate care plans. Non-licensed PS do not conduct any activities requiring evaluation or interpretation of clinical information. Program Specialists are required to refer all potential adverse determinations to the designated Medical Director.

Affirmative Statement about Incentives

All individuals involved in UM decision making annually sign an 'Affirmative Statement about Incentives' acknowledging that UM decisions are based on appropriateness of care and existence of coverage. The organization does not reward practitioners or other individuals for issuing denials of coverage or care. There are no financial incentives for UM decisions makers that would encourage decisions that result in underutilization of services. (UM.04.01 - See Affirmative Statement about Incentives).

REFERENCES:

UM.01 - Utilization Management Program Description
UM.04.01 – Affirmative Statement About Incentives
UM.52 – Use of Board Certified Consultants
NCQA Health Plan Standards and Guidelines
42 CFR § 422.562(a)(4)
42 CFR § 423.562(a)(5)

ATTACHMENTS:

WellCare of Kentucky Addendum

ROLES & RESPONSIBILITIES: N/A

REGULATORY REPORTING REQUIREMENTS: N/A

REVISION LOG

REVISION TYPE	REVISION SUMMARY	DATE APPROVED & PUBLISHED
Annual Review	Annual review; added minor detail to Policy section regarding duties of UM supervisory staff; removed revision history prior to 2014.	09/17
Annual Review	Annual review; no substantive changes.	11/18
Ad Hoc Review	Added Addendum for <i>Louisiana Healthcare Connections</i> .	07/19
Annual Review	Annual review; removed revision history prior to 2017. Removed addendum for <i>Louisiana Healthcare Connections</i> .	07/20
Ad Hoc Review	Added CFR reference numbers to REFERENCES/ASSOCIATED PROCESSES section.	10/20
Annual Review	No substantive changes.	10/21
Annual Review	No substantive changes.	10/22

Ad Hoc Review	Added WellCare of Kentucky addendum information from retired policy <i>WC-C7-UM-017 Plan Authorization and Availability</i> . Replaced "Wellcare" with "the Plan". Updated language to present tense. Removed pharmacy, service authorization and communication services information from addendum.	12/22
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POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, the Company's P&P management software, is considered equivalent to a signature.

POLICY AND PROCEDURE

POLICY NAME: Interrater Reliability - Staff, Medical Directors, and Therapists	POLICY ID: CC.UM.32
BUSINESS UNIT: Please refer to system of record – Archer	FUNCTIONAL AREA: Utilization Management
EFFECTIVE DATE: 11/01/2005	PRODUCTS: Marketplace, Medicaid, Medicare
REVIEWED/REVISED DATE: 2/15; 08/15; 02/16; 01/17; 01/18; 01/19; 01/20; 10/20; 10/21; 04/22; 07/22; 08/22; 09/22	
REGULATOR MOST RECENT APPROVAL DATE: N/A	

POLICY STATEMENT:

This policy outlines the procedure for Interrater Reliability (IRR) testing for Staff, Medical Directors and Therapist.

PURPOSE:

To promote appropriate and consistent application of clinical criteria in decision making that is based on medical criteria, expert clinical opinion, and supported through a process of interrater reliability (IRR) testing. These steps ensure consistent application of medical policies, quality standards, and established timeframes; and identify areas where additional education and training are necessary. Annual IRR testing is mandatory to achieve and maintain National Committee for Quality Assurance (NCQA) accreditation.

SCOPE:

This policy applies to Population Health and Clinical Operations (PHCO)

DEFINITIONS:

Clinical Criteria Team: Organization and PHCO Learning and Development (L&D) Senior Learning and Development Specialists

Clinical Reviewer: Registered Nurse (RN), Licensed Practical Nurse (LPN), Medical Directors (MD), Therapist or Licensed Behavioral Health Professional responsible for reviewing service requests for Medical Necessity, Appeals and Auditing.

Interrater Reliability (IRR): The process of ensuring consistent application of criteria in making Utilization Management (UM) decisions.

Therapist: A collective term for the physical, occupational, and speech therapists employed at the corporate level (unless otherwise specified) for the purpose of completing secondary level Durable Medical Equipment (DME) and therapy reviews.

POLICY:

It is the Plan's policy that Population Health Clinical Operations (PHCO) L & D Clinical Criteria team - administers New Hire Initial and Annual Interrater Reliability testing to all licensed clinicians with the responsibility to conduct, educate, audit and/or oversee UM medical necessity reviews. PHCO leaders monitor staff performance on test outcomes and ongoing staff chart audits in order to ensure consistent utilization of designated clinical criteria decision-making tools. UM clinicians must maintain a minimum of a 90% accuracy rate as evidenced by Interrater Reliability testing scores. Clinicians scoring less than 90% receive remediation in order to ensure consistent application of criteria. The assessment of Interrater Reliability (IRR) applies only to Medical Necessity determinations made as part of a UM process. Any service request that requires prior approval is considered a UM Medical Necessity determination.

PROCEDURE:

All new staff, including temporary, contractor, or other individuals who use clinical criteria decision-making tools in their role, must complete the New Hire Initial IRR training.

- PHCO L&D Clinical Criteria team assigns the New Hire Initial IRR test(s) post InterQual and/or MCG training.
- Staff who use **InterQual** criteria have 45 calendar days to complete the New Hire Initial IRR test from assignment. The InterQual New Hire Initial IRR test(s) are assigned 60 days from the conclusion of InterQual training.
- Staff who use **MCG** criteria have 15 calendar days to complete the New Hire Initial IRR test from assignment. The MCG New Hire Initial IRR test(s) are assigned 60 days from the conclusion of MCG training.

If the assignment date of the New Hire Initial IRR test(s) coincides within 90 calendar days from the start date of Annual IRR testing, the staff participates in the Annual IRR testing. If there are more than 90 calendar days separating the assignment date of the New Hire Initial IRR test(s) and start of the Annual IRR testing, staff is required to take both test(s).

Successful demonstration of the UM process and proficient application of relevant medical necessity criteria including InterQual, MCG, American Society of Addiction Medicine (ASAM), Level of Care Utilization/Child/Adolescents Of Care

Utilization System, and/or Applied Behavioral Analysis must be validated through audits and testing prior to release from orientation. Managers and Clinical Trainers receive scores for their respective staff. A score of **less than 90% for any IRR test is considered not passing.**

At least annually, the Organization Vice President of Population Health and Clinical Operations (VPPHCO) and Vice President of Medical Affairs (VPMA), in conjunction with the Organization and PHCO Clinical Criteria team, initiates and conducts the IRR testing to assess the consistency with which Clinical Reviewers apply clinical criteria decision-making tools.

InterQual or MCG Users include:

- Medical Directors
- Behavioral and Physical Health Clinical Reviewers for Concurrent Review, Prior Authorization and Appeals
- Clinical Managers and Supervisors
- Clinical Auditors
- Clinical Trainers

For those utilizing InterQual criteria, the IRR consists of a test derived from the Change Healthcare® IRR test applicable for the current InterQual criteria used to make UM decisions. Separate tests are created for each InterQual Product. The MCG criteria IRR test consists of case studies selected from the MCG Learning Management System. Separate case studies are selected based on clinical role.

- A. The PHCO L&D Clinical Criteria team provides communication and training in preparing clinical staff for IRR testing. Information consists of annual revisions to clinical criteria, tools for successful IRR testing and remediation for clinical staff who did not pass the initial IRR test. In addition, IRR testing timelines are shared.
- B. The PHCO L&D Clinical Criteria team distributes IRR communications via the PHCO Clinical Criteria mailbox and in partnership with the PHCO L&D Regional Managers.
- C. All staff who utilize IQ or MCG clinical criteria are required to take the IRR tests that are pertinent to their role in the Organization.
- D. Once annual IRR testing is completed, the PHCO Clinical Criteria team prepares an analysis of the testing period. The Organization VPPHCOs, VPMAs, and designees receive scorecards for their respective staff and the Plan VPPHCO and VPMA receives scores for all plans.
- E. The PHCO L&D Clinical Criteria team collaborates with Plan leadership to ensure that testing is completed as outlined in this policy.

The process for the completion of IRR is as follows:

- A. Staff is provided one (1) attempt to pass the New Hire Initial, Annual, and Retake IRR test(s). There is **no** practice New Hire Initial, Annual, or Retake IRR tests.
- B. IRR testing is to be completed on an individual basis. Sharing of IRR test(s) and/or test answers is a violation of the Centene Business Ethics and Code of Conduct and have consequences ranging from disciplinary action up to and including termination.
- C. At the conclusion of New Hire Initial and Annual IRR testing, the PHCO L&D Clinical Criteria team identifies any staff with a score of less than 90% for any IRR test. The identified staff must attend remediation within 30 calendar days of completing the last initial IRR test. For example, four (4) IRR tests have been assigned however, the staff has failed one or more IRR tests. The date the last test was completed is used to calculate the start of the 30-day window for completing all required remediation. Upon conclusion of remediation, the PHCO L&D Clinical Criteria team assigns the IRR Retake test for **all** InterQual or MCG tests with a score of less than 90%. InterQual and MCG IRR testers are provided 30 and 15 days, respectively, to complete the Retake IRR test(s).
- D. A Corrective Action Plan (CAP) should be initiated by the People Leader for any staff with a final score of less than 90% for any IRR Retake test. A passing score for all tests is required.
- E. A Corrective Action Plan (CAP) may include but is not limited to the following: precepting of staff, retraining of the staff by reviewing the Initial/Retake IRR test(s) or auditing five (5) cases in production, for any IRR Product(s) not passed on the Retake over a 90-day period.
- F. Inability to pass retesting/audit review as a condition of the Corrective Action Plan (CAP) is subject to further action as defined by the Plan VPPHCO or VPMA, up to and including termination.

- G. In the event the New Hire and Annual IRR test(s) are not completed within the designated testing period, a failure of all applicable IRR tests is applied, and a Corrective Action Plan (CAP) is initiated by the People Leader.
- H. This excludes all excused absences per *CC.HUMR.08*. Remediation is not required for these staff.
 - 1. Staff with excused absences spanning the initial period of Annual testing should be assigned their IRR test(s) upon returning from leave by the People Leader.
- F. In the instance where the state mandates specific validation and documentation of staff proficiencies:
 - 1. Appropriate documentation must be provided to support the need for testing variances. The Plan is still required to complete all foundational statements in this policy. The Plan holds the responsibility for the execution, monitoring, and documentation of state required nuances.

In addition to IRR testing, the Organization works to ensure staff are notified of the Annual Content Release revisions to InterQual and MCG clinical criteria. The PHCO L&D Clinical Criteria team provides to PHCO, Medical Affairs leadership and staff a Summary of Changes outlining the Annual Content Release revisions from the previous year's InterQual and MCG criteria. The Summary of Changes is presented within a quarter of the Annual Content Release revisions being shared with the Organization. All staff who use InterQual and MCG must complete the Summary of Changes training prior to using the new criteria. The Plan leadership ensures this training is complete prior to directing staff to use the current year's criteria. PHCO L&D Clinical Criteria team sends a communication on the launch date for using the Annual Content Release. The PHCO L&D Clinical Criteria team validates completion of the Summary of Changes by utilizing Centene University reporting and MCG Learning Management System.

MEDICAL DIRECTOR AND THERAPIST IRR AND PEER REVIEW

Results of each Medical Director and Therapist's IRR test results and peer review participation is collected and tracked over time. It may be determined that additional education and/or increased supervision of review decisions is necessary based on the results. Testing may be done more frequently than once per year if the need is identified. The IRR testing focuses on the correct application of clinical criteria as well as the appropriateness of identifying quality issues. Medical Directors and Therapist's also participate in Peer Review discussions three times per year. The purpose of Peer Review is to measure compatibility amongst Medical Directors and Therapists in order to ensure fairness and equality in the process of medical necessity review.

The below Medical Director and Therapist IRR and Peer Review is applicable to many of the health plans within the Organization. If your Peer Review process differs, please follow your health plan specific policy.

MEDICAL DIRECTOR PEER REVIEW

- A. Physician Peer Review discussions occur three times per year and are overseen by the Medical Affairs department.
- B. A Medical Director is required to participate in Peer Review if they have completed at least 15 advisor reviews in the prior quarter.
- C. For each Peer Review, at least five diverse cases are selected by the Medical Affairs department. Cases are blinded and sent to each Medical Director to review.
- D. The Medical Directors have two weeks to review the assigned cases and consider the following elements:
 - 1. The medical appropriateness of care provided and/or requested
 - 2. Identification of care delays
 - 3. The appropriate setting and provider type (for example, inpatient versus outpatient versus home)
 - 4. The criteria which are applicable (i.e., a specific clinical policy, subset of InterQual, etc.)
 - 5. The intensity of services provided
- E. The cases are discussed in a group format. Each case is assigned to a member of the group who is responsible for summarizing the case and leading the discussion. There are 3-4 sessions scheduled and every Medical Director eligible to participate is required to attend and participate in one meeting.
- F. After the discussions have taken place, a summary of the outcomes is sent to all Medical Directors.

THERAPIST PEER REVIEW

- A. Therapist peer review discussion occurs three times per year and are overseen by the Medical Affairs department.

- B. A therapist is required to participate in Peer Review if they have completed at least 15 advisor reviews in the prior quarter.
- C. The last instance of peer review for the year, usually occurring in October, focuses on InterQual to serve as a hybrid of IRR test prep and peer review. Therapists who are exempt from the IRR test are exempt from this peer review activity.
- D. For each instance of therapist peer review:
1. For physical and occupational therapists:
 - a. Ten diverse cases to include at least five therapy requests and five durable medical equipment (DME) requests consisting of a mix of wheelchair, orthotic, and prosthetic items are selected by the Medical Affairs department. Cases are blinded and sent to each therapist to review.
 - b. Each physical or occupational therapist completes all cases that are relevant to their specialty training. No therapist should complete less than five cases.
 - c. The therapists have two weeks to review the assigned cases and consider the following elements:
 - The medical appropriateness of care provided or requested in the case
 - The criteria guidelines which are applicable (i.e., a specific clinical policy, subset of InterQual, etc.)
 - The intensity of services provided
 - d. The therapists submit a written response for each case that they review. The results of each case are aggregated and reviewed for consistency and reliability.
 - e. A summary of the outcomes, consideration of discrepancies and feedback on process improvement is sent to all therapists for review and further discussion.
 2. For speech therapists:
 - a. The speech therapist submits reviews for five separate cases involving speech therapy or speech generating devices over a two-week period of time. The cases and case summaries are reviewed by the Specialty Therapy Advisor Team Manager to determine consistency and provide feedback on the responses.

REFERENCES:

Change HealthCare® Interrater Reliability Tool
 Milliman® Interrater Reliability Tool
 NCQA Health Plan Standards and Guidelines
 UM.02 - Clinical Decision Criteria and Application

ATTACHMENTS:

Managed Health Services IN Addendum

SUPPORT/HELP: N/A

REVISION LOG

REVISION TYPE	REVISION SUMMARY	DATE APPROVED & PUBLISHED
Annual Review	NCQA updated to reflect current; updated approver titles; removed revision history prior to 2015; no substantive content change.	01/17
Annual Review	No substantive content changes.	01/18
Annual Review	Removed revision history prior to 2016, no other substantive changes.	01/19
Annual Review	Removed revision history prior to 2017. Numerous updates throughout policy. Added ' <i>MEDICAL DIRECTOR AND THERAPIST IRR AND PEER REVIEW, MEDICAL</i>	10/20

	<i>DIRECTOR PEER REVIEW, and THERAPIST PEER REVIEW</i> sections.	
Annual Review	Several updates made to clarify work process and add PHCO L&D responsibilities.	10/21
Ad Hoc Review	Merged the legacy WellCare <i>WC-C7-UM-015 Interrater Reliability</i> policy with the Centene work process, <i>CC.UM.02.05 - Interrater Reliability</i> . Changed ID number to CC.UM.32. Retired WC-C7-UM-015.	04/22
Ad Hoc Review	Added addendum for Managed Health Services IN.	07/22
Ad Hoc Review	Several updates to IRR process, grammatical edits, clarification of testing timelines and Compliance requirement.	08/22
Ad Hoc Review	Updated addendum for Managed Health Services IN.	09/22

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, the Company's P&P management software, is considered equivalent to a signature.

Clinical Policy: Clinical Policy Committee

Reference Number: CP.CPC.01

Date of Last Revision: 02/22

[Revision Log](#)

Description

The Clinical Policy Committee ensures that clinical policies provide a guide to medical necessity, are reviewed and approved by appropriately qualified physicians, and are available to all Centene Health Plans.

Clinical policies provide a guide to medical necessity. Benefit determinations should be based in all cases on the applicable contract provisions governing plan benefits (“Benefit Plan Contract”) and applicable state and federal requirements, as well as applicable plan-level administrative policies and procedures. To the extent there are any conflicts between these policies and the Benefit Plan Contract provisions, the Benefit Plan Contract provisions will control.

Clinical policies reflect current scientific research and evidence-based clinical standards. Clinical policies are not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care and are solely responsible for the medical advice and treatment given to members. All clinical policies are available to providers in compliance with all federal, statutory and regulatory requirements and upon request.

I. Purpose

- A.** The Centene Corporate Chief Medical Officer (CMO) or his/her designee is responsible for establishing and maintaining a Clinical Policy Committee (CPC) composed of physicians and other medical and operational representatives as appropriate from Corporate Medical Management and each Plan to assist in the identification of need, development, revision, and/or review of clinical policy. All corporate clinical policies require approval by the CPC. Physicians participating in the CPC shall be board-certified and shall be licensed in good standing in at least one state.
- B.** Clinical policies include medical, and durable medical equipment and devices. These policies include but are not limited to:
 - 1. New and emerging technologies
 - 2. New uses for existing technologies
 - 3. Coverage issues relating to new and existing technologies
 - 4. Clinical guidelines for the evaluation and treatment of specific conditions
 - 5. Clinical/medical criteria or information used in pre- or post-service review
- C.** The CMO or designee performs an annual review of all existing corporate clinical policies to determine continued applicability and appropriateness. In connection with this annual review, the CMO or designee is responsible for identifying which policies require revisions. The CMO or designee shall send any such policies to the CPC to oversee the revision process and for subsequent re-approval.

II. Membership

The CMO or designee recruits and replaces, as needed, CPC members to maintain a committee that includes:

- A.** Voting members:

CLINICAL POLICY

Clinical Policy Committee

1. One Medical Director from each Plan (at minimum);
 2. Senior Corporate Medical Directors
- B.** Non-voting members:
1. One representative from each Plan's medical operations department
 2. Corporate clinical policy leadership
 3. Corporate Medical Management Staff
- C.** Ad hoc advisors
1. Representatives from Centene subsidiaries
 2. Internal legal counsel
 3. Plan compliance directors
 4. Outside experts and/or relevant interested parties depending upon the specialty area or special needs of the clinical policy.

III. Committee Maintenance and Oversight

- A.** The CMO or designee acts as the chairperson for meetings and activities performed by the CPC (Committee Chair). The Corporate Director of Clinical Policy reports to the Committee Chair.
- B.** The Corporate Director of Clinical Policy oversees the Clinical Policy Department which is tasked with the following responsibilities in connection with the development and approval of clinical policies:
1. Coordinating research and development of clinical policies, which includes:
 - a. Prioritizing all inquiries for new corporate policies and maintaining an electronic log of all requests for research and new policies with the requestor and subject of review.
Highest priority is given to inquiries based on open medical management cases such as pending authorizations or appeals cases. Response to these requests typically occurs within 24 hours. Priority then continues based on requests originating from providers or members, needs identified through financial analysis, followed by inquiries by vendors and technologies identified through trade publications.
 - b. Conducting preliminary review of topics as follows:
 - i. A critical appraisal of the current published medical literature from peer-reviewed publications including systematic reviews, randomized controlled trials, cohort studies, case control studies, and diagnostic test studies with statistically sound methods.
 - ii. Evidence-based guidelines developed by national organizations and recognized authorities.
 - iii. Opinions and assessments by nationally recognized medical associations including physician specialty societies, consensus panels, or other nationally recognized research or technology assessment organizations such as Hayes, UpToDate, or ECRI.
 - iv. Reports and publications of government agencies such as the Food and Drug Administration (FDA), Centers for Disease Control (CDC), or National Institutes of Health (NIH).
 - v. External review organization recommendations.

- c. Conveying the findings of the preliminary review to the requestor within the priority-based time frame. In cases of open medical management decisions, the requestor will use the information provided by the clinical policy staff and the specifics of the particular case to render a decision. Preliminary review findings are saved in an electronic file for future policy development.
 - d. For topics identified through medical management needs, if two requests for the same topic are submitted, a formal medical policy may be developed. Requests identified through financial analysis will follow this policy development process.
 - i. The clinical policy staff utilizes the preliminary research to draft a policy. Relevant CPT, HCPCS and ICD-10 codes are identified and included in the policy. A review of historical handling and/or payment of the policy topic is also conducted to share with the CPC as appropriate.
 - ii. Opinions from external physicians are solicited as appropriate, including behavioral health physicians. The policy is sent for CPC review and approval.
 - iii. Subsequent to each new policy approval, the clinical policy staff sends a notice to all medical directors and medical management leadership to inform them of new policies that have been approved by the CPC.
 - iv. The completed policies are reviewed annually or updated more frequently as dictated by current medical literature, medical director or other relevant staff requests and appeals analysis.
 - v. Completed policies are posted on CNet and in Adobe Experience Manager for access by internal staff and for plans to link to plan websites for providers.
 - e. Communication of these policies to provider networks is arranged by the plan marketing or provider network department.
2. Coordinating activities of the CPC including, but not limited to, the review, revision, approval, and maintenance processes of all corporate clinical policies. This includes scheduling meetings, sending necessary agendas and attachments, documenting meeting minutes, clinical policy reference number assignment, and the maintenance of such documents in electronic files and within the organizational internal database.
 3. Generating reports reflecting CPC activity on a quarterly basis, or more frequently as needed, for the Committee Chair.
 4. Notifying all relevant persons/departments and health plans regarding approved policies and related materials through email, including:
 - a. Claim support service teams for dissemination to IS and claims. The clinical policy team offers direction/coordination for any system needs to support the clinical policy.
 - b. Corporate Medical Management VPs and Corporate medical auditing and training teams for dissemination and auditing.
 - c. CPC members, plan medical management VPs and directors, and other health plan contacts for dissemination to their plan UM personnel. This includes notification to plan representatives for inclusion in the plan UM or QI committee responsible for plan level policy approval. Marketing and/or provider relations are included for appropriate provider notification of policy changes.
 5. Facilitating training, as needed, with the corporate Medical Management Training Department.

IV. Meeting Frequency

- A. CPC meetings are held, at minimum, on a quarterly basis. Frequency is dependent upon clinical policy revision cycles and/or clinical policy need (as determined by the CMO or designee).
- B. Meetings may be held in a physical location or through the use of alternative media as determined by the participation of members from remote locations or by the urgency of the clinical policy. Such media include video, telephonic conference call, or email.

V. Committee Member Activities and Responsibilities:

- A. Identification of new subjects to consider for clinical policy development can occur in the following ways:
 - 1. Through UM authorization requests;
 - 2. New technologies identified through trade publications;
 - 3. Inquiries from providers and vendors;
 - 4. Review of appeals cases;
 - 5. Suggestion of the Medical Policy Governance Team;
- B. Review of clinical policies which includes:
 - 1. New clinical policy drafts;
 - 2. Policies due for scheduled review;
 - 3. Updates or revisions to existing policies outside of the scheduled review due to advances or changes in standards of care, new information, missing information or content error;
 - 4. Updates regarding the status of any policies under review;
 - 5. Policy and prioritization requests for new clinical policies;
- C. Electronic approval of clinical policies
Policies will be reviewed and approved through an electronic web poll process.
 - 1. All draft clinical policies are loaded into the Qualtrics survey tool.
 - 2. An email notification is sent to each of the CPC members with a link for the current survey with policies due for review as well as the required completion date for review. Standard surveys allow one week for review of clinical policies.
 - 3. The survey directs CPC members to indicate if the policy meets their approval with a vote stating either (a) “yes,” (b) “yes, with comments,” (c) “no,” or (d) “abstain.” “Yes, with comments” and “no” votes require feedback to be supplied before the reviewer can complete the survey.
 - 4. The Committee Chair determines, based on voting feedback, whether an issue identified during the voting process will be included on the agenda for discussion at the following CPC meeting. If so, the feedback will be distributed with the agenda for consideration prior to the meeting.
 - 5. In the context of the electronic approval process, CPC actions are determined by a majority vote of the voting members responding. A majority of the voting committee members must respond to the review request to be considered a quorum. If a quorum does not respond, a follow-up email is sent to request additional members to respond.
 - 6. Survey results are maintained electronically in the folder dated with the survey fielded date, along with all of the policies that were submitted for approval at that time.
- D. Attendance and Participation

CLINICAL POLICY
Clinical Policy Committee

1. Committee members are expected to attend all scheduled meetings and participate in the review of documents forwarded electronically for review and consensus.
2. The Committee Chair has the right to replace a committee member who does not participate in 2 or more consecutive committee meetings.
3. In the context of CPC meetings, CPC actions are determined by a majority vote of the voting members present. A majority of the voting committee members must be present to constitute a quorum.
4. A Corporate designee will document meeting minutes. Meeting minutes include the agenda topic, pertinent discussion, proposed changes submitted/discussed, and any action taken or consensus reached with respect to the proposed changes.

E. Approvals

The CMO or designee approves all clinical policies. The Committee Chair is authorized to act as the CMO designee for the purpose of approving clinical policies.

1. Within 10 business days of the survey poll close date or CPC meeting date, the Corporate Clinical Policy team incorporates any agreed changes and loads the approved policy into the clinical policy SharePoint site.
2. The CMO designee locks the policy in an approved status in the policy management system for immediate use by the Health Plans.

Reviews, Revisions, and Approvals	Approval Date
Policy developed	09/08
Under II.B, added language consistent with Health Net MAC Charter that will be incorporated into CPC process Under IV.A clarified areas where topics can be identified to be consistent with HN MAC charter language	09/16
Changed IV.E. to 10 days, from 5 days, based on processing time due to volume of policies being reviewed.	09/17
Changed “Compliance 360” to “policy management system” in IV.E.2. Removed pharmacists as voting members.	07/18
Reviewed against the 2019 NCQA Health Plan Accreditation Standards and Guidelines	05/19
Under ad-hoc advisors in the committee members section, changed “Centene pharmacy subsidiary” to “Centene subsidiaries.” In the committee maintenance and oversight section, changed the requirement for statistically significant results demonstrating safety and effectiveness to a requirement for statistically sound methods. Added that policies are posted to Adobe Experience Manager and clinical policy SharePoint site. Changed references to Compliance 360 to Clinical Policy SharePoint Site. Added to committee maintenance and oversight section that committee members “and other health plan contacts” would be notified for policy dissemination to plan personnel, including the UM or QI committee. In meeting frequency section, changed statement to say CPC meetings may occur in a physical location or via alternate media, instead of “as well as.”	07/19
Added that new policy requests may come through the Medical Policy Governance Team. Removed mention of BH voters on the CPC, and BH	03/20

CLINICAL POLICY
Clinical Policy Committee

Reviews, Revisions, and Approvals	Approval Date
policy topics. Specified throughout the policy that the CPC addresses corporate clinical policies.	
Restricted voting privileges for corporate MDs to senior MDs only.	04/20
Annual review.	02/21
Annual review.	02/22

Clinical Policy: Medical Necessity Criteria

Reference Number: CP.CPC.05

Date of Last Revision: 06/22

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

Medical necessity criteria and related definitions.

Note: This policy may not be referenced in denial letters as the sole criteria for adverse determinations. The denial notification must reference the specific medical necessity criterion used to make the denial decision.

Policy/Criteria

Health plans affiliated with Centene Corporation® will use the following guidelines to make medical necessity decisions (listed in order of significance) on a case-by-case basis, based on the information provided on the member's health status:

- A. Federal law (e.g., National Coverage Determinations (NCD), Local Coverage Determinations (LCD), and Medicare Coverage Articles for Federal programs such as Medicare);
- B. State law/guidelines (e.g., when State requirements trump or exceed federal requirements);
- C. Plan-specific clinical policy (including plan-specific clinical policies in InterQual® as custom content);
- D. Centene clinical policy (including Centene clinical policies in InterQual as custom content);
- E. If no Plan- or Centene-specific clinical policy exists, then nationally recognized decision support tools such as InterQual Clinical Decision Support Criteria or MCG (formerly Milliman Care Guidelines®) criteria are used;
- F. In the case of no guidance from A-E, additional information that the applicable health plan Medical Director will consider, when available, includes:
 1. Reports from peer reviewed medical literature, from which a higher level of evidence and study quality is more strongly considered in determinations;
 2. Professional standards of safety and effectiveness recognized in the US for diagnosis, care, or treatment;
 3. Nationally recognized drug compendia resources such as Facts & Comparisons®, DRUGDEX®, and The National Comprehensive Cancer Network® (NCCN®) Guidelines
 4. Medical association publications, such as those from American Society of Addiction Medicine, American College of Obstetricians and Gynecologists, etc.;
 5. Government-funded or independent entities that assess and report on clinical care decisions and technology such as Agency for Healthcare Research and Quality (AHRQ), Hayes Technology Assessment, Cochrane Reviews, National Institute for Health and Care Excellence (NICE), etc.;
 6. Published expert opinions, including in UpToDate;
 7. Opinion of health professionals in the area of specialty involved;
 8. Opinion of attending provider in case at hand.

CLINICAL POLICY
Medical Necessity Criteria

Only appropriate practitioners can make the decision to deny coverage of a requested service based on medical necessity guidelines. Practitioner types appropriate for making the following types of denial decisions include*:

Provider Type	Denial Decision
Physicians, all types	Medical, behavioral healthcare, pharmaceutical, dental, chiropractic, vision, and physical therapy denials
Doctoral-level clinical psychologists or certified addiction-medicine specialists	Behavioral healthcare denials
Doctoral-level board-certified behavioral analysts, doctoral-level clinical psychologists, child and adolescent psychiatrist.	Applied Behavioral Analysis denials and appeals.
Pharmacists	Pharmaceutical denials
Dentists	Dental denials
Chiropractors	Chiropractic denials
Physical therapists	Physical therapy denials
Advanced practice registered nurses (such as nurse practitioners and clinical nurse specialists)	Requests within the scope of the license, when acting as independent practitioners in accordance with the state practice act or regulation

*State mandates may alter which practitioner types are appropriate for denial decisions.

Definitions

Unless defined differently by the members’ Benefit Plan Contract or the applicable provider agreement, the Health Plan uses the following definitions:

- A. **Medically necessary** or medical necessity shall mean health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms, and that are:
 1. In accordance with generally accepted standards of medical practice;
 2. Clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for the patient’s illness, injury, or disease; and
 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.

Medically necessary health care services may not include experimental and/or investigational technologies or carve-out days. For further information, please refer to CP.MP.36, Experimental Technologies.

- B. **Generally accepted standards of medical practice** means standards that are based upon credible scientific evidence published in peer-reviewed medical literature recognized by the medical community at large or otherwise consistent with the standards set forth in policy issues involving clinical judgment.

- C. **Experimental and/or investigational technologies** are defined as any drugs, procedures, treatments, devices, supplies, and other health care services (“Service”) that are any of the following:
1. It is currently the subject of active and credible evaluation (e.g., clinical trials or research) to determine:
 - a. Clinical efficacy;
 - b. Therapeutic value or beneficial effects on health outcomes;
 - c. Benefits beyond any established medical based alternatives.
 2. It does not have final clearance from applicable governmental regulatory bodies (such as the US Food and Drug Administration "FDA") and unrestricted market approval for use in the treatment of a specified medical condition or the condition for which authorization of the Service is requested and is the subject of an active and credible evaluation.
 3. The most recent peer-reviewed scientific studies published or accepted for publication by nationally recognized medical journals do not conclude, or are inconclusive in finding, that the Service is safe and effective for the treatment of the condition for which authorization of the Service is requested.
- D. **Not medically necessary and not investigational:** evaluations and clinical recommendations that are assessed according to the scientific quality of the supporting evidence and rationale (e.g., national medical associations, independent panels, or technology assessment organizations). A service is considered not medically necessary and not investigational when:
1. There are no studies of the service described in recent, published peer-reviewed medical literature;
 2. There are no active or ongoing credible evaluations being undertaken of the service which has previously been considered not medically necessary;
 3. There is conclusive evidence in published peer-reviewed medical literature that the service is not effective;
 4. There are no peer-reviewed scientific studies published or accepted for publication by nationally recognized medical journals that demonstrate the safety and efficacy of the use of the service;
 5. It is contraindicated.
- E. In relation to inpatient stays, **carve-out days** are defined as non-medically necessary inpatient hospital days that occur during an approved admission (i.e., the inpatient stay was prolonged unnecessarily). Examples of circumstances giving rise to a carve-out day(s) include, but are not limited to:
1. A day in which a member meets concurrent inpatient criteria, and needs a service during the stay (e.g., imaging, surgery, etc.), but the service is not performed on the earliest possible date for reasons unrelated to the member’s clinical condition (e.g., MRI machine is down, operating room time is not available, patient is bumped off schedule, or a specialist did not come in to perform a consult, etc.);
 2. A day that is solely “social” in nature (e.g., the member is waiting for foster placement, discharge instructions, etc.);
 3. A day at the end of a stay in which discharge criteria are met but the member is not discharged (due to, e.g., a transportation problem, DME not delivered to the home, staff

too busy to discharge the member, provider did not come in to write discharge order, the member is waiting for a SNF placement, etc.).

4. A day of care that is, or appears to be, necessitated by quality of care issues or largely preventable issues [e.g., complication due to wrong medication dose, central line-associated blood stream infections (which can include PICC lines and both tunneled and non-tunneled central lines), ventriculitis or meningitis in a patient with a reservoir who is receiving taps in place of a shunt and who is 2000 grams or greater in weight; infections with resistant hospital flora such as MRSA (methicillin-resistant Staphylococcus aureus) or VRE (vancomycin-resistant enterococcus), etc.].
- F. The terms “**never events**,” “**serious reportable events**,” and “**non-reimbursable serious hospital-acquired conditions**” all refer to serious adverse events occurring in facilities that are largely preventable and of concern to both the public and to health care providers. Based on the benefit plan contract, the event and services resulting directly from a never event may not be a covered benefit and/or may be non-reimbursable. Examples of such events include:
1. Surgery on wrong body part
 2. Surgery on wrong patient
 3. Wrong surgery on patient
 4. Retained foreign body after surgery
 5. Death/disability associated with intravascular air embolism
 6. Death/disability associated with incompatible blood
 7. Death/disability associated with hypoglycemia
 8. Stage 3 or 4 pressure ulcers after admission
 9. Death/disability associated with electric shock
 10. Death/disability associated with a burn incurred within facility
 11. Death/disability associated with a fall within facility
 12. Various surgical site infections, i.e., following coronary artery bypass graft, bariatric surgery or certain orthopedic procedures, etc.

Background

Centene clinical policies are intended to be reflective of current scientific research and clinical practice and judgment. They are developed with oversight of board-certified physicians and practitioners, reviewed on an annual basis for appropriateness and approved by the Centene Clinical Policy Committee. The Clinical Policy Committee is composed of physicians and other medical and operational representatives, as appropriate, from Centene Corporate and each Plan to assist in the identification of need, development, revision, and/or review of clinical policy. Clinical policies include medical, behavioral health, medical pharmacy benefits, durable medical equipment and devices. These policies include but are not limited to:

- New and emerging technologies
- New uses for existing technologies
- Clinical guidelines for the evaluation and treatment of specific conditions
- Criteria used in the authorization of drugs included on a Plan prior authorization list
- Clinical/medical criteria or information used in pre- or post-service review

InterQual criteria are proprietary and cannot be publicly published and/or distributed. On an individual member basis, the specific criteria document used to make a medical necessity determination can be made available upon request. Registered providers can obtain the

CLINICAL POLICY

Medical Necessity Criteria

appropriate InterQual criteria by logging in to the secure provider portal. The InterQual criteria can be submitted with the authorization request to help expedite the process.

Change Healthcare is the owner/licensor of the InterQual Clinical Decision Support Criteria and related software. Change Healthcare has prepared this Work for exclusive use of its licensees of software applications embodying the Clinical Content. This Work contains confidential and trade secret information of Change Healthcare and is provided to licensees who have an existing license agreement in force only under the time-limited license as provided under that license agreement.

Licensee and any recipient thereunder shall use the Clinical Content in accordance with the terms and conditions of the license agreement.

The MCG guideline(s) and products are not intended to be used without the judgment of a qualified health care provider with the ability to take into account the individual circumstances of each patient's case.

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Policy developed	06/13	06/13
Added definitions for experimental/investigational, carve-out days, and serious adverse events; information about clinical policy committee	08/13	10/13
Move LCD from #2 to #1 in Policy section	07/14	10/14
Added Plan specific policy under Policy/Criteria Converted into new template	10/15	10/15
Added Medicare Coverage Articles under criteria A. Redefined experimental/investigational per Health Net definition and added definition of not medically necessary and not investigational. Added footnote that the types of practitioners able to make a coverage denial may be mandated by specific states.	09/16	09/16
Clarified in provider/denial decision table that these are denial decisions <i>allowed</i> to be made by a given provider, instead of <i>requiring</i> a certain provider. Added PT as a denial decision allowed to be made by an MD.	09/17	09/17
Added that Centene clinical policy includes Centene custom content criteria in InterQual.	06/18	06/18
Specified that state-specific InterQual custom content is included in plan-specific clinical policy.	03/19	
Renumbered the policy from CP.MP.68 to CP.CPC.05. Changed references of McKesson to Change Healthcare. Added a note in description that this policy may not be referenced in denial letters as the sole criteria for adverse determinations. Added advanced practice registered nurses and doctoral-level Board-Certified Behavioral Analysts to provider type table.	04/19	06/19
Specified that doctoral-level Board-Certified Behavioral Analysts are needed for appeals and not all denials.	08/19	

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Edits approved by the behavioral health subcommittee: Applied Behavior Analysis denials and appeals can be completed by doctoral-level board-certified behavior analysts, doctoral-level clinical psychologists, child and adolescent psychiatrists	10/19	09/19
Removed Up-To-Date from list of resources to use when no guidance is available in A-E in Policy/Criteria F.5, and added to F6 under “published expert opinion.” References reviewed and updated.	05/20	06/20
In F.4., added examples of medical associations, such as ASAM and ACOG.	10/20	
Updated Section F., adding “12.” referring to “various surgical site infections” found on CMS (added reference). Added reference to CP.MP.36 Experimental Technologies. Changed “review date” in the header to “date of last revision” and “date” in the revision log header to “revision date.” References reviewed and updated.	06/21	06/21
Annual review completed. Definition section C. and D. replaced “or” with a semi-colon. Background updated to reflect InterQual “criteria” and not “SmartSheets.” Minor wording changes in the background with no clinical significance. References reviewed and updated.	06/22	06/22

References

1. American Medical Association (AMA). Statement of the AMA to the Institute of Medicine’s Committee on Determination of Essential Health Benefits. January 14, 2011.
2. Lembitz A, Clarke TJ. Clarifying "never events and introducing "always events". *Patient Saf Surg.* 2009;3:26. Published 2009 Dec 31. doi:10.1186/1754-9493-3-26
3. Change Healthcare InterQual[®] criteria.
4. MCG (formerly Milliman Care Guidelines[®]) guidelines.
5. National Committee for Quality Assurance. NCQA Standards and Guidelines for the Accreditation of Health Plans 2022.
6. National Quality Forum (NQF). Serious Reportable Events in Healthcare 2011 Update: A Consensus Report, Washington, DC: NQF; 2011.
7. Steinberg EP, Tunis S, Shapiro D. Insurance coverage for experimental technologies. *Health Aff (Millwood).* 1995;14(4):143-158. doi:10.1377/hlthaff.14.4.143
8. National Academies of Sciences, Engineering, and Medicine. *Essential Health Benefits: Balancing Coverage and Cost.* Appendix G: Medical necessity. Institutes of Medicine. Washington, DC: The National Academies Press, 2012 <https://doi.org/10.17226/13234>.
9. CMS.gov. Centers for Medicare and Medicaid Services. Hospital-Acquired Conditions. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Hospital-Acquired_Conditions

Clinical Policy: Experimental Technologies

Reference Number: CP.MP.36

Date of Last Revision: 02/22

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

This policy outlines general guidelines to use in determining coverage of experimental or investigational, or potentially experimental or investigational medical and behavioral health technologies. These guidelines are to be used only when there is no other policy, criteria, or coverage statement available.

Note: For coverage of routine costs as part of a clinical trial, please refer to CP.MP.94 Clinical Trials.

Policy

It is the policy of health plans affiliated with Centene Corporation[®] that all coverage determinations regarding technologies (i.e., drugs, procedures, devices, services, or supplies) that are or may be considered experimental or investigational must be considered on a case-by-case basis by a physician or ad hoc committee and must be made in accordance with the Benefit Plan Contract provisions and applicable state and federal requirements.

A technology is considered experimental or investigational if it meets any of the following criteria:

- A. It is currently the subject of active and credible evaluation (e.g., clinical trials or research) to determine:
 1. Clinical efficacy;
 2. Therapeutic value or beneficial effects on health outcomes;
 3. Benefits beyond any established medical based alternatives.
- B. It does not have final clearance from applicable governmental regulatory bodies (such as the US Food and Drug Administration (FDA)) and unrestricted market approval for use in the treatment of a specified medical condition or the condition for which authorization of the service is requested and is the subject of an active and credible evaluation.
- C. The most recent peer-reviewed scientific studies published or accepted for publication by nationally recognized medical journals do not conclude, or are inconclusive in finding, that the service is safe and effective for the treatment of the condition for which authorization of the service is requested.

Under no circumstances is this policy to be construed as an acknowledgement or acceptance by the Health Plans of any obligation to cover experimental or investigational technologies where such technologies are not included in the benefits set forth in the Benefit Plan Contract or by applicable state and federal requirements. The Plan reserves the right to refuse coverage of an experimental or investigational technology on the grounds that such coverage is not required under the member/enrollee's benefit plan. Approval of an experimental technology with respect to a particular case does not guarantee coverage of the same technology with respect to any other cases.

Criteria

The criteria listed below should be weighed when evaluating the medical necessity of a technology that is or may be experimental or investigational. Where medical necessity of a technology is confirmed under this policy, steps should be taken to ensure that the technology is furnished by a participating or in-state provider to the extent possible.

- A.** The technology should have final approval from appropriate governmental regulatory bodies. Regulatory bodies include the U.S. Food and Drug Administration (FDA) or any other governmental body with authority to regulate the technology. The indication for the technology under review does not need to be the same indication for which the technology has been approved.
- B.** At least two studies published in peer-reviewed medical literature should be available that would support conclusions regarding the effect of the technology and its likely net health impact. Such studies must, by the standards of accepted medical research, be well-designed and well-conducted investigations yielding quality and consistent results, and the results of such studies should demonstrate the effect the technology will have on the disease, injury, illness, or condition in question.

The opinions and evaluations of national medical associations, consensus panels, and other technology evaluation bodies, or other specialists or professionals, who are subject matter experts with respect to the technology, may be taken into consideration according to the scientific quality of the supporting evidence and rationale for such opinions and evaluations.

- C.** The technology should be used to improve net health outcome of a severely disabling or life-threatening condition. The health benefits of the technology must outweigh any harmful effects or risks to the member/enrollee.
- D.** Other established treatment alternatives to the technology should have been exhausted and failed or no established treatment exists.
- E.** The improvement to be gained by employing the technology should be attainable outside the control setting (i.e., in practice).
- F.** In the case of diagnostic procedures, it is anticipated that the results of the procedure will help determine the best plan of care. There must be some potential intervention or alteration to the current plan of care based on the diagnostic results.
- G.** The member/enrollee fully understands the risks and benefits regarding the requested technology or treatment and has given informed consent.

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Initial effective date.		06/09
Moved information from Authorization Protocols to Policy section. Added reference to CP.MP.94 Clinical Trials	10/14	10/14

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Removed “To the extent coverage....administrative reasons” sentence from 1 st paragraph under criteria Converted into new template	10/15	10/15
Redefined experimental/investigational per Health Net definition.	09/16	09/16
References reviewed and updated.	09/17	09/17
References reviewed.	06/18	06/18
References reviewed	05/19	06/19
References reviewed. Added note: For clinical trials, refer to CP.MP. 94 Clinical Trials.	06/20	06/20
Removed duplicative statement in Criteria A. regarding request for clinical trials. References reviewed and updated. Replaced all instances of member with “member/enrollee.”	04/21	04/21
Annual review. Changed “review date” in the header to “date of last revision” and “date” in the revision log header to “revision date.” References reviewed, updated and reformatted.	02/22	02/22

References

1. Bischel, MD. Medical review criteria guidelines for managing care. 12th edition. Apollo Managed Care Consultants. 2013.
2. Local coverage determination: Category III codes (L35490). Centers for Medicare and Medicaid Services. <https://www.cms.gov/medicare-coverage-database/new-search/search.aspx>. Published October 1, 2015 (revised January 1, 2022). Accessed January 20, 2022.
3. Steinberg, EP, Tunis, S, Shapiro, D. Insurance coverage for experimental technologies. *Health Aff (Millwood)*. 1995;14(4):143-158. doi:10.1377/hlthaff.14.4.143

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy,

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Experimental Technologies

contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.

Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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Clinical Policy: Ultrasound in Pregnancy

Reference Number: CP.MP.38

Date of Last Revision: 03/22

[Revision Log](#)
[Coding Implications](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

This policy outlines the medical necessity criteria for ultrasound use in pregnancy. Ultrasound is the most common fetal imaging tool used today. Ultrasound is accurate at determining gestational age, fetal number, viability, and placental location; and is necessary for many diagnostic purposes in obstetrics. The determination of the time and type of ultrasound should allow for a specific clinical question(s) to be answered. Ultrasound exams should be conducted only when indicated and must be appropriately documented.

Policy/Criteria

It is the policy of health plans affiliated with Centene Corporation® that the following ultrasounds during pregnancy are considered **medically necessary** when the following conditions are met:

- I. [Standard first trimester ultrasound](#) (76801)
- II. [Standard second or third trimester ultrasound](#) (76805)
- III. [Detailed anatomic ultrasound](#) (76811)
- IV. [Transvaginal ultrasound](#) (76817)
- V. [Not medically necessary conditions](#)

- I. One standard *first trimester ultrasound* (76801) is allowed per pregnancy.

Subsequent standard first trimester ultrasounds are considered **not medically necessary** as a limited or follow-up ultrasound assessment (76815 or 76816) should be sufficient to provide a re-examination of suspected concerns.

- II. One standard *second or third trimester ultrasound* (76805) is allowed per pregnancy.

Subsequent standard second or third trimester ultrasounds are considered **not medically necessary** as a limited or follow-up ultrasound assessment (76815 or 76816) should be sufficient to provide a re-examination of suspected concerns.

- III. One *detailed anatomic ultrasound* (76811) is allowed per pregnancy when performed to evaluate for suspected anomaly based on history, laboratory abnormalities, or clinical evaluation; or when there are suspicious results from a limited or standard ultrasound. Further indications include the possibility of fetal growth restriction and multifetal gestation. This ultrasound must be billed with an appropriate high risk diagnosis code from Table 4 below.

A second detailed anatomic ultrasound is considered **medically necessary** if a new maternal fetal medicine specialist group is taking over care, a second opinion is required, or the patient

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Ultrasound in Pregnancy

has been transferred to a tertiary care center in anticipation of delivery of an anomalous fetus requiring specialized neonatal care.

Further detailed anatomic ultrasounds are considered **not medically necessary** as there is inadequate evidence of the clinical utility of multiple detailed fetal anatomic examinations.

IV. Transvaginal ultrasounds (TVU) are considered **medically necessary** when conducted in the first trimester for the same indications as a standard first trimester ultrasound, and later in pregnancy to assess cervical length, location of the placenta in women with placenta previa, or after an inconclusive transabdominal ultrasound. Cervical length screening is conducted for women with a history of preterm labor or to monitor a shortened cervix based on Table 1 below. Up to 13 transvaginal ultrasounds are allowed per pregnancy.

Table 1: Berghella approach to TVU measurement of cervical length for screening singleton gestations

Past pregnancy history	TVU cervical length screening	Frequency	Maximum # of TVU
Prior preterm birth 14 to 27 weeks	Start at 14 weeks and end at 24 weeks	Every 2 weeks as long as cervix is at least 30 mm*	11
Prior preterm birth 28 to 36 weeks	Start at 16 weeks and end at 24 weeks	Every 2 weeks as long as cervix is at least 30 mm*	9
No prior preterm birth	One exam between 18 and 24 weeks	Once	1

* Increase frequency to weekly in women with TVU cervical length of 26 to 29 mm, through 24 weeks. If ≤ 25 mm before 24 weeks, consider cerclage.

V. 3D and 4D ultrasounds are considered **not medically necessary**. Studies lack sufficient evidence that they alter management over two-dimensional ultrasound in a fashion that improves outcomes.

The following additional procedures are considered **not medically necessary**:

- Ultrasounds performed solely to determine the sex of the fetus or to provide parents with photographs of the fetus;
- Scans for growth evaluation performed less than 2 weeks apart;
- Ultrasound to confirm pregnancy in the absence of other indications;
- A follow-up ultrasound in the first trimester in the absence of pain or bleeding.

Classifications of fetal ultrasounds include:

I. Standard First Trimester Ultrasound - 76801

A standard first trimester ultrasound is performed before 14 weeks and 0 days of gestation. It can be performed transabdominally, transvaginally, or transperineally. When performed transvaginally, CPT 76817 should be used. It includes an evaluation of the presence, size, location, and number of gestational sac(s); and an evaluation of the gestational sac(s).

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Indications for a first trimester ultrasound include the following:

- To confirm an intrauterine pregnancy
- To evaluate a suspected ectopic pregnancy
- To evaluate vaginal bleeding
- To evaluate pelvic pain
- To estimate gestational age
- To diagnose and evaluate multiple gestations
- To confirm cardiac activity
- As adjunct to chorionic villus sampling, embryo transfer, or localization and removal of an intrauterine device
- To assess for certain fetal anomalies, such as anencephaly, in high risk patients
- To evaluate maternal pelvic or adnexal masses or uterine abnormalities
- To screen for fetal aneuploidy (nuchal translucency) when a part of aneuploidy screening
- To evaluate suspected hydatidiform mole

II. Standard Second or Third Trimester Ultrasound - 76805

A standard ultrasound in the second or third trimester involves an evaluation of fetal presentation and number, amniotic fluid volume, cardiac activity, placental position, fetal biometry, and an anatomic survey.

Indications for a standard second or third trimester ultrasound include the following:

- Screening for fetal anomalies
- Evaluation of fetal anatomy
- Estimation of gestational age
- Evaluation of fetal growth
- Evaluation of vaginal bleeding
- Evaluation of cervical insufficiency
- Evaluation of abdominal and pelvic pain
- Determination of fetal presentation
- Evaluation of suspected multiple gestation
- Adjunct to amniocentesis or other procedure
- Evaluation of discrepancy between uterine size and clinical dates
- Evaluation of pelvic mass
- Examination of suspected hydatidiform mole
- Adjunct to cervical cerclage placement
- Evaluation of suspected ectopic pregnancy
- Evaluation of suspected fetal death
- Evaluation of suspected uterine abnormality
- Evaluation of fetal well-being
- Evaluation of suspected amniotic fluid abnormalities
- Evaluation of suspected placental abruption
- Adjunct to external cephalic version
- Evaluation of prelabor rupture of membranes or premature labor
- Evaluation for abnormal biochemical markers

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- Follow-up evaluation of a fetal anomaly
- Follow-up evaluation of placental location for suspected placenta previa
- Evaluation with a history of previous congenital anomaly
- Evaluation of fetal condition in late registrants for prenatal care
- Assessment for findings that may increase the risk of aneuploidy

III. Detailed Anatomic Ultrasound - 76811

A detailed anatomic ultrasound is performed when there is an increased risk of an anomaly based on the history, laboratory abnormalities, or the results of the limited or standard ultrasound.

IV. Other Ultrasounds – 76817

A transvaginal ultrasound of a pregnant uterus can be performed in the first trimester of pregnancy and later in a pregnancy to evaluate cervical length and the position of the placenta relative to the internal cervical os. When this exam is done in the first trimester, the same indications for a standard first trimester ultrasound, 76801, apply.

Background

The Routine Antenatal Diagnostic Imaging with Ultrasound (RADIUS) trial showed that routine U/S screening of a low risk population did not lead to improved perinatal outcomes. This was a practice based, multi-center randomized trial. There were no significant differences in birth weight or preterm delivery rates.

Ultrasound is used most often in pregnancy for the estimation of gestational age. It has been shown that the use of multiple biometric parameters can allow for accuracy to within 3-4 days in a mid-trimester study (14-22 weeks). Accurate dating of a pregnancy is crucial as many important decisions might be made based on this date—whether or not to resuscitate an infant delivered prematurely, when to give antenatal steroids, when to electively deliver a term infant, and when to induce for post-dates.

Pregnancy dating with a first trimester or mid-trimester ultrasound will reduce the number of misdated pregnancies and subsequent unnecessary inductions for post-dates pregnancies. Third trimester ultrasounds for pregnancy dating are much less dependable.

Ultrasound is a helpful tool for the evaluation of fetal growth in at-risk pregnancies and the diagnosis of a small-for-gestational age baby (SGA). Those SGA babies with actual chronic hypoxemia and/or malnutrition can be termed growth restricted (FGR) if it is suspected that their growth has been less than optimal.

ACOG does not yet recommend the use of three- or four-dimensional ultrasound as a replacement for any necessary two-dimensional study. ACOG states “the technical advantages of three-dimensional ultrasonography include its ability to acquire and manipulate an infinite number of planes and to display ultrasound planes traditionally inaccessible by two-dimensional ultrasonography. Despite these technical advantages, proof of a clinical advantage of three-dimensional ultrasonography in prenatal diagnosis in general still is lacking.”

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The Society of Maternal Fetal Medicine specifically addresses what is often considered a level II screening U/S or routine U/S, stating:

“CPT 76811 is not intended to be the routine scan performed for all pregnancies. Rather, it is intended for a known or suspected fetal anatomic or genetic abnormality (i.e., previous anomalous fetus, abnormal scan this pregnancy, etc.). Thus, the performance of CPT 76811 is expected to be rare outside of referral practices with special expertise in the identification of, and counseling about, fetal anomalies.

It is felt by all organizations involved in the codes development and description that only one medically indicated CPT 76811 per pregnancy, per practice is appropriate. Once this detailed fetal anatomical exam (76811) is done, a second one should not be performed unless there are extenuating circumstances with a new diagnosis. It is appropriate to use CPT 76811 when a patient is seen by another maternal-fetal medicine specialist practice, for example, for a second opinion on a fetal anomaly, or if the patient is referred to a tertiary center in anticipation of delivering an anomalous fetus at a hospital with specialized neonatal capabilities.

Follow-up ultrasound for CPT 76811 should be CPT 76816 when doing a focused assessment of fetal size by measuring the BPD [biparietal diameter], abdominal circumference, femur length, or other appropriate measurements, OR a detailed re-examination of a specific organ or system known or suspected to be abnormal. CPT 76805 would be used for a fetal maternal evaluation of the number of fetuses, amniotic/chorionic sacs, survey of intracranial, spinal, and abdominal anatomy, evaluation of a 4-chamber heart view, assessment of the umbilical cord insertion site, assessment of amniotic fluid volume, and evaluation of maternal adnexa when visible when appropriate.”

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2021, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

Table 2: CPT® Codes Covered When Supported by Appropriate Diagnosis

CPT Codes	Description
76801	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (<14 weeks 0 day), transabdominal approach; single or first gestation
76805	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (≥14 weeks 0 day), transabdominal approach; single or first gestation

CPT Codes	Description
76811	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; single or first gestation
76817	Ultrasound, pregnant uterus, real time with image documentation, transvaginal

Table 3: CPT Codes considered Not Medically Necessary:

CPT Codes	Description
76376	3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image post-processing under concurrent supervision; not requiring image post-processing on an independent workstation
76377	requiring image post-processing on an independent workstation

Table 4: ICD-10 Diagnosis Codes that Support Medical Necessity for First Detailed Fetal Ultrasound (ICD-10 codes with an + indicate additional digits are needed)

ICD-10-CM Code	Description
B06.00 – B06.9	Rubella [German measles]
B50.0 – B54	Malaria
B97.6	Parvovirus as the cause of diseases classified elsewhere
E66.01	Morbid (severe) obesity due to excess calories [severe obesity with a BMI of 35 or >]
O09.511 – O09.519	Supervision of elderly primigravida
O09.521 – O09.529	Supervision of elderly multigravida
O09.811 – O09.819	Supervision of pregnancy resulting from assisted reproductive technology
O24.011 – O24.019, O24.111 – O24.119, O24.311 – O24.319, O24.811 – O24.819, O24.911 – O24.919	Diabetes mellitus in pregnancy
O28.3	Abnormal ultrasonic finding on antenatal screening of mother
O28.5	Abnormal chromosomal and genetic finding on antenatal screening of mother
O30.001 – O30.099	Twin pregnancy
O30.101 – O30.199	Triplet pregnancy
O30.201 – O30.299	Quadruplet pregnancy
O30.801 – O30.899	Other specified multiple gestation
O31.10x+ - O31.23x+	Continuing pregnancy after spontaneous abortion / intrauterine death of one fetus or more

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ICD-10-CM Code	Description
O33.6xx+	Maternal care for disproportion due to hydrocephalic fetus
O33.7xx+	Maternal care for disproportion due to other fetal deformities
O35.0xx+	Maternal care for (suspected) central nervous system malformation in fetus
O35.1xx+	Maternal care for (suspected) chromosomal abnormality in fetus
O35.2xx+	Maternal care for (suspected) hereditary disease in fetus
O35.3xx+	Maternal care for (suspected) damage to fetus from viral disease in mother
O35.4xx+	Maternal care for (suspected) damage to fetus from alcohol
O35.5xx+	Maternal care for (suspected) damage to fetus by drugs
O35.6xx+	Maternal care for (suspected) damage to fetus by radiation
O35.8xx+	Maternal care for other (suspected) fetal abnormality and damage
O35.9xx+	Maternal care for (suspected) fetal abnormality and damage, unspecified
O36.011+ - O36.099+	Maternal care for rhesus isoimmunization
O36.111+ - O36.199+	Maternal care for other isoimmunization
O36.511+ - O36.599+	Maternal care for other known or suspected poor fetal growth
O40.1xx+ - O40.9xx+	Polyhydramnios
O41.00x+ - O41.03x+	Oligohydramnios
O69.81x+ - O69.89x+	Labor and delivery complicated by other cord complications
O71.9	Obstetric trauma, unspecified
O76	Abnormality in fetal heart rate and rhythm complicating labor and delivery
O98.311 – O98.319, O98.411 – O98.419, O98.511 – O98.519, O98.611 – O98.619, O98.711 – O98.719, O98.811 – O98.819	Other maternal infectious and parasitic diseases complicating pregnancy
O99.310-O99.313	Alcohol use complicating pregnancy
O99.320 – O99.323	Drug use complicating pregnancy
O99.411 – O99.419	Diseases of the circulatory system complicating pregnancy
Q04.8	Other specified congenital malformations of brain [choroid plexus cyst]
Q30.1	Agenesis and underdevelopment of nose [absent or hypoplastic nasal bone]
Q62.0	Congenital hydronephrosis [fetal pyelectasis]
Q71.811 – Q71.819	Congenital shortening of upper limb [humerus]
Q72.811 – Q72.819	Congenital shortening of lower limb [femur]
Q92.0 – Q92.9	Other trisomies and partial trisomies of the autosomes, not elsewhere classified [fetuses with soft sonographic markers of aneuploidy]

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ICD-10-CM Code	Description
R93.5	Abnormal findings on diagnostic imaging of other abdominal regions, including retroperitoneum
R93.811-R93.89	Abnormal findings on diagnostic imaging of other specified body structures
Z68.35 – Z68.45	Body mass index [BMI] 35.0 – 70 or greater, adult

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Policy created & reviewed by Obstetrical specialist	01/11	01/11
Reviewed with no changes Obstetrical specialist reviewed	02/12	03/12
Reviewed with no changes	04/13	05/13
Nuchal translucency removed Divided criteria into first and second trimester Added indications for transvaginal ultrasound Obstetrical specialist reviewed	05/14	08/14
Reformatted policy Added ICD-9 and ICD-10 codes for when a standard ultrasound would be appropriate Obstetrical specialist reviewed Removed prior authorization language	08/15	08/15
Removed ICD-9 codes	11/15	
Added follow-up ultrasound as an alternative in Policy/Criteria sections I and II	02/16	
Reviewed with no criteria changes.	08/16	08/16
Allowed up to 6 TVU per pregnancy and added ICD-10 codes indicating when > 6 TVUs are appropriate	11/16	
Added to ICD-10 code list for standard ultrasounds: O02.0 – O02.9, O03.9, O28.0 – O28.9, Z32.01	01/17	
Removed ICD-10 code tables for 76801 and 76805, and 76817 No diagnosis code limitations in place for these codes. 76817 frequency over time changed to 12 from 6	05/17	
Added that transperineal u/s can be appropriate for a standard first trimester ultrasound scan per updated ACOG guidelines. Added “possibility of fetal growth restriction and multifetal gestation” to indications for detailed ultrasound in section III. Added “as an adjunct to embryo transfer” as an indication for standard first trimester ultrasound in “classifications of fetal ultrasound” section I. Added “The maternal cervix and adnexa are examined as clinically appropriate and when feasible” to description of standard second or third trimester ultrasound in “classifications of fetal ultrasound” section II. Minor wording clarifications made to criteria throughout policy to ensure consistency with latest ACOG practice bulletin for Ultrasound in Pregnancy, No. 175.	08/17	08/17

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Removed – in the primary diagnosis position from section III as this is not a requirement for the edit.	12/17	
Added code range O30.801 – O30.899 to Table 4. References reviewed and updated.	06/18	06/18
Annual review. Added O28.3, O28.5, O99.310 – O99.313. Expanded code range of R93.811 – R93.89	05/19	06/19
References reviewed and updated. Reviewed by specialist.	05/20	06/20
Per 10/1/20 ICD-10 code updates, code set Z68.35 – Z68.45 was revised changing parenthesis around BMI to brackets with no change to code descriptor. Removed “member” from I.A and replaced “member” with “member/enrollee” in all instances	10/20	
Section IV.Table 1, revised note * Increase frequency to weekly in women with TVU cervical length of 25 to 29 mm, to 26 to 29mm and changed “If < 25 mm before 24 weeks...” to < = 25mm; edited maximum # TVU to 11 for prior preterm birth at 14-27 weeks, and 9 for prior preterm birth at 28 to 36 weeks. Changed total number of allowed TVUS per pregnancy to 13. Removed “experimental” from section V. Changed “review date” in the header to “date of last revision” and “date” in the revision log header to “revision date.” References reviewed and updated.	06/21	06/21
Annual review. Removed table 5, diagnosis codes supporting medical necessity for TVU, which was included in the previous version in error.Added “detailed “ to criteria statement, section III:“Further detailed anatomic ultrasounds.....” for clarification.References reviewed and updated. Specialist review.	03/22	03/22

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Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of

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physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

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This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

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Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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Clinical Policy: Drugs of Abuse: Definitive Testing

Reference Number: CP.MP.50

Date of last Revision: 03/22

[Coding Implications](#)

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

Urine drug testing is a key diagnostic and therapeutic tool that is useful for patient care and monitoring of adherence to a controlled substance treatment regimen (e.g., for chronic non-cancer pain) and to identify drug misuse or addiction prior to starting or during treatment with controlled substances.

Policy/Criteria

- I. It is the policy of health plans affiliated with Centene Corporation® that *outpatient* testing for drugs of abuse (DOA) is **medically necessary** for confirmatory/definitive (quantitative) testing for a specific drug(s) when meeting *the criteria in A, B, or C*:
 - A. Documented history or suspicion of illicit or prescription drug use or noncompliance or a high probability of non-adherence to a prescribed drug regimen documented in the medical record; *and all of the following*:
 1. A preliminary/presumptive drug test has been previously performed, unless no reliable test exists;
 2. The findings from that preliminary/presumptive (qualitative) test (either positive or negative) are either:
 - a. Inconsistent with the expected results as suggested by medical history, clinical presentation, and/or member's/enrollee's own statement after a detailed discussion about their recent medication and drug use;
 - b. Consistent with the clinical scenario but drug class-specific assays are needed to identify the precise drug(s) that resulted in the positive test result;
 3. Resolving the inconsistency is essential to the ongoing care of the member/enrollee;
 4. The requested confirmatory/definitive test(s) is for ≤14 drugs/drug classes;
 5. Tests are only for the specific drug(s) or number of drug classes for which preliminary analysis has yielded unexpected results;
 - B. The provider expects the presumptive test to be positive (e.g. the member/enrollee reports recent use), *and all of the following*:
 1. Information regarding specific substance and/or quantity is desired;
 2. There are established benchmarks for clinical decision making based on specific substance and/or quantitative levels;
 3. ≤14 drugs/drug classes are requested;
 4. Tests are only for the specific drug(s) or number of drug classes for which the presumptive test is expected to be positive;
 - C. The request is for a serum therapeutic drug level in relation to the medical treatment of a disease or condition (e.g. phenobarbital level in the treatment of seizures).
- II. It is the policy of health plans affiliated with Centene Corporation that outpatient confirmatory/definitive (quantitative) drug testing of more than 14 drugs/drug classes (HCPCS codes G0482, G0483) is **not medically necessary**.

- III.** It is the policy of health plans affiliated with Centene Corporation that urine drug testing (UDT) is considered **not medically necessary** if provided for reasons that include, but are not limited to, the following:
- A.** As a condition of:
 - 1. Employment or pre-employment purposes (pre-requisite for employment or as a requirement for continuation of employment);
 - 2. Participation in school or community athletic or extracurricular activities or programs;
 - B.** Screening for medico-legal purposes such as court-ordered drug screening (unless required by state regulations);
 - C.** Screening in asymptomatic patients, except as listed in sections I or II;
 - D.** As a component of a routine physical/medical examination; e.g. (enrollment in school, enrollment in the military, etc.);
 - E.** As a component of a medical examination for any other administrative purposes not listed above (e.g., for purposes of marriage licensure, insurance eligibility, etc.);
 - F.** Same-day screening of drug metabolites in specimens sourced from any combination of blood, saliva and urine by either preliminary or confirmatory/definitive analyses;
 - G.** Blanket orders;
 - H.** Reflex definitive drug tests when presumptive testing is performed at point of care;
 - I.** Routine standing orders for all patients in a physician's practice. Physician-defined standing orders for pre-determined drug panels according to specific patient profiles for a limited sequential period may be reasonable and necessary and must be documented in the patient's medical record;
 - J.** Billing of individual definitive CPT codes when a comprehensive definitive drug testing panel (CDDP) is ordered;
 - K.** Performing presumptive point of care testing and ordering presumptive immunoassay (IA) testing from a reference laboratory;
 - L.** Performing presumptive IA testing and ordering presumptive IA testing from a reference laboratory with or without reflex testing;
 - M.** Performing IA presumptive screening prior to definitive testing without a specific physician's order for the presumptive testing;
 - N.** IA testing, regardless of whether it is qualitative or semi-quantitative used to "confirm" or definitively identify a presumptive test result obtained by cups, dipsticks, cards, cassettes or other CLIA-waived methods. Semi-quantitative IA testing provides a presumptive test (numerical) result. Definitive UDT provides specific identification and/or quantification by GC-MS or LC-MS/MS;
 - O.** Specimen validity/adulteration testing, as this is considered part of the laboratory quality control practices.

Background

A drug of abuse (DOA) is defined as a drug, chemical, or plant product known to be misused for recreational purposes.⁸ In the United States, the basic screening test for DOA includes five drugs: amphetamine, cocaine, marijuana, opioids, and phencyclidine.^{3,8,12} Other common drugs tested for include benzodiazepines, a wider range of opioids, barbiturates, and methamphetamines.^{3,8,12} These tests can vary by region based on epidemiologic trends. There currently is no uniformity

for what is included in extended DOA testing or cutoff values that should be used for detection of drugs that are not covered by workplace testing laws.⁸

According to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA), a review examining the relevance and role of urine drug testing for treatment of opioid misuse found that providers are better equipped to evaluate opioid therapy with the aid of urine drug testing.²² However, two literature searches, one from the timeframe 1995-2017 and one from 2000 to present, revealed a significant gap in research evidence regarding the clinical significance of urine drug screening for substance-related disorders.^{22,23}

The three methods of drug assays include immunoassay, chromatography, and mass spectrometry. Immunoassay is the most widely used method for initial testing for DOA and offers results within minutes.⁸ These tests provide a relatively inexpensive method to detect low concentrations of a substance with an increased degree of specificity.⁸ This can be most easily performed using point-of-care test kits such as a urine drug cup. Unfortunately, in the clinical setting, point-of-care testing does not perform to manufacturers' claims and untrained staff can improperly interpret test results.

Gas chromatography/mass spectrometry (GC/MS) or liquid chromatography (LC/MS) are typically used as confirmatory tests.¹ Chromatography is used to separate a specimen into its component parts and mass spectrometry is used to identify those parts. Chromatography, LC/MS and GC/MS require specialized training for lab staff and instruments to provide a highly sensitive and specific technique for detecting drugs or metabolites.⁸ It often takes many hours to obtain results; therefore, these tests are generally not used for preliminary screening in the clinical setting.⁸ The mass spectrometer is capable of detecting even minute amounts of a given substance and is considered to have the highest specificity of all lab detection methods.⁸ It is most commonly used for confirmatory test results that are primarily of forensic importance.^{1,8} GC/MS rarely provides results that are clinically necessary or useful beyond those obtained by standard immunoassays or chromatography.⁸

The ordering clinician must be knowledgeable regarding the type of testing being requested, level of suspicion for drug use or exposure, the reason for obtaining the test, and the likelihood of false-positive or false-negative results.⁸ Knowledge of potential drug exposure allows a clinician working in an addiction or chronic pain management program to include testing for a metabolite of a parent drug, instead of simply testing for the parent drug, for a patient with a tendency for opioid abuse.⁸ If initial screening does not correlate with expected findings and there is concern for false-positive or false-negative results, then confirmatory testing improves the accuracy of initial results.⁹

Immunoassays can yield false-positive results when cross-reacting medications or drugs are present.⁸ Cross-reacting substances can be found in common prescription medications, over-the-counter cold medications, and even in some food substances.⁸ The highest false-positive results occur with amphetamine testing due to the chemical structure of amphetamine being present in many over-the-counter medications and herbal supplements.⁸ False-negative results can occur from inappropriate specimen collection, transport, testing procedures or from patient attempts to undermine the testing.⁸ The most common cause of false-negative results is failure to detect a

specific drug within a given class of drugs because the chemical combination makes it unreactive with the test.⁸

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2021, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT® Codes That Support Coverage Criteria

CPT®* Codes	Description
0011U	Prescription drug monitoring, evaluation of drugs present by LC-MS/MS, using oral fluid, reported as a comparison to an estimated steady-state range, per date of service including all drug compounds and metabolites
80184	Phenobarbital
80320	Alcohols
80321	Alcohol biomarkers; 1 or 2
80322	Alcohol biomarkers; 3 or more
80323	Alkaloids, not otherwise specified
80324	Amphetamines; 1 or 2
80325	Amphetamine; 3 or 4
80326	Amphetamines; 5 or more
80327	Anabolic steroids; 1 or 2
80328	Anabolic steroids; 3 or more
80332	Antidepressants, serotonergic class; 1 or 2
80333	Antidepressants, serotonergic class; 3-5
80334	Antidepressants, serotonergic class; 6 or more
80335	Antidepressants, tricyclic and other cyclicals; 1 or 2
80336	Antidepressants, tricyclic and other cyclicals; 3-5
80337	Antidepressants, tricyclic and other cyclicals; 6 or more
80338	Antidepressants, not otherwise specified
80339	Antiepileptics, not otherwise specified; 1-3
80340	Antiepileptics, not otherwise specified; 4-6
80341	Antiepileptics, not otherwise specified; 7 or more
80342	Antipsychotics, not otherwise specified; 1-3
80343	Antipsychotics, not otherwise specified; 4-6
80344	Antipsychotics, not otherwise specified; 7 or more
80345	Barbiturates
80346	Benzodiazepines; 1-12
80347	Benzodiazepines; 13 or more
80348	Buprenorphine
80349	Cannabinoids, natural
80350	Cannabinoids, synthetic; 1-3

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CPT[®] Codes	Description
80351	Cannabinoids, synthetic; 4-6
80352	Cannabinoids, synthetic; 7 or more
80353	Cocaine
80354	Fentanyl
80356	Heroin metabolite
80357	Ketamine and norketamine
80358	Methadone
80359	Methylenedioxyamphetamines (MDA, MDEA, MDMA)
80360	Methylphenidate
80361	Opiates, 1 or more
80362	Opioids and opiate analogs; 1 or 2
80363	Opioids and opiate analogs; 3 or 4
80364	Opioids and opiate analogs; 5 or more
80365	Oxycodone
80366	Pregbalin
80367	Propoxyphene
80368	Sedative Hypnotics (non-benzodiazepines)
80369	Skeletal muscle relaxants; 1 or 2
80370	Skeletal muscle relaxants; 3 or more
80371	Stimulants, synthetic
80372	Tapentadol
80373	Tramadol
80374	Stereoisomer (enantiomer) analysis, single drug class
80375	Drug(s) or substance(s), definitive, qualitative or quantitative, not otherwise specified; 1-3
80376	Drug(s) or substance(s), definitive, qualitative or quantitative, not otherwise specified; 4-6
80377	Drug(s) or substance(s), definitive, qualitative or quantitative, not otherwise specified; 7 or more
82077	Alcohol (ethanol); any specimen except urine and breath, immunoassay (eg, IA, EIA, ELISA, RIA, EMIT, FPIA) and enzymatic methods (eg, alcohol dehydrogenase)
83992	Phencyclidine (PCP)

CPT Codes That Do Not Support Coverage Criteria

CPT[®] Codes	Description
0054U	Prescription drug monitoring, 14 or more classes of drugs and substances, definitive tandem mass spectrometry with chromatography, capillary blood, quantitative report with therapeutic and toxic ranges, including steady-state range for the prescribed dose when detected, per date of service
0143U	Drug assay, definitive, 120 or more drugs or metabolites, urine, quantitative liquid chromatography with tandem mass spectrometry (LC-MS/MS) using multiple reaction monitoring (MRM), with drug or metabolite description, comments including sample validation, per date of service
0144U	Drug assay, definitive, 160 or more drugs or metabolites, urine, quantitative liquid chromatography with tandem mass spectrometry (LC-MS/MS) using multiple

CPT® Codes	Description
	reaction monitoring (MRM), with drug or metabolite description, comments including sample validation, per date of service
0145U	Drug assay, definitive, 65 or more drugs or metabolites, urine, quantitative liquid chromatography with tandem mass spectrometry (LC-MS/MS) using multiple reaction monitoring (MRM), with drug or metabolite description, comments including sample validation, per date of service
0146U	Drug assay, definitive, 80 or more drugs or metabolites, urine, by quantitative liquid chromatography with tandem mass spectrometry (LC-MS/MS) using multiple reaction monitoring (MRM), with drug or metabolite description, comments including sample validation, per date of service
0147U	Drug assay, definitive, 85 or more drugs or metabolites, urine, quantitative liquid chromatography with tandem mass spectrometry (LC-MS/MS) using multiple reaction monitoring (MRM), with drug or metabolite description, comments including sample validation, per date of service
0148U	Drug assay, definitive, 100 or more drugs or metabolites, urine, quantitative liquid chromatography with tandem mass spectrometry (LC-MS/MS) using multiple reaction monitoring (MRM), with drug or metabolite description, comments including sample validation, per date of service
0149U	Drug assay, definitive, 60 or more drugs or metabolites, urine, quantitative liquid chromatography with tandem mass spectrometry (LC-MS/MS) using multiple reaction monitoring (MRM), with drug or metabolite description, comments including sample validation, per date of service
0150U	Drug assay, definitive, 120 or more drugs or metabolites, urine, quantitative liquid chromatography with tandem mass spectrometry (LC-MS/MS) using multiple reaction monitoring (MRM), with drug or metabolite description, comments including sample validation, per date of service

HCPCS Codes That Support Coverage Criteria

HCPCS Codes	Description
G0480	Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to, GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources(s), includes specimen validity testing, per day, 1-7 drug class(es), including metabolite(s) if performed

HCPCS Codes	Description
G0481	Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to, GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); definitive, qualitative or quantitative, all sources(s), includes specimen validity testing, per day, 8-14 drug class(es), including metabolite(s) if performed
G0659	Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including but not limited to, GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem), excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase), performed without method or drug-specific calibration, without matrix-matched quality control material, or without use of stable isotope or other universally recognized internal standard(s) for each drug, drug metabolite or drug class per specimen; qualitative or quantitative, all sources, includes specimen validity testing, per day, any number of drug classes

HCPCS Codes That Do Not Support Coverage Criteria

HCPCS Codes	Description
G0482	Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to, GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources, includes specimen validity testing, per day; 15-21 drug class(es), including metabolite(s) if performed
G0483	Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to, GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase)), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources, includes specimen validity testing, per day; 22 or more drug class(es), including metabolite(s) if performed

ICD-10-CM Codes That Support Coverage Criteria

ICD-10-CM	Description
F10.10-F10.19	Alcohol abuse
F10.20-F10.29	Alcohol dependence

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ICD-10-CM	Description
F10.920- F10.99	Alcohol use, unspecified
F11.10-F11.19	Opioid abuse
F11.20-F11.29	Opioid dependence
F11.920- F11.99	Opioid use, unspecified
F12.10-F12.19	Cannabis abuse
F12.20-F12.29	Cannabis dependence
F12.920- F12.99	Cannabis use, unspecified
F13.10-F13.19	Sedative, hypnotic or anxiolytic abuse
F13.20-F13.29	Sedative, hypnotic or anxiolytic- related dependence
F13.920- F13.99	Sedative, hypnotic or anxiolytic- related use, unspecified
F14.10-F14.19	Cocaine abuse
F14.20-F14.29	Cocaine dependence
F14.920- F14.99	Cocaine use, unspecified
F15.10-F15.19	Other stimulant abuse
F15.20-F15.29	Other stimulant dependence
F15.920- F15.99	Other stimulant use, unspecified
F16.10-F16.9	Hallucinogen abuse
F16.20-F16.29	Hallucinogen dependence
F16.920- F16.99	Hallucinogen use, unspecified
F18.10-F18.19	Inhalant abuse
F18.20-F18.29	Inhalant dependence
F18.920- F18.99	Inhalant use, unspecified
F19.10-F19.19	Other psychoactive substance abuse
F19.20-F19.29	Other psychoactive substance dependence
F19.920- F19.99	Other psychoactive substance use, unspecified
F55.0	Abuse of antacids
F55.1	Abuse of herbal or folk remedies
F55.2	Abuse of laxatives
F55.3	Abuse of steroids or hormones
F55.4	Abuse of vitamins
F55.8	Abuse of other non-psychoactive substances
Z79.81	Long term (current) use of opiate analgesic

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Drugs of Abuse: Definitive Testing

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Policy developed	09/12	09/12
Added under Criteria: A.2.b option for concordant test results but specific quantitative analysis needed to identify specific drug	10/15	10/15
Added new 2016 G codes for definitive drug testing, clarified in criteria the addition of definitive testing	02/16	
Added same day urine/blood screening and sample validity testing limitations to the not medically necessary section. Replaced “qualitative” language with “preliminary,” and “quantitative” with “confirmatory/definitive.”	09/16	10/16
Added term “presumptive” and “qualitative” to preliminary drug testing. Codes reviewed and updated. Reviewed by neurology/pain management specialist. References reviewed and updated.	09/17	09/17
Modified criteria in I.A.1 that a presumptive test must be performed before a definitive test unless no reliable test is available. Added an indication for testing when the presumptive test is assumed to be positive based on patient history, but quantitative levels are required. Modified II.C. to state that screening in asymptomatic patients is medically unnecessary, unless otherwise stated in section I.	07/18	07/18
Revised background to clarify that immunoassays are able to detect low concentrations of a drug with a high degree of sensitivity but lack some specificity.	03/19	
Revised policy to state that HCPCS codes G0482 & G0483 are not medically necessary, and to reflect a 10 day post-collection authorization period. Updated coding tables to include 80367, 80368, 80369, 80370, 80372, 80373. Revised I.A.1 from “unless no reliable test is available” to “unless no reliable test is in existence” for clarification.	05/19	05/19
References reviewed and updated.	06/19	
Added criteria for presumptive testing. In II.B, added that “Tests are only for the specific drug(s) or number of drug classes for which the presumptive test is expected to be positive.” Added the following not medically necessary indications: blanket orders; reflex definitive testing when presumptive testing is performed at point of care; physician standing orders for all patients; billing codes for individual drugs which are included in a billed panel; presumptive immunoassay testing in a lab when presumptive POC testing has been performed; presumptive screening before definitive testing if presumptive testing not ordered; IA testing used to confirm a presumptive test result obtained by cups, dipsticks, cards, cassettes or other CLIA-waived methods. Removed authorization protocol information about requests for ages <6 not being on PA, and for a 10 day window to submit PA requests after testing. Removed request requirements section. Added more CPT codes to support coverage criteria. Added the following CPT codes as not medically necessary: 0143U, 0144U, 0145U, 0146U, 0147U, 0148U,	05/20	06/20

Reviews, Revisions, and Approvals	Revision Date	Approval Date
0149U, 0150U. Added HCPCS codes 0011U and G0659 as medically necessary. Added ICD-10-CM codes. References reviewed and updated.		
Reinstated notes regarding PA not being required for children < 6 years of age, and a 10 day post-test window for PA.	07/20	
Corrected medical necessity statement in section I. to state that “one” of the following must be met, instead of “both.”	08/20	
Added presumptive drug testing limits in chronic opioid therapy to I.B. Replaced all instances of “member” with “member/enrollee.”	09/20	10/20
Changed name of policy from Outpatient Testing for Drugs of Abuse to Drugs of Abuse: Definitive Testing. Removed presumptive drug testing criteria from policy and created new policy, CP.MP.208 Drugs of Abuse: Presumptive Testing. Removed codes for presumptive drug testing: 80305, 80306, 80307. Added CPT-0054U to list of codes that do not support coverage criteria. Removed CPT-0006U, as code is deleted in 2021. Removed UM language regarding PA not being required for children < 6 years of age, and a 10 day post-test window for PA.	02/21	
Added 2021 CPT- 82077 to list of codes that support coverage criteria.	03/21	
Annual review. References updated and coding reviewed. Changed “review date” in the header to “date of last revision” and “date” in the revision log header to “revision date.” Updated ICD-10 codes to include code ranges.	06/21	06/21
Deleted note referring to CP.MP.208 Drugs of Abuse, Presumptive Testing	11/21	
Annual review. References reviewed and updated. Added “It is the policy of health plans affiliated with Centene Corporation” to criteria III. Updated background with no impact to criteria. Description updated for CPT code 80370. Reviewed by specialist.	03/22	03/22

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Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to

applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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Clinical Policy: Ambulatory Electroencephalography

Reference Number: CP.MP.96

Date of Last Revision: 07/21

[Coding Implications](#)

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

Ambulatory electroencephalogram (EEG) testing in the outpatient setting (*e.g.*, at home) is a diagnostic test used to evaluate an individual in whom a seizure disorder or possibly nonepileptic attacks are suspected but not conclusively confirmed by the person's medical history, physical examination, and a previous routine or standard (awake and asleep) EEG. Ambulatory EEG monitoring allows extended interictal EEG recording outside of a clinic or a hospital and can allow patients to “mark” events experienced on the EEG recording.

Policy/Criteria

- I. It is the policy of health plans affiliated with Centene Corporation® that ambulatory EEG is **medically necessary** following an inconclusive or nondiagnostic standard (awake and asleep) EEG for any of the following indications:
 - A. To investigate episodic events where epilepsy is suspected but the history, examination, and routine EEG do not resolve the diagnostic uncertainties;
 - B. To confirm epilepsy in those individuals experiencing suspected nonepileptic events;
 - C. To differentiate between neurological and cardiac related episodes, such as syncope;
 - D. To characterize seizure type, such as focal versus generalized seizures, and frequency;
 - E. To localize seizure focus for enhanced patient management;
 - F. To evaluate seizures precipitated by naturally occurring cyclic events or environmental stimuli that are not reproducible in the hospital or clinic setting.

Note: Ambulatory EEG should always be preceded by an awake and drowsy/sleep EEG.

- II. It is the policy of health plans affiliated with Centene Corporation that ambulatory EEG is considered **not medically necessary** for studies of unattended, non-cooperative patients.

Background

In most instances, a standard EEG performed at a clinic or outpatient epilepsy facility can identify brain activity specific to seizures; however, when routine EEG is inconclusive and the clinical history strongly suggests seizure activity, an ambulatory EEG may be indicated. An ambulatory EEG may increase the chance of detecting an epileptiform abnormality in these individuals and significantly impact clinical management. An estimated 12% to 25% of individuals who previously had a normal or non-diagnostic routine EEG have epileptiform activity on ambulatory EEG.³

Ambulatory EEG recordings can be utilized in the evaluation and differential diagnosis of other conditions, that includes syncope, if these episodes are not diagnosed by conventional studies. It may also allow an estimate of seizure frequency, which may at times help to evaluate the effectiveness of a drug and determine its appropriate dosage.

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Ambulatory EEG testing provides a continuous recording of the brain's electrical activity that can range from several hours to up to a week (typically 48 hours to 72 hours). In the outpatient setting (physician office, clinic), a set of electrodes with leads is secured to the person's scalp and a digital recording unit is attached to the waist or a shoulder harness. Currently, portable recordings of up to 36 channels can record computer-assisted spike and seizure detection rates over several days. Event detection computer software is designed to increase the chance of recording an ictal event during a seizure or interictal epileptiform discharges occurring between seizures, during the person's routine daily activities and sleep. The person being tested and observers (family members, caregiver) have the opportunity to "tag" portions of the recording during clinical events using a push button device to signal when an observable event occurs.⁹

Coding Implications

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CPT® Codes	Description
95700	Electroencephalogram (EEG) continuous recording, with video when performed, setup, patient education, and takedown when performed, administered in person by EEG technologist, minimum of 8 channels
95705	Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, 2-12 hours; unmonitored
95708	Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, each increment of 12-26 hours; unmonitored
95717	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation and report, 2-12 hours of EEG recording; without video
95719	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, each increment of greater than 12 hours, up to 26 hours of EEG recording, interpretation and report after each 24-hour period; without video
95721	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 36 hours, up to 60 hours of EEG recording, without video
95723	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike

CPT® Codes	Description
	and seizure detection, interpretation, and summary report, complete study; greater than 60 hours, up to 84 hours of EEG recording, without video
95725	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 84 hours of EEG recording, without video

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
F44.5	Conversion disorder with seizures or convulsions
G40.001- G40.919	Epilepsy and recurrent seizures
R25.0 – R25.8	Abnormal involuntary movements
R40.4	Transient alteration of awareness
R55	Syncope and collapse
R56.1	Post-traumatic seizures
R56.9	Unspecified convulsions

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Policy developed	09/15	09/15
Converted to new policy template. Removed the following as Not Medically Necessary indications per specialist review: studies of neonates and studies to localize seizure focus in the presence of bilateral foci or rapid generalization. Reviewed by neurologist/sleep medicine specialist.	09/16	09/16
References reviewed and updated.	09/17	09/17
References reviewed and updated.	08/18	08/18
References reviewed and updated with two added. Coding reviewed. Specialty review completed. Reviewed by neurologist. Added last sentence, “Ambulatory EEG monitoring...” to the description. Within criteria, removed “for classification of seizure type” from “B.” and updated “D.” with “To characterize seizure type.....”, also removing “To adjust antiepileptic medication levels”. Removed “F. To identify and medicate absence seizures.” Removed “G. To differentiate between epileptic and sleep disorder related episodes.” Removed paragraph in Background section on psychogenic nonepileptic spells and the paragraph on analysis.	08/19	08/19
Removed CPT codes 95950, 95953-codes deleted 1/1/2020. Added the following 2020 CPT codes: 95700, 95705, 95708, 95717, 95719, 95721, 95723, and 95725. Removed CPT codes from criteria note specifying which CPT codes should precede which ambulatory EEG codes.	04/20	
Annual review completed. References reviewed and updated. Added the following ICD-10 codes: R40.4, R55	06/20	07/20

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Annual review completed. References reviewed, updated, and reformatted. Replaced all instances of member with member/enrollee. Changed “review date” in the header to “date of last revision” and “date” in the revision log header to “revision date.” Background updated with no clinical significance. Specialist reviewed.	07/21	07/21

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Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program

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approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

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Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take

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precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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Clinical Policy: Testing for Select Genitourinary Conditions

Reference Number: CP.MP.97

Date of Last Revision: 03/22

[Coding Implications](#)

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

Various diagnostic methods are available to identify the etiology of the signs and symptoms of vaginitis.¹ The purpose of this policy is to define medical necessity criteria for the diagnostic evaluation of vaginitis (excluding *Trichomonas vaginalis*, vaginal pH testing, and microscopic examination with saline and KOH) in members/enrollees ≥ 13 years of age. This policy also defines unspecified amplified DNA-probe testing for genitourinary conditions.

Policy/Criteria

- I. It is the policy of health plans affiliated with Centene Corporation[®] that the following diagnostic tests for symptomatic women for the evaluation of vaginitis are **medically necessary** for members/enrollees age ≥ 13 :
 - A. KOH “whiff test” (i.e., amine odor test);
 - B. Assay for sialidase activity;
 - C. Direct DNA probe tests to detect the presence of *Candida* and *Gardnerella vaginalis*.

- II. It is the policy of health plans affiliated with Centene Corporation that screening of asymptomatic pregnant women for bacterial vaginosis (BV) to reduce the incidence of pre-term birth or other complications of pregnancy is **not medically necessary** as there is no evidence that treatment of BV in asymptomatic pregnant women reduces these complications.²

- III. It is the policy of health plans affiliated with Centene Corporation that unspecified amplified DNA-probe testing for genitourinary conditions for asymptomatic women during routine exams, contraceptive management care, or pregnancy care is considered **not medically necessary** for members/enrollees ≥ 13 year of age, as it has not been shown to improve clinical outcomes over direct DNA-probe testing.

- IV. It is the policy of health plans affiliated with Centene Corporation that unspecified amplified DNA-probe testing for the diagnostic evaluation of symptomatic women for the following genitourinary conditions is considered **not medically necessary** for members/enrollees ≥ 13 of age, as it has not been shown to improve clinical outcomes over direct DNA-probe testing:
 - A. Acute vaginitis or vulvitis (≤ 4 episodes per year);
 - B. Gynecologic and obstetric conditions triggered by etiologies other than complicated vaginitis inducing mechanisms as listed in Table 5, including:
 1. Urinary tract infections;
 2. Pelvic inflammatory disease;
 3. Inflammatory disorders of the vagina, vulva, and perineum;
 4. Irregular menstruation or abnormal uterine and vaginal bleeding;
 5. Dysmenorrhea;
 6. Complications with pregnancy, including all of the following:

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- a. Pre-term labor;
- b. Ectopic pregnancy;
- c. High risk pregnancy.

V. It is the policy of health plans affiliated with Centene Corporation that current literature does not support the use of multiplex/multitarget polymerase chain reaction (PCR) panel testing of genitourinary pathogens commonly associated with vaginitis.

Background

Vaginitis refers to disorders of the vagina caused by infection, inflammation, or changes in normal vaginal flora.³ The infections most frequently associated with vaginitis are bacterial vaginosis (BV), trichomoniasis, and vulvovaginal candidiasis (VVC).¹ Various diagnostic methods are available to identify the etiology of the signs and symptoms of vaginitis.¹

The cause of vaginal symptoms can usually be determined by pH testing, a potassium hydroxide (KOH) test, and microscopic examination of fresh vaginal discharge samples.¹ An elevated pH (>4.5) is commonly associated with BV or trichomonas, but because pH testing is not highly specific, the vaginal discharge being tested should be further examined microscopically with both a saline and KOH solution.¹ The saline solution specimen might yield motile *T. vaginalis* or clue cells (i.e., epithelial cells with borders obscured by small bacteria), which are characteristic of BV, whereas the presence of white blood cells without evidence of trichomonads or yeast in this solution is suggestive of cervicitis.¹

The KOH specimen is typically used to identify the yeast or pseudohyphae of *Candida* species. Testing sensitivity is approximately 50% through microscopic examination, so the absence of trichomonads or pseudohyphae in KOH samples does not rule out these infections.¹ In settings where pH paper, KOH, and microscopy are not available or are inconclusive, alternative point-of-care tests, such as commercially available direct DNA-probe tests or clinical laboratory testing can be used to diagnose vaginitis.⁴

Bacterial Vaginosis

BV is a polymicrobial clinical syndrome resulting from replacement of the normal hydrogen peroxide-producing *Lactobacillus* species in the vagina with high concentrations of anaerobic bacteria, including *Prevotella* species, *Mobiluncus* species, *G. vaginalis*, *A. vaginae*, and other fastidious or uncultivated anaerobes.^{1,4} BV is the most prevalent cause of vaginal discharge or malodor; however, in a nationally representative survey, most women with BV were asymptomatic.^{1,3-4}

BV can be diagnosed by the use of clinical criteria such as Amsel's Diagnostic Criteria or by determining the Nugent score through a vaginal Gram stain, which is considered the gold standard laboratory method for diagnosing BV.¹ If a Gram stain is not available, clinical criteria can be used and require 3 of the following signs or symptoms^{1,3}:

- Homogeneous, thin, white discharge that smoothly coats the vaginal walls;
- Presence of clue cells on microscopic examination;
- pH of vaginal fluid >4.5;

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- A fishy odor of vaginal discharge before or after addition of 10% KOH (i.e., the whiff test).

Detection of three of these criteria has been correlated with results by Gram stain.¹ Other tests, including a DNA probe-based test for high concentrations of *G. vaginalis* and the OSOM BVBlue test have acceptable performance characteristics compared with Gram stain.¹ The BVBlue test is a colorimetric test that detects sialidase activity. Culture of *G. vaginalis* is not recommended as a diagnostic tool because it is not specific.¹ Additionally, there is no clinical utility for diagnosing BV with cervical pap tests due to their low sensitivity and specificity.¹

Vulvovaginal Candidiasis

VVC is usually caused by *C. albicans* but occasionally is caused by other *Candida* species or yeasts. Typical symptoms of VVC include pruritus, vaginal soreness, dyspareunia, external dysuria, and abnormal vaginal discharge.^{3,5-6} None of these symptoms is specific for VVC. An estimated 75% of women will have at least 1 episode of VVC, and 40%–45% will have 2 or more episodes within their lifetime. On the basis of clinical presentation, microbiology, host factors, and response to therapy, VVC can be classified as either uncomplicated or complicated.¹

A diagnosis of *Candida* vaginitis is suggested clinically by the presence of external dysuria and vulvar pruritus, pain, swelling, and redness.⁵ Signs include vulvar edema, fissures, excoriations, or thick, curdy vaginal discharge.⁵ The diagnosis can be made in a woman who has signs and symptoms of vaginitis when either a wet preparation (saline, 10% KOH) or Gram stain of vaginal discharge demonstrates yeasts, hyphae, or pseudohyphae or when a culture or other test yields a yeast species.^{5,7} *Candida* vaginitis is associated with a normal vaginal pH (<4.5), so pH testing is not a useful diagnostic tool.³ Use of 10% KOH in wet preparations improves the visualization of yeast and mycelia by disrupting cellular material that might obscure the yeast or pseudohyphae.⁵ Examination of a wet mount with KOH preparation should be performed for all women with symptoms or signs of VVC, and women with a positive result should receive treatment.⁷ For women with negative wet mounts who are symptomatic, vaginal cultures for *Candida* should be considered.⁵ If the wet mount is negative and *Candida* cultures cannot be done, empiric treatment can be considered for symptomatic women with any sign of VVC on examination.⁵ Identifying *Candida* by culture in the absence of symptoms or signs is not an indication for treatment because approximately 10%-20% of women harbor *Candida* species and other yeasts in the vagina. VVC can occur concomitantly with sexually transmitted infections. Most healthy women with uncomplicated VVC have no identifiable precipitating factors.¹

Complicated or recurrent vulvovaginal candidiasis (RVVC) is usually defined as 4 or more episodes of symptomatic VVC in 1 year and affects a small percentage of women (<5%). The pathogenesis of RVVC is poorly understood, and most women with RVVC have no apparent predisposing or underlying conditions. Vaginal cultures should be obtained from patients with RVVC to confirm the clinical diagnosis and to identify unusual species such as nonalbicans species and particularly *Candida glabrata*. Although *C. glabrata* and other nonalbicans *Candida* species are observed in 10%-20% of patients with RVVC, *C. glabrata* does not form pseudohyphae or hyphae and is not easily recognized on microscopy.¹

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VVC occurs more frequently and has greater persistence, but not greater severity, in HIV- (human immunodeficiency virus) infected women with very low cluster of differentiation 4 (CD4) counts and high viral load.⁸ However, this population is likely to manifest other acquired immune deficiency syndrome –related sentinel conditions.⁸ HIV testing of women only for the indication of RVVC is not justified, given that this condition is common in women without HIV.^{1,3}

DNA-probe tests have been developed to directly detect the presence of *Candida*, *Trichomonas* and *G. vaginalis*.⁹⁻¹⁰ Since *G. vaginalis* is a normal part of the vaginal flora, the DNA-probe test is designed to be relatively insensitive, detecting only pathogenic levels of *G. vaginalis*.⁹ DNA probes amplified by polymerase chain reaction (PCR) testing can also detect these pathogens.¹¹ In PCR tests, the sample is treated with enzymes that amplify specific regions of the DNA. After amplification, the number of DNA fragments is quantified. PCR testing has proven to be the most accurate diagnostic method in recent studies, however PCR testing has not been shown to improve clinical outcomes over direct DNA-probe testing.^{1,11} An advanced single-swab panel test that combines multiplex PCR and DNA-probe technology can diagnose bacterial vaginosis by determining the ratio of lactobacilli species (“good bacteria”) to several bacterial vaginosis-associated bacterial species (“bad bacteria”) in a patient-collected or physician-collected single-swab sample and has demonstrated comparable diagnostic sensitivity and specificity to Nugent scoring and Amsel criteria.¹¹ This multiplex PCR panel can also detect other common causes of vaginitis, such as trichomoniasis and candidiasis.¹¹ The clinical utility of multiplex PCR testing for the diagnosis of bacterial vaginosis is still being evaluated. There are a lack of studies that demonstrate the clinical utility of panel testing for multiple genitourinary pathogens.

Pediatric Patients

Females less than 13 years of age tend to have a different etiology for vaginitis than older females due to the lack of estrogenization of the vagina and the consequential alkalinity and vaginal atrophy.⁴ Common causes of vulvovaginal symptoms may include respiratory organisms such as group A streptococci and *Hemophilus influenzae*, as well as enteric and sexually transmitted pathogens. Pinworms or foreign bodies may also lead to vaginitis in this population.⁶

Centers for Disease Control and Prevention (CDC)¹

The CDC recommends the gram stain as the gold standard for diagnosis of bacterial vaginosis and recommends the use of Amsel's criteria if a gram stain is not available.

U.S. Preventive Services Task Force (USPSTF)²

The USPSTF does not recommend screening for bacterial vaginosis in pregnant women at low risk for preterm delivery.² In addition, the USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for bacterial vaginosis in pregnant persons at increased risk for preterm delivery.

American College of Obstetricians and Gynecologists (ACOG)⁴

ACOG recommends the use of Amsel clinical criteria or Gram stain with Nugent scoring for the diagnosis of bacterial vaginosis.⁴ In a symptomatic patient, diagnosis of vulvovaginal candidiasis requires one of the following two findings:

- visualization of spores, pseudohyphae, or hyphae on wet-mount microscopy;

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- vaginal fungal culture or commercial diagnostic test results positive for Candida species.

Per ACOG, new commercially available single swab multiplex PCR panels can detect other common causes of vaginitis such as trichomoniasis and candidiasis. The clinical utility of multiplex PCR testing for the diagnosis of bacterial vaginosis is still being evaluated and may be a promising alternative to microscopy.¹¹

Coding Implications

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Table 1. CPT codes considered medically necessary when billed with an ICD-10-CM code in Table 2

CPT®* Codes	Description
82120	Amines, vaginal fluid, qualitative
87480	Infectious agent detection by nucleic acid (DNA or RNA); Candida species, direct probe technique
87510	Infectious agent detection by nucleic acid (DNA or RNA); Gardnerella vaginalis, direct probe technique
87905	Infectious agent enzymatic activity other than virus (eg, sialidase activity in vaginal fluid)

Table 2. ICD-10-CM diagnosis codes that support medical necessity for codes in table 1

ICD 10 CM Code	Description
B37.3	Candidiasis of vulva and vagina
L29.2, L29.3	Pruritus of genitals
N76.0 – N76.3	Vaginitis and vulvitis
N77.1	Vaginitis, vulvitis, and vulvovaginitis in diseases classified elsewhere
N89.8	Other specific noninflammatory disorders of vagina
O23.511– O23.93	Infection of genitourinary tract in pregnancy
Z72.51 – Z72.53	High risk sexual behavior
Z86.19	Personal history of other infectious and parasitic diseases [history of STDs]

Table 3. CPT codes considered not medically necessary

CPT Codes	Description
0330U	Infectious agent detection by nucleic acid (DNA or RNA), vaginal pathogen panel, identification of 27 organisms, amplified probe technique, vaginal swab

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CPT Codes	Description
81513	Infectious disease, bacterial vaginosis, quantitative real-time amplification of RNA markers for Atopobium vaginae, Gardnerella vaginalis, and Lactobacillus species, utilizing vaginal-fluid specimens, algorithm reported as a positive or negative result for bacterial vaginosis
81514	Infectious disease, bacterial vaginosis and vaginitis, quantitative real-time amplification of DNA markers for Gardnerella vaginalis, Atopobium vaginae, Megasphaera type 1, Bacterial Vaginosis Associated Bacteria-2 (BVAB-2), and Lactobacillus species (L. crispatus and L. jensenii), utilizing vaginal-fluid specimens, algorithm reported as a positive or negative for high likelihood of bacterial vaginosis, includes separate detection of Trichomonas vaginalis and/or Candida species (C. albicans, C. tropicalis, C. parapsilosis, C. dubliniensis), Candida glabrata, Candida krusei, when reported
87511	Infectious agent detection by nucleic acid (DNA or RNA); Gardnerella vaginalis, amplified probe technique

Table 4. CPT codes considered not medically necessary when billed with an ICD-10-CM code listed in Table 5 below.

CPT Codes	Description
87798	Infectious agent detection by nucleic acid (DNA or RNA), not otherwise specified; amplified probe technique, each organism

Table 5. ICD-10-CM diagnosis codes considered not medically necessary when billed with CPT code 87798 per this policy.

ICD 10 CM Code	Description
N39.0	Urinary tract infection, site not specified
N72	Inflammatory disease of cervix uteri
N76.0	Acute vaginitis
N76.2	Acute vulvitis
N89.9	Noninflammatory disorder of vagina, unspecified
N90.89	Other specified noninflammatory disorders of vulva and perineum
N90.9	Noninflammatory disorder of vulva and perineum, unspecified
N91.0 – N91.5	Absent, scanty and rare menstruation
N92.0	Excessive, frequent menstruation with regular cycle
N93.0	Postcoital and contact bleeding
N93.8	Other specified abnormal uterine and vaginal bleeding
N93.9	Abnormal uterine and vaginal bleeding, unspecified
N94.3	Premenstrual tension syndrome
N94.4 – N94.6	Dysmenorrhea
N94.89	Other specified conditions associated with female genital organs and menstrual cycle

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ICD 10 CM Code	Description
N94.9	Unspecified condition associated with female genital organs and menstrual cycle
O09.00-O09.03	Supervision of pregnancy with history of infertility
O09.10-O09.13	Supervision of pregnancy with history of ectopic pregnancy
O09.A0-O09.A3	Supervision of pregnancy with history of molar pregnancy
O09.211-O09.219	Supervision of pregnancy with history of pre-term labor
O09.291-O09.299	Supervision of pregnancy with other poor reproductive or obstetric history
O09.30-O09.33	Supervision of pregnancy with insufficient antenatal care
O09.40-O09.43	Supervision of pregnancy with grand multiparity
O09.511-O09.519	Supervision of elderly primigravida
O09.521- O09.529	Supervision of elderly multigravida
O09.611-O09.619	Supervision of young primigravida
O09.621-O09.629	Supervision of young multigravida
O09.70-O09.73	Supervision of high risk pregnancy due to social problems
O09.811-O09.819	Supervision of pregnancy resulting from assisted reproductive technology
O09.821-O09.829	Supervision of pregnancy with history of in utero procedure during previous pregnancy
O09.891-O09.899	Supervision of other high risk pregnancies
O09.90-O09.93	Supervision of high risk pregnancy, unspecified
Z00.00	Encounter for general adult medical examination without abnormal findings
Z00.8	Encounter for other general examination
Z01.419	Encounter for gynecological examination (general) (routine) without abnormal findings
Z11.3	Encounter for screening for infections with a predominantly sexual mode of transmission
Z11.51	Encounter for screening for human papillomavirus (HPV)
Z22.330	Carrier of Group B streptococcus
Z23	Encounter for immunization
Z30.011 – Z30.019	Encounter for initial prescription of contraceptives
Z30.02	Counseling and instruction in natural family planning to avoid pregnancy
Z30.09	Encounter for other general counseling and advice on contraception
Z30.40 – Z30.9	Encounter for surveillance of contraceptives
Z32.00	Encounter for pregnancy test, result unknown
Z33.1	Pregnant state, incidental
Z34.00 – Z34.03	Encounter for supervision of normal first pregnancy
Z34.80 – Z34.83	Encounter for supervision of other normal pregnancy
Z34.90 – Z34.93	Encounter for supervision of normal pregnancy, unspecified
Z36.0-Z36.5	Encounter for antenatal screening of mother
Z36.81-Z36.9	Encounter for other antenatal screening
Z38.00 – Z38.01	Single liveborn infant, born in hospital

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ICD 10 CM Code	Description
Z38.30 – Z38.31	Twin liveborn infant, born in hospital
Z38.61 – Z38.69	Other multiple liveborn infant, born in hospital
Z39.0 – Z39.2	Encounter for maternal postpartum care and examination
Z3A.00 – Z3A.49	Weeks of gestation
Z97.5	Presence of (intrauterine) contraceptive device

Table 6. CPT codes considered not medically necessary when billed with an ICD-10-CM code listed in Table 7 below.

CPT Codes	Description
87481	Infectious agent detection by nucleic acid (DNA or RNA); Candida species, amplified probe technique

Table 7. ICD-10-CM diagnosis codes considered not medically necessary when billed with CPT code 87481 per this policy.

ICD 10 CM Code	Description
B37.3	Candidiasis of vulva and vagina
L29.2, L29.3	Pruritus of genitals
N39.0	Urinary tract infection, site not specified
N72	Inflammatory disease of cervix uteri
N76.0	Acute vaginitis
N76.1	Subacute and chronic vaginitis
N76.2	Acute vulvitis
N76.3	Subacute and chronic vulvitis
N76.81	Mucositis (ulcerative) of vagina and vulva
N76.89	Other specified inflammation of vagina and vulva
N77.1	Vaginitis, vulvitis, and vulvovaginitis in diseases classified elsewhere
N89.8	Other specific noninflammatory disorders of vagina
N89.9	Noninflammatory disorder of vagina, unspecified
N90.89	Other specified noninflammatory disorders of vulva and perineum
N90.9	Noninflammatory disorder of vulva and perineum, unspecified
N91.0 – N91.5	Absent, scanty and rare menstruation
N92.0	Excessive, frequent menstruation with regular cycle
N93.0	Postcoital and contact bleeding
N93.8	Other specified abnormal uterine and vaginal bleeding
N93.9	Abnormal uterine and vaginal bleeding, unspecified
N94.3	Premenstrual tension syndrome
N94.4 – N94.6	Dysmenorrhea
N94.89	Other specified conditions associated with female genital organs and menstrual cycle
N94.9	Unspecified condition associated with female genital organs and menstrual cycle

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ICD 10 CM Code	Description
O09.00-O09.03	Supervision of pregnancy with history of infertility
O09.10-O09.13	Supervision of pregnancy with history of ectopic pregnancy
O09.A0-O09.A3	Supervision of pregnancy with history of molar pregnancy
O09.211-O09.219	Supervision of pregnancy with history of pre-term labor
O09.291-O09.299	Supervision of pregnancy with other poor reproductive or obstetric history
O09.30-O09.33	Supervision of pregnancy with insufficient antenatal care
O09.40-O09.43	Supervision of pregnancy with grand multiparity
O09.511-O09.519	Supervision of elderly primigravida
O09.521- O09.529	Supervision of elderly multigravida
O09.611-O09.619	Supervision of young primigravida
O09.621-O09.629	Supervision of young multigravida
O09.70-O09.73	Supervision of high risk pregnancy due to social problems
O09.811-O09.819	Supervision of pregnancy resulting from assisted reproductive technology
O09.821-O09.829	Supervision of pregnancy with history of in utero procedure during previous pregnancy
O09.891-O09.899	Supervision of other high risk pregnancies
O09.90-O09.93	Supervision of high risk pregnancy, unspecified
O23.511– O23.93	Infection of genitourinary tract in pregnancy
Z00.00	Encounter for general adult medical examination without abnormal findings
Z00.8	Encounter for other general examination
Z01.419	Encounter for gynecological examination (general) (routine) without abnormal findings
Z11.3	Encounter for screening for infections with a predominantly sexual mode of transmission
Z11.51	Encounter for screening for human papillomavirus (HPV)
Z22.330	Carrier of Group B streptococcus
Z23	Encounter for immunization
Z30.011 – Z30.019	Encounter for initial prescription of contraceptives
Z30.02	Counseling and instruction in natural family planning to avoid pregnancy
Z30.09	Encounter for other general counseling and advice on contraception
Z30.40 – Z30.9	Encounter for surveillance of contraceptives
Z32.00	Encounter for pregnancy test, result unknown
Z33.1	Pregnant state, incidental
Z34.00 – Z34.03	Encounter for supervision of normal first pregnancy
Z34.80 – Z34.83	Encounter for supervision of other normal pregnancy
Z34.90 – Z34.93	Encounter for supervision of normal pregnancy, unspecified
Z36.0-Z36.5	Encounter for antenatal screening of mother
Z36.81-Z36.9	Encounter for other antenatal screening
Z38.00 – Z38.01	Single liveborn infant, born in hospital

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ICD 10 CM Code	Description
Z38.30 – Z38.31	Twin liveborn infant, born in hospital
Z38.61 – Z38.69	Other multiple liveborn infant, born in hospital
Z39.0 – Z39.2	Encounter for maternal postpartum care and examination
Z3A.00 – Z3A.49	Weeks of gestation
Z72.51 – Z72.53	High risk sexual behavior
Z86.19	Personal history of other infectious and parasitic diseases [history of STDs]
Z97.5	Presence of (intrauterine) contraceptive device

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Policy developed, reviewed by specialist.	06/16	06/16
Added age restriction of ≥ 13 , with supporting background information.	08/16	
Removed trichomonas from I.A. section listing criteria for direct DNA probe. Added to ‘background information’ under bacterial vaginosis that the use of the proline-aminopeptidase test card (Pip Activity TestCard) is no longer recommended because of low sensitivity and specificity. Removed CPT code for detection of trichomonas- 87661 from the not medically necessary code tables.	06/17	06/17
Added CPT 87798 – not otherwise specified amplified DNA probe as not medically necessary when performed for indications listed in the policy related to GU conditions, asymptomatic women, and asymptomatic women during pregnancy. Slight rewording of criteria with no clinical implications. Renamed to “Testing for Select Genitourinary Conditions.” Reviewed by external OB/Gyn.	08/17	09/17
Removed ICD-9-CM V22 pregnancy code set and replaced with ICD-10-CM pregnancy code set.	12/17	
Section I, removed “based on the following indications”. Background updated with no clinical implications. References reviewed and updated.	08/18	08/18
Removed criteria in I. regarding amplified DNA probe testing for trichomonas, as the amplified probe for trichomonas does not require specific symptoms to be present.	07/19	
Annual review completed. Specialty review completed. Removed direct probe for trichomonas vaginalis from the policy (CPT 87660) to allow trichomonas testing to be performed without symptoms. Added ICD-10 N89.8 as medically necessary for testing. Background removed related to trichomonas vaginalis.	08/19	08/19
Minor rewording in I.A. with no impact on meaning. Table 5: Added ICD 10 codes: O09.521- O09.529. Removed code Z36.3 as code is already included in the range Z36.0-Z36.5 noted in the policy. References reviewed and updated.	07/20	08/20

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Corrected typo in the coding note below Table 2 to indicate that Z13.89 should be billed with the F-series codes, and not Z11.89 (not a valid code).	09/20	
Added criteria V. Multiplex PCR panel testing as investigational and updated background accordingly. Added 2021 CPT codes 81513 and 81514 codes to Table 3 as not medically necessary. Replaced “member” with “member/enrollee” in all instances.	12/20	1/21
Noted in the description that the policy does not apply to the diagnosis of Trichomonas vaginalis, vaginal pH testing, and wet mount microscope tests, and updated background accordingly. Changed “review date” in the header to “date of last revision” and “date” in the revision log header to “revision date.” References reviewed, reformatted and updated. Removed 83986 and 87210 from the coding table requiring symptom diagnosis codes, as they could be used for testing for conditions other than vaginitis. Removed the following codes from table 2: A59.01, F11.10 - F11.19, F11.20 – F11.29, F14.10 – F14.19, F14.20 – F14.29, F15.10 – F15.19, F15.20 – F15.29, F18.10 – F18.19, F18.20 – F18.29, F19.10 – F19.19, F19.20 – F19.29, Z11.2, Z11.8, Z13.89. Specialist review.	07/21	07/21
Annual review. “Investigational” verbiage replaced in criteria V. with descriptive language. Updated description and background with no impact on criteria. Moved code 87481 from Table 3, “CPT codes considered not medically necessary” to Table 6 and added Table 7, ICD-10 codes considered not medically necessary for code 87481. References reviewed and updated.	03/22	03/22
Added 0330U to the not medically necessary CPT code table 3.	08/22	

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Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible

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for the medical advice and treatment of member/enrollees. This clinical policy is not intended to recommend treatment for member/enrollees. Member/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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Note: For Medicaid member/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare member/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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Clinical Policy: Allergy Testing and Therapy

Reference Number: CP.MP.100

Date of Last Revision: 09/22

[Coding Implications](#)

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

Allergy testing is performed to determine immunologic sensitivity or reaction to antigens for the purpose of identifying the cause of the allergic state. This policy addresses immediate (IgE-mediated) hypersensitivity and delayed (cell-mediated) hypersensitivity.¹⁴ Allergen immunotherapy is the repeated administration of specific allergens to patients with IgE-mediated conditions, for the purpose of providing protection against the allergic symptoms and inflammatory reactions associated with exposure to these allergens.²

Please note: unit limitations for allergy testing and treatment are based on state specific guidelines (defined in the provider fee schedule). In the absence of state-specific rules, the CMS Medicaid/Medicare NCCI MUE limitations are applied.

Policy/Criteria

- I. It is the policy of health plans affiliated with Centene Corporation[®] that allergy testing is **medically necessary** for members/enrollees with clinically significant allergic symptoms and the following indications:
 - A. As part of a complete diagnostic evaluation by a licensed practitioner acting within their scope of practice to perform allergy and immunology services;
 - B. Antigens include only those that are reasonably possible for the member/enrollee to be exposed to;
 - C. Chosen test and units allowed per year are as follows:
 1. *Percutaneous* testing (scratch, puncture, prick) CPT 95004, 95017, 95018) for offending allergens such as pollen, molds, mites, dust, feathers, animal fur or dander, venoms, foods, or drugs.
 2. *Intracutaneous* (intra-dermal), *sequential and incremental testing* (CPT 95024, 95027, 95028) when percutaneous tests are negative;
 3. *Skin endpoint titration* (95027) for determining the starting dose for immunotherapy for member/enrollee highly allergic to an inhalant allergen or hymenoptera venom allergy (insect stings);
 4. *In vitro testing* (CPT 86003, 86005, 86008);
 5. *Patch testing* (CPT 95044);
 6. If photo patch test(s) (CPT 95052) are performed (same antigen/same session) with patch or application test(s) (CPT 95044), only the photo patch tests should be reported;
 7. If photo tests (CPT 95056) are performed with patch or application test(s) (CPT 95044), only the photo tests should be reported.
- II. It is the policy of health plans affiliated with Centene that allergy immunotherapy administered in a medical facility is **medically necessary** when meeting all of the following indications:

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- A. Positive skin test or serologic evidence of an IgE-mediated antibody for allergens which cause any of the following:
 - 1. Allergic (extrinsic) asthma,
 - 2. Dust mite atopic dermatitis,
 - 3. Hymenoptera (bees, hornets, wasps, fire ants) allergic reactions,
 - 4. Mold-induced allergic rhinitis,
 - 5. Perennial allergic rhinitis,
 - 6. Seasonal allergic rhinitis or conjunctivitis;
- B. Symptoms of allergic rhinitis or asthma after natural exposure to the allergen; or a life-threatening allergy to insect stings (bees, hornets, wasps, and fire ants);
- C. Avoidance or pharmacologic therapy does not control allergic symptoms or member/enrollee has unacceptable side effects with pharmacologic therapy;
- D. If rapid desensitization/rush immunotherapy is requested, it is only medically necessary for medication or hymenoptera (bees, hornets, wasps, fire ants) sensitivities;
- E. Antigens are prepared by the clinical staff directly overseen by the physician who examined the patient and who has training and expertise in allergen immunotherapy (i.e., allergist, immunologist or otolaryngologist. Other specialties must provide evidence of expertise and training consistent with the ACAAI Allergen Immunotherapy Extract Preparation Instructional Guide).^{19*}

Note: Please see background section for information on training requirements for immunotherapy preparation and administration.*

Note: For FDA approved sublingual immunotherapy, please refer to applicable pharmacy policy for coverage criteria.

III. It is the policy of health plans affiliated with Centene that the following are considered **not medically necessary** because safety or effectiveness have not been established:

- A. Testing for the following antigens:
 - 1. Newsprint;
 - 2. Tobacco smoke;
 - 3. Dandelion;
 - 4. Orris root;
 - 5. Phenol;
 - 6. Alcohol;
 - 7. Sugar;
 - 8. Yeast;
 - 9. Grain mill dust;
 - 10. Soybean dust (except when the patient has a known exposure to soybean dust such as a food processing plant);
 - 11. Wool (unless patient has history of continuous exposure to sheep or unprocessed wool);
 - 12. Marigold;
 - 13. Honeysuckle;
 - 14. Fiberglass;
 - 15. Green tea;

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16. Chalk;
17. Cornstarch;
18. Cotton;
19. Formaldehyde;
20. Smog.

B. The following tests for the evaluation allergic reactions:

1. Antigen leukocyte cellular antibody (ALCAT) automated food allergy testing;
2. Applied kinesiology or Nambudripad's allergy elimination test (NAET (i.e., muscle strength testing or measurement after allergen ingestion));
3. Anti-Fc epsilon receptor antibodies testing;
4. Anti-IgE receptor antibody testing;
5. Blood, urine, or stool micro-nutrient assessments;
6. Candidiasis test;
7. Chemical analysis of body tissues (e.g., hair);
8. Chlorinated pesticides (serum);
9. Chronic urticarial index testing;
10. Clifford materials reactivity testing;
11. Complement (total or components);
12. Complement antigen testing;
13. C-reactive protein;
14. Cytokine and cytokine receptor assay;
15. Cytotoxic testing for food, environmental or clinical ecological allergy testing (Bryans Test, ACT);
16. Electrodermal testing or electro-acupuncture;
17. Electromagnetic sensitivity syndrome/disorder (allergy to electricity, electro-sensitivity, electrohypersensitivity, and hypersensitivity to electricity);
18. Environmental cultures and chemicals;
19. Eosinophil cationic protein (ECP) test;
20. ELISA/Act qualitative antibody testing;
21. Food immune complex assay (FICA);
22. General immune system assessments;
23. Immune complex assay;
24. Ingestion challenge food testing for diagnosing rheumatoid arthritis, depression, or respiratory disorders not associated with anaphylaxis or similar systemic reactions;
25. In vitro metal allergy testing;
26. Iridology;
27. Leukocyte histamine release test (LHRT)/basophil histamine release test;
28. Live Cell Analysis;
29. Lymphocyte function assay;
30. Lymphocytes (B or T subsets);
31. Lymphocyte Response Assay (LRA) by ELISA/ACT and Lymphocyte Mitogen Response Assays (LMRA) by ELISA/Act;
32. Mediator release test (MRT);
33. Metabolic assessments;
34. Ophthalmic mucus membrane tests/conjunctival challenge test;

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35. Prausnitz-Kustner (P-K testing) passive cutaneous transfer test;
 36. Provocative and neutralization testing and neutralization therapy (sublingual, intracutaneous and subcutaneous) also referred to as the Rinkel Test, for food allergies, inhalants, and environmental chemicals because available evidence does not show these tests and therapies are effective;
 37. Provocative nasal test;
 38. Pulse test (pulse response test, reaginic pulse test);
 39. Qualification of nutritional assessments;
 40. Rebeck skin window test;
 41. Secretory IgA (salvia);
 42. Sage Complement Antigen Test;
 43. Testing for multiple chemical sensitivity syndrome (a.k.a., idiopathic environmental intolerance [IEI], clinical ecological illness, clinical ecology, environmental illness, chemical AIDS, environmental/chemical hypersensitivity disease, total allergy syndrome, cerebral allergy, 20th century disease);
 44. Testing of specific immunoglobulin G (IgG) (e.g., by Radioallergosorbent [RAST] or Enzyme-linked immunosorbent assay [ELISA]);
 45. Testing of total serum IgG, immunoglobulin A (IgA) and immunoglobulin M (IgM);
 46. Testing for venom blocking antibodies;
 47. VeriMAP Peanut Diagnostic™ (bead-based epitope assay).
- C. The following services in relation to allergy testing and immunotherapy:
1. Desensitization with commercially available extracts of poison ivy, poison oak, or poison sumac;
 2. Desensitization for hymenoptera sensitivity using whole body extracts, with the exception of venom extracts and fire ant extracts;
 3. Desensitization with bacterial vaccine (BAC: bacterial, antigen complex, streptococcus vaccine, staphylo/strepto vaccine, serobacterin, staphylococcus phage lysate);
 4. Food allergenic extract immunotherapy;
 5. Intracutaneous desensitization (Rinkel Injection Therapy, RIT);
 6. Neutralization therapy (intra-dermal and subcutaneous);
 7. Repository emulsion therapy;
 8. Non-FDA approved sublingual immunotherapy;
 9. Urine autoinjection (autogenous urine immunotherapy);
 10. Allergen immunotherapy for the management of skin and mucous membrane disease such as urticaria, and Candida vulvovaginitis;
 11. Home administration of allergy immunotherapy;
 12. Ingestion challenge food testing performed by the patient in the home;
 13. Intra-dermal testing for food allergies;
 14. Food allergen testing for patients who present with gastrointestinal symptoms suggestive of food intolerance;
 15. Rush immunotherapy for inhalant allergens.

Limitations

Allergy Testing^{6, 15, 20}

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- Retesting with the same antigen(s) should rarely be necessary within a 3-year period. Exceptions include children and adolescents with documented food allergy requiring follow up and young children with negative skin tests or older children and adults with negative skin tests in the face of persistent symptoms;
- Routine repetition of skin tests is not indicated (e.g., annually);
- Measurements of total IgE levels (CPT code 82785-Gammaglobulin [immunoglobulin]; IgE) are not appropriate for most general allergies for the purpose of identifying the cause of the allergic state. Total serum IgE levels should not be billed unless evidence exists for allergic bronchopulmonary Aspergillosis (ABPA), select immunodeficiencies, such as the syndrome of hyper-IgE, eczematous dermatitis, atopic dermatitis in children and recurrent pyogenic infections, or in the evaluation for omalizumab therapy;
- Serial, repeat testing of total IgE will be subject to medical review.

Documentation Requirements

Medical record documentation (e.g., history & physical, office/progress notes, procedure report, test results) must include the following information:

- A complete medical and immunologic history and appropriate physical exam obtained by face-to-face contact with the patient;
- The medical necessity for performing the test;
- The test methodology used;
- The measurement (in mm) of reaction sizes of both wheal and erythema response (in vivo testing);
- The quantitative result (in kIU/L) for specific IgE testing (in vitro testing);
- The interpretation of the test results and how the results of the test will be used in the patient's plan of care;
- Periodic clinical evaluation of treatment benefits and, if no benefit within 12-24 months, other treatment options which should be considered;
- Clinical re-evaluation at 3 to 5 years to determine need for continuing immunotherapy.

Background

Allergy Testing

Allergy is a form of exaggerated sensitivity or hypersensitivity to a substance that is either inhaled, ingested, injected, or comes in contact with the skin or eye. The term allergy is used to describe situations where hypersensitivity results from heightened or altered reactivity of the immune system in response to external substances. Allergic or hypersensitivity disorders may be manifested by generalized systemic reactions as well as localized reactions in any part of the body. The reactions may be acute, subacute, or chronic; immediate or delayed, and may be caused by a variety of offending agents (e.g., pollen, molds, mites, dust, feathers, animal fur or dander, venoms, foods, drugs).¹⁶ Allergy testing is performed to determine a patient's immunologic sensitivity or reaction to particular allergens for the purpose of identifying the cause of the allergic state.¹⁷

Allergy testing must be a part of a complete diagnostic evaluation by a physician with specialized training in allergy and immunotherapy. A complete medical and immunologic history and appropriate physical examination must be done prior to performing diagnostic testing. The testing must be performed based on this history and a physical exam, which documents that the

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antigens being used for testing exist with a reasonable probability of exposure in the patient's environment. The number of tests performed must be judicious and related to the history, physical findings, and clinical judgment specific to each individual.¹⁴

In vivo immunologic tests have been shown to be reliable and valid diagnostic tools and include skin tests with standardized allergenic extracts by prick/puncture (percutaneous) and intradermal (intracutaneous) techniques, photo and patch testing, inhalation bronchial challenge testing, and ingestion challenge testing. Percutaneous testing remains the test of choice in most clinical situations where immediate hypersensitivity reactions are suspected. Percutaneous tests require medical supervision, since there is a small but significant risk of anaphylaxis. Overall, skin testing is quick, safe, and cost-effective.¹⁴

Intradermal tests are usually performed when increased sensitivity is needed when percutaneous tests (CPT codes 95004, 95017, 95018) are negative and there is still a strong suspicion of allergen sensitivity. For intradermal testing, the clinician should narrow the area of investigation so that the minimal number of skin tests necessary for diagnosis is performed. Intradermal testing is appropriate when IgE-mediated reactions occur to inhalants, hymenoptera (insect stings), and specific drugs, such as penicillins and macroglobular agents.¹⁵ The usual testing program may include two concentrations of an extract: a weaker concentration and a stronger concentration. It would not be expected that three or more concentrations of one extract would be necessary. Skin end-point dilution testing is a variant of intradermal testing that analyzes the highest dilution of a substance that produces a reaction, and may be used to determine the starting dose(s) of allergen immunotherapy.¹⁴

Delayed hypersensitivity skin testing measures the presence of activated T cells that recognize a certain substance. It has been commonly used in three ways: anergy testing, testing for infection with intracellular pathogens, and testing for sensitivity to contact allergens. Accurate testing for contact allergy requires careful attention to technique, and limitation of testing to the specific allergens known to be associated with a contact reaction.¹⁴

Other skin tests include photo testing and patch testing. Photo testing is skin irradiation with a specific range of ultraviolet light. Photo tests are performed for the evaluation of photosensitivity disorders. Patch testing is indicated to evaluate a nonspecific dermatitis, allergic contact dermatitis, pruritus, and other dermatitis to determine the causative antigen. Photo Patch testing uses two patches, with one of them being irradiated with ultraviolet light half way through the occlusive period. It is indicated to evaluate unique allergies resulting from light exposure.¹⁴

Inhalation bronchial challenge testing involves the inhalation of agents that can trigger respiratory responses. The agents include drugs that cause airway constriction, antigens, and chemical sensitizers, usually related to occupational breathing problems. Generally, three measures of each determination (e.g., spirometry, prolonged post exposure evaluation of bronchospasm) are performed. The best of the three is accepted and represents one unit of service. A unit is defined as each set of three measurements.¹⁴

Ingestion challenge test involves the administration of sequentially or incrementally larger doses of the test item. The test items may include food or antibiotics. The service is allowed once per

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patient encounter, regardless of the number of items tested, and includes evaluation of the patient's response to the test items.¹⁴

Quantitative or semi-quantitative in vitro allergen specific IgE testing includes radioallergosorbent test (RAST), multiple radioallergosorbent tests (MAST), fluorescent allergosorbent test (FAST), enzyme-linked immunosorbent assay (ELISA) and ImmunoCAP. These tests detect specific IgE antibodies in the patient's blood serum. Examples of indications for in vitro testing (CPT codes 86003, 86005 and 86008) include:

- Severe dermatographism, ichthyosis or generalized eczema;
- Increased risk for anaphylactic response to skin testing based on clinical history (e.g., when an unusual allergen is not available as a licensed skin test extract);
- Inability to discontinue long-acting antihistamines, tricyclic antidepressants, or medications that may put the patient at undue risk if they are discontinued long enough to perform skin tests;
- Those with mental or physical impairments who are uncooperative;
- History is highly suggestive of an allergy and skin testing is negative or equivocal; or
- Evaluation of cross-reactivity between insect venoms.

Total serum IgE concentration testing is not indicated in all allergic patients but should be reserved for those patients suspected of having allergic bronchopulmonary aspergillosis, immune deficiency disease (e.g., Wiskott-Aldrich syndrome, hyper-IgE staphylococcal abscess syndrome), IgE myeloma or pemphigoid, or for consideration of Xolair (omalizumab) administration in patients with moderate to severe asthma.

Allergen Immunotherapy¹⁸

Allergen immunotherapy is effective for pollen, mold, animal allergens, cockroach, and dust mite. Immunotherapy is indicated for patients who show evidence of specific IgE antibodies to clinically relevant allergens and whose allergic symptoms warrant the time and risk of allergen immunotherapy. This includes those with allergic asthma, allergic conjunctivitis, allergic rhinitis, or stinging insect hypersensitivity depending on the results of allergy testing (immediate hypersensitivity skin tests or in vitro tests for specific IgE). Initiating allergen immunotherapy may depend on the degree to which symptoms can be reduced by medication, the amount and type of medication required to control symptoms, and whether appropriate avoidance is possible.

There is limited data showing effectiveness in atopic dermatitis when this condition is associated with aeroallergen sensitivity. Immunotherapy should not be given to patients with negative results for specific IgE antibodies or those with positive test results for specific IgE antibodies that do not correlate with suspected triggers, clinical symptoms, or exposure.

Venom immunotherapy is indicated for patients who have anaphylaxis after an insect sting and a positive skin test or other documented IgE sensitivity to specific insect venom. Patients with delayed systemic reactions with symptoms of anaphylaxis or serum sickness and with a positive skin test or presence of venom specific IgE by in vitro testing are also recommended for treatment.

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Rapid desensitization is indicated in cases of allergy to insulin, penicillin, and horse serum, as well as sulfonamides, cephalosporins and other commonly used drugs. In patients with a positive history of reaction and with documented skin test reactivity, every effort should be made to avoid the use of these substances. When circumstances require the use of one of these substances, the patient will have to be desensitized. Full-dose therapy should be initiated immediately after reactions (treated and controlled), requiring strict physician monitoring in a setting with continuous monitoring of vital signs and cardio-respiratory status. In most cases, this can be performed in a physician's office if a physician trained to treat anaphylaxis is physically present for the entire duration. In cases where the initial reaction was severe, desensitization should be performed in the ambulatory care department of a hospital.

Desensitization may need to be repeated if future circumstances require an additional course of the offending allergen. Rapid desensitization in the form of rush immunotherapy may also be appropriate for hymenoptera venom (bees, hornets, wasps, fire ants), according to a recent American Academy of Allergy, Asthma & Immunology practice parameter.

Sublingual Immunotherapy⁸

The American Academy of Allergy, Asthma & Immunology recommends only FDA-approved sublingual immunotherapy (SLIT) products for the treatment of allergic rhinitis/rhinoconjunctivitis and not for any other related or unrelated condition. Off label use of aqueous SLIT extracts or any other non- FDA approved SLIT formulation is not endorsed.

Treatment Schedules¹⁸

The starting dose of an allergenic extract and the progression of the dose must be individualized for each patient. The immunotherapy build-up schedule entails administration of gradually increasing doses during a period of approximately 14 to 28 weeks. In conventional schedules a single dose increase is given on each visit, and the visit frequency can vary from 1 to 3 times a week. Accelerated schedules such as rush or cluster immunotherapy entail administration of several injections at increasing doses on a single visit. Accelerated schedules offer the advantage of achieving the therapeutic dose earlier but might be associated with increased risk of systemic reaction in some patients.

Length of Therapy¹⁸

The duration of all forms of immunotherapy must be individualized. A presumption of failure can be made when, after 12 to 24 months of therapy, a person does not experience a noticeable decrease of symptoms, an increase in tolerance to the offending allergen and a reduction in medication usage. Treatment will not be reimbursed after a 2 year period when there is no apparent clinical benefit.

Immunotherapy Preparation and Administration¹⁹

The training of personnel involved in preparation of allergen immunotherapy extracts is a critical requirement for safety and efficacy. It is a technical skill that requires specific training and a high level of attention to detail.

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The suggested qualifications of extract preparation personnel based on the AAAAI Practice Parameter on Allergen Immunotherapy and The United States Pharmacopeial Convention (USP) Chapter 797 Pharmaceutical Compounding- Sterile Preparations standards include the following:

- Demonstrate understanding of appropriate hand hygiene, garbing, surface disinfection, aseptic technique, achieving and/or maintaining sterility, calculating/measuring/mixing, use of equipment and documentation.
- Pass a written test on aseptic technique and extract preparation.
- Annually pass a media-fill or equivalent test verifying use of aseptic technique.
- Annually pass a gloved fingertip-thumb sampling test verifying hand sterility after passing three initial tests.
- Be instructed and reevaluated if failing the written test, media-fill test or gloved fingertip-thumb sampling test.
- Allergist offices must keep records of training, assessment results, evaluations and qualifications for all compounding personnel, including any corrective actions following assessments and evaluations.

The major risk of allergen immunotherapy is anaphylaxis. Allergen immunotherapy should, therefore, be administered under the supervision of an appropriately trained physician who can recognize early symptoms and signs of anaphylaxis and administer emergency medications where necessary. In addition, immunotherapy should be administered only in facilities equipped to treat anaphylaxis.

Evaluation and management codes are separately reimbursable on the same day as allergen immunotherapy only when a significant, separately identifiable service is performed.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2020, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT Code Table 1: Procedure codes considered medically necessary when diagnosis code requirements are met per the ICD-10 tables.

CPT® Codes	Description
86003	Allergen specific IgE; quantitative or semiquantitative, crude allergen extract, each
86005	Allergen specific IgE; qualitative, multiallergen screen (eg., disk, sponge, card)
86008	Allergen specific IgE; quantitative or semiquantitative, recombinant or purified component, each
86160	Complement; antigen, each component

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CPT®* Codes	Description
86161	Complement; functional activity, each component
86162	Complement; total hemolytic (CH50)
95004	Percutaneous tests (scratch, puncture, prick) with allergenic extracts, immediate type reaction, including test interpretation and report, specify number of tests
95017	Allergy testing, any combination of percutaneous (scratch, puncture, prick) and intracutaneous (intradermal), sequential and incremental, with venoms, immediate type reaction, including test interpretation and report, specify number of tests
95018	Allergy testing, any combination of percutaneous (scratch, puncture, prick) and intracutaneous (intradermal), sequential and incremental, with drugs or biologicals, immediate type reaction, including test interpretation and report, specify number of tests
95024	Intracutaneous (intradermal) tests with allergenic extracts, immediate type reaction, including test interpretation and report, specify number of tests
95027	Intracutaneous (intradermal) tests, sequential and incremental, with allergenic extracts for airborne allergens, immediate type reaction, including test interpretation and report, specify number of tests
95028	Intracutaneous (intradermal) tests with allergenic extracts, delayed type reaction, including reading, specify number of tests
95044	Patch or application test(s) (specify number of tests)
95052	Photo patch test(s) (specify number of tests)
95056	Photo tests
95070	Inhalation bronchial challenge testing (not including necessary pulmonary function tests), with histamine, methacholine, or similar compounds
95076	Ingestion challenge test (sequential and incremental ingestion of test items, eg, food, drug or other substance); initial 120 minutes of testing
95079	Ingestion challenge test (sequential and incremental ingestion of test items, eg, food, drug or other substance); each additional 60 minutes of testing (list separately in addition to code for primary procedure)
95115	Professional services for allergen immunotherapy not including provision of allergenic extracts; single injection
95117	Professional services for allergen immunotherapy not including provision of allergenic extracts; 2 or more injections
95144	Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy, single dose vial(s) (specify number of vials)
95145	Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); single stinging insect venom
95146	Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); 2 single stinging insect venoms

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CPT®* Codes	Description
95147	Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); 3 single stinging insect venoms
95148	Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); 4 single stinging insect venoms
95149	Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); 5 single stinging insect venoms
95165	Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; single or multiple antigens (specify number of doses)
95170	Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; whole body extract of biting insect or other arthropod (specify number of doses)
95180	Rapid desensitization procedure, each hour (eg, insulin, penicillin, equine serum)
95199	Unlisted allergy/clinical immunologic service or procedure

CPT Code Table 2: Procedure codes considered not medically necessary

CPT®* Codes	Description
86001	Allergen specific IgG quantitative or semiquantitative, each allergen
86332	Immune complex assay
86343	Leukocyte histamine release test (LHR)
86485	Skin test; candida
86628	Antibody; Candida
95060	Ophthalmic mucous membrane tests
95065	Direct nasal mucous membrane test
0165U	Peanut allergen-specific quantitative assessment of multiple epitopes using enzyme-linked immunosorbent assay (ELISA), blood, individual epitope results and probability of peanut allergy
0178U	Peanut allergen-specific quantitative assessment of multiple epitopes using enzyme-linked immunosorbent assay (ELISA), blood, report of minimum eliciting exposure for a clinical reaction

ICD-10 codes with an * indicate additional digits are needed.

ICD-10-CM Code Table 1: Diagnoses that support medical necessity for CPT codes 86003, 86005, 86008, 95004, 95017, 95018, 95024, 95027, 95028

ICD 10 CM Code	Description
B44.81	Allergic bronchopulmonary aspergillosis
H10.01* through H10.45	Conjunctivitis

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ICD 10 CM Code	Description
J30.1 through J30.9	Allergic rhinitis
J30.0	Vasomotor rhinitis
J31.0	Chronic rhinitis
J45.2* through J45.998	Asthma
L20.0 through L20.9	Atopic dermatitis
L23.0 through L23.9*	Allergic contact dermatitis
L24.9	Irritant contact dermatitis, unspecified cause
L25.1 through L25.9	Unspecified contact dermatitis
L27.0 through L27.9	Dermatitis due to substances taken internally
L30.2	Cutaneous autosensitization
L50.0	Allergic urticaria
L50.1	Idiopathic urticaria
L50.6	Contact urticaria
L50.8	Other urticaria
L50.9	Urticaria, unspecified
R06.2	Wheezing
T36.0X5A through T50.995S	Adverse effect of drugs
T63.001* through T63.94*	Toxic effects of venoms
T78.00X* through T78.1XXS	Anaphylactic reaction due to food
T78.49XA through T78.49XS	Other allergy
T80.52XA through T80.52XS	Anaphylactic reaction due to vaccination
T88.6XXA through T88.6XXS	Anaphylactic reaction due to adverse effect of correct drug or medicament properly administered
Z91.010 through Z91.018	Food allergy status

ICD-10-CM Code Table 2: Diagnoses that support medical necessity for CPT code 95044

ICD 10 CM Code	Description
L20.84	Intrinsic (allergic) eczema
L20.89	Other atopic dermatitis
L20.9	Atopic dermatitis, unspecified

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ICD 10 CM Code	Description
L23.0 through L23.9	Allergic contact dermatitis
L50.0	Allergic urticaria
L50.1	Idiopathic urticaria
L50.6	Contact urticaria
L50.8	Other urticaria
L50.9	Urticaria, unspecified

ICD-10-CM Code Table 3: Diagnoses that support medical necessity for CPT codes 95052, 95056

ICD 10 CM Code	Description
L56.1	Drug photoallergic response
L56.2	Photocontact dermatitis (berloque dermatitis)
L56.3	Solar urticaria

ICD-10-CM Code Table 4: Diagnoses that support medical necessity for CPT codes 95076, 95079

ICD 10 CM Code	Description
L27.2	Dermatitis due to ingested food
T36.0X5A through T50.995S	Adverse effect of drugs
T78.00X* through T78.1XXS	Anaphylactic reaction due to food
Z88.0 through Z88.9	Allergy status to drugs, medicaments and biological substances
Z91.010 through Z91.018	Food allergy status

ICD-10-CM Code Table 5: Diagnoses that support medical necessity for CPT codes 95115, 95117, 95144, 95145, 95146, 95147, 95148, 95149, 95165, 95170, and 95199

ICD 10 CM Code	Description
H10.01* through H10.45	Conjunctivitis
J30.1 through J30.9	Allergic rhinitis
J31.0	Chronic rhinitis
J45.20 through J45.998	Asthma
L20.84	Intrinsic (allergic) eczema
L20.89	Other atopic dermatitis
L20.9	Atopic dermatitis, unspecified
L23.0 through L23.9*	Allergic contact dermatitis

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ICD 10 CM Code	Description
L25.1 through L25.9	Unspecified contact dermatitis
L27.0 through L27.9	Dermatitis due to substances taken internally
L50.0	Allergic urticaria
L50.6	Contact urticaria
T36.0X5A through T50.995S	Adverse effects of drugs
T63.001* through T63.94*	Toxic effects of venoms
T78.49XA through T78.49XS	Other allergy
T80.52XA through T80.52XS	Anaphylactic reaction due to vaccination
T88.6XXA through T88.6XXS	Anaphylactic reaction due to adverse effect of correct drug or medicament properly administered
Z88.0 through Z88.9	Allergy status to drugs, medicaments, and biological substances
Z91.030 through Z91.038	Insect allergy status

ICD-10-CM Code Table 6: Diagnoses that support medical necessity for CPT code 95180

ICD 10 CM Code	Description
T36.0X5A through T50.995S	Adverse effect of other drugs, medicaments and biological substances
Z91.030 through Z91.038	Insect allergy status

ICD-10-CM Code Table 7: Diagnoses that do *not* support medical necessity for CPT codes 86160, 86161 and 86162

ICD 10 CM Code	Description
B44.81	Allergic bronchopulmonary aspergillosis
H10.01* through H10.45	Conjunctivitis
J30.1 through J30.9	Allergic rhinitis
J30.0	Vasomotor rhinitis
J31.0	Chronic rhinitis
J45.2* through J45.998	Asthma
L20.84	Intrinsic (allergic) eczema
L20.89	Other atopic dermatitis
L20.9	Atopic dermatitis, unspecified

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ICD 10 CM Code	Description
L23.0 through L23.9*	Allergic contact dermatitis
L25.1 through L25.9	Unspecified contact dermatitis
L27.0 through L27.9	Dermatitis due to substances taken internally
L50.0	Allergic urticaria
L50.1	Idiopathic urticaria
L50.6	Contact urticaria
L50.8	Other urticaria
L50.9	Urticaria, unspecified
L56.1	Drug photoallergic response
L56.2	Photocontact dermatitis (berloque dermatitis)
L56.3	Solar urticaria
R06.2	Wheezing
T36.0X5A through T50.995S	Adverse effect of drugs
T63.001* - T63.94*	Toxic effects of venoms
T78.00X* through T78.1XXS	Anaphylactic reaction due to food
T78.49XA through T78.49XS	Other allergy
T80.52XA through T80.52XS	Anaphylactic reaction due to vaccination
T88.6XXA through T88.6XXS	Anaphylactic reaction due to adverse effect of correct drug or medicament properly administered
Z88.0 through Z88.9	Allergy status to drugs, medicaments and biological substances
Z91.010 through Z91.018	Food allergy status

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Policy created, specialist reviewed	01/16	02/16
Added anaphylactic reaction due to vaccinations to ICD-10-CM code list that support medical necessity for CPT Codes 86003, 86005, 95004, 95017, 95018, 95024, 95027, 95028; removed food allergy testing for patients who present with respiratory symptoms from III.C	12/16	01/17
Clarified that rapid desensitization is appropriate only for medication and hymenoptera sensitivities and added ICD-10 codes for insect allergy status to CPT 95180 for rapid desensitization.	02/17	

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Reviews, Revisions, and Approvals	Revision Date	Approval Date
<p>Combined code ranges in all ICD-10 coding tables including J30.1 – J30.9; J45.2* - J45.998; L25.1 – L25.9; L27.0 – L27.9; T78.00X* - T78.1XXS.</p> <p>Added initial encounters to ICD-10 codes that previously only included subsequent and sequela encounter.</p> <p>Added H10.01* - H10.45; T63.001* - T63.94* to ICD-10-CM code table 1</p> <p>Added expanded code range for conjunctivitis H10.01* through H10.45; L23.0 through L23.9*; L25.1 through L25.9; L27.0 through L27.9; L50.0, L50.6, T36.0X5A through T50.995S; T78.49XA through T78.49XS; T80.52XA through T80.52XS; Z88.0 through Z88.9 to ICD-10-CM code table 5.</p> <p>Added expanded code range T36.0X5A through T50.995S to ICD-10 code table 6</p>		
<p>Under Documentation requirements, removed statement about medical necessity for in vitro vs in vivo testing</p>	04/17	
<p>Frequency limitations for allergy testing and treatment have been removed from this policy as they are based on state specific guidelines (defined in the provider fee schedule). In the absence of state-specific rules, the CMS Medicaid/Medicare NCCI MUE limitations are applied.</p>	6/17	
<p>Added L50.1, L50.8, and L50.9 to ICD-10-CM Code Table 1 and Table 2</p>	07/17	
<p>References reviewed and updated. Codes reviewed.</p>	01/18	01/18
<p>Added to III.A, testing of the following antigens as not medically necessary: cornstarch, cotton, formaldehyde and smog. References reviewed and updated. Added 86008 to in vitro testing, and CPT code table 1 and relevant to ICD-10 code table 1. Added B44.81 to ICD-10 code table 1. Added T88.6XXA through T88.6XXS to ICD-10 code table 5.</p>	01/19	01/19
<p>Under III. C. revised “sublingual provocative therapy” to state “non FDA approved sublingual immunotherapy” and added reference to refer to pharmacy benefit for coverage criteria. Removed background statement "In vitro testing is appropriate under conditions where skin testing is not possible or is not reliable." Specialist reviewed. Added R06.2 to ICD-10-CM code table 1.</p>	11/19	12/19
<p>Added “(scratch, puncture, prick)” to description in I.C.1. Updated IIIB. adding several not medically necessary tests. Updated background, adding section on sublingual immunotherapy. CPT codes added to not medically necessary CPT Table 2: 86160, 86161, 86162, 86332, 86343, 86485, 86628, 0165U, 0178U. Revised description of ICD-10 codes Z88.0 through Z88.9 in ICD-10 Tables 4 & 5. References reviewed and updated. Replaced member with member/enrollee in all instances.</p>	10/20	10/20
<p>Added ICD-10 code range Z91.010 through Z91.018 to Tables 1 & 4.</p>	10/20	

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Added J30.0 to ICD-10-CM Code Table 1. Minor revision to description of CPT 95070. CPT 95071 deleted in 2021.	03/21	
Annual review. References reviewed and updated. Changed “review date” in the header to “date of last revision” and “date” in the revision log header to “revision date.” Criteria and coding reviewed by specialist.	09/21	09/21
Removed codes 86160, 86161 and 86162 from the not medically necessary table. Added ICD-10 Table 7 with codes that do not support medical necessity for 86160 through 86162.	03/22	
Added the following ICD-10 codes as medically necessary in ICD-10 code table 1: L20.0, L20.81-L20.83 (within code range L20 through L20.9), L24.9, L30.2.	05/22	
Annual review. Updated criteria in II. E. to “Antigens are prepared by the clinical staff directly overseen by the physician who examined the patient and who has training and expertise in allergen immunotherapy (i.e., allergist, immunologist or otolaryngologist. Other specialties must provide evidence of expertise and training consistent with the AAAI Allergen Immunotherapy Extract Preparation Instructional Guide).” Added note to reference new information in background for information on training requirements for immunotherapy preparation and administration. Separated criteria from III. B. 42. into 43. In “Limitations” section for retesting added “Exceptions include children and adolescents with documented food allergy requiring follow up”. Updated background with information on training requirements for immunotherapy preparation and administration. Added CPT codes 86160, 86161, and 86162 to the medically necessary CPT code list and added “when diagnosis code requirements are met per the ICD-10 tables” to the medically necessary CPT code table description. Added 86001 to the not medically necessary CPT code table. Reviewed, updated, and added references and included citations.	09/22	09/22

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Important reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers,

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members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.

Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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Clinical Policy: Fractional Exhaled Nitric Oxide

Reference Number: CP.MP.103

Last Review Date: 11/20

[Coding Implications](#)

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

Fractional exhaled nitric oxide (FeNO) measurement is a noninvasive and simple test thought to reflect eosinophilic airway inflammation. While measurement of FeNO is standardized, there are currently no reference guidelines available to aid practitioners in appropriately applying test results in practice.

Policy/Criteria

It is the policy of health plans affiliated with Centene Corporation® that testing for fractionated exhaled nitric oxide (FeNO) is **investigational** for diagnosing and guiding the treatment of asthma, as well as all other conditions, as there is insufficient evidence proving it more than or as effective as existing standards of care.

Background

There are multiple methods for diagnosing and assessing control of asthma and, according to the American Thoracic Society (ATS), no single test is an adequate indicator of asthma control.¹ Conventional, objective methods to assess asthma include spirometry/peak flow and degree of airway hyper-responsiveness.² These methods are often used as measures of asthma control in addition to patient symptoms, clinical questionnaires, and use of rescue medications.^{2,3} Newer methods of diagnosing and assessing control of asthma include the use of biomarkers of airway inflammation such as FeNO and induced sputum analysis.⁴

FeNO describes the levels of exhaled nitric oxide (NO) in the breath and NO is a mediator involved in lung inflammation that is largely formed in the lower airways.⁵ Increased levels of FeNO are associated with eosinophilic inflammation, severe asthma, and inhaled glucocorticoid-naïve asthma.⁴ Although there are some correlations between FeNO and characteristics related to asthma, there is large variability in FeNO levels between individuals. Other factors that may affect FeNO include atopy, sex, age, and cigarette smoking.³ However, there are no established guidelines for adjusting FeNO values according to these factors,³ potentially making the test less accurate for certain populations.

There are currently three types of FeNO tests approved by the FDA⁵ and there is a large body of literature on FeNO testing for the diagnosis and management of asthma. Overall, the evidence is mixed for using FeNO as an adjunct to the diagnosis or management of asthma. Multiple studies have shown that FeNO can serve as an indicator of glucocorticoid response.^{3,4,6} However, large studies, randomized control trials and a meta-review have found no clinical benefit to the use of FeNO testing over other methods of assessing or managing asthma.^{2,4,7-9}

Among the studies that found a benefit to the use of FeNO testing,^{6,10-13} there was little agreement regarding FeNO cutoff values which would indicate asthma diagnosis or control.^{3,5} Although the ATS has recommended specific FeNO cutoff values to serve as guidelines for the

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diagnosis and treatment of asthma,¹⁴ these standardized values have not been consistently used in the research to date on FeNO testing.³⁻⁵ An additional drawback to FeNO testing for the diagnosis or management of asthma is that it is most indicative of inflammation caused by eosinophils, which characterizes only one subtype of asthma.⁴

A 2016 Cochrane Review evaluating the use of FeNO in guiding treatment for adults with asthma concluded that, while management guided by FeNO levels results in reduced exacerbations, it cannot be advocated universally since it does not affect day-to-day clinical symptoms, end-of-study FeNO levels, or inhaled corticosteroid dose.¹⁵ Furthermore, a systematic review and meta-analysis evaluating the diagnostic accuracy of FeNO in asthmatic children found that FeNO has only moderate diagnostic performance.¹⁶

A recent meta-analysis of pooled randomized controlled trial (RCT) data by Fielding, et al. concluded that the role of repeated FeNO measurements in predicting asthma outcomes in children is uncertain, as large changes in FeNO were associated with small changes in the risk of asthma exacerbation and indicators of asthma control.²³ A different meta-analysis by Fielding, et al. of the same seven pooled RCTs suggested that asthma treatment guided by FeNO may improve outcomes in non-obese children not treated with leukotriene receptor antagonists.²⁴ However, the treatment protocols in the included RCTs varied in their management protocols based on FeNO levels, and included only data from trials that found positive results from FeNO management.

Given the equivocal results of research on the accuracy and usefulness of FeNO testing for the diagnosis and management of asthma, the lack of standardized cutoff values, and the need for further study, FeNO testing for the diagnosis and/or management of asthma is considered experimental, investigational, or unproven.

Coding Implications

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CPT® Codes	Description
95012	Nitric Oxide expired gas determination

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
N/A	

Reviews, Revisions, and Approvals	Date	Approval Date
Policy created	12/15	01/16
Changed FeNO to investigational from not medically necessary. References reviewed and updated, along with background information.	12/16	01/17
References reviewed and updated.	12/17	01/18
References reviewed and updated.	12/18	12/18
References reviewed and updated.	11/19	11/19
Added that testing FeNO is investigational for all other conditions, in addition to asthma, with supporting sources.	12/19	12/19
Background updated. Replaced all instances of “member” with “member/enrollee.” References reviewed and updated.	11/20	11/20

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Important reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or

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Fractional Exhaled Nitric Oxide



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Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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CLINICAL POLICY
Fractional Exhaled Nitric Oxide

Clinical Policy: Endometrial Ablation

Reference Number: CP.MP.106

Date of Last Revision: 09/22

[Revision Log](#)
[Coding Implications](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

This policy describes the medical necessity guidelines for an endometrial ablation. Endometrial ablation is a minimally invasive surgical procedure used to treat premenopausal abnormal uterine bleeding. Although this procedure preserve the uterus, endometrial ablation is indicated for those who have no desire for future fertility.¹² The two major classifications of endometrial ablation procedures are first generation resectoscopic techniques and second generation non-resectoscopic methods. Quality of life may improve following endometrial ablation procedures.

Policy/Criteria

- I. It is the policy of health plans affiliated with Centene Corporation® that endometrial ablation using an FDA approved device is **medically necessary** when all the following criteria are met:
 - A. One of the following indications:
 1. Menorrhagia unresponsive to at least 3 months of hormonal or medical therapy (unless contraindicated to such therapy);
 2. Abnormal uterine bleeding, including residual menstrual bleeding after at least 6 months of androgen therapy in a member/enrollee with a female reproductive system undergoing treatment for gender affirmation;
 - B. Cervical cytology or HPV testing and gynecological exam excludes significant cervical disease;
 - C. Endometrial sampling prior to the procedure has excluded malignancy or hyperplasia;
 - D. No structural anomalies, such as fibroids or polyps that require transmural surgery or represent a contraindication to an ablation procedure;
 - E. If anatomic or pathologic conditions exist that may result in a weakened myometrium, only a resectoscopic endometrial ablation is appropriate;
 - F. Does not have any of the following contraindications:
 1. Premenopausal with future desire for fertility;
 2. Untreated disorders of hemostasis;
 3. Pregnancy at time of procedure;
 4. Intrauterine device at time of procedure;
 5. Active pelvic infection;
 6. Previous classical cesarean or other transmural surgery.
- II. It is the policy of health plans affiliated with Centene Corporation that there is insufficient scientific evidence to support effectiveness for the following:
 - A. Photodynamic endometrial ablation procedures;
 - B. Endometrial ablation for the treatment of all other conditions than those specified above.

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Endometrial Ablation

Background

Menstrual disorders are among the most prevalent gynecological health problems in the United States, and abnormal menstrual bleeding affects up to 30% of people at some time during their reproductive years.⁵ Traditionally, medication therapy has been the initial treatment of choice, followed by hysterectomy, when medication does not provide the desired outcome. The levonorgestrel (LNG)-releasing intrauterine device (e.g., Mirena or Liletta; referred to as LNG 52) is an option in patients who do not desire pregnancy. Both the LNG 52 IUD and endometrial ablation are effective in reducing menstrual blood loss. The decision to use the LNG 52 or endometrial ablation depends on a patient's preferences regarding treatment factors, such as plans for fertility and contraception, convenience, and risks of anesthesia.^{22,25} Endometrial ablation can offer an alternative to the more invasive hysterectomy treatment option.¹⁰ Endometrial ablation is a minimally invasive surgical procedure used to treat premenopausal, abnormal uterine bleeding.

Endometrial ablation can also be used to treat residual menstrual bleeding in transgender men.²⁴ Generally, masculinizing hormones cause cessation of menses within 2 – 6 months of initiation.¹⁸ The addition of a progestational agent or endometrial ablation may be considered for those wishing to completely cease menses.¹⁸

Endometrial ablation encompasses several techniques of targeted destruction of the endothelial surface of the uterine cavity through a vast array of energy sources. While hysterectomies provide permanent relief from abnormal uterine bleeding, they are associated with longer recovery times, higher rates of postoperative complications, substantial convalescent time and morbidity.^{9,10} Although endometrial ablation has a high success rate, there are specific cases of endometrial ablation failures in which the patient will return for repeat care, often for a hysterectomy.¹⁰ Among patients who return for hysterectomy after failure of endometrial ablation, endometriosis is the most common contributing diagnosis.²¹

Pregnancy following endometrial ablation can occur, and premenopausal patients should be counseled that an appropriate contraception method should be used.¹ Endometrial ablation is predominately indicated for patients who have no desire for future fertility.¹ Post-operative complications from endometrial ablation include: (1) pregnancy after endometrial ablation; (2) pain-related to obstructed menses (hematometra, post ablation tubal sterilization syndrome); (3) failure to control menses; (4) risk from preexisting conditions (endometrial neoplasia, cesarean section; and (5) infection.¹⁴ Uterine perforation has been reported in 0.3 percent of non-resectoscopic endometrial ablation procedures and 1.3 percent of resectoscopic ablations or resections.²²

Table 1: FDA-Approved Techniques Approved For Endometrial Ablation

Procedure ^{1,2,3}	System ^{1,2,13}	Device	Treatment
Resectoscopic Ablation			
Laser Vaporization			37%
Electrosurgical Rollerball			25-60%
Transcervical resection of endometrium			26-40%
Radiofrequency Vaporization			N/A
Non-Resectoscopic Ablation			

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Procedure ^{1,2,3}	System ^{1,2,13}	Device	Treatment	Amenorrhea
Cryotherapy	Her Option	4.5	10–18	53%
Heated Free Fluid	Hydro ThermAblator	7.8	~ 14 *	71%
Microwave (no longer available in U.S.)		8.5	2.5–4.5	61%
Vapor ablation	Mara		2.0	
Radiofrequency Electricity	NovaSure	7.2	1.5	41%
Thermal Balloon	ThermaChoice	5.5	8.0	
Combined thermal and bipolar radiofrequency ablation device	Minerva		2.0	

* 3 minutes to heat the fluid to 90°C, 10 minutes to maintain that temperature to ablate the endometrium, and approximately 1 minute for the fluid to cool down allowing the device to be removed.

Coding Implications

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CPT® Codes	Description
58353	Endometrial ablation, thermal, without hysteroscopic guidance
58356	Endometrial cryoablation with ultrasonic guidance, including endometrial curettage, when performed
58563	Hysteroscopy, surgical; with endometrial ablation (eg, endometrial resection, electro-surgical ablation, thermoablation)

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD 10 CM Code	Description
N92.0	Excessive and frequent menstruation with regular cycle
N92.1	Excessive and frequent menstruation with irregular cycle
N92.4	Excessive bleeding in the premenopausal period
N92.5	Other specified irregular menstruation
N92.6	Irregular menstruation, unspecified
N93.8	Other specified abnormal uterine and vaginal bleeding
N93.9	Abnormal uterine and vaginal bleeding, unspecified

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Policy developed, reviewed by specialist	12/15	01/16

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Endometrial Ablation

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Language clarifications d/t confusion in criteria, no specific criteria change: I.C clarified that structural anomalies be limited to those requiring surgery or are otherwise a contraindication to EA I.E language clarified I.F removed anatomic or pathologic conditions affecting the myometrium as this is similar to I.C. I.F.2 added “untreated” for disorders of hemostasis	06/16	
Changed active pelvic inflammatory disease to active pelvic infection Removed postmenopausal women from contraindications as this is a relative, not absolute, contraindication.	08/16	9/16
Added indication for residual menstrual bleeding in female to male transgender persons after androgen therapy, no codes added as ICD-10 codes would still be applicable for new indication.	09/16	10/16
References reviewed and updated	08/17	09/17
Added “previous transmyometrial uterine surgery” in I.D. References reviewed and updated.	06/18	07/18
Added additional FDA approved devices (i.e., Mara, Minerva) to table 1. References reviewed and updated. Specialist review.	06/19	07/19
Added “abnormal uterine bleeding” as an indication and combined this with the residual menstrual bleeding after androgen therapy in a female to male transgender person indication. Removed reference to criteria in CP.MP.95 Gender Affirming Procedures. Added the following codes as medically necessary: N92.5, N92.6, N93.8, N93.9.	10/19	11/19
References reviewed and updated.	07/20	07/20
Annual review completed. References reviewed and updated and reformatted for AMA style. Changed “members” to “members/enrollees.” Removed “experimental and investigation” from II, changing to “insufficient evidence.” Changed “review date” in the header to “date of last revision” and “date” in the revision log header to “revision date.” Specialty review completed. Added ThermaChoice to Table 1 per UpToDate reference “3”.	07/21	07/21
Annual review completed. Added “or HPV testing” to I.B. References reviewed and updated. Background updated with no impact to criteria.	03/22	03/22
Changed criteria I.D. from “no structural anomalies, such as fibroids or polyps that require surgery or represent a contraindication to an ablation procedure, or previous transmyometrial uterine surgery (including classical cesarean)” to “no structural anomalies, such as fibroids or polyps that require transmural surgery or represent a contraindication to an ablation procedure.” Added contraindication criteria I.F.6. “Previous classical cesarean or other transmural surgery.”	04/22	04/22
In I.A.2, reworded portion pertaining to abnormal bleeding in transgender members from “female to male transgender person” to	09/22	

Reviews, Revisions, and Approvals	Revision Date	Approval Date
“member/enrollee with a female reproductive system undergoing treatment for gender affirmation.”		

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Important reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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Endometrial Ablation

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Clinical Policy: Attention Deficit Hyperactivity Disorder

Assessment and Treatment

Reference Number: CP.MP.124

Date of Last Revision: 02/22

[Coding Implications](#)

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

Attention deficit hyperactivity disorder (ADHD) is one of the most common neurobehavioral disorders in children, with an increasing prevalence of diagnosis in adults. ADHD affects the cognitive, academic, emotional, and social well-being of individuals and can persist throughout life. While there is no single test to diagnose ADHD, a clinical assessment based on defined clinical parameters establishes criteria for diagnosis in children and adults.

Policy/Criteria

- I. It is the policy of health plans affiliated with Centene Corporation[®] that the following services are **medically necessary** when requested for the assessment and treatment of ADHD:
 - A. Assessment
 1. Complete medical evaluation with history and physical examination;
 2. Parent/child interview or patient interview, if adult, to obtain information listed in Diagnostic and Statistical Manual of Mental Health Disorders, Fifth Edition (DSM-5);
 3. Collection of collateral information, if available, such as the Vanderbilt or Conners assessment;
 4. Complete psychiatric evaluation or other services provided by a psychiatrist, psychologist, or other behavioral health professional;
 5. Laboratory evaluation prior to stimulant medication therapy, including any of the following:
 - a. Complete blood count;
 - b. Liver function tests;
 - c. Toxicology screen, if drug use is suspected;
 - d. Cardiac evaluation and screening. Electrocardiogram (ECG), if clinically indicated (e.g., family or personal history of cardiovascular disease or those with congenital heart disease);
 6. Measurement of thyroid hormone levels, if patient exhibits clinical manifestations of hyperthyroidism;
 7. Assessment of comorbid behavioral health and/or medical diagnoses and associated symptoms;
 8. When not otherwise excluded, other services for the assessment of ADHD to meet the DSM-5 criteria.
 - B. Treatment:
 1. Pharmacotherapy;
 2. Behavioral modification;

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3. Treatment of comorbid behavioral health and/or medical diagnoses and associated symptoms;
4. When not otherwise excluded, other services for the treatment of ADHD;
5. Ongoing assessment and application of standardized scales to assess treatment benefit.

II. It is the policy of health plans affiliated with Centene Corporation that there is insufficient evidence to support the following for the assessment or treatment of ADHD (may not be all-inclusive):

A. Assessment:

1. Actometer
2. AFF2 gene testing
3. Assessment of serum lipid profiles
4. Computerized electroencephalogram (EEG)
5. Computerized Tests of Attention and Vigilance
6. Education and achievement testing
7. Electronystagmography in the absence of symptoms of vertigo or balance dysfunction
8. Evaluation of iron status (e.g. measurement of serum iron and ferritin levels)
9. Event-related potentials
10. Functional near-infrared spectroscopy
11. Hair analysis
12. IgG blood tests
13. Measurement of peripheral brain-derived neurotrophic factor
14. Measurement of zinc
15. Neuroimaging (e.g., CT [computed tomography], CAT [computerized axial tomography], MRI [magnetic resonance imaging], including diffusion tensor imaging), MRS (magnetic resonance spectroscopy), PET (positron emission tomography), and SPECT (single-photon emission computerized tomography)
16. Neuropsychiatric EEG-based assessment aid system
17. Neuropsychological testing for suspected uncomplicated cases of ADHD (without history of head trauma, seizures)
18. Pharmacogenetic tools
19. Otoacoustic emissions in the absence of signs of hearing loss
20. Quotient ADHD system / test
21. Synaptosomal-associated protein (SNAP) 25 gene polymorphisms testing
22. Transcranial magnetic stimulation – evoked measures (e.g., short-interval cortical inhibition in motor cortex) as a marker of ADHD symptoms
23. Tympanometry in the absence of hearing loss.

B. Treatment:

1. Acupuncture/acupressure
2. Anti-*candida albicans* medication
3. Anti-fungal medication
4. Anti-motion sickness medication
5. Auditory Integration Therapy
6. Applied kinesiology

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7. Brain integration
8. Cannabidiol oil
9. Chelation
10. Chiropractic manipulation
11. Cognitive behavior modification
12. Cognitive rehabilitation
13. Cognitive training
14. Computerized training on working memory
15. Deep pressure sensory vest
16. Dietary counseling and treatments, i.e., Feingold diet
17. Dore program / dyslexia – dyspraxia attention treatment (DDAT)
18. Educational intervention (e.g., classroom environmental manipulation, academic skills training, and parental training)
19. Neuro Biofeedback/EEG Biofeedback
20. External trigeminal nerve stimulation (eTNS)
21. Herbal remedies
22. Homeopathy
23. Intensive behavioral intervention programs
24. Megavitamin therapy
25. Metronome training
26. Mindfulness
27. Mineral supplementation
28. Music therapy
29. Optometric vision training
30. Psychopharmaceuticals (lithium, benzodiazepines, and selective serotonin reuptake inhibitors, unless the patient also exhibits anxiety and depression)
31. Reboxetine
32. Sensory integration therapy
33. Supportive counseling
34. The Good Vibrations Device
35. The Neuro Emotional Technique
36. Therapeutic eurythmy (movement therapy)
37. Transcranial magnetic stimulation / cranial electric stimulation
38. Vayarin
39. Vision therapy
40. Yoga.

Background

ADHD (Attention Deficit Hyperactivity Disorder) is one of the most commonly diagnosed neurodevelopmental disorders in children and adolescents and is increasingly being diagnosed in adults.⁵ The main characteristics of ADHD are symptoms of inattention, hyperactivity, and impulsivity that have continued for at least six months and are maladaptive and inconsistent with development level.¹ There is no single genetic or behavioral test to diagnose ADHD. Instead, a clinical diagnosis based on the *Diagnostic and Statistical Manual of Mental Disorders-5* (DSM-5) criteria is applicable for both children and adults.² The prevalence of adult ADHD has been estimated to be around 4.4% in the United States and 3.4% internationally. National survey data

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estimates the prevalence of ADHD in children and adolescents in the United States is 9.4% and a recent meta-analysis indicates worldwide prevalence in children and adolescents to be 7.2%, with some community-based samples indicating rates of 8.7% - 15.5%.^{2,3,5} Due to the prevalence of children and adolescents with this diagnosis, the treatment of ADHD is often managed in the primary care setting, and evidence supports that appropriate diagnosis can be accomplished in this setting.⁵ However, primary care providers should refer children to a specialist for complex ADHD symptoms.¹⁶ Some of the more common comorbid disorders include anxiety, autism spectrum disorder, depression, disruptive behavior disorders, substance use disorders and Tic disorders.^{3,16} Suggested first line treatment for adults with ADHD is medication rather than cognitive-behavioral therapy (CBT).¹⁸

In 2011, the American Academy of Pediatrics (AAP) published a clinical practice guideline to clarify the diagnosis, evaluation, and treatment parameters of ADHD and this guideline was updated in 2019.⁴ This guideline expanded the age range of children to include preschool aged children (4 – 6 years of age) and adolescents (12 – 18 years of age), and suggests an expanded scope for behavioral interventions.⁴ The evaluation of comorbid conditions, including behavioral, emotional, developmental, and physical, that might coexist with ADHD must also be considered.^{4,5} Most children and adolescents diagnosed with ADHD also meet diagnostic criteria for other behavioral health conditions. In some situations, the presence of a comorbid diagnosis will alter the course of ADHD treatment. Additionally, when an adolescent receives a new diagnosis of ADHD, an assessment for substance use, anxiety, depression, and learning disorders should also be conducted, as these are common comorbid conditions that may alter the treatment approach of the adolescent population.⁵ Similar clinical recommendations have been made by various organizations for adults, including the Canadian ADHD Resource Alliance, the American Academy of the Child and Adolescent Psychiatry, the National Institutes of Health, and the British Association for Psychopharmacology.⁵ Pharmacotherapy can provide a way to manage ADHD symptoms and improve quality of life.

In 2020, The Society for Developmental and Behavioral Pediatrics (SDBP) published Clinical Practice Guideline for the Assessment and Treatment of Children and Adolescents with Complex Attention-Deficit/Hyperactivity Disorder and Process of Care Algorithms (POCA) that are meant to be used as companion documents to the published guidelines. The algorithms include suggested steps in the treatment of complex ADHD and key concepts include focus on functional impairment to improve long-term outcomes, psychosocial treatment as foundational in the treatment of complex ADHD, shared decision making, interprofessional care, using mental health diagnostic assessment and testing appropriately, identifying and treating impairments caused by coexisting conditions, and a lifelong perspective. These algorithms are based on expert consensus, and review of existing publications and practice guidelines and are meant to improve the care that children and adolescents with complex ADHD receive.

Stimulants and non-stimulants are common examples of medications prescribed to treat ADHD. A systemic review of sixteen randomized clinical trials and one meta-analysis that involved 2668 participants and evaluated pharmacological and psychosocial treatments of ADHD in adolescents 12 to 18 years of age was completed.⁷ The findings demonstrated that extended-release methylphenidate and amphetamine formulations, atomoxetine, and extended-release guanfacine led to clinically significant symptom reduction.⁷ Nonstimulants are not approved by the FDA for

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use in preschool-aged children. There is strong evidence for stimulant medications and significant evidence, but less strong, for atomoxetine, extended release guanfacine, and extended-release clonidine. Due to the lack of significant studies in school-aged children for nonstimulant medication and dextroamphetamine, methylphenidate is recommended as the first line of pharmacologic treatment for this population.⁵ Findings from clinical trials studying adults with noncomorbid ADHD suggest amphetamines as first-line treatment when compared to other medications or cognitive-behavioral therapy (CBT).¹⁸ Methylphenidate is noted as the first option of treatment for adults with moderate or severe ADHD; however, the evidence on the effects of immediate-release (IR) methylphenidate is limited and controversial in the treatment of the adult population.¹⁷

The AAP (American Academy of Pediatrics) has established recommendations regarding treatment modalities based on age. It is recommended that preschool children (4 – 6 years of age) are first prescribed evidence-based behavioral Parent Training in Behavior Management (PTBM) and/or classroom interventions. If these methods are not effective, Methylphenidate can be considered. For elementary and middle school children (6 – 12 years of age), a combination of FDA approved medications for ADHD and PTBM and classroom interventions should be prescribed. Educational interventions and supports, including an Individualized Education Program (IEP) are a vital part of treatment. Adolescents (12 -18 years of age) should be treated with FDA approved medications in conjunction with evidence-based training or behavioral interventions. Educational interventions and supports are also an important aspect of treatment in this age group and can include an IEP or 504 plan. Additionally, planning for adulthood is an important component of the chronic care model for ADHD.⁵

The AAP also recognizes psychosocial treatments as effective for the treatment of ADHD. These treatments may include behavioral therapy and training interventions. Behavioral therapy can help adults (parents and school staff) to learn how to respond effectively and prevent certain behaviors, such as interrupting, aggression, non-compliance with requests, and non-completion of tasks. Skill development is targeted in training interventions and include repeated practice and performance feedback. The effectiveness of certain training interventions, such as social skills training, is not supported by research.⁵

While the pathogenesis of ADHD is unknown, the clinical impairments in neurobehavioral and neurodevelopmental functioning pathways elicit deficiencies in vigilance, perceptual-motor speed, working memory, verbal learning, and response inhibition.² Consequently, ADHD affects the cognitive, academic, emotional, and social wellbeing of individuals and can persist throughout life. ADHD is a chronic condition and children and adolescents with ADHD should be managed in the same way those with special health care needs would be managed. Principles of the chronic care model and the medical home should be followed.⁵

Coding Implications

This clinical policy references Current Procedural Terminology (CPT[®]). CPT[®] is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2021, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for

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informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT codes considered not medically necessary when billed with a sole diagnosis of ADHD

CPT® Codes	Description
70450	Computed tomography, head or brain; without contrast material
70460	Computed tomography, head or brain; with contrast material(s)
70470	Computed tomography, head or brain; without contrast material, followed by contrast material(s) and further sections
70551	Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material
70552	Magnetic resonance (eg, proton) imaging, brain (including brain stem); with contrast material(s)
70553	Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material, followed by contrast material(s) and further sequences
76390	Magnetic resonance spectroscopy
78600	Brain imaging, less than 4 static views;
78601	Brain imaging, less than 4 static views; with vascular flow
78605	Brain imaging, minimum 4 static views;
78606	Brain imaging, minimum 4 static views; with vascular flow
78608	Brain imaging, positron emission tomography (PET); metabolic evaluation.
78609	Brain imaging, positron emission tomography (PET); perfusion evaluation
78803	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); tomographic (SPECT), single area (eg, head, neck, chest, pelvis), single day imaging
80061	Lipid panel This panel must include the following: Cholesterol, serum, total (82465) Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718) Triglycerides (84478)
81171	AFF2 (AF4/FMR2 family, member 2 [FMR2]) (eg, fragile X mental retardation 2 [FRAXE]) gene analysis; evaluation to detect abnormal (eg, expanded) alleles
81172	AFF2 (AF4/FMR2 family, member 2 [FMR2]) (eg, fragile X mental retardation 2 [FRAXE]) gene analysis; characterization of alleles (eg, expanded size and methylation status)
81229	Cytogenomic (genome-wide) analysis for constitutional chromosomal abnormalities; interrogation of genomic regions for copy number and single nucleotide polymorphism (SNP) variants, comparative genomic hybridization (CGH) microarray analysis
82365	Calculus; Infrared spectroscopy
82465	Cholesterol, serum or whole blood, total
82728	Ferritin
82784	Gammaglobulin (immunoglobulin); IgA, IgD, IgG, IgM, each
82787	Gammaglobulin (immunoglobulin); immunoglobulin subclasses (eg, IgG1, 2, 3, or 4), each

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CPT® Codes	Description
83540	Iron
83550	Iron binding capacity
83718	Lipoprotein, direct measurement; high density cholesterol (HDL cholesterol)
83719	Lipoprotein, direct measurement; VLDL cholesterol
83721	Lipoprotein, direct measurement; LDL cholesterol
83722	Lipoprotein, direct measurement; small dense LDL cholesterol
84475	Triglycerides
84630	Zinc
86001	Allergen specific IgG quantitative or semiquantitative, each allergen
92065	Orthoptic training
90867	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; initial, including cortical mapping, motor threshold determination, delivery and management
90868	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent delivery and management, per session
90869	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent motor threshold re-determination with delivery and management
90901	Biofeedback training by any modality
92540	Basic vestibular evaluation, includes spontaneous nystagmus test with eccentric gaze fixation nystagmus, with recording, positional nystagmus test, minimum of 4 positions, with recording, optokinetic nystagmus test, bidirectional foveal and peripheral stimulation, with recording, and oscillating tracking test, with recording
92541	Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording
92542	Positional nystagmus test, minimum of 4 positions, with recording
92544	Optokinetic nystagmus test, bidirectional, foveal or peripheral stimulation, with recordings
92547	Use of vertical electrodes (List separately in addition to code for primary procedure)
92550	Tympanometry and reflex threshold measurements
92558	Evoked otoacoustic emissions, screening (qualitative measurement of distortion product or transient evoked otoacoustic emissions), automated analysis
92567	Tympanometry (impedance testing)
92587	Distortion product evoked otoacoustic emissions; limited evaluation (to confirm the presence or absence of hearing disorder, 3-6 frequencies) or transient evoked otoacoustic emissions, with interpretation and report
92588	Distortion product evoked otoacoustic emissions; comprehensive diagnostic evaluation (quantitative analysis of outer hair cell function by cochlear mapping, minimum of 12 frequencies), with interpretation and report
92650	Auditory evoked potentials; screening of auditory potential with broadband stimuli, automated analysis
92651	Auditory evoked potentials; for hearing status determination, broadband stimuli, with interpretation and report
92652	Auditory evoked potentials; for threshold estimation at multiple frequencies, with interpretation and report

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CPT® Codes	Description
92653	Auditory evoked potentials; neurodiagnostic, with interpretation and report
93000	Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report
93005	Electrocardiogram, routine ECG with at least 12 leads; tracing only, without interpretation and report
93010	Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only
95803	Actigraphy testing recording, analysis, interpretation, and report (minimum of 72 hours to 14 consecutive days of recording)
95812	Electroencephalogram (EEG) extended monitoring; 41-60 minutes
95813	Electroencephalogram (EEG) extended monitoring; 61-119 minutes
95816	Electroencephalogram (EEG); including recording awake and drowsy
95819	Electroencephalogram (EEG); including recording awake and asleep
95705	Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, 2-12 hours; unmonitored
95706	Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, 2-12 hours; with intermittent monitoring and maintenance
95707	Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, 2-12 hours; with continuous, real-time monitoring and maintenance
95708	Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, each increment of 12-26 hours; unmonitored
95709	Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, each increment of 12-26 hours; with intermittent monitoring and maintenance
95710	Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, each increment of 12-26 hours; with continuous, real-time monitoring and maintenance
95711	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, 2-12 hours; unmonitored
95712	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, 2-12 hours; with intermittent monitoring and maintenance
95713	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, 2-12 hours; with continuous, real-time monitoring and maintenance
95714	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, each increment of 12-26 hours; with continuous, real-time monitoring and maintenance
95715	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, each increment of 12-26 hours; with intermittent monitoring and maintenance
95716	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, each increment of 12-26 hours; with continuous, real-time monitoring and maintenance

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CPT® Codes	Description
95717	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation and report, 2-12 hours of EEG recording; without video
95718	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation and report, 2-12 hours of EEG recording; with video (VEEG)
95719	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, each increment of greater than 12 hours, up to 26 hours of EEG recording, interpretation and report after each 24-hour period; without video
95720	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, each increment of greater than 12 hours, up to 26 hours of EEG recording, interpretation and report after each 24-hour period; with video (VEEG)
95721	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 36 hours, up to 60 hours of EEG recording, without video
95722	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 36 hours, up to 60 hours of EEG recording, with video (VEEG)
95723	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 60 hours, up to 84 hours of EEG recording, without video
95724	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 60 hours, up to 84 hours of EEG recording, with video (VEEG)
95725	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 84 hours of EEG recording, without video
95726	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 84 hours of EEG recording, with video (VEEG)
95925	Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper limbs
95926	Short latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in lower limbs

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CPT® Codes	Description
95927	Short latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in the trunk or head
95928	Central motor evoked potential study (transcranial motor stimulation); upper limbs
95929	Central motor evoked potential study (transcranial motor stimulation); lower limbs
95930	Visual evoked potential (VEP), checkerboard or flash testing, central nervous system except glaucoma, with interpretation and report
95933	Orbicularis oculi (blink) reflex, by electrodiagnostic testing
95937	Neuromuscular junction testing (repetitive stimulation paired stimuli), each nerve, any 1 method
95938	Short latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper and lower limbs
95939	Central motor evoked potential study (transcranial motor stimulation); in upper and lower limbs
96116	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report, first hour
96121	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; each additional hour
96132	Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour
96133	Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour (List separately in addition to code for primary procedure)
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour
96366	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure)
96367	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); additional sequential infusion, up to 1 hour (List separately in addition to code for primary procedure)

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CPT® Codes	Description
97129	Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; initial 15 minutes
97130	Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; each additional 15 minutes (List separately in addition to code for primary procedure)
97530	Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact, each 15 minutes
97810	Acupuncture, one or more needles, w/o electric stimulation; initial 15 minutes of personal one-one contact with the patient
97811	Acupuncture, one or more needles, w/o electric stimulation; each additional 15 minutes of personal one-one contact with the patient, with re-insertion of needles
97813	Acupuncture, one or more needles, with electric stimulation; initial 15 minutes of personal one-one contact with the patient
97814	Acupuncture, one or more needles, with electric stimulation; each additional 15 minutes of personal one-one contact with the patient, with re-insertion of the needle(s) (List separately in addition to code for primary procedure)
98940	Chiropractic manipulative treatment (CMT); spinal, 1-2 regions
98941	Chiropractic manipulative treatment (CMT); spinal, 3-4 regions
98942	Chiropractic manipulative treatment (CMT); spinal, 5 regions
98943	Chiropractic manipulative treatment (CMT); extraspinal, 1 or more regions

HCPCS codes considered not medically necessary when billed with a sole diagnosis of ADHD

HCPCS Codes	Description
G0176	Activity therapy, such as music, dance, art or play therapies not for recreation, related to the care and treatment of patient's disabling mental health problems, per session (45 minutes or more)
P2031	Hair analysis (excluding arsenic)
S8040	Topographic brain mapping

ICD-10-CM Diagnosis Codes that Support Medical Necessity

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ICD-10-CM Code	Description
F90.0 – F90.9	Attention-deficit hyperactivity disorders

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Policy developed	08/16	08/16
References reviewed and updated	07/17	08/17
Assessment: Added “Evaluation of iron status (e.g. measurement of serum iron and ferritin levels)” as not medically necessary. References and Codes reviewed and updated.	05/18	05/18
Added AFF2 gene testing and measurement of peripheral brain-derived neurotrophic factor as investigational to II.A. Code updates-deleted CPT 96101, 96102, 96103, 96118, 96119, 96120, and 97532. Added CPT-96130, 96131, 96132, 96133, 96136, 96137, 96138, 96139, 96146, and 97127. References reviewed and updated. Specialist reviewed.	04/19	05/19
Revised description for CPT-96116	05/19	
Removed the following codes from the list of CPT codes considered not medically necessary when billed with a sole diagnosis of ADHD: 96136, 96137, 96138, 96139, 96146.	12/19	
Clarified in the medical necessity statement in I. that the following services are medically necessary <i>when requested</i> . Removed the following codes from the list of CPT codes considered not medically necessary when billed with a sole diagnosis of ADHD: 96130, 96131.	01/20	
Policy reviewed. References reviewed and updated. Updated Section I.A. to include “collection of collateral information” and “toxicology screen.” Updated Section I.B. to include “ongoing assessment and application of standardized scales to assess treatment benefit.” Updated Section II. “investigational or unproven” assessments and treatments with the following: pharmacogenetic tools; Cannabidiol oil; cognitive training; external trigeminal nerve stimulation (eTNS); mindfulness; and supportive counseling, to reflect the 2019 version of American Academy of Pediatrics (AAP) Clinical Practice Guidelines. Edited Section II.A.19. to read “Neuro Biofeedback/EEG Biofeedback.” Updated AAP recommended treatment modalities. Added information regarding The Society for Developmental and Behavioral Pediatrics (SDBP) Clinical Practice Guidelines and Process of Care Algorithms for Assessment and Treatment of Children and Adolescents with Complex ADHD. Updated Background section to include most recent prevalent statistics and the necessity of treatment by Primary Care Providers. CPT Code Updates: Removed 78607, 95827, 97127. Added 78803, 81171, 81172, 92547, 95705, 95706, 95707, 95708, 95709, 95710, 95711, 95712, 95713, 95714, 95715, 95716, 95717, 95718, 95719, 95720, 95721, 95722, 95723, 95724, 95725, 95726, 96121, 97129, 97130. HCPCS Code Updates: Added G0176.	04/20	05/20

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Reviews, Revisions, and Approvals	Revision Date	Approval Date
<p>Revised language in I.A.5.d. to specify ECG can be performed only if clinically indicated. Added applicable CPT codes 93000, 93005 and 93010 to not medically necessary table when billed with a sole diagnosis of ADHD. Added assessment of serum lipid profiles to II.A, as well as applicable codes 80061, 83718, 83719, 82721, 83722 and 84475 to not medically necessary table when billed with a sole diagnosis of ADHD. Removed CPT-92585, 92586- codes deleted in 2021. Replaced with 92650, 92651, 92652 and 92653. Revised description of CPT- 95930. Replaced all instances of “member” with “member/enrollee.”</p>	04/21	05/21
<p>Annual review. “Experimental/investigational” verbiage replaced in policy statement with “there is insufficient evidence to support”. References reviewed, updated, and reformatted. Duplicate reference removed. Changed “review date” in the header to “Date of Last Revision” and “Date” in the revision log header to “Revision date”. Added “Findings from clinical trials studying adults with noncomorbid ADHD suggest amphetamines as first-line treatment when compared to other medications or cognitive-behavioral therapy (CBT). Methylphenidate is also the first option of treatment for adults with moderate or severe ADHD; however, the evidence on the effects of immediate-release (IR) methylphenidate is limited and controversial in the treatment of the adult population” and “Suggested first line treatment for adults with ADHD is medication rather than cognitive-behavioral therapy (CBT)” to the Background section with no impact to criteria. Revised description of CPT-81229, 92065, 96366, 96367 and 97814. Approval by BH Clinical Policy Subcommittee.</p>	02/22	02/22

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Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in regard to diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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Clinical Policy: Evoked Potential Testing

Reference Number: CP.MP.134

Date of Last Revision: 09/22

[Coding Implications](#)

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information

Description

Types of evoked potentials include somatosensory, brainstem auditory, visual and motor. Sensory evoked potentials evaluate electrical activity in the nervous system in response to stimulation of specific nerve pathways. Monitoring of neurophysiologic evoked potentials intraoperatively helps prevent neurologic injury during neurological, orthopedic, and other types of surgeries. This policy describes the medically necessary indications for neurophysiologic evoked potentials.

Policy/Criteria

- I. It is the policy of health plans affiliated with Centene Corporation[®] that evoked potential testing is **medically necessary** for the following indications:
 - A. Somatosensory Evoked Potentials Testing
 1. Aid in the evaluation of prognosis of acute anoxic encephalopathy, within the initial 72 hours of onset (e.g. after cardiac arrest);
 2. Assessment of a decline in status which may warrant emergent surgery in unconscious spinal cord injury patients who show specific structural damage to the somatosensory system, and who are candidates for emergency spinal cord surgery;
 3. Aid in the diagnosis of multiple sclerosis;
 4. Aid in the assessment of coma following traumatic, hypoxic-ischemic, and other diffuse brain injuries;
 5. Assessment of central nervous system deficiency identified on clinical exam when not explained by appropriate imaging studies;
 6. Management of conditions causing spinocerebellar degeneration, such as Friedreich's ataxia or peripheral nerve degeneration (e.g. diabetic neuropathy);
 7. Intraoperative monitoring during surgeries that may affect neural structures.
 - B. Brainstem Auditory Evoked Potential Testing
 1. Assessment of brainstem function such as during tumor infiltration of the brainstem and after a lesion has been surgically removed;
 2. Diagnosis and monitoring of demyelinating and degenerative diseases affecting the brain stem such as multiple sclerosis, central pontine myelinolysis, and olivopontocerebellar degeneration;
 3. Diagnosis of lesions in the auditory system (e.g., acoustic neuroma);
 4. Aid in the evaluation of prognosis in coma within the initial 72 hours of onset, excluding evaluation of brain death;
 5. Screening for hearing loss of infants and preverbal children or children with developmental delay or intellectual disability;
 6. Intraoperative monitoring during surgeries that may affect neural structures.
 - C. Visual Evoked Potential Testing

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1. Diagnosis and monitoring of optic nerve function and/or during demyelinating disorders of the optic nerve (e.g., multiple sclerosis, optic neuritis);
2. Assessment of suspected disorder of the optic nerve, optic chiasm or pre-optic chiasmatic radiations (visual evoked potentials are not useful for post-chiasmatic disease);
3. Evaluation of visual loss in those unable to communicate.

II. It is the policy of health plans affiliated with Centene Corporation that somatosensory evoked potentials, motor evoked potentials using transcranial electrical stimulation, and brainstem auditory evoked potentials are **medically necessary** during intracranial, orthopedic, spinal, and vascular surgeries.

III. It is the policy of health plans affiliated with Centene Corporation that there is insufficient evidence in the published peer-reviewed literature to support evoked potential testing for the following indications:

- A. Intraoperative monitoring of visual evoked potentials;
- B. Motor evoked potentials from transcranial magnetic stimulation.

IV. It is the policy of health plans affiliated with Centene Corporation that evoked potential testing is **not medically necessary** for the following indications:

- A. Motor evoked potentials for non-operative monitoring;
- B. Visual evoked potentials, any of the following:
 1. Glaucoma or glaucoma suspect;
 2. Amblyopia;
 3. Diabetes.
- C. For the evaluation/assessment of all other conditions than those specified above.

Background

Sensory evoked potentials provide electrical recordings of afferent and efferent networks within the central and peripheral nervous systems in response to specific stimulation. These sophisticated tests facilitate the diagnosis nerve damage or locate the specific site of nerve damage. There are several types of evoked potentials, including, sensory evoked potentials and motor evoked potentials. Examples of sensory evoked potentials include somatosensory, brainstem auditory, and visual evoked potentials. Somatosensory evoked potentials generate sensory information from peripheral nerve stimulation.² Brainstem auditory evoked potentials are created in response to aural cues and are evaluated at the brainstem and posterior fossa.² Visual evoked potentials provide information regarding conduction within the visual pathway, including the retino-striate conduction time.² Motor evoked potentials are elicited by electrical or magnetic stimulation of the motor cortex or spinal cord.

Intraoperative monitoring of neurophysiologic responses involves the electrophysiologic measurement of myogenic and neural responses during the course of surgeries. These measurements and testing are in response to controlled and modality specific stimulation. According to the American Speech Language Hearing Association's Position Statement on Intraoperative Monitoring, the primary objectives of intraoperative monitoring include: (1) to avoid intraoperative injury to neural structures; (2) to facilitate specific stages of the surgical

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procedure; (3) to reduce the risk of permanent postoperative neurological injury; and (4) to assist the surgeon in identifying specific neural structures.¹

The American Academy of Neurology published an assessment of intraoperative neurophysiologic monitoring with an evidence-based guideline update in 2012.³ This guideline specifically addressed whether spinal cord intraoperative monitoring with somatosensory and motor evoked potentials predict adverse surgical outcomes. All studies that met inclusion criteria were consistent in showing all of the occurrences of paraparesis, paraplegia, and quadriplegia in the intraoperative monitoring of patients with evoked potential changes, and showed no occurrences of paraparesis, paraplegia, and quadriplegia in patients without evoked potential changes.³ Thus, intraoperative neurophysiologic monitoring provides operating teams with information regarding increased risk of severe adverse neurologic outcomes. Furthermore, the American Society of Clinical Neurophysiology has published specific guidelines on an array of specifications, including the amplifier, safety, filtering, calibration, replication, and interpretation of results.⁴

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2020, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT® Codes	Description
92652	Auditory evoked potentials; for threshold estimation at multiple frequencies, with interpretation and report
92653	Auditory evoked potentials; neurodiagnostic, with interpretation and report
95925	Short–latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper limbs
95926	Short–latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in lower limbs
95927	Short–latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in the trunk or head
95928	Central motor evoked potential study (transcranial motor stimulation); upper limbs
95929	Central motor evoked potential study (transcranial motor stimulation); lower limbs

CPT® Codes	Description
95930	Visual evoked potential (VEP) testing central nervous system, checkerboard or flash testing, central nervous system except glaucoma, with interpretation and report.
95938	Short–latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper and lower limbs
95939	Central motor evoked potential study (transcranial motor stimulation), in upper and lower limbs
0333T	Visual evoked potential, screening of visual acuity, automated

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD 10 CM Code	Description
A17.0 through A17.89	Tuberculosis of nervous system
A39.82	Meningococcal retrobulbar neuritis
C30.1	Malignant neoplasm of middle ear
C41.0	Malignant neoplasm of bones of skull and face
C41.2	Malignant neoplasm of vertebral column
C70.0 through C70.9	Malignant neoplasm of meninges
C71.0 through C71.9	Malignant neoplasm of brain
C72.0 through C72.9	Malignant neoplasm of spinal cord, cranial nerves and other parts of the central nervous system
C79.31 through C79.32	Secondary malignant neoplasm of brain and cerebral meninges
C79.49	Secondary malignant neoplasm of other parts of nervous system
D02.3	Carcinoma in situ of other parts of respiratory system
D14.0	Benign neoplasm of middle ear, nasal cavity and accessory sinus
D16.6	Benign neoplasm of vertebral column
D18.02	Hemangioma of intracranial structures
D32.0 through D32.9	Benign neoplasm of meninges
D33.0 through D33.9	Benign neoplasm of brain and other parts of central nervous system
D38.5	Neoplasm of uncertain behavior of other respiratory organs
D42.0 through D42.9	Neoplasm of uncertain behavior of meninges
D43.0 through D43.9	Neoplasm of uncertain behavior of brain and central nervous system
D44.3	Neoplasm of uncertain behavior of pituitary gland
D44.4	Neoplasm of uncertain behavior of craniopharyngeal duct
D44.5	Neoplasm of uncertain behavior of pineal gland
D49.1	Neoplasm of unspecified behavior of respiratory system
D49.6	Neoplasm of unspecified behavior of brain
E08.40	Diabetes mellitus due to underlying condition with diabetic neuropathy, unspecified

ICD 10 CM Code	Description
E08.41	Diabetes mellitus due to underlying condition with diabetic mononeuropathy
E08.42	Diabetes mellitus due to underlying condition with diabetic polyneuropathy
E08.43	Diabetes mellitus due to underlying condition with diabetic autonomic (poly)neuropathy
E08.44	Diabetes mellitus due to underlying condition with diabetic amyotrophy
E08.49	Diabetes mellitus due to underlying condition with other diabetic neurological complication
E71.520	Childhood cerebral X-linked adrenoleukodystrophy
E71.521	Adolescent X-linked adrenoleukodystrophy
E71.522	Adrenomyeloneuropathy
E71.528	Other X-linked adrenoleukodystrophy
E71.529	X-linked adrenoleukodystrophy, unspecified type
G06.0 through G06.2	Intracranial and intraspinal abscess and granuloma
G11.10	Early-onset cerebellar ataxia, unspecified
G11.11	Friedreich ataxia
G11.19	Other early-onset cerebellar ataxia
G23.0	Hallervorden-Spatz disease
G23.1	Progressive supranuclear ophthalmoplegia (Steele-Richardson-Olszewski)
G23.2	Striatonigral degeneration
G23.8	Other specified degenerative diseases of basal ganglia
G31.89	Other specified degenerative diseases of nervous system
G31.9	Degenerative disease of nervous system, unspecified
G35	Multiple sclerosis
G36.0 through G36.9	Other acute disseminated demyelination
G37.0 through G37.9	Other demyelinating diseases of central nervous system
G50.0 through G50.9	Disorders of trigeminal nerve
G52.0 through G52.9	Disorders of other cranial nerves
G54.0	Brachial plexus disorders
G54.1	Lumbosacral plexus disorders
G54.2	Cervical root disorders, not elsewhere classified
G54.3	Thoracic root disorders, not elsewhere classified
G54.4	Lumbosacral root disorders, not elsewhere classified
G90.3	Multi-system degeneration of the autonomic nervous system
G90.8	Other disorders of autonomic nervous system
G90.9	Disorder of the autonomic nervous system, unspecified
G93.0	Cerebral cysts
G93.1	Anoxic brain damage, not elsewhere classified
G93.5	Compression of the brain
G95.9	Disease of spinal cord, unspecified
G96.89	Other specified disorders of central nervous system

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ICD 10 CM Code	Description
H35.54	Dystrophies primarily involving the retinal pigment epithelium
H46.0 through H46.9	Optic neuritis
H47.011 through H47.649	Other disorders of optic (2nd) nerve and visual pathways
H53.001 through H53.9	Visual disturbances
H54.3	Unqualified visual loss, both eyes
H54.60 through H54.62	Unqualified visual loss, one eye
H81.01 through H81.09	Meniere's disease
H81.391 through H81.399	Other peripheral vertigo
H81.4	Vertigo of central origin
H90.0 through H90.72	Conductive and sensorineural hearing loss
H91.01 through H91.93	Other and unspecified hearing loss
H93.3x1 through H93.3x9	Disorders of acoustic nerve
I60.00 through I60.8	Nontraumatic subarachnoid hemorrhage
I61.0 through I61.8	Nontraumatic intracerebral hemorrhage
I62.00 through I62.1	Other and unspecified nontraumatic intracranial hemorrhage
I63.00 through I63.9	Cerebral infarction
I65.01 through I65.9	Occlusion and stenosis of precerebral arteries, not resulting in cerebral infarction
I66.01 through I66.9	Occlusion and stenosis of cerebral arteries, not resulting in cerebral infarction
I67.0 through I67.7	Other cerebral vascular diseases
I71.00 through I71.9	Aortic aneurysm and dissection
I72.0	Aneurysm of carotid artery
I77.71	Dissection of carotid artery
I77.74	Dissection of vertebral artery
M40.00 through M40.57	Kyphosis and lordosis
M41.00 through M41.9	Scoliosis
M43.00 through M43.09	Spondylolysis
M43.10 through M43.19	Spondylolisthesis
M47.011 through M47.9	Spondylosis

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ICD 10 CM Code	Description
M48.00 through M48.08	Spinal stenosis
M50.00 through M50.93	Cervical disc disorders
M51.04 through M51.9	Thoracic, thoracolumbar, and lumbosacral intervertebral disc disorders
P10.0 through P10.9	Intracranial laceration and hemorrhage due to birth injury
P11.0 through P11.9	Other birth injuries to central nervous system
P14.0 through P14.9	Birth injury to peripheral nervous system
Q01.0-Q01.9	Encephalocele
Q04.0 through Q04.9	Other congenital malformations of brain
Q05.0 through Q05.9	Spina bifida
Q07.00 through Q07.03	Arnold –Chiari syndrome
Q28.0 through Q28.9	Other congenital malformations of circulatory systems
Q76.2	Congenital spondylolisthesis
Q85.00 through Q85.09	Phakomatoses, not elsewhere classified
R40.20 through R40.2444	Coma
R44.1	Visual hallucinations
R48.3	Visual agnosia
R94.110 through R94.138	Abnormal results of function studies of peripheral nervous system and special senses
S02.0XX through S02.42X (add 7 th digit A through S)	Fracture of skull and facial bones
S04.011 through S04.9XX (add 7 th digit A through S)	Injury of optic nerve and pathways
S06.0X0 through S06.898 (add 7 th digit A through S)	Intracranial injury
S07.0XX through S07.9XX (add 7 th digit A through S)	Crushing injury of head
S12.000 through S12.9XX (add 7 th digit A through S)	Fracture of cervical vertebrae and other parts of the neck
S14.0XX through S14.9XX (add 7 th digit A through S)	Injury of nerves and spinal cord at neck level
S22.000 through S22.089 (add 7 th digit A through S)	Fracture of thoracic vertebrae

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ICD 10 CM Code	Description
S24.101 through S24.9XX(add 7th digit A through S)	Other and unspecified injuries of thoracic spinal cord
S34.01X through S34.9XX (add 7th digit A through S)	Injury of lumbar and sacral spinal cord and nerves at abdomen, lower back and pelvis level
Z01.110	Encounter for hearing examination following failed hearing screening
Z08	Encounter for follow-up examination after completed treatment for malignant neoplasm
Z87.710 through Z87.798	Personal history of (corrected) congenital malformations

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Policy developed, Neurological surgery specialist reviewed.	11/16	11/16
References reviewed and updated. 2018 ICD-10 CM coding clarifications.	11/17	11/17
References reviewed and updated. Codes reviewed.	10/18	10/18
Removed age limit in I.B.6 and replaced with “infants and preverbal children or children with developmental delay or intellectual disability.” References reviewed and updated. ICD-10 codes deleted in 2019: H81.41, H81.42, H81.43, H81.49. Specialist review	10/19	10/19
Minor language update in description and criteria. SSEP (I.A.): Added time- frame for evaluation of prognosis during acute anoxic encephalopathy; removed evaluation of brain death; removed assessment of CNS deficiency and localization of the cause of neurologic deficits as inclusive to assessment of CNS deficiency noted in I.A.5. Added peripheral nerve degeneration to I.A.7. BAEP (I.B) Removed indication “testing in acquired metabolic function”; added “during tumor infiltration to the brainstem” to assessment of brainstem function; Added acoustic neuroma as an example of lesion of auditory system; Added evaluation of prognosis during coma within the initial 72 hours of coma onset as an indication. VEP (I.C.) Added examples of demyelinating disorders; Added assessment of pre-optic chiasmic radiations to criteria. Added ICD-10 codes: E08.40, E08.41, E08.42, E08.43, E08.44, E08.49, E71.520, E71.521, E71.522, E71.528, E71.529, G31.89, G31.9, G90.8, G90.9, H46.0-H46.9, H54.3, H54.60- H54.7. Deleted the following ICD-10 codes: G93.6, G93.82, R40.2, R40.3, R42, R47.01. Specialist reviewed.	01/20	01/20
Reorganized section IV and added indications when visual evoked potentials are not medically necessary. Revised IV.C, “Treatment of all other conditions than those specified above” to “evaluation/assessment of all other conditions...” Added additional ICD 10 codes A39.82 H35.54, R44.1 and R48.3 as supporting medical necessity. Removed	09/20	09/20

Reviews, Revisions, and Approvals	Revision Date	Approval Date
code H54.7 from list of medically necessary codes. ICD-10 code updates, 1-/20: Replaced G11.1 with G11.10 and revised description. Added subcategories G11.11 and G11.19. Replaced G96.8 with G96.89. References reviewed and updated. Replaced “members” with “members/enrollees” in all instances.		
CPT code 92585 deleted 1/1/21. Added replacement CPT codes 92652 and 92653. “Experimental/investigational” verbiage replaced with descriptive language in in policy statement III.	04/21	
Annual review completed. Minor typo corrections. Changed “review date” in the header to “date of last revision” and “date” in the revision log header to “revision date.” References reviewed, updated, and reformatted. Coding reviewed and updated. Removed intraoperative CPT codes 95940, 95941, and HCPCS code G0453.	08/21	08/21
Annual review. References reviewed and updated. Specialist reviewed.	09/22	09/22

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Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program

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approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

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Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take

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precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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Clinical Policy: Measurement of Serum 1,25-dihydroxyvitamin D

Reference Number: CP.MP.152

Date of Last Revision: 09/22

[Coding Implications](#)

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

Vitamin D is metabolized in the liver to 25-hydroxyvitamin D [25(OH)D], also known as calcidiol), and then in the kidney to 1,25-dihydroxyvitamin D [1,25(OH)2D], also known as calcitriol. 25(OH)D is the major circulating form of vitamin D while 1,25(OH)2D is the active form of vitamin D. In individuals at risk for vitamin D deficiency, the best method for determining a person's vitamin D status is to measure a 25(OH)D concentration. Measurement of 1,25(OH)2D is not useful for monitoring the vitamin D status, as it does not reflect vitamin D reserves.¹ This policy addresses when measurement of 1,25(OH)2D is appropriate and medically necessary.

Policy/Criteria

- I. It is the policy of health plans affiliated with Centene Corporation[®] that measurement of serum 1,25(OH)2D (CPT 82652) is **medically necessary** for monitoring certain conditions, such as acquired and inherited disorders of vitamin D and phosphate metabolism, including any of the following indications:
 - A. Chronic kidney disease;
 - B. Hereditary phosphate-losing disorders;
 - C. Oncogenic osteomalacia;
 - D. Pseudovitamin D-deficiency rickets;
 - E. Vitamin D-resistant rickets;
 - F. Chronic granuloma-forming disorders (e.g., sarcoidosis and some lymphomas).

- II. It is the policy of health plans affiliated with Centene Corporation that measurement of serum 1,25(OH)2D for routine screening of average risk, asymptomatic individuals is **not medically necessary**.

Background

Vitamin D or calciferol, is a fat-soluble vitamin that plays an important role in calcium homeostasis and bone health. Vitamin D comes in two forms, D₂ and D₃. It is unique among hormones because the major source of vitamin D is exposure to natural sunlight. Very few foods naturally contain, or are fortified with, vitamin D, thus, the major cause of vitamin D deficiency is inadequate exposure to sunlight.

The optimal serum 25(OH)D concentration for skeletal health is controversial, however, experts agree that levels lower than 20 ng/mL are suboptimal for skeletal health.⁵ Vitamin D deficiency is defined by the Endocrine Society as a 25(OH)D below 20 ng/ml (50 nmol/liter). Vitamin D deficiency results in abnormalities in calcium, phosphorus, and bone metabolism. It causes a decrease in the efficiency of intestinal calcium and phosphorus absorption of dietary calcium and phosphorus, resulting in an increase in parathyroid hormone (PTH) levels. Secondary

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hyperparathyroidism maintains serum calcium in the normal range at the expense of mobilizing calcium from the skeleton and increasing phosphorus wasting in the kidneys.

Screening for Vitamin D deficiency is recommended for individuals at risk, such as those with osteomalacia, osteoporosis, chronic kidney disease, hepatic failure, malabsorption syndromes, hyperparathyroidism, African American and Hispanic children and adults, pregnant or lactating women, older adults with history of falls or non-traumatic fractures, obese children or adults (BMI greater than 30 kg/m²), granuloma-forming disorders, and some lymphomas.¹

Circulating 25(OH)D is the best indicator to monitor for vitamin D status as it is the main circulating form of vitamin D and has a half-life of two to three weeks. In contrast, 1,25(OH)2D, has a much shorter half-life of about four hours, circulates in much lower concentrations than 25(OH)D, and is susceptible to fluctuations induced by PTH in response to subtle changes in calcium levels. Serum 1,25(OH)2D is frequently either normal or even elevated in those with vitamin D deficiency, due to secondary hyperparathyroidism.¹

The Endocrine Society

The Endocrine Society recommends using the serum circulating 25-hydroxyvitamin D [25(OH)D] level, measured by a reliable assay, to evaluate vitamin D status in patients who are at risk for vitamin D deficiency and in whom a prompt response to optimization of vitamin D status could be expected. They note further, 1,25(OH)2D measurement does not reflect vitamin D status as levels are tightly regulated by serum levels of PTH, calcium, and phosphate. Serum 1,25(OH)2D does not reflect vitamin D reserves, and measurement of 1,25(OH)2D is not useful for monitoring the vitamin D status of patients. Serum 1,25(OH)2D is frequently either normal or even elevated in those with vitamin D deficiency, due to secondary hyperparathyroidism. Measurement of 1,25(OH)2D is useful in acquired and inherited disorders in the metabolism of 25(OH)D and phosphate, including chronic kidney disease, hereditary phosphate-losing disorders, oncogenic osteomalacia, pseudovitamin D-deficiency rickets, vitamin D-resistant rickets, as well as chronic granuloma-forming disorders such as sarcoidosis and some lymphomas.

United States Preventive Services Task Force (USPSTF)

The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for vitamin D deficiency in asymptomatic community-dwelling, nonpregnant adults.²

American Congress of Obstetricians and Gynecologists

At this time, there is insufficient evidence to support a recommendation for screening all pregnant women for vitamin D deficiency. For pregnant women thought to be at increased risk of vitamin D deficiency, maternal serum 25-hydroxyvitamin D levels can be considered and should be interpreted in the context of the individual clinical circumstance.³

Coding Implications

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from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT® Codes	Description
82652	Vitamin D; 1, 25 dihydroxy, includes fraction(s), if performed

HCPCS Codes	Description
N/A	

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD 10 CM Code	Description
A15.0 through A19.9	Tuberculosis
C81.00 through C81.99	Hodgkin lymphoma
C82.00 through C82.99	Follicular lymphoma
C83.00 through C83.99	Non-follicular lymphoma
C84.00 through C84.99	Mature T/NK-cell lymphomas
C88.0 through C88.9	Malignant immunoproliferative diseases and certain other B-cell lymphomas
D86.0 through D86.9	Sarcoidosis
E20.0	Idiopathic hypoparathyroidism
E20.8	Other hypoparathyroidism
E21.0 through E21.5	Hyperparathyroidism and other disorders of parathyroid gland
E55.0	Rickets, active
E83.30 through E83.39	Disorder of phosphorus metabolism and phosphatases
E83.50 through E83.59	Disorders of calcium metabolism

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ICD 10 CM Code	Description
N18.1 through N18.9	Chronic kidney disease (CKD)
N25.0	Renal osteodystrophy
N25.81	Secondary hyperparathyroidism of renal origin
P37.0	Congenital tuberculosis

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Policy developed	11/17	12/17
Removed CPT code 82306 as the policy does not apply to this test.	09/18	
References reviewed and updated	10/18	11/18
References reviewed and updated. Code E20.00 corrected to E20.0.	11/19	11/19
Changed “member” to “member/enrollee” throughout policy. References reviewed and updated.	10/20	10/20
Annual review. Expanded ICD-10 code range for tuberculosis from A15.0-A15.5 to A15.0-A19.9. Added N25.81 as a code supporting coverage criteria. Changed “review date” in the header to “date of last revision” and “date” in the revision log header to “revision date.” References reviewed, reformatted, and updated. Reviewed by specialist.	10/21	10/21
Annual review. References reviewed and updated.	09/22	09/22

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Important Reminder

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CLINICAL POLICY

Measurement of Serum 1,25-dihydroxyvitamin D

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Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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Clinical Policy: EEG in the Evaluation of Headache

Reference Number: CP.MP.155

Date of Last Revision: 09/22

[Coding Implications](#)

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

An electroencephalogram (EEG) is a non-invasive method for assessing neurophysiological function. EEG measures the electrical activity that is recorded from many different standard sites on the scalp according to the international (10 to 20) electrode placement system. It is a useful diagnostic test in evaluating epilepsy. This policy addresses the use of EEG in the diagnostic evaluation of headache.

Policy/Criteria

- I. It is the policy of health plans affiliated with Centene Corporation® that there is insufficient evidence in the published peer-reviewed literature to support the use of EEG in the routine evaluation of headache. EEG has not been convincingly shown to identify headache subtypes, nor has it been shown to be an effective screening tool for structural causes of headache.

Background

An EEG is an important diagnostic test in the evaluation of a patient with possible epilepsy, providing evidence that helps confirm or refute the diagnosis, as well as guide management. An EEG may also be performed for other indications, including but not limited to, states of altered consciousness, cerebral infections, and various other encephalopathies.

Headache is a common disorder with many potential causes. The primary headaches, which include migraine, tension-type headache and cluster headache, are benign and account for the majority of headaches. They are usually recurrent and have no organic disease as their cause. Secondary headaches, are less common and caused by underlying organic diseases ranging from sinusitis to subarachnoid hemorrhage.³ In most instances, the physician can accurately diagnose a patient's headache and determine whether additional laboratory testing or neuroimaging is indicated by considering the various headache types in each category (primary or secondary), obtaining a thorough headache history and performing a focused clinical examination.⁴

The presence of warning signs of a possible disorder, other than primary headache, that should prompt further investigation (e.g. limited laboratory testing, neuroimaging, lumbar puncture) include, but are not limited to:

- Subacute and/or progressive headaches that worsen over time (months)
- A new or different headache
- Any headache of maximum severity at onset
- Headache of new onset after age 50
- Persistent headache precipitated by a Valsalva maneuver
- Evidence such as fever, hypertension, myalgias, weight loss or scalp tenderness suggesting a systemic disorder
- Presence of neurological signs that may suggest a secondary cause

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Electroencephalogram in the Evaluation of Headache

- Seizures

Studies designed to determine whether headache patients have an increased prevalence of EEG abnormalities report conflicting results. The American Academy of Neurology reports that EEG has no advantage over clinical evaluation in diagnosing headache, does not improve outcomes, and increases costs. A literature review of 40 articles describing EEG findings in headache patients reported that studies did not show that the EEG is an effective screening tool for structural causes of headache, nor does the EEG effectively identify headache subgroups with different prognoses.⁵

American Academy of Neurology (AAN)

AAN reports that no study has consistently demonstrated that the EEG improves diagnostic accuracy for the headache sufferer. The AAN makes the following recommendations:

- The EEG is not useful in the routine evaluation of patients with headache (guideline). This does not exclude the use of EEG to evaluate headache patients with associated symptoms suggesting a seizure disorder, such as atypical migrainous aura or episodic loss of consciousness. Assuming head imaging capabilities are readily available, EEG is not recommended to exclude a structural cause for headache (option).¹
- EEG is not recommended in the routine evaluation of a child with recurrent headaches, as it is unlikely to provide an etiology, improve diagnostic yield, or distinguish migraine from other types of headaches (Level C; class II and class III evidence).²
- Although the risk for future seizures is negligible in children with recurrent headache and paroxysmal EEG, future investigations for epilepsy should be determined by clinical follow up (Level C; class II and class III evidence).²

International Headache Society

The EEG is not included in the diagnostic criteria of the International Headache Society for migraine or any other major headache categories.

Coding Implications

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Table 1: CPT codes not medically necessary when billed with a corresponding ICD-10-CM code in Table 2

CPT® Codes	Description
95812	Electroencephalogram (EEG) extended monitoring; 41 to 60 minutes
95813	Electroencephalogram (EEG) extended monitoring; 61 to 119 minutes
95816	Electroencephalogram (EEG); including recording awake and drowsy

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Electroencephalogram in the Evaluation of Headache

CPT® Codes	Description
95819	Electroencephalogram (EEG); including recording awake and asleep
95822	Electroencephalogram (EEG); recording in coma or sleep only

Table 2: ICD-10-CM codes not medically necessary when billed with a corresponding CPT code in Table 1.

ICD 10 CM Code	Description
G43.001 to G43.919	Migraine
G44.001 to G44.89	Other headache syndromes
R51.0	Headache with orthostatic component, not elsewhere classified
R51.9	Headache, unspecified

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Policy developed	12/17	12/17
References reviewed and updated	11/18	12/18
References reviewed and updated. Specialist review.	11/19	12/19
Revised CPT 95813 description	04/20	
Replaced all instances of “member” with “member/enrollee.” References reviewed and updated.	10/20	10/20
Added code 95822 to Table 1, and G43.A0 and G43.A1 to Table 2. “Experimental/investigational” verbiage replaced in policy statement with descriptive language.	04/21	
Removed codes G43.A0 and G43.A1 from table 2, as they are already included in range G43.001 to G43.919. Updated references.	05/21	
Revised ICD-10 code from R51 to R51.0 and added R51.9 to Table 2	06/21	
Annual review complete. Coding reviewed. References reviewed, updated, and reformatted. Changed “review date” in the header to “date of last revision” and “date” in the revision log header to “revision date.” Reviewed by specialist.	10/21	10/21
Annual review. References reviewed and updated. Reviewed by specialist.	09/22	09/22

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Electroencephalogram in the Evaluation of Headache

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Clinical Policy: Cardiac Biomarker Testing

Reference Number: CP.MP.156

Date of Last Revision: 09/22

[Coding Implications](#)

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

The release of cardiac biomarkers is among the cascade of events that occur during acute coronary syndromes and cardiac ischemia.¹ This policy discusses the medical necessity requirements for testing of these cardiac biomarkers.

Policy/Criteria

- I. It is the policy of health plans affiliated with Centene Corporation[®] that troponin I or T testing is **medically necessary** and the appropriate cardiac biomarker for evaluating for suspected acute myocardial infarctions (AMI) or myocardial injury due to other mechanisms.
- II. It is the policy of health plans affiliated with Centene Corporation that creatine kinase myocardial isoenzyme (CK-MB) and myoglobin testing are **not medically necessary** in the evaluation for suspected AMI because troponin is the recommended biomarker due to its superior sensitivity and accuracy.

Background

Detection of specific cardiac biomarkers in blood serum is a useful clinical indication of acute myocardial infarctions (AMI), myocarditis, or heart failure.² Cardiac troponins I and T have become the preferred biomarkers used for diagnoses of acute coronary syndromes due to their high specificity and sensitivity and because these subunits are expressed in the myocardium.¹⁻⁷ Furthermore, troponin levels are also elevated for acute and chronic decompensated heart failure in instances of myocyte injury and/or necrosis.⁷⁻⁸

Other cardiac peptides that were previously assessed for AMI include creatine kinase myocardial isoenzyme (CK-MB) and myoglobin.¹ However, recent evidence suggests that the sensitivity and specificity of these biomarkers are inferior compared to the troponins, suggesting that troponins are a more accurate biomarker of myocardial injury.^{1-2,7} According to the 2014 American College of Cardiologists/American Heart Association (ACC/AHA) clinical practice guidelines, CK-MB and myoglobin are no longer necessary for acute coronary syndrome diagnosis as a result of the advent of troponin assays.² CK-MB detection is comparatively less sensitive and less specific.¹⁻⁷ A 2010 retrospective cohort study was performed in an emergency department over a 12 month period examining patients who had troponin testing.⁹ The study included 11,092 visits where at least one troponin test was ordered, and 97.9% of these patients also had a CK-MB ordered.⁹ The authors concluded that CK-MB testing can be omitted during the initial screening of AMIs since the study showed a 0% rate of positive CK-MB index with negative troponin.⁹ Eggers et al. evaluated the role of myoglobin with troponin I to detect AMI in a sample of 197 patients and determined that neither myoglobin nor CK-MB added clinical diagnostic value.¹⁰ Aviles et al. analyzed AMI amongst patients with elevated cardiac troponins in a prospective cohort and noted that at least 20% of patients had normal CK-MB levels, thereby further questioning the validity of CK-MB as a valuable cardiac biomarker.¹¹ Of note,

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Singh et al. measured CK-MB testing from 2007 to 2013 and found a dramatic decrease from 12,057 tests in 2007 to 36 tests in 2013.¹²

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2020, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

Table 1: CPT codes not medically necessary when billed with CPT 84484 Troponin

CPT Codes	Description
82553	Creatine kinase (CK), (CPK); MB fraction only
83874	Myoglobin

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Policy developed	12/17	12/17
Deleted Table 2, diagnosis code list. Clarified in criteria point II that CK-MB and myoglobin are not medically necessary <i>when billed with 84484</i> troponin. Specialist reviewed	03/18	03/18
References reviewed and updated.	02/19	02/19
References reviewed and updated. Coding reviewed.	01/20	01/20
Added “or myocardial injury due to other mechanisms” in addition to acute myocardial infarction for approval in criteria I. References reviewed and updated. Coding reviewed. Replaced “member” with “member/enrollee” in all instances.	12/20	01/21
Annual review. Changed “review date” in the header to “date of last revision” and “date” in the revision log header to “revision date.” References reviewed, and updated. Reviewed by specialist.	10/21	10/21
Annual review. Background updated with no impact on criteria. References reviewed and updated.	09/22	09/22

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Ambetter from Peach State Health Plan Exchange Availability of Practitioners Annual Assessment 2022

Introduction

Managed care health plans often require members to utilize a designated practitioner network. The organization must ensure there are adequate numbers and geographic distribution of primary care, behavioral health, and specialty care practitioners to meet member needs. Ambetter from Peach State Health Plan monitors practitioner availability annually against established standards, and initiates actions, as needed, to improve practitioner availability. This report describes the monitoring methodology, results, and analysis for the period of January 1, 2021 through December 31, 2021.

Availability of Primary Care, Specialty Care and Behavioral Health Care Practitioners

Practitioner availability monitoring is completed for primary care practitioners, high-volume and high-impact specialty care practitioners, and high-volume behavioral health practitioner types. The health plan defines the mechanism utilized to monitor the type, number and geographic distribution of primary care, high-volume and high-impact specialty care, and high-volume behavioral healthcare practitioners as applicable to monitor the adequacy of the network and how effectively this network meets the needs, preferences, and diversity of the health plan’s membership.

Standards and Methodology

To evaluate the availability of practitioners who provide primary care, high-volume and high-impact specialty care and high-volume behavioral healthcare services, the health plan annually monitors the following:

- Ratio of number of each type of practitioners to number of members
- Geographic distribution of each type of practitioner (distance and/or driving time to practitioner’s office)

Table 1: Number of Practitioners in Network

Network Evaluation	Exchange
# of Practitioners	33,277

Section I: Primary Care

A PCP includes general practitioners, family practitioners, pediatricians, internists, nurse practitioners, and providers within Federally Qualified Health Centers (FQHCs). Primary care providers are those that fully accept the duties of a PCP and can be designated as a member’s assigned PCP.

Table 2 lists the primary care practitioner standards, results, and determines if the goal was met for each PCP type for whom availability is monitored. The health plan conducts an analysis to identify potential opportunities to improve practitioner availability.

A. Results and Analysis of the Availability of Primary Care Practitioners

Table 2: Primary Care Practitioner Numeric and Geographic Standards and Results

Practitioner Type Primary Care	Standards	2021 Results	Goal Met?
Primary Care Practitioners: All	90% of members have at least 1 PCP within 5 miles or 10 minutes of the member’s home in Large Metro counties.	99.1%	Yes
	90% of members have at least 1 PCP within 10 miles or 15 minutes of the member’s home in Metro counties.	97.8%	Yes

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	90% of members have at least 1 PCP within 20 miles or 30 minutes of the member's home in Micro counties.	99.9%	Yes
	90% of members have at least 1 PCP within 30 miles or 40 minutes of the member's home in Rural counties.	100%	Yes
	90% of members have at least 1 PCP within 60 miles or 70 minutes of the member's home in CEAC counties.	100%	Yes
	At least 1 PCP per 2,500 members	1:153.4	Yes
Primary Care Practitioners: Family/General Practitioners (FP/GP)	90% of members have at least 1 FP/ GP within 5 miles or 10 minutes of the member's home in Large Metro counties.	99.1%	Yes
	90% of members have at least 1 FP/ GP within 10 miles or 15 minutes of the member's home in Metro counties.	97.4%	Yes
	90% of members have at least 1 FP/ GP within 20 miles or 30 minutes of the member's home in Micro counties.	99.7%	Yes
	90% of members have at least 1 FP/ GP within 30 miles or 40 minutes of the member's home in Rural counties.	100%	Yes
	90% of members have at least 1 FP/GP within 60 miles or 70 minutes of the member's home in CEAC counties.	100%	Yes
	At least 1 FP/ GP per 2,500 members	1:276.8	Yes
Primary Care Practitioners: Internal Medicine Practitioners	90% of members have at least 1 Internal Medicine Practitioner within 5 miles or 10 minutes of the member's home in Large Metro counties.	98.2%	Yes
	90% of members have at least 1 Internal Medicine Practitioner within 10 miles or 15 minutes of the member's home in Metro counties.	94.0%	Yes
	90% of members have at least 1 Internal Medicine Practitioner within 20 miles or 30 minutes of the member's home in Micro counties.	94.5%	Yes
	90% of members have at least 1 Internal Medicine Practitioner within 30 miles or 40 minutes of the member's home in Rural counties.	99.9%	Yes
	90% of members have at least 1 Internal Medicine Practitioner within 60 miles or 70 minutes of the member's home in CEAC counties.	100%	Yes
	At least 1 Internal Medicine Practitioner per 2,500 members	1:344.1	Yes
Primary Care Practitioners: Pediatrics Practitioners (PEDS)	90% of members have at least 1 Pediatrics Practitioner within 5 miles or 10 minutes of the member's home in Large Metro counties.	93.8%	Yes
	90% of members have at least 1 Pediatrics Practitioner within 10 miles or 15 minutes of the member's home in Metro counties.	93.7%	Yes
	90% of members have at least 1 Pediatrics Practitioner within 20 miles or 30 minutes of the member's home in Micro counties.	85.8%	No
	90% of members have at least 1 Pediatrics Practitioner within 30 miles or 40 minutes of the member's home in Rural counties.	90.0%	Yes
	90% of members have at least 1 Pediatrics Practitioner within 60 miles or 70 minutes of the member's home in CEAC counties.	100%	Yes
	At least 1 Pediatrics Practitioner per 2,500 members	1:624.7	Yes

1. Primary Care Practitioners Quantitative Analysis

Family/General Practitioners (FP/GP)

In 2021, the ratio of practitioners to members was met.

Large Metro

- goal for at least 1 FP/GP within 5 miles or 10 minutes of member home was met in large metro counties.
- rate in large metro counties exceeded the goal by 9.1 percentage points.

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Metro

- goal for at least 1 FP/GP within 10 miles or 15 minutes of member home was met in metro counties.
- rate in metro counties exceeded the goal by 7.4 percentage points.

Micro

- goal for at least 1 FP/GP within 20 miles or 30 minutes of member home was met in micro counties.
- rate in micro counties exceeded the goal by 9.7 percentage points.

Rural

- goal for at least 1 FP/GP within 30 miles or 40 minutes of member home was met in rural counties.
- rate in rural counties exceeded the goal by 10.0 percentage points.

CEAC

- goal for at least 1 FP/GP within 60 miles or 70 minutes of member home was met in CEAC counties.
- rate in CEAC counties exceeded the goal by 10.0 percentage points.

Internal Medicine Practitioners

In 2021, the ratio of practitioners to members was met.

Large Metro

- goal for at least 1 internist within 5 miles or 10 minutes of member home was met in large metro counties.
- rate in large metro counties exceeded the goal by 8.2 percentage points.

Metro

- goal for at least 1 internist within 10 miles or 15 minutes of member home was met in metro counties.
- rate in metro counties exceeded the goal by 4.0 percentage points.

Micro

- goal for at least 1 internist within 20 miles or 30 minutes of member home was met in micro counties.
- rate in micro counties exceeded the goal by 4.5 percentage points.

Rural

- goal for at least 1 internist within 30 miles or 40 minutes of member home was not met in rural counties.
- rate in rural counties exceeded the goal by 9.9 percentage points.

CEAC

- goal for at least 1 internist within 60 miles or 70 minutes of member home was not met in CEAC counties.
- rate in CEAC counties exceeded the goal by 10.0 percentage points.

Pediatrics Practitioners (PEDS)

In 2021, the ratio of practitioners to members was met.

Large Metro

- goal for at least 1 pediatrician within 5 miles or 10 minutes of member home was met in large metro counties.
- rate in large metro counties exceeded the goal by 3.8 percentage points.

Metro

- goal for at least 1 pediatrician within 10 miles or 15 minutes of member home was met in metro counties.

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- rate in metro counties exceeded the goal by 3.7 percentage points.

Micro

- goal for at least 1 pediatrician within 20 miles or 30 minutes of member home was not met in micro counties.
- rate in micro counties missed the goal by 4.2 percentage points.

Rural

- goal for at least 1 pediatrician within 30 miles or 40 minutes of member home was not met in rural counties.
- rate in rural counties met the goal.

CEAC

- goal for at least 1 pediatrician within 60 miles or 70 minutes of member home was not met in CEAC counties.
- rate in CEAC counties exceeded the goal by 10.0 percentage points.

2. Primary Care Practitioners Qualitative Analysis

For this analysis period, the health plan met the goal for the ratio standard for all primary care practitioner types assessed. Goals for geographic counties reviewed in this analysis were also met for each of the PCP types observed in each county except for pediatrician in micro counties. The health plan evaluated the counties that were not met to identify causes and determined there is a general lack of practitioners, especially in the large rural areas of the state. Services in these areas are augmented or supplemented with tele-health services. Ambetter will continue to recruit and credential PCPs new to these counties to improve the practitioner-to-member ratios and the geographic distance from the member's home.

Section II: Specialty Care

The health plan identifies high-volume specialty care practitioners as those who treat a significant portion of the health plan's members, as identified through analysis of the number of visits, based on claim and encounter data. At a minimum, high-volume specialists were identified as Obstetrics & Gynecology (OB/GYN). At a minimum, high-impact specialists were identified as Oncology.

Evaluation to identify high-impact practitioners utilizes an assessment of conditions with serious consequences for the member, requiring significant health system resources, including high-cost medications and therapy options (i.e., chemotherapy and radiation) and increased inpatient and outpatient medical claims. Oncology was selected as high impact specialists since the care of cancer patients from diagnosis through primary treatment is complex, involving several diagnostic and treatment steps. These steps generally include staging, general medical assessments, definitive therapy (surgery or radiation depending on tumor type and stage) to control local disease, and often adjuvant therapy (i.e., radiation therapy, chemotherapy, hormonal therapy, or immunotherapy) to reduce the risk of recurrence. According to the Journal of the National Cancer Institute, oncologists face challenges of providing comprehensive care to cancer patients across the continuum including significant comorbid conditions or psychosocial issues.

Table 3 lists the specialty care practitioner standards, results, and determines if the goal was met for each high-volume and high-impact specialty care practitioner type for whom availability is monitored. The health plan conducts an analysis to identify potential opportunities to improve practitioner availability.

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B. Results and Analysis of the Availability of High-volume & High-impact Specialty Care Practitioners

Table 3: Specialty Care Practitioner Numeric and Geographic Standards and Results

Practitioner Type Specialty Care	Standards	2021 Results	Goal Met?
High-volume Specialty Care Practitioners: Obstetrics & Gynecology (OB/GYN)	90% of members have at least 1 OB/GYN within 15 miles or 30 minutes of the member's home in Large Metro counties.	100%	Yes
	90% of members have at least 1 OB/GYN within 40 miles or 60 minutes of the member's home in Metro counties.	100%	Yes
	90% of members have at least 1 OB/GYN within 75 miles or 100 minutes of the member's home in Micro counties.	100%	Yes
	90% of members have at least 1 OB/GYN within 90 miles or 110 minutes of the member's home in Rural counties.	100%	Yes
	90% of members have at least 1 OB/GYN within 130 miles or 145 minutes of the member's home in CEAC counties.	100%	Yes
	At least 1 OB/GYN per 5,000 members	1:402.6	Yes
High-impact Specialty Care Practitioners: Oncologists	90% of members have at least 1 Oncologist within 10 miles or 20 minutes of the member's home in Large Metro counties.	99.7%	Yes
	90% of members have at least 1 Oncologist within 30 miles or 45 minutes of the member's home in Metro counties.	99.9%	Yes
	90% of members have at least 1 Oncologist within 45 miles or 60 minutes of the member's home in Micro counties.	100%	Yes
	90% of members have at least 1 Oncologist within 60 miles or 75 minutes of the member's home in Rural counties.	100%	Yes
	90% of members have at least 1 Oncologist within 100 miles or 110 minutes of the member's home in CEAC counties.	100%	Yes
	At least 1 Oncologist per 5,000 members	1:525.0	Yes

1. Specialty Care Practitioners Quantitative Analysis

High-volume Practitioners (OB/GYN)

In 2021, the ratio of practitioners to members was met.

Large Metro

- goal for at least 1 OB/GYN within 15 miles or 30 minutes of member home was met in large metro counties.
- rate in large metro counties exceeded the goal by 10.0 percentage points.

Metro

- goal for at least 1 OB/GYN within 40 miles or 60 minutes of member home was met in metro counties.
- rate in metro counties exceeded the goal by 10.0 percentage points.

Micro

- goal for at least 1 OB/GYN within 75 miles or 100 minutes of member home was met in micro counties.
- rate in micro counties exceeded the goal by 10.0 percentage points.

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Rural

- goal for at least 1 OB/GYN within 90 miles or 110 minutes of member home was met in rural counties.
- rate in rural counties exceeded the goal by 10.0 percentage points.

CEAC

- goal for at least 1 OB/GYN within 130 miles or 145 minutes of member home was met in CEAC counties.
- rate in CEAC counties exceeded the goal by 10.0 percentage points.

High-impact Practitioners (Oncologist)

In 2021, the ratio of practitioners to members was met.

Large Metro

- goal for at least 1 oncologist within 10 miles or 20 minutes of member home was met in large metro counties.
- rate in large metro counties exceeded the goal by 9.7 percentage points.

Metro

- goal for at least 1 oncologist within 30 miles or 45 minutes of member home was met in metro counties.
- rate in metro counties exceeded the goal by 9.9 percentage points.

Micro

- goal for at least 1 oncologist within 45 miles or 60 minutes of member home was met in micro counties.
- rate in micro counties exceeded the goal by 10.0 percentage points.

Rural

- goal for at least 1 oncologist within 60 miles or 75 minutes of member home was met in rural counties.
- rate in rural counties exceeded the goal by 10.0 percentage points.

CEAC

- goal for at least 1 oncologist within 100 miles or 110 minutes of member home was met in CEAC counties.
- rate in CEAC counties exceeded the goal by 10.0 percentage points.

2. Specialty Care Practitioners Qualitative Analysis

In 2021, both the numeric/ratio standards and the geographic standards for high-volume and high-impact specialty care practitioners within an established distance of the member's home were met for OB/GYN and Oncology practitioners observed. Although the goals were met, the health plan will continue to monitor the ratio of practitioners-to-members and the geographically distance from the member's home to ensure the network has an adequate number of high-volume and high-impact specialists available to meet the needs of its membership.

Section III: Behavioral Healthcare

The health plan identifies high-volume behavioral healthcare practitioners through analysis of the number of visits, based on claim and encounter data. High-volume behavioral health specialties based on volume of healthcare visits were: Prescribing Psychiatrists and Non-prescribing Clinical Psychologists and Licensed Mental Health Practitioner (LMHP) including clinical social workers, professional counselors, marriage & family therapists, etc.

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Table 4 lists the BH practitioner standards, results, and determines if the goal was met for each high-volume behavioral healthcare practitioner type for whom availability is monitored. The health plan conducts an analysis to identify potential opportunities to improve practitioner availability.

C. Results and Analysis of the Availability of High-volume BH Practitioners

Table 4: Behavioral Healthcare (BH) Practitioner Numeric and Geographic Standards and Results

Practitioner Type Behavioral Healthcare	Standards	2021 Results	Goal Met?
High-volume BH Prescribing Practitioners: Psychiatrists	90% of members have at least 1 Psychiatrists within 10 miles or 20 minutes of the member's home in Large Metro counties.	99.0%	Yes
	90% of members have at least 1 Psychiatrists within 30 miles or 45 minutes of the member's home in Metro counties.	100%	Yes
	90% of members have at least 1 Psychiatrists within 45 miles or 60 minutes of the member's home in Micro counties.	99.8%	Yes
	90% of members have at least 1 Psychiatrists within 60 miles or 75 minutes of the member's home in Rural counties.	100%	Yes
	90% of members have at least 1 Psychiatrists within 100 miles or 110 minutes of the member's home in CEAC counties.	100%	Yes
	At least 1 Psychiatrist per 5,000 members	1:607.1	Yes
High-volume BH Non- prescribing Practitioners: Clinical Psychologists	90% of members have at least 1 Psychologists 10 miles or 20 minutes of the member's home in Large Metro counties.	99.7%	Yes
	90% of members have at least 1 Psychologists 30 miles or 45 minutes of the member's home in Metro counties.	99.1%	Yes
	90% of members have at least 1 Psychologists within 45 miles or 60 minutes of the member's home in Micro counties.	87.8%	No
	90% of members have at least 1 Psychologists within 60 miles or 75 minutes of the member's home in Rural counties.	94.5%	Yes
	90% of members have at least 1 Psychologists within 100 miles or 110 minutes of the member's home in CEAC counties.	100%	Yes
	At least 1 Psychologist per 5,000 members	1:1457.7	Yes
High-volume BH Non- prescribing Practitioners: Licensed Mental Health Professionals (LMHP)	90% of members have at least 1 LMHP within 10 miles or 20 minutes of the member's home in Large Metro counties.	99.8%	Yes
	90% of members have at least 1 LMHP within 30 miles or 45 minutes of the member's home in Metro counties.	98.0%	Yes
	90% of members have at least 1 LMHP within 45 miles or 60 minutes of the member's home in Micro counties.	98.0%	Yes
	90% of members have at least 1 LMHP within 60 miles or 75 minutes of the member's home in Rural counties.	100%	Yes
	90% of members have at least 1 LMHP within 100 miles or 110 minutes of the member's home in CEAC counties.	100%	Yes
	At least 1 LMHP per 5,000 members	1:408.4	Yes

1. BH Practitioners Quantitative Analysis

High-volume Prescribing Practitioners

Psychiatrists

In 2021, the ratio of practitioners to members was met.

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Large Metro

- goal for at least 1 psychiatrist within 10 miles or 20 minutes of member home was met in large metro counties.
- rate in large metro counties exceeded the goal by 9.0 percentage points.

Metro

- goal for at least 1 psychiatrist within 30 miles or 45 minutes of member home was met in metro counties.
- rate in metro counties exceeded the goal by 10.0 percentage points.

Micro

- goal for at least 1 psychiatrist within 45 miles or 60 minutes of member home was met in micro counties.
- rate in micro counties exceeded the goal by 9.8 percentage points.

Rural

- goal for at least 1 psychiatrist within 60 miles or 75 minutes of member home was met in rural counties.
- rate in rural counties exceeded the goal by 10.0 percentage points.

CEAC

- goal for at least 1 psychiatrist within 100 miles or 110 minutes of member home was not met in CEAC counties.
- rate in CEAC counties exceeded the goal by 10.0 percentage points.

High-volume Non-prescribing Practitioners

Clinical Psychologists

In 2021, the ratio of practitioners to members was met.

Large Metro

- goal for at least 1 psychologist within 10 miles or 20 minutes of member home was met in large metro counties.
- rate in large metro counties exceeded the goal by 9.7 percentage points

Metro

- goal for at least 1 psychologist within 30 miles or 45 minutes of member home was met in metro counties.
- rate in metro counties exceeded the goal by 9.1 percentage points.

Micro

- goal for at least 1 psychologist within 45 miles or 60 minutes of member home was not met in micro counties.
- rate in micro counties missed the goal by 2.2 percentage points.

Rural

- goal for at least 1 psychologist within 60 miles or 75 minutes of member home was met in rural counties.
- rate in rural counties exceeded the goal by 4.5 percentage points.

CEAC

- goal for at least 1 psychologist within 100 miles or 110 minutes of member home was not met in CEAC counties.
- rate in CEAC counties exceeded the goal by 10.0 percentage points.

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Licensed Mental Health Practitioner (LMHP)

In 2021, the ratio of practitioners to members was met.

Large Metro

- goal for at least 1 LMHP within 10 miles or 20 minutes of member home was met in large metro counties.
- rate in large metro counties exceeded the goal by 9.8 percentage points.

Metro

- goal for at least 1 LMHP within 30 miles or 45 minutes of member home was met in metro counties.
- rate in metro counties exceeded the goal by 8.0 percentage points.

Micro

- goal for at least 1 LMHP within 45 miles or 60 minutes of member home was met in micro counties.
- rate in micro counties exceeded the goal by 8.0 percentage points.

Rural

- goal for at least 1 LMHP within 60 miles or 75 minutes of member home was met in rural counties.
- rate in rural counties exceeded the goal by 10.0 percentage points.

CEAC

- goal for at least 1 LMHP within 100 miles or 110 minutes of member home was not met in CEAC counties.
- rate in CEAC counties exceeded the goal by 10.0 percentage points.

2. BH Practitioners Qualitative Analysis

In 2021, the health plan met the goal for the numeric/ratio standards for both high-volume prescribing and non-prescribing BH practitioners. Goals for geographic counties reviewed in this analysis were also met for each of the BH practitioner type observed in each county except for clinical psychologists in micro counties. The health plan evaluated the counties that were not met to identify causes and determined there are a limited number of clinical psychologists in the following counties Ben Hill, Coffee, Laurens, Pierce, and Toombs Counties. The limited number of clinical psychologists in these counties is the key driver for missing the goal in micro counties by 2.2 percentage points. These are small rural counties with very limited available psychologist to contract. The pattern of care for members is to receive care from multi-clinic and masters level clinicians within these counties.

For services specific for psychologists that are not found in community mental health centers or as they are known in Georgia, Community Service Boards, such as psychological testing within these counties, the following patterns of care are available:

- For Ben Hill, members can receive care from psychologists in Tifton and Metter Ga.
- For Laurens County, members can receive care from psychologists in Dublin and Warner Robins, GA.
- For Coffee County, members can receive care from psychologists in Matter and Coolidge, GA.
- For Pierce County, members can receive care from psychologists in Coolidge and Thomasville, Ga.
- For Toombs County, members can receive care in Metter and Statesboro, GA.

It is well documented that Georgia is experiencing a workforce shortage in rural areas of the state. Advocacy groups, provider associations and health plans have been working in concert to advocate for additional practitioner resources. In 2022, the Georgia legislature will take up a bill that will address behavioral health practitioner's shortage.

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D. County Level Gap Analysis

The health plan conducts analysis at the county level to identify potential opportunities to improve practitioner availability. County-level gaps are analyzed below.

Table 5: County Level Gap Analysis of the Availability of Practitioners

County	Practitioner Specialty Gap	Analysis
Butts, Chattooga, Cook, Dade, Elbert, Evans, Haralson, Harris, Lanier, McDuffie, Morgan, Pierce, Polk, Putnam, Tattnall, and Toombs Counties	Pediatrician	<p>Of the 45 micro counties, there were 16 counties that have a network gap of pediatricians. These counties either do not have Pediatricians located within those counties or Pediatrician's location(s) doesn't reach the geographic standard.</p> <p>Members in these counties are encouraged to see pediatrician in adjacent counties, as well as other PCP types. The plan also promotes and encourages members to utilize telehealth and virtual visits when available to get care in these micro counties</p>
Ben Hill, Coffee, Laurens, Pierce, and Toombs Counties	Clinical Psychology	<p>Of the 45 micro counties, there were 5 counties that have a network gap of clinical psychologists. The plan has contract with all available psychologists in the service area and will continue to recruit, contract and credential non-par BH practitioners as they enter the service area.</p> <p>Members also can see clinical psychologists in adjacent counties and utilize telehealth and virtual visits to get the care needed as soon as needed.</p>

Reporting

This quality improvement activity was reported to the following committee(s):

Table 6: Committee Reporting

Committee Name	Meeting Date	Committee Actions or Recommendations
National Marketplace Quality Improvement Committee	4.27.22	Approved with no further recommendations

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APPROVED DATE: 09/14/14	RETIRED: N/A
EFFECTIVE DATE: 01/01/2014	REVIEWED/REVISED: 04/08/2015; 01/06/2017, 5/27/2018, 5/24/2019, 6/23/2020, 01/18/2022, 10/31.2022
PRODUCT TYPE: Health Insurance Marketplace	REFERENCE NUMBER: HIM.NTWK.02

SCOPE:

This policy is designed to apply to all Ambetter, Marketplace plans affiliated with Centene Corporation.

PURPOSE:

This policy identifies the standards and requirements for Marketplace network adequacy, reporting and filing, and ongoing monitoring and development.

POLICY:

Health plans will contract with providers to meet the network adequacy requirement in *45 C.F.R. 156.230(a) (2)*:

Maintain a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay.

Network adequacy will follow additional guidance provided by CMS and state DOIs on how *45 C.F.R. 156.230(a) (2)* will be evaluated each year.

Per the Letter to Issuers for Plan Year 2019, CMS is deferring network adequacy review to states with adequate network adequacy review. Centene will follow state-specific Department of Insurance (DOI), or other applicable state agency, network adequacy standards. When a DOI, or other applicable state agency, does not have network adequacy standards, Centene health plans will apply a set of standards developed by corporate network development, based on the most recent CMS Medicare standards.

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Annually, corporate network development in conjunction with Regulatory Operations will review state DOI guidance on current year requirements and update the adequacy standards; accordingly, states without DOI requirements will be updated to reflect the current years CMS Medicare standards.

A county must meet the minimum network adequacy requirement, or have a mutually (Centene Commercial Solutions, health plan, and corporate network development) agreed upon development plan in place, to be included in the service area for QHP filing.

Providers who qualify as Primary Care Providers (PCPs) vary by state. Adequacy will be assessed based on the individual states' definition. This will vary the inclusion/exclusion of mid-level practitioners in the PCP category or analyzed separately as PCP Extenders.

Network adequacy will be monitored on an ongoing basis which will be no less than monthly.

PROCEDURE:

Network Adequacy Standards and Service Areas

Corporate network development will work with Regulatory Operations and each health plan to determine health plan specific network adequacy standards based on CMS requirements and state DOI (or other state agency) regulations.

When no regulatory requirements exist, corporate standards will be applied to the health plan's network based on CMS' current Medicare network adequacy standards.

Refer to Addendum A

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If the state is using the CMS Medicare standards, 90% of members must have access to the provider type within the distance and time standard.

Network adequacy will be evaluated on a county basis. A county will need to meet all applicable network adequacy requirements *by the date established annually to meet the QHP Filing deadline* in order to be included in the Marketplace service area.

In addition to geographic adequacy, health plans will evaluate capacity based upon *minimum* member-to-provider ratios as follows:

Specialty	Ratio
Primary Care	1:2,000
Pediatrics	1:2,000
Allergy/Immunology	1:15,000
Cardiology	1:3,700
Endocrinology	1:15,000
Hematology/Oncology	1:15,000
Infectious Disease	1:15,000
Neurology	1:15,000
Psychiatry	1:15,000
Rheumatology	1:15,000
General Surgery	1:5,000
OB/GYN	1:2,000

Network Strategy/Provider Outreach

The Centene Ambetter network strategy is to offer affordable, high-quality products. The Health Plans will work with Corporate Network Strategy to accomplish the following:

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- Identify target providers at the beginning of the annual network development process who can:
 - (a) meet network adequacy requirements,
 - (b) achieve unit cost objectives for the service area,
 - (c) support traditional patterns of care for the population,
 - (d) achieve excellent clinical care results/outcomes, and
 - (e) support achieving sufficient scale in the market, based on target membership and membership size.

- Track rate negotiations and status of hospitals, key physician groups, etc. in the “checkbook” against target rates.

- Outreach will give priority to the provider types and specialties identified as requirements and priorities for CMS, as well as any state specific requirements.

- Contract with provider types that may not be targeted for their Medicaid business so as to provide a full range of services to members and alleviate concerns over balance billing of members. These provider types include hospital-based physicians (anesthesia, pathology, radiology, emergency medicine, etc.), ambulance, and others.

Network Adequacy Data and Status

Health plans will be responsible for keeping their contract status/provider information up-to-date. Corporate network operations will support each health plan in providing the appropriate tool(s) to track network development activities for both existing and new (proposed) service areas as listed below.

Network Adequacy Reporting – During Network Development

Network adequacy will be evaluated on a weekly basis (or as needed) during the network development process. The corporate Network operations team will create network adequacy maps and detail reports for each health plan, based

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on each health plan’s current and/or proposed service area and adequacy requirements. These reports will be shared with the health plans on a weekly basis. Health plans will be responsible for weekly review of the reports to find and focus network development opportunities, identify whether or not providers exist for contracting, and identify any data or reporting issues.

Network Adequacy Reporting – QHP Filing

Corporate network operations will outline a process each year to meet network adequacy prior to the QHP Filing deadline. The process will involve:

- Learning the latest state or CMS network adequacy filing requirements including obtaining the latest filing template.
- Determining which health plans require state specific network adequacy reporting
- Health plans keeping their contract status/provider information up-to-date on an ongoing basis.
- Educating the health plans on the impact of reporting requirements on how their network data is represented.
- Tracking the data source(s) for each health plan.
- Building the QHP reports, incorporating all state or CMS requirements.
- Providing the health plans with draft data/reports to review, give input on, and address issues.
- Creating the final templates for filing.

Network Adequacy Monitoring and Auditing

Health plans are responsible for ensuring that their provider networks remain adequate and continuously meet all state, federal, and corporate requirements. The Health Plan and Network Strategy should create plans to immediately address closing gaps created by providers moving or leaving the network.

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PRODUCT TYPE: Health Insurance Marketplace	REFERENCE NUMBER: HIM.NTWK.02

To assist health plan network monitoring, corporate network operations will provide regular network adequacy reports. Corporate network operations and strategy will also review reports and work with the health plans to help identify network gaps and data/configuration issues, as well as provide support in finding resources to assist in closing gaps, as needed.

Notification of Material Network Changes

Health plans should notify corporate network operations in a timely manner of any material network changes that could cause risk to network adequacy or provider access. Examples include:

- Provider terminations, acquisitions, or closures that could impact network adequacy
- Any time a hospital terminates or is terminated

A plan should be developed at this time to analyze the network impact and determine how to best close the adequacy or access gap.

REFERENCES:

- 45 CFR 156.230 – Network adequacy standards
- 2018 Letter to Issuers in the Federally-facilitated Marketplaces
- 2019 Letter to Issuers in the Federally-facilitated Marketplaces
- 2022 Letter to Issuers in the Federally-facilitated Marketplaces
- NCQA 2021 HP Accreditation Network Standards

ATTACHMENTS:

- [Addendum A – Ambetter Access Standards 20220118](#)
- [Addendum B – Primary Care Provider – Definition_20220118](#)

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PRODUCT TYPE: Health Insurance Marketplace	REFERENCE NUMBER: HIM.NTWK.02

DEFINITIONS:

- DOI – Department of Insurance, or the equivalent for each state in which we operate
- QHP – Qualified Health Plan, as defined by the Affordable Care Act in 45 C.F.R. 155.20
- PCP Defined as Primary Care Practitioner. A physician or nonphysician (e.g., nurse practitioner, physician assistant, certified nurse midwife) who offers primary care medical services. Licensed practical nurses and registered nurses are not considered PCPs. Only certified Federally Qualified Health Centers (FQHC) are considered PCPs. This must be reviewed and approved by an auditor.
 - To be certified as an FQHC, an entity must meet any one of the following criteria:
 - Is receiving a grant under Section 330 of the Public Health Service (PHS) Act (42 United States Code Section 254a) or is receiving funding from such a grant and meets other requirements.
 - Is not receiving a grant under Section 330 of the PHS Act but is determined by the Secretary of the Department of Health & Human Services (HHS) to meet the requirements for receiving such a grant (qualifies as a “FQHC look-alike”) based on the recommendation of the Health Resources and Services Administration.
 - Was treated by the Secretary of HHS for purposes of Medicare Part B as a comprehensive Federally-funded health center as of January 1, 1990.
 - Is operating as an outpatient health program or facility of a tribe or tribal organization under the Indian Self Determination Act or as an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act as of October 1991.
 - For certification as an FQHC, the entity must meet all of the following criteria (in addition to one of the criteria above):
 - Provide comprehensive services and have an ongoing quality assurance program.
 - Meet other health and safety requirements
 - Not be concurrently approved as a Rural Health Clinic (RHC). § Only certified RHCs are considered PCPs. This must be reviewed and approved by an auditor. § To be certified as an RHC, the entity must meet CMS requirements to qualify for payment via an all-inclusive rate (AIR) for medically necessary primary health services and qualified preventive health services furnished by an RHC practitioner.
- See Addendum B for State Specific PCP definition

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PRODUCT TYPE: Health Insurance Marketplace	REFERENCE NUMBER: HIM.NTWK.02

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REVISION LOG

REVISION	DATE
Full review of P&P, updated to reflect latest CMS guidance and current systems	01/2017
Update to describe current network adequacy standards (defer to states when they have standards), formatting changes	05/2018
Updated section about Network Insight team to just corporate Network team	6/2020
Added PCP Definition and updated Standards	1/2022
Updated Addendum A – Ambetter Access Standards 20221031	10/2022

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in Compliance 360, Centene's P&P management software, is considered equivalent to a physical signature.

Director of Department: Approval on file

Vice President of Department: Approval on file

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APPROVED DATE: 03/01/2015	RETIRED: N/A
EFFECTIVE DATE: 01/14/2016	REVIEWED/REVISED: 01/03/2017, 5/28/2018, 5/1/2019, 11/8/2021, 11/16/2022
PRODUCT TYPE: Health Insurance Marketplace	REFERENCE NUMBER: HIM.NTWK.03

SCOPE:

This policy is designed to apply to all Ambetter, Marketplace plans affiliated with Centene Corporation.

PURPOSE:

This policy identifies the requirements for Essential Community Providers (ECPs) and how the health plans will meet those requirements, with corporate support for monitoring and reporting.

POLICY:

Health plans will contract with Essential Community Providers to meet the general access requirement in *45 CFR 156.230(a)(2)*.

A QHP issuer must have a sufficient number and geographic distribution of essential community providers, where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in the QHP's service area, in accordance with the Exchange's network adequacy standards.

Annually, corporate network development, in conjunction with compliance, will review CMS guidance on current year requirements and update the adequacy requirements and procedure details accordingly.

The latest ECP requirements for QHPs, based on benefit year 2023, are:

1. Contracted with at least 35 percent of available ECPs in each plan's service area to participate in the plan's provider network;*
2. Offered contracts in good faith to at least one ECP in each ECP category in each county in the service area to participate in the plan's provider network for the respective QHP certification plan year, where an ECP in that category is available (not applicable to SADP applicants);* and
3. Offered contracts in good faith to all available Indian health care providers in the plan's service area to participate in the plan's provider network for the respective QHP certification plan year.

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PRODUCT TYPE: Health Insurance Marketplace	REFERENCE NUMBER: HIM.NTWK.03

In cases where a state DOI, or other governmental agency, has additional requirements or different access standards, the affected health plan(s) will adhere to the broadest and most stringent standards.

PROCEDURE:

Essential Community Providers will be reviewed and offered contracts on an annual basis to meet the policy outlined above.

Identifying Essential Community Providers

1. Annually, corporate network development will research the most recent ECP list (“Non-Exhaustive ECP List”) and categories published by CMS.
2. For state-based and partnership exchanges, the health plan implementation lead and compliance lead will annually identify and provide any state-specific ECP requirements, categories, and provider lists to corporate network development (for instance: WA, AR).
3. The list(s) will be provided to each health plan network lead to share with their contracting and operations teams. The list(s) will also be shared with national contracting and specialty companies who may have providers on the list(s).
4. The previous year’s ECPs should be reviewed against the latest ECP list(s). Only ECPs on the most recent list can be considered to be in compliance.

Outreach and Contracting with Essential Community Providers

1. Annually, the health plans will compare the most recent ECP list (“Non-Exhaustive ECP List”) published by CMS against the providers who have already been contracted by the health plan for Ambetter.
2. The health plan will identify which of the providers on the ECP list are targets for early outreach and include them on the list for contract or amendment, as appropriate.
3. Contracting will occur with at least the number of ECPs to meet the % required to be contracted for the benefit year, prior to the date corporate

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PRODUCT TYPE: Health Insurance Marketplace	REFERENCE NUMBER: HIM.NTWK.03

network development identifies as the deadline to produce reports for compliance and QHP/DOI filings.

4. Prior to April 1st of each year (or the date indicated in the Corporate Network Development timeline), good faith offers to contract will be made:
 - a. To all Indian Health providers within the plan service area.
 - b. To at least one ECP in each ECP category (see Attachment 1) in each county in the service area, where an ECP in that category is available.
5. Contracts with Indian Health providers will include the QHP addendum for Indian Health providers.
6. By these same deadlines, National contracting and specialty companies, including Dental Health and Wellness, will contract (or offer to contract, as appropriate) with any applicable ECPs to help meet the % of ECPs required to be contracted.

Reporting and Reviewing Contracted Essential Community Providers

ECP Requirement 1 must be met prior to the annual QHP filing and will be reported on the applicable CMS template (and state templates, if applicable).

1. As contracts with ECPs are received, they will follow the standard process for updating Contracted/Par status in CRM-P or Portico.
2. Contracted providers that meet the % of ECPs required to be contracted will be reported on the QHP filing template, along with any applicable state reporting requirements.
3. Corporate network development will determine a process and timeline annually to meet that year's deadline for filing.
4. The timeline developed will include checkpoints to determine whether or not the health plan is on track to meet the % of ECPs contracted requirement.
 - a. If the requirement is not met or is at risk of being met on the timeline outlined, outreach plans will be developed, as appropriate.
 - b. If the requirements cannot be met, the health plan, with support from corporate network development, will write a "satisfactory narrative justification describing how the issuer's provider network(s), as

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presently constituted, provides an adequate level of service for low-income and medically underserved individuals and how the issuer plans to increase ECP participation in the issuer’s provider network(s) in future years. At a minimum, such narrative justification would include the number of contracts offered to ECPs for plan years beginning in 2020, the number of additional contracts an issuer expects to offer and the timeframe of those planned negotiations, the names of the specific ECPs to which the issuer has offered contracts that are still pending, and contingency plans for how the issuer’s provider network, as currently designed, will provide adequate care to enrollees who might otherwise be cared for by relevant ECP types that are missing from the issuer’s provider network (*2023 Letter to Issuers in the Federally-facilitated Marketplaces*),” or other narrative based on the current year requirements.

5. Corporate network development will annually determine the resources necessary to develop the ECP reports:
 - a. For state-specific reports, the health plan will be the responsible party, with support from corporate network development.
 - b. For federal reports, corporate network development will be responsible for developing and compiling the reports. The health plans will be responsible for reviewing the report contents and their accuracy and providing sign-off/approval.
6. The corporate network development and Network Insights team will be responsible for developing the QHP ECP filing templates.
 - a. Matching who is contracted vs. the ECP list will be done by attempting to match NPI numbers. Health plan network team is ultimately responsible for ensuring that the ECPs submitted in the filing have a signed contract, and that the contract is housed in Emptoris.
 - b. Completion of the QHP templates will follow the directions provided annually by CMS.

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- c. CMS may, on occasion, provide directions that contradict Centene standards (for instance, submitting address and FTE data from the ECP list when Centene may have more current or correct information). The filing process will defer to CMS instructions for filing in these scenarios.
7. Corporate network development will submit the final QHP ECP templates for filing to the Regulatory Operations team, or their designee, and, prior to submitting the ECP reports, will calculate the final % of ECPs contracted.

Good Faith Offers to Essential Community Providers

ECP Requirements 2 & 3 must be met prior to the filing deadline for the next Plan Year. In order to provide time for documentation and reporting, all Ambetter plans will make good faith offers to ECPs to meet these requirements by April 1 annually, unless otherwise determined by the corporate network development team.

In order to document that good faith offers have been made, corporate network development will work with compliance to build attestations that each health plan network lead will need to complete prior to April 1st or date indicated in the Corporate Network Development timeline of each year. The attestation will consist of the following components:

- Good faith offer to contract made to all Indian Health providers in the service area
- Good faith offer to contract made to at least one ECP in each ECP category (see Attachment 1) in each county in the service area, where an ECP in that category is available.
- List of providers to whom good faith offers were made
- Sample letter of offer to contract

See sample of text in Attachment 2.

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Annual Review of this Policy and Procedure

It is expected that CMS will review and change the Essential Community Provider requirements each year. As necessary, the procedure will be amended and different components may apply to different requirements than outlined above in order to meet the changing ECP contracting requirements.

REFERENCES:

- 45 CFR 156.235 Essential Community Providers
- 2023 Letter to Issuers in the Federally-facilitated Marketplaces

ATTACHMENTS:

- Attachment 1 – Essential Community Provider Categories
- Attachment 2 – Sample ECP Attestation

DEFINITIONS:

Essential Community Providers (based on *45 CFR 156.230(a)(2)*) - providers that serve predominantly low-income, medically underserved individuals, including providers that meet the criteria of paragraph (c)(1) or (2) of this section, and providers that met the criteria under paragraph (c)(1) or (2) of this section on the publication date of this regulation unless the provider lost its status under paragraph (c)(1) or (2) of this section thereafter as a result of violating Federal law:

- (1) Health care providers defined in section 340B(a)(4) of the PHS Act; and
- (2) Providers described in section 1927(c)(1)(D)(i)(IV) of the Act as set forth by section 221 of Public Law 111-8.

Good Faith Offer – a contract should offer terms that a willing, similarly-situated, non-ECP provider would accept or has accepted.

QHP – Qualified Health Plan, as defined by the Affordable Care Act in 45 C.F.R. 155.20

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[CMS information obtained via: ECP and Network Adequacy \(cms.gov\)](#)

REVISION LOG

REVISION	DATE
Full review of P&P. Updated to account for 2018 guidance. Remove references to Portico UDA for ECPs.	01/2017
Updated to account for 2019 guidance.	05/2018
Update ECP % and Verbiage to include 20%	11/2021
Update for 2023	11/2022

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in Centene's P&P management software is considered equivalent to a physical signature.

Director of Department: Approval on file

Vice President of Department: Approval on file

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Attachment 1 – Essential Community Provider Categories

Major ECP Category	ECP Provider Types
Family Planning Providers	Title X Family Planning Clinics and Title X “Look-Alike” Family Planning Clinics
Federally Qualified Health Centers (FQHCs)	FQHCs and FQHC “Look-Alike” Clinics, Outpatient health programs/facilities operated by Indian tribes, tribal organizations, programs operated by Urban Indian Organizations
Hospitals	Disproportionate Share Hospitals (DSH) and DSH-eligible Hospitals, Children’s Hospitals, Rural Referral Centers, Sole Community Hospitals, Free-standing Cancer Centers, Critical Access Hospitals
Indian Health Care Providers	IHS providers, Indian Tribes, Tribal organizations, and urban Indian Organizations
Ryan White Providers	Ryan White HIV/AIDS Program Providers
Other ECP Providers	STD Clinics, TB Clinics, Hemophilia Treatment Centers, Black Lung Clinics, Community Mental Health Centers, Rural Health Clinics, and other entities that serve predominantly low-income, medically underserved individuals.

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Attachment 2 – Sample ECP Attestation

To be completed by the health plan Vice President of Network Development:

Per 45 CFR 156.230(a)(2), “A QHP issuer must have a sufficient number and geographic distribution of essential community providers, where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in the QHP’s service area, in accordance with the Exchange’s network adequacy standards.”

Accordingly, I attest that my health plan meets the following requirements as outlined in the “2023 Letter to Issuers in the Federally-facilitated Marketplaces:”

1. Contracts with at least 35 percent of available ECPs in each plan’s service area to participate in the plan’s provider network
2. Offers contracts in good faith to all available Indian Health care providers in the service area, to include the Indian Health Service (IHS), Indian Tribes, Tribal organizations, and urban Indian organizations, applying the special terms and conditions necessitated by Federal law and regulations as referenced in the recommended model QHP Addendum for Indian Health care providers developed by CMS
3. Offers contracts in good faith to at least one ECP in each ECP category in each county in the service area, where an ECP in that category is available and provides medical or dental services that are covered by the issuer plan type.

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Major ECP Category	ECP Provider Types
Family Planning Providers	Title X Family Planning Clinics and Title X “Look-Alike” Family Planning Clinics
Federally Qualified Health Centers (FQHCs)	FQHCs and FQHC “Look-Alike” Clinics, Outpatient health programs/facilities operated by Indian tribes, tribal organizations, programs operated by Urban Indian Organizations
Hospitals	Disproportionate Share Hospitals (DSH) and DSH-eligible Hospitals, Children’s Hospitals, Rural Referral Centers, Sole Community Hospitals, Free-standing Cancer Centers, Critical Access Hospitals
Indian Health Care Providers	IHS providers, Indian Tribes, Tribal organizations, and urban Indian Organizations
Ryan White Providers	Ryan White HIV/AIDS Program Providers
Other ECP Providers	STD Clinics, TB Clinics, Hemophilia Treatment Centers, Black Lung Clinics, Community Mental Health Centers, Rural Health Clinics, and other entities that serve predominantly low-income, medically underserved individuals.

A good faith offer to contract means “a contract should offer terms that a willing, similarly-situated, non-ECP provider would accept or has accepted.”

Attachments:

1. List of providers to whom good faith offers were made
2. Sample letter of offer to contract

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SCOPE:

This policy is designed to apply to all Ambetter Marketplace plans affiliated with Centene Corporation.

PURPOSE:

This policy will ensure the provider network satisfies adequacy requirements outlined in *45 C.F.R. 156.230(a)(2)* and also complies with all state-specific requirements and standards at the time of QHP filing and CMS QHP certification. It will document the steps required to ensure timely and accurate reporting and monitoring of Ambetter provider network adequacy throughout the QHP product cycle, the filing process, during CMS certification and at the time of annual open enrollment. Lastly, this policy will enhance current network development and monitoring as described in Policy and Procedure HIM.NTWK.02 by outlining a chain of reporting and review to ensure ***awareness at all impacted organizational levels*** – Health Plan, Centene Commercial Solutions (CCS) and Centene Corporate leadership - of existing network deficiencies or gaps and the corrective action proposals developed to address them.

POLICY:

Corporate Network Operations will run network adequacy reports to ensure the provider network satisfies adequacy requirements outlined in *45 C.F.R. 156.230(a)(2)* and also complies with all state-specific requirements and standards at the time of QHP filing and CMS QHP certification. The Health Plan is responsible for reviewing, validating and researching the adequacy reports to address and fill reported gaps and address contracting concerns. Health Plan, CCS and Centene Corporate leadership will be notified of any known gaps in the Ambetter network and provided with corrective action plans, including estimated time frames for correction, by the Health Plan Network teams. Network visibility and assessment will be accomplished throughout the QHP filing and approval cycle as follows.

PROCEDURE:

I. Ongoing

- **Corporate Network Operations** will distribute weekly *State Access Summary* and *Marketplace Network Adequacy/Gap Analysis* reports providing an ongoing, week-over-week assessment of network adequacy and known gaps, including those determined to be high risk (see Appendix A). Distribution will include the Health Plan Network Leads, Corporate Network Strategy, Health Plan leadership, Health Plan Compliance Officers, CCS Regulatory Operations and Corporate Compliance.

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- Health Plan **Grievance and Appeals** leads will provide the Health Plan Compliance officer, CCS Regulatory Operations, Corporate Commercial Compliance and Corporate Network Strategy with notification and summary of complaints, appeals or grievances related to network adequacy, difficulty with provider access, availability or any other network-related issue. This includes consumer-initiated complaints and all related inquiries from state regulatory entities.

II. Plan Filing

- Health Plan Network and Health Plan Compliance will report and confirm network adequacy in line with the filing plan developed by Corporate Network Operations and Strategy and no later than thirty (30) days prior to the initial QHP plan filing. Known gaps will be disclosed along with a defined action plan and time frame for correction. A gap report (see Appendix B) will be developed by Corporate Network Operations and distributed to Health Plan leadership for acknowledgement and to implement the action plan to close any gaps.
- Appendix C contains a sample email that may be sent to Health Plan CEOs, Ambetter Leads and Compliance at the Health Plans by Regulatory Operations to ensure transparency and awareness of network standing.
- Regulatory Operations may annually send a reminder email to Health Plan CEOs, Ambetter Leads and Compliance at the Health Plans as a reminder about the policy and upcoming notices.
- Corporate Network Operations will continue to provide weekly reports throughout the filing season for the Health Plan Network team to review and to provide information on the gaps assessed.

III. Certification - CMS/QHP Agreements

- Health Plan Network and Health Plan Compliance will report and confirm network adequacy in line with the filing plan developed by Corporate Network Strategy and Operations no later than five (5) days prior to the signing of the QHP certification agreement with CMS for the upcoming policy year. Known gaps will be disclosed to the Health Plan. The Health Plan will develop an action plan and time frame to close the gaps, with the expectation that all gaps will be closed prior to annual open enrollment.

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- Appendix D contains a sample email that is sent to Health Plan CEOs, Ambetter Leads and Compliance at the Health Plans by Regulatory Operations.

IV. Open Enrollment

- Health Plan Network and Health Plan Compliance will report any network gaps remaining open within ten (10) days of the start of open enrollment to Health Plan leadership, CCS Regulatory Operations, Corporate Commercial Compliance and Corporate Network Development. Corporate Compliance and Regulatory Operations will meet with our CMS Account Manager, as determined necessary, to make them aware of the deficiencies and to outline the corrective action plan to close network gaps prior to January 1. CCS Regulatory Operations will additionally notify and arrange a meeting with state regulatory entities as necessary and in coordination with Health Plan leadership.
- Appendix E contains a sample email that is sent to Health Plan CEOs, Ambetter Leads and Compliance at the Health Plans by Regulatory Operations.

REFERENCES:

- Specific adequacy standards and requirements are discussed in existing Policy and Procedure HIM.NTWK.02.

ATTACHMENTS:

- Appendix A – Network Adequacy/Gap Analysis (example)
- Appendix B – Gap Report (example)
- Appendix C- Sample GAP Report E-mail for Plan Filing (example)
- Appendix D- Sample GAP Report E-mail for QHP Certification (example)
- Appendix E- Sample GAP Report E-mail for Open Enrollment (example)

DEFINITIONS:

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- | |
|--|
| <ul style="list-style-type: none"> • QHP – Qualified Health Plan as defined by 45 CFR 155.20 • Federal network adequacy standards - 45 CFR 156.230(a)(2) |
|--|

REVISION LOG

REVISION	DATE
Revised reporting to include only areas where providers are available, Added Appendix A-D within document	03/14/19
Removed red lines	11/16/2022

POLICY AND PROCEDURE APPROVAL

Please Sign and date on the lines provided (if applicable):

Approval on file _____

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APPENDIX A: Network Adequacy/Gap Analysis (example)

Contracted Provider Locations		Arkansas	Ashley	Baxter	Benton	Boone	Bradley	Calhoun	Carroll	Chicot	Clark	Clay	Cleburne	Cleveland
		2018	2018	2018	2018	2018	2018	2018	2018	2018	2018	2018	2018	2018
Hospital														
	General Acute Care Hospital	100	100	100	100	100	100	100	100	100	99.8	100	100	100
PCP														
	Primary Care	100	100	100	100	100	100	100	100	100	100	100	100	100
	Primary Care Extended	100	100	100	100	100	100	100	100	100	100	100	100	100
Practitioners														
	Allergy and Immunology	100	100	0	100	56.7	99.5	70.5	100	100	100	97.9	94.7	100
	Cardiothoracic Surgery	100	2.5	100	100	97.6	97.3	100	100	0	100	100	100	100
	Cardiovascular Disease	100	100	100	100	100	100	100	100	100	100	100	100	100
	Chiropracty	100	100	100	100	100	100	100	100	100	100	100	100	100
	Dental	63.4	100	100	100	100	98.7	12	100	100	100	100	100	70.3
	Dermatology	100	2.8	100	100	100	100	100	100	0	100	100	100	100
	Endocrinology	100	46.9	0	100	35.7	94.6	65.7	100	88.5	100	100	87.4	100
	ENT/Otolaryngology	100	84.2	100	100	100	100	100	100	0	100	100	100	100
	Gastroenterology	100	99.7	100	100	100	100	100	100	71.1	100	100	95.2	100
	General Surgery	100	100	100	100	100	100	100	100	100	100	100	100	100
	Gynecology (OB/GYN)	100	100	100	100	100	100	100	100	100	100	100	100	100
	Infectious Diseases	60.6	0	0	100	53.9	0	0	100	0	100	100	100	46.9
	Mental Health with Licensed Providers	100	100	100	100	100	100	100	100	100	100	100	100	100
	Nephrology	100	84.2	100	100	100	100	100	100	0	100	100	95.1	100
	Neurological Surgery	100	2.5	100	100	100	95.5	70.5	100	0	100	100	100	100
	Neurology	100	99.7	100	100	100	100	100	100	71.1	100	100	100	100
	Oncology (Medical/Surgical)	100	99.7	100	100	100	100	100	100	71.1	100	100	100	100

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APPENDIX B: GAP Report (example)

County	Specialty	Current Week Access	Previous Week Access	Gap Closure Progress	Expansion Year	Priority Gap	Providers Available to Close Gap	Notes/Targets to Close Gap	Gap Analysis	Gap Needing Research - Age ≥ 14 Days
Arkansas, AR	Primary Care	100.0	100.0	OK	2018	No				
Arkansas, AR	Primary Care Extended	100.0	100.0	OK	2018	Yes	N			
Arkansas, AR	Allergy and Immunology	100.0	100.0	OK	2018	No				
Arkansas, AR	Ambulatory Health Care Facilities - Infusion Therapy/Oncology/Radiology	100.0	100.0	OK	2018	No				
Arkansas, AR	Cardiac Catheterization Services	65.0	65.0	0.0	2018	No	N		Gaps w/o Providers Available	
Arkansas, AR	Cardiac Surgery Program	65.0	65.0	0.0	2018	No	N		Gaps w/o Providers Available	
Arkansas, AR	Cardiothoracic Surgery	100.0	100.0	OK	2018	No				
Arkansas, AR	Cardiovascular Disease	100.0	100.0	OK	2018	Yes				
Arkansas, AR	Chiropractic	100.0	100.0	OK	2018	No				
Arkansas, AR	Critical Care Services - Intensive Care Units (ICU)	100.0	100.0	OK	2018	No				
Arkansas, AR	Dental	63.4	63.4	0.0	2018	No		Forwarded to Dental Health and Wel	Gaps w/ Providers Available	
Arkansas, AR	Dermatology	100.0	100.0	OK	2018	No				
Arkansas, AR	Diagnostic Radiology	100.0	100.0	OK	2018	No				
Arkansas, AR	Durable Medical Equipment	100.0	100.0	OK	2018	No				
Arkansas, AR	Endocrinology	100.0	100.0	OK	2018	Yes				
Arkansas, AR	ENT/Otolaryngology	100.0	100.0	OK	2018	No				
Arkansas, AR	Gastroenterology	100.0	100.0	OK	2018	No				
Arkansas, AR	General Acute Care Hospital	100.0	100.0	OK	2018	Yes				
Arkansas, AR	General Surgery	100.0	100.0	OK	2018	No				
Arkansas, AR	Gynecology (OB/GYN)	100.0	100.0	OK	2018	Yes				
Arkansas, AR	Home Health	100.0	100.0	OK	2018	No				
Arkansas, AR	Infectious Diseases	80.6	80.6	0.0	2018	No	N		Gaps w/o Providers Available	
Arkansas, AR	Inpatient Psychiatry	100.0	100.0	OK	2018	Yes				
Arkansas, AR	Mammography	73.8	73.8	0.0	2018	No	N		Gaps w/o Providers Available	
Arkansas, AR	Mental Health with Licensed Providers	100.0	100.0	OK	2018	Yes				
Arkansas, AR	Nephrology	100.0	100.0	OK	2018	No				
Arkansas, AR	Neurological Surgery	100.0	100.0	OK	2018	No				
Arkansas, AR	Neurology	100.0	100.0	OK	2018	No				
Arkansas, AR	Occupational Therapist	100.0	100.0	OK	2018	No				
Arkansas, AR	Oncology (Medical/Surgical)	100.0	100.0	OK	2018	No				
Arkansas, AR	Ophthalmology	100.0	100.0	OK	2018	No				
Arkansas, AR	Orthopaedic Surgery	100.0	100.0	OK	2018	No				
Arkansas, AR	Orthotics and Prosthetics	100.0	100.0	OK	2018	No				
Arkansas, AR	Outpatient Dialysis	100.0	100.0	OK	2018	Yes				

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APPENDIX C: Sample GAP Report E-mail for Plan Filing (example)

Good morning <Health Plan CEO>,

As you know, we are planning to submit <state> QHP filing on <day>, <date>, which will include the Network Adequacy template. For the <20xx> plan year, we have initiated a new internal protocol (P&P, [HIM.NTWK.09](#)) for transparency of network adequacy reporting (1) at the time of filing, (2) at the time of approval and (3) prior to open enrollment. With the Ambetter growth nationally, we expect continued regulatory/media scrutiny on network adequacy and access, and therefore want to ensure proper notification of known gaps are reported to leadership throughout the filing process.

Please allow this email to provide an overview of the gaps still remaining within your state, which either require additional research or for which there are providers available. Please work with your network leads and provide a summary of how these gaps will be addressed prior to the QHP application deadline on <DATE>.

County	Specialty	Current Week Access	Previous Week Access	Gap Closure Progress	Expansion Year	Priority Gap	Providers Available to Close Gap	Notes/Targets to Close Gap	Gap Analysis
Alachua, FL	Orthopaedic Surgery	38.9	38.9	0.0	2018	No	Y	There are two large orthopaedic groups in Alachua, UF Shands and The Orthopaedic Institute. We are not contracted with the UF system. We have contacted The Orthopaedic Institute on various occasions and they have declined. We continue to outreach to this group and are looking to surrounding counties.	Gaps w/ Providers Available
Alachua, FL	Pediatrics - Routine/Primary Care	85.5	85.5	0.0	2018	No	Y	Alliance Pediatrics was loaded but did not move the needle. Breen Health LLC has added a Pediatrician and borders a very rural edge of Alachua. We have expedited the load and this will most likely close the gap.	Gaps w/ Providers Available

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PRODUCT TYPE: Health Insurance Marketplace	REFERENCE NUMBER: HIM. NTWK. 09

APPENDIX D: Sample GAP Report E-mail for QHP Certification (example)

Dear <Health Plan CEO>,

As you may know, QHP agreements have been signed (we are pending the counter-executed document back from CMS) and we are swiftly approaching Open Enrollment. Please allow this email to provide an overview of the gaps still remaining within your state, which either require additional research or for which there are providers available.

Please work with your network leads and provide a summary of how these gaps will be addressed prior to <Insert Date>.

Please feel free to reach out with questions.

County	Specialty	Current Week Access	Previous Week Access	Gap Closure Progress	Expansion Year	Priority Gap	Providers Available to Close Gap	Notes/Targets to Close Gap	Gap Analysis
Alachua, FL	Orthopaedic Surgery	38.9	38.9	0.0	2018	No	Y	There are two large orthopaedic groups in Alachua, UF Shands and The Orthopaedic Institute. We are not contracted with the UF system. We have contacted The Orthopedic Institute on various occasions and they have declined. We continue to outreach to this group and are looking to surrounding counties.	Gaps w/ Providers Available
Alachua, FL	Pediatrics - Routine/Primary Care	85.5	85.5	0.0	2018	No	Y	Alliance Pediatrics was loaded but did not move the needle. Breen Health LLC has added a Pediatrician and borders a very rural edge of Alachua. We have expedited the load and this will most likely close the gap.	Gaps w/ Providers Available

POLICY AND PROCEDURE

DEPARTMENT: Network Development and Contracting. Health Plan Network, Health Plan Compliance.	DOCUMENT NAME: Health Insurance Marketplace Network Oversight and Reporting
PAGE: 9 of 9	REPLACES DOCUMENT: N/A
APPROVED DATE:	RETIRED: N/A
EFFECTIVE DATE: 6/30/18	REVIEWED/REVISED: 06/11/2020; 1/18/2022; 11/16/2022
PRODUCT TYPE: Health Insurance Marketplace	REFERENCE NUMBER: HIM. NTWK. 09

APPENDIX E: Sample GAP Report E-mail for Open Enrollment (example)

Good morning <Health Plan CEO>,

Pursuant to P&P HIM.NTWK.09, we are providing this update on the network gaps still impacting <State> for PY <20xx>. As you know, Open Enrollment is underway and go live will occur on <1/1/xx>. Please provide an overview of how these gaps will be closed for PY <20xx> prior to <Insert Date>. Some of the gaps contain notes, please confirm if any further updates have occurred since those notes were provided to the network team.

County	Specialty	Current Week Access	Previous Week Access	Gap Closure Progress	Expansion Year	Priority Gap	Providers Available to Close Gap	Notes/Targets to Close Gap	Gap Analysis
Alachua, FL	Orthopaedic Surgery	38.9	38.9	0.0	2018	No	Y	There are two large orthopaedic groups in Alachua, UF Shands and The Orthopaedic Institute. We are not contracted with the UF system. We have contacted The Orthopedic Institute on various occasions and they have declined. We continue to outreach to this group and are looking to surrounding counties.	Gaps w/ Providers Available
Alachua, FL	Pediatrics - Routine/Primary Care	85.5	85.5	0.0	2018	No	Y	Alliance Pediatrics was loaded but did not move the needle. Breen Health LLC has added a Pediatrician and borders a very rural edge of Alachua. We have expedited the load and this will most likely close the gap.	Gaps w/ Providers Available

WORK PROCESS

DEPARTMENT: Population Health and Clinical Operations	POLICY ID: HIM.UM.01.08
EFFECTIVE DATE: 03/02/15	WORK PROCESS NAME: Use of Out of Network Providers and Steerage
POLICY NAME: CC.UM.01 - UM Program Description	REVIEWED/REVISED DATE: 01/17; 08/17; 10/17; 03/18, 03/19; 12/19; 01/20; 9/20; 2/21; 03/21; 04/21; 08/21
RETIRED DATE: N/A	

SCOPE:

This policy applies to Marketplace Plan Population Health and Clinical Operations (PHCO) Department

PURPOSE:

The purpose of this work process is to ensure timely access to care when In Network/In Service Area Providers are not available.

DEFINITIONS: N/A

WORK PROCESS:

This work process outlines how the Company evaluates requests for services from a member or provider for care to be provided by an out of network (OON) and/or out of area provider.

The work process also provides guidance for PHCO, outlining the process for reviewing access for requested services in network, and denial for OON/out of area providers when there is an in network or in service area provider that meets access standards.

This work process does not apply to emergent or urgent care or those services specifically exempt from prior authorization by contract (i.e., family planning, etc.).

Product Benefits	In Network Benefits	Out of Network Benefits	Out of Service Area Benefits
Exclusive Benefit Provider (EPO)	Yes	Emergent/Urgent only unless prior authorized	N/A
Health Maintenance Organization (HMO)	Yes	Emergent/Urgent only unless prior authorized	N/A
Preferred Provider Organization (PPO)	Yes	Yes with prior authorization	Yes with prior authorization

All EPO and HMO OON requests require prior authorization with the exception of emergent/urgent care services.

PPO members have the option to self-refer to an OON provider within their service area. All PPO OON **and** out of service area requests require prior authorization with the exception of emergent/urgent care services.

For EPO, HMO and PPO, OON services will be paid based on the benefit coverage for OON services as defined in their Evidence of Coverage and Summary of Benefits.

Approval/prior authorization for OON providers is limited to cases where services cannot be reasonably obtained by a network provider or during a transition period for continuity of care (COC). For services to be approved OON we must confirm services are a covered benefit and are medically necessary.

Criteria for OON or Out of Service Area Approval

Approvals for OON and out of area providers are limited to special circumstances for our members as outlined below:

1. When services cannot be reasonably obtained by an in network provider: Out of network requests are considered when no in network provider can be located within the state network adequacy requirements for a covered benefit that meets medical necessity. This may vary by state and also within each state based on whether the individual resides in an urban or rural area. The access will be measured based on the availability of an in network provider of the same or similar specialty within the distance outlined in the state network adequacy standards (reference the Marketplace Access Standards SharePoint site for your Plan's state specific standards") or within 60 miles of the member (if state network adequacy standards do not specify a mileage).

2. When services cannot be reasonably obtained inside the service area: Out of service area requests are considered when no in network provider **or** in service area provider can be located within the state network adequacy requirements for a covered benefit that meets medical necessity as outlined above in 'When services cannot be reasonably obtained by an In Network Provider'.
3. During a transition period when continuity of care exists: When COC exists, as outlined in *Continuity and Coordination of Services CC.UM.20*, use of an OON or out of service area provider for a covered benefit that meets medical necessity may be considered.
 - a. Applicable to requests during transition for COC for newly enrolled members or for services where the provider has been terminated. Members seen on a regular basis by a provider terminating from the network should receive a 30 day advance notice of the provider termination along with information on who to contact related to continuity of care requests as per *CC.PRVR.23 Provider Termination Policy*.
 - b. Qualified Health Plan (QHP) guidance extends COC for cases where a provider is terminated without cause, to allow an enrollee in an active course of treatment to continue treatment until the treatment is complete or for 90 days, whichever is shorter, at In Network cost sharing rates. This is typically based on the care needs, the complexity of the case, and/or the lack of ability to ensure a safe transition of care to an alternate provider within the network.

For all OON or out of service area requests, attempts will be made to direct to an in network provider. We will apply our Medical Coverage Policies when evaluating the medical necessity for services from the OON or out of service area provider, which includes considering the absence of or the exhaustion of all in network and in service area resources. Failure to request prior authorization will result in denial of coverage. Prior authorization does not guarantee payment or assure coverage.

The above criteria should be considered anytime there is a complaint received that a member can either not locate an in network provider or is unable to obtain access due to closed panel status or limited availability (*please reference Provider Manual for Appointment availability standards*) to determine if the request should be considered for OON or Out of Service Area. Plan, state and/or federal contractual requirements will be followed where applicable.

Follow the steps for Out of Network Providers and Steerage:

- A. All OON/out of area requests should be documented using the OON INN Steerage structured note type.
- B. Check if services are available in network.
 1. In network Provider search and steerage process
 - a. UM designee will search using the “**Find a Provider**” (FAP) tool on the plan website (or other local Plan provider search tool).
 - i. Search by member zip code and provider type, and exclude any closed practices unless the member is an existing patient (provider, hospital or other).

Note: Specialty type and language may also be available in the search tool.
 - ii. Search results will provide distance from the member’s zip code.
 - iii. UM designee should make sure all in network provider options have been explored to include the Health Plan’s Provider Contracting department before OON options are considered and to notify the Health Plan’s contracting team of potential network gaps.

Note: Provider contracting may know of a new in network provider who is in the credentialing process; A single case agreement (SCA) will still be needed in this case.

Note: WA - reference Washington State addendum to HIM.UM.17 Single Case Agreements when determining if an SCA is needed.
 - b. If search results do not meet the established geographic or accessibility standards (reference the Market Place Access Standards share point site for your Health Plan’s state specific standards) for availability of providers, the request for an OON or out of area provider would be sent for advisor review (Medical Director).
 - i. Medical Director to reinforce there is no available in network providers to meet access standards. If access standards are not met, the Medical Director shall approve the OON provider and trigger the rate negotiations as outlined in section D below. A copy of the approval will be sent to the to the Health Plan Contracting department.
 - c. If in network providers are located, PHCO designee will contact at least three (3) providers to ensure they are available to provide the requested service(s), are accepting new members, and are able to accommodate seeing the member within a reasonable timeframe per CC.QI.05 – *Evaluation of Accessibility of Services* or established plan, state, federal and/or contractual requirements.
 - i. If less than three (3) provider names display in the search, PHCO designee will contact all providers listed.

- ii. If any network provider shows an open panel but is indicating they wish to close their panel and will no longer accept Marketplace members, notify to the network access team to update the provider status in the online directory and FAP tool.
 - iii. The PHCO designee will also report any inaccuracy found with the FAP tool using the link found at the bottom the FAP tool; to ensure the inaccuracy is addressed.
2. If in network providers are available, the PHCO designee will contact the requesting provider/member phone or fax and provide information on the in network providers that were located and their availability to accept the member.
- Note:* During the review process; it will be confirmed that the in network provider will be able to actually perform the services requested.
- a. If the **requesting provider/member agrees to the use of an in network provider:**
 - i. The Plan designee will cancel/withdraw the need to further review the request for OON services, since an in network provider was identified and the requesting provider/member agreed to utilize a Plan Provider. The Plan designee will update the authorization with the in network provider's information within the clinical documentation system in the OON INN Steerage structured note type and will communicate to the appropriate PHCO staff for completion of issuing a prior authorization.
 - a) If the service(s) does not require a prior authorization, the PHCO staff will void the request for the authorization within the clinical documentation system, and document the date and time that the member was advised and whom the member can access within the network and with no authorization required. *Member communication is imperative.*
 - b. If the requesting **provider is unwilling to use an in network or in area provider** and there are contracted providers available; the request will be denied for a non-covered benefit using the “*Non Covered Benefit Notice*”, along with communication to redirect the member to available services within the network along with appeal rights.
 - i. The UM designee will send the OON request to the Medical Director for advisor review.
 - ii. The Medical Director will review and deny the request. The authorization status is “Deny” and add the applicable denial verbiage non-emergency services outside of service area, benefit denial) in the CDS claims information field. The PHCO designee will follow the CC.UM.07 Adverse Determination (Denial) Notices work process. A Non-Covered Benefit Denial notice will be sent to both the provider and member.
 - iii. If the service(s) does not require a prior authorization, the PHCO staff will void the current authorization from the clinical documentation system, advising the member who they can access in network and/or in their service area with no authorization.
 - c. **If the member is unwilling to use an in network provider** and there are contracted providers available:
 - i. The PHCO designee will inform the member if they choose to see an OON provider then they will be liable for the services that are billed on their behalf as there is no contractual obligation between the plan and the OON provider. The PHCO designee will document the conversation in the clinical documentation system.
 - ii. The PHCO designee will complete and send both the member and the OON provider an “*Out of Network Commercial Service Denial Notice*” to provide written documentation of the verbal conversation and to remind the member they may be responsible for the remaining billed services.

C. Out of Network Inpatient Concurrent Review

The Concurrent Review Nurse (CRN) or Discharge Planner (DCP) is responsible to steer the member from the OON facility to an in network facility.

1. Out of Network inpatient admissions may occur as a result of an emergent or urgent situation. The Plan will evaluate the unique circumstances surrounding the health care needs of the member.
2. When the Referral Specialist (RS) team receives a request for an OON emergent admission, the RS verifies in Amisys the provider status then creates the auth for the inpatient stay.
 - a. The RS provides the initial notification of OON and provides two to three in network options to the OON facility. The facility is notified of their OON status via fax notification.
 - b. The RS documents this in the clinical documentation system under the structure note OON_INN Steerage
 - c. The RS routes the authorization to the CRN.
3. The CRN completes the remainder of this process unless otherwise noted. Verify the OON_INN Steerage note has been documented by the RS and faxed notification of in network options has been submitted to the OON facility. If the Plan has a designated UM DCP, a notification task is sent to the DCP to request assistance for OON steerage. The task description includes the admission date, primary diagnosis, in network status: OON, level of care member admitted to, and reliable phone number for the CM/UR dept.
4. Conduct a clinical review and complete the auth process as per normal, bringing the auth to the most current date of the stay. The most appropriate OON letter notification is sent to the member and provider.
5. In the event the OON facility Utilization Review & Case Management department operate as separate entities:

- a. Outreach to Patient Information at the facility.
- b. Confirm the member remains at the facility
- c. Ask to be transferred to the unit the member is admitted to, and request to speak to the unit case manager
all units have assigned Case Managers that are required to follow up with patient needs
6. Provide verbal notification via phone to the assigned Case Manager, and indicate that the member is OON and inquire if the OON notification was received with in network options.
 - a. If this was not received by the floor/unit CM, provide 2-3 in network options and educate the CM on OON utilization/benefits.
 - b. Based on the clinical information and the Medical Director review, if available, if the member is deemed clinically stable, identify any potential barriers the OON facility may have with transferring to in network facility during the call and document this within the clinical documentation system under the current authorization.
 - c. Provide contact information and request a call back from the OON facility to follow up with progress or barriers in transferring the member out.
 - d. Request that the Provider notify the member that they are at an out-network facility.
 - e. Set a task for the next day to review the case to inquire on status of transfer to a in network facility
7. For the member to be transferred out of the OON facility, the attending provider must deem the member medically stable and the attending and member must agree to the transfer to an in network facility.
 - a. Document any refusal to transfer by the member within the clinical documentation system and send a task for *CM Referral* to the Care Management team to follow up with the member post-discharge to provide education on benefits. The Refusal to Transfer notification must be sent to the member.
 - b. The CM team is encouraged to outreach to the member while the member is hospitalized to educate the member on their benefits, notify of adverse determinations of OON utilization and possible balance billing. Collaboration with a CM Program Coordinator is preferred so that all attempts at providing notification to the provider/member are made.
8. Call the facility daily to inquire on the progress with transferring the member to an in network facility.
 - a. If unable to make contact with the OON facility, document the failed attempts within the clinical documentation system and communicate to the medical director that follow up attempts were unsuccessful.
 - b. If contact was made with the facility and the provider reports barriers with transferring to an in network facility, document in the clinical documentation system the detail of the barriers/concerns the provider reports.
 - c. If the in network facilities that were provided are not willing to accept the member due to bed availability, provide additional in network options within the member's service area.
 - d. If the OON Provider reports the member is not medically stable, conduct continued stay review and send to the Medical Director for determination.
9. If the continued stay is approved by the Medical Director based on the barriers the provider is encountering and the member clinical status, continue daily follow up and documentation of the most current clinical information and progress on transferring to a in network facility.
10. If the auth is denied for lack of medical necessity because in network facilities are not available, follow up daily with the provider to obtain updates on the progress of transferring the member to a in network facility. Continue to assist with transfer to the in network facility and assist with any discharge needs.
11. By day three of admission, if there has been no success with transfer to an in network facility due to barriers or the member's clinical status, begin the OON rate negotiations.

D. Out of Network Rate Negotiations

1. Out of network authorization request received.
 - a. The PHCO designee will contact the OON provider to determine if the provider is willing to accept 100% of Payor Fee Schedule (FS) and agrees that the member will not be balance billed for charges that are incurred above that amount.
 Note: MI reference the MI.HIM.UM.01.08 Addendum for step 2 and 3
 - b. Verbal Agreement to accept 100% of Payor FS rates:
 - i. If the requesting provider, facility, or office designee agrees verbally, a note indicating acceptance of the 100% of Payor FS will be entered into the member's record in the clinical documentation system using the SCA-Non Par Agreement note type. The note will include the date, time, name and contact number of the person agreeing to the fee schedule.
 - ii. The PHCO designee will follow *Medical Necessity Review CC.UM.02.01* work process and a "PA Non-Par Prior Authorization Letter" will be sent to provide written documentation of this verbal agreement and to remind the provider not to balance bill the member. Within the authorization, the determination will be documented as follows:
 - a) Explanation Field: User will select "Negotiated Rate". This will generate communication to the Provider that they are not to balance bill the member.

Note: A SCA is not required if the non-participating Provider or facility is willing to accept 100% of Payor Fee Schedule rates.

Note, in WA: Reference Washington State addendum to HIM.UM.17 Single Case Agreements when determining if an SCA is needed.

- c. No Verbal Agreement - Single Case Agreement Required
 - i. In cases where no verbal agreement can be reached as referenced above, further negotiation is attempted by the Plan’s contracting team. The PHCO designee will document next steps in the clinical documentation system using the SCA-needed initial request note type.
 - ii. The PHCO designee will ensure that any disagreement is communicated to the appropriate PHCO designee as soon as possible for completion of a level two (2) review, following the *HIM.UM.05 – Timeliness of UM Decisions and HIM.UM.17 – Single Case Agreement and Notifications policy*.
- d. Refer to the “*Ambetter Out-of-Network Approval Notice*” for a copy of the member communication related to the approval for OON services, which includes the notification process on who to contact at the health plan to resolve any balance billing issues. In cases where network adequacy or access to care is an issue, the health plan will work with the member to resolve this through the appeals process so we eliminate DOI complaints about the network inadequacy.

The Plan Contracting Department is to attempt to negotiate all single case agreements. The plan contracting department negotiates all facility agreements including hospitals, outpatient facilities, skilled nursing facilities and all other non-contracted in and out of state facilities.

E. Special Considerations

- 1. Out of network requests are considered when no contracted provider can be located within the state network adequacy requirements for a covered procedure that meets medical necessity or where a participating provider is only affiliated with an out of network facility and will require advisor review and SCA if facility does not agree to 100% of the Payor FS.
- 2. Out of network providers are considered for second opinion requests based on member contract, but will require advisor review and SCA if provider does not agree to 100% of the Payor FS.
- 3. Inpatient or outpatient “out of area services” will be considered for treatment of unexpected illness or injury. Advisor review and SCA is required if facility/provider does not agree to 100% of the Payor FS.
- 4. If an authorization is approved based on the above special considerations to allow a member to use an OON Provider, the PHCO designee will:
 - a. Send the non-par request to the Medical Director for advisor review.
 - i. The Medical Director will review and approve or deny the request. The PHCO designee will leave the authorization status in “*pend*” Status.
 - ii. The PHCO designee will complete and send both the member and the OON provider an “*Out of Network Commercial Service Approval Notice*” to provide written documentation of the verbal conversation and to remind the member they may be responsible for the remaining billed services.

Note: All information must be documented in detail in the clinical documentation system ensuring notes are entered into or associated with the authorization.

REFERENCES:

HIM.UM.05 - Timeliness of UM Decisions and Notifications
 CC.UM.07 - Adverse Determination (Denial) Notices
 HIM.UM.17 - Single Case Agreement (SCA)
 CC.UM.20 - Continuity and Coordination of Services
 HIM.UM.01.09 - Management of an Admission to a Non-Participating Facility
 CC.PRVR.47- Evaluation of Practitioner Availability
 Provider Manual - Appointment Availability Standards

ATTACHMENTS: N/A

REVISION LOG

REVISION TYPE	REVISION SUMMARY	DATE PUBLISHED
Ad Hoc Review	OON Commercial Denial Notice added.	08/2017

Ad Hoc Review	<p>Revisions added: Regarding Medical Director review of non-covered benefit denials. (Pg.4 bullet f.) Decisions about the following require medical necessity review:</p> <ul style="list-style-type: none"> • Covered medical benefits defined by the organization's Certificate of Coverage or Summary of Benefits. • Preexisting conditions, when the member has creditable coverage and the organization has a policy to deny preexisting care or services. • Care or services whose coverage depends on specific circumstances. • Dental surgical procedures that occur within or adjacent to the oral cavity or sinuses and are covered under the member's medical benefits. • Out-of-network services that are only covered in clinically appropriate situations. • Prior authorizations for pharmaceuticals and pharmaceutical requests requiring prerequisite drug for a step therapy program. • "Experimental" or "investigational" requests, unless the requested services or procedures are specifically excluded from the benefits plan and deemed never medically necessary under any circumstance in the organization's policies, medical necessity review is not required. <p>Decisions about the following do not require medical necessity review:</p> <ul style="list-style-type: none"> • Services in the member's benefits plan that are limited by number, duration or frequency. • Extension of treatments beyond the specific limitations and restrictions imposed by the member's benefits plan. • Care that does not depend on any circumstances. <p>Requests for coverage of out-of-network services that are only covered when medically necessary or in clinically appropriate situations require medical necessity review. Such requests indicate the member has a specific clinical need that the requestor believes cannot be met in network (e.g., a service or procedure not provided in network; delivery of services closer or sooner than provided or allowed by the organization's access or availability standards).</p> <p>If the certificate of coverage or summary of benefits specifies that the organization never covers an out-of-network service for any reason or if the request does not indicate the member has a specific clinical need for which out-of-network coverage may be warranted, the request does not require medical necessity review.</p>	10/2017
Ad Hoc Review	OON policy revised to reflect the member communication process with Member communication letter under step 2; page 6.	03/18
Annual Review	No substantive changes.	03/19
Ad Hoc Review	Reimbursement language revised to reflect the removal of Medicare from the Payor Fee Schedule. New language Payor Fee Schedule.	12/19
Ad Hoc Review	Updated the Policy to reference WA addendum. Note: Please reference Washington State addendum to HIM.UM.17 Single Case Agreements when determining if an SCA is needed.	01/20
Ad Hoc Review	<p>Added OON Urgent care billing information on pg.6 bullet g.</p> <p>g. If a member is goes to an OON Urgent Care Center outside the ER (standalone building, independent, chain, etc.), then the service(identified by the presence of REV code 516 or 526 billed on the claim) will be denied as a non-covered benefit (specifically using EXy1- DENIED:OUT-OF-NETWORK PROVIDER NOT COVERED PER HMO/EPO POLICY)</p> <ul style="list-style-type: none"> • Note: <i>If the member goes to an ER and the member is directed to go to an OON Urgent Care, then authorization is not required as identified by the presence of REV code 456 billed on the claim. (Effective 9-1-2020)</i> 	09/20
Annual Review	Annual review: Revised work process to reference Population Health and Clinical Operations (PHCO) and remove Medical Management (MM) references.	02/21

Ad Hoc Review	Added addendum for Michigan Health Plan.	03/21
Ad Hoc Review	Updated policy to include PPO and added language to the PPO Self-Referral section to support in network for PPO networks (i.e. OON requires PA). Added section to outline process for inpatient OON facility steerage Update and clarified language in Purpose section General updates to language throughout for consistency	04/21
Ad Hoc Review	Updated language under Purpose for clarity, added product benefits grid. Clarified all OON requests should be documented via OON_INN Steerage structured note. Added section C to address inpatient OON steerage process. Updated section E to remove points that were duplicated.	08/21

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, the Company's P&P management software, is considered equivalent to a signature.

POLICY AND PROCEDURE

DEPARTMENT: Individual and Family Plans	REFERENCE NUMBER: IFP.PHAR.03
EFFECTIVE DATE: 02/14	POLICY NAME: Pharmacy & Therapeutics Committee
REVIEWED/REVISED DATE: 02/15, 02/16, 11/16, 02/17, 02/18, 02/19, 02/20, 02/21, 02/22	RETIRED DATE: N/A

SCOPE:

Individual and Family Plans, Centene Shared Pharmacy Services, Centene Corporate Pharmacy and Therapeutics Committee.

PURPOSE: To establish a Pharmacy & Therapeutics Committee Charter

PHARMACY & THERAPEUTICS COMMITTEE CHARTER

1. THE CPTC SHALL:

- a. Objectively appraise, evaluate, and select drugs for coverage on the Individual and Family Plan formulary and/or medical benefit and review the coverage requirements as directed by the Centers for Medicare and Medicaid Services (CMS) with at least 1 drug in every USP class and/or State specific benchmark requirements.
- b. Meet quarterly, and if necessary more frequently, to review and update the formulary to consider adding newly approved drugs and recommending changes to existing drug coverage in consideration of changes in FDA-approved labeling, safety concerns, or current market conditions. Ad hoc meetings, if necessary, may be in the form of an in-person meeting, via phone or an online meeting with online vote. Decisions rendered through ad hoc meetings are considered effective as of the date of the final vote and will be brought to quarterly meeting for review and notation in meeting minutes. This section does not absolve the CPTC from all requirements provided for under the Membership and Organization section.
- c. Review and approve Drug Utilization Review (DUR) initiatives delegated to Centene Shared Pharmacy Services that are sent to the Individual and Family Plans for provider or member intervention.
- d. Review and approve policies and procedures governing provisions of the Individual and Family Plan pharmacy benefits.
- e. Review and approve criteria guidelines for the use of restricted access drugs and non-formulary covered drug therapy.
- f. Review newly FDA-approved drug products within 90 days, and reach a coverage decision for each newly FDA-approved drug within 180 days of its market availability.

POLICY AND PROCEDURE

DEPARTMENT: Individual and Family Plans	REFERENCE NUMBER: IFP.PHAR.03
EFFECTIVE DATE: 02/14	POLICY NAME: Pharmacy & Therapeutics Committee
REVIEWED/REVISED DATE: 02/15, 02/16, 11/16, 02/17, 02/18, 02/19, 02/20, 02/21, 02/22	RETIRED DATE: N/A

2. **MEMBERSHIP & ORGANIZATION:**

The CPTC will be chaired by the Centene VP of Medical Affairs, or the Centene Chief Medical Officer or his/her designee. Voting members of the Committee will include practicing community-based practitioners and pharmacists representing various clinical specialties that adequately represent the needs of Individual and Family Plan members. The Committee includes at least one practicing physician and one practicing pharmacist who are experts regarding the care of elderly or disabled individuals.

Outside specialty consultants, independent and free of conflict with respect to Centene Health Plans and pharmaceutical manufacturers, may be recruited, as deemed necessary, to provide input related to their areas of expertise and to provide advice on specialty practice standards. A quorum is required to transact business and make decisions. A quorum shall consist of more than 50% of members, 3 of whom must be community-based practitioners.

- a. At least 20 percent of the CPTC members will have no conflict of interest with respect to Centene Health Plans and pharmaceutical manufacturers.
- b. No CPTC member with a conflict of interest with respect to Centene Health plans or a pharmaceutical manufacturer will vote on any matters for which the conflict exists.
- c. All members of the P&T committee shall be required to disclose any conflict of interest, including but not limited to compensation or funding from a pharmaceutical manufacturer, developer, labeler, wholesaler, or distributor.

Attendance of greater than 50% of P&T Committee meetings in a rolling 12 months is required to maintain the rights of a voting member.

All members shall serve a two-year term. Every two years members will be contacted to confirm their willingness to continue participation in the P&T. Once a member confirms willingness to continue a member will fill a subsequent two-year appointment unless member resigns or attends less than 50% of P&T Committee meetings in a rolling 12 months.

POLICY AND PROCEDURE

DEPARTMENT: Individual and Family Plans	REFERENCE NUMBER: IFP.PHAR.03
EFFECTIVE DATE: 02/14	POLICY NAME: Pharmacy & Therapeutics Committee
REVIEWED/REVISED DATE: 02/15, 02/16, 11/16, 02/17, 02/18, 02/19, 02/20, 02/21, 02/22	RETIRED DATE: N/A

3. **RESPONSIBILITIES:**

The CPTC will carry out its mission and perform its duties by applying the following principles:

- a. Clinical decisions are based on the strength of scientific evidence and standards of practice that include, but are not limited to, the following:
 - i. Assessing peer reviewed medical literature, randomized clinical trials, pharmacoeconomic studies, and outcomes research data;
 - ii. Employing well established clinical practice guidelines developed by means of an evidenced-based process and making use of other sources of appropriate information;
 - iii. Comparing the safety, efficacy, the frequency of side effects and potential drug interactions among alternative drug products;
 - iv. Assessing the likely impact of a drug product on patient compliance when compared to alternative products;
 - v. Basing formulary and/or medical benefit coverage decisions on a thorough evaluation of the benefits, risks and potential outcomes for patients;
 - vi. Reviewing and monitoring medication utilization trends and comparing data to recognized and established professional practice standards or protocols to facilitate the development or revision of coverage criteria, to assess appropriate use, to make recommendations for changes in formulary positioning and to provide feedback to prescribers;
 - vii. Reviewing, at least annually, the prior authorization criteria guidelines for drug coverage to ensure that they reflect current market conditions and standards of care.
- b. Economic considerations that include, but are not limited to the following will be delegated to Strategy Development Committee:
 - i. Basing formulary coverage decisions on cost factors only after the safety, efficacy and therapeutic need have been established by the CPTC
 - ii. Evaluating drug products and therapies in terms of their impact on total health care costs.
- c. Administrative considerations include, but are not limited to, the following:

POLICY AND PROCEDURE

DEPARTMENT: Individual and Family Plans	REFERENCE NUMBER: IFP.PHAR.03
EFFECTIVE DATE: 02/14	POLICY NAME: Pharmacy & Therapeutics Committee
REVIEWED/REVISED DATE: 02/15, 02/16, 11/16, 02/17, 02/18, 02/19, 02/20, 02/21, 02/22	RETIRED DATE: N/A

- i. Notifying Individual and Family Plans regarding any suggestions for additions, deletions or changes to the formulary, clinical guidelines, or utilization edits.
- ii. Notifying Individual and Family Plans, via committee meeting minutes, of the proceedings and decisions made by the Committee.
- iii. Notifying Individual and Family Plans of the Committee's meeting schedule on an annual basis.

4. **VOTING**

- a. Attendance at the meeting is required for a vote to be counted.
- b. Permanent voting members not in attendance will not vote by proxy.
- c. All voting members have equal voting privileges.
- d. Decisions are documented by counting Yea, Nay, and Abstain options.

5. **DELEGATED FUNCTIONS:**

P&T delegates creation of oncology product(s) clinical criteria to an external vendor, for those plans that have signed delegation agreement(s). Such agreement(s) are subject to vendor oversight and annual review of external vendor clinical policies.

6. **REVIEW OF CHARTER:**

The CPTC will review this charter annually from the date of original approval or revision date, whichever is more current.

REFERENCES: 45 CFR 156.122(a)(3)

ATTACHMENTS: N/A

DEFINITIONS: N/A

REVISION LOG

REVISION	DATE
Changed reference from Corporate Pharmacy Department to US Script Utilization Management Pharmacy Department.	02/16

POLICY AND PROCEDURE

DEPARTMENT: Individual and Family Plans	REFERENCE NUMBER: IFP.PHAR.03
EFFECTIVE DATE: 02/14	POLICY NAME: Pharmacy & Therapeutics Committee
REVIEWED/REVISED DATE: 02/15, 02/16, 11/16, 02/17, 02/18, 02/19, 02/20, 02/21, 02/22	RETIRED DATE: N/A

Changed reference from US Script Utilization Management Pharmacy Department to Envolve Pharmacy Solutions to reflect change in branding. Removed: "The secretary of the Committee will be Centene's VP of Pharmacy or his/her designee" as there is no longer Corporate Pharmacy department. Under section b. added that the economic considerations will be delegated to Strategy Development Committee (SDC). Under section b. i. added "by the P&T Committee at the end of the sentence. Minor grammatical changes.	11/16
Expanded section b. to include information on ad hoc meeting.	02/17
Reviewed Policy. No changes.	02/18
Reviewed Policy. Created new section #4 Delegated Functions.	02/19
Revised section 1. to add "and/or provided under the Ambetter Health Insurance Marketplace (HIM) medical benefit." Revised section 2. a. and 4. v. to add "and/or medical benefit". Under section 2. subsection b. added "via phone" to indicate that ad-hoc meetings can take place via phone as well.	02/20
Under Membership and Organization added: "The Committee includes at least one practicing physician and one practicing pharmacist who are experts regarding the care of elderly or disabled individuals." Edited Membership section to add: Attendance of greater than 50% of P&T Committee meetings in a rolling 12 months is required to maintain the rights of a voting member. AND All members shall serve a two-year term. Every two years members will be contacted to confirm their willingness to continue participation in the P&T. Once a member confirms willingness to continue a member will fill a subsequent two year appointment unless member resigns	02/21

POLICY AND PROCEDURE

DEPARTMENT: Individual and Family Plans	REFERENCE NUMBER: IFP.PHAR.03
EFFECTIVE DATE: 02/14	POLICY NAME: Pharmacy & Therapeutics Committee
REVIEWED/REVISED DATE: 02/15, 02/16, 11/16, 02/17, 02/18, 02/19, 02/20, 02/21, 02/22	RETIRED DATE: N/A

<p>or attends less than 50% of P&T Committee meetings in a rolling 12 months.</p> <p>Added new section #4 VOTING Deleted: The Centene Pharmacy & Therapeutics Committee (CPTC) is responsible for reviewing, evaluating and deciding on changes to drugs listed for coverage and associated edits related to controls or limitations of drug coverage, and the policies and procedures governing provision of drug coverage under the Ambetter Health Insurance Marketplace (HIM) formularies and/or provided under the Ambetter Health Insurance Marketplace (HIM) medical benefit due to redundancy.</p>	
<p>Policy reviewed. Changed reference of the document from HIM.PHAR.03 to IFP.PHAR.03; Changed references from Envolve Pharmacy Solutions to Centene Shared Clinical Pharmacy Services and from Ambetter/Health Insurance Marketplace to Individual and Family Plans. Under Section 2. Membership and Organization added subsection c. "All members of the P&T committee shall be required to disclose any conflict of interest, including but not limited to compensation or funding from a pharmaceutical manufacturer, developer, labeler, wholesaler, or distributor." This was a suggestion from our Oklahoma plan.</p>	02/22

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, the Company's P&P management software, is considered equivalent to a signature.

WORK PROCESS

DEPARTMENT: Population Health and Clinical Operations	POLICY ID: IFP.UM.01.09
EFFECTIVE DATE: 04/16/2015	WORK PROCESS NAME: Management of an Admission to a Non-Participating Facility
POLICY NAME: IFP.UM.17 - Single Case Agreements	REVIEWED/REVISED DATE: 02/16; 01/17; 01/18; 02/19;12/19; 12/20; 05/22
RETIRED DATE: N/A	

PURPOSE:

The purpose of this document is to outline a process for the management of an inpatient admission to a non-participating facility.

SCOPE:

Ambetter Health Insurance Marketplace Health Plan Population Health and Clinical Operations Department

DEFINITIONS: N/A

WORK PROCESS:

Background Definitions:

Emergency services are covered at non-participating facilities for covered services as outlined in the Evidence of Coverage when clinical criteria are met.

Emergency Services

Emergency services are covered inpatient and outpatient services that are:

- Furnished by a provider qualified to furnish emergency services; and
- Needed to evaluate or treat an emergency medical condition.

Emergency Medical Condition

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child
- Serious impairment to bodily functions or
- Serious dysfunction of any bodily organ or part

Once emergency treatment occurs and a member is stabilized, this is referred to as Post-Stabilization care (refer to the Emergency Medical Treatment and Labor Act (EMTALA) for the basis for defining Post Stabilization care).

In general, Post-stabilization care services are covered services that are:

- Related to an emergency medical condition,
- Provided after member is stabilized, and
- Provided to maintain the stabilized condition, or under certain circumstances, to improve or resolve the member's condition

Ambetter Process:

Initial Emergency Medical Treatment is covered as noted above at either a contracted Participating (Par) facility or at a non-contracted or non-participating facility (Non-Par). Once a member has had initial emergency treatment and is stabilized, every effort should be made to ensure the member can be safely and effectively transported to a Par facility for ongoing care. This would optimally occur if the member is stabilized in the Emergency Department, prior to any inpatient admission. This would also occur for any elective admissions unless the Par facility is unable to provide the specific service or procedure being requested. By directing a member's care to a participating facility, the member is protected from balance billing and provided optimal coverage. (See *HIM.UM.01.08 – Use of Out-of-Network Providers and Steerage.*)

Optimally, a patient is stabilized in the Emergency Department and can be transported to a Par facility prior to admission. If UM has not provided any prior authorization for care and a member is admitted to a Non-Par facility from an Emergency Department or notification is made following an admission to a non-participating facility, the utilization management (UM) designee follows the process outlined below.

I. Is the Member's Health Status Considered Stable:

- A. Determine member's current health status through medical record review and/or from updates provided by facility staff.
 - Is the member under observation status or active treatment?
 - Is the level of care consistent with services being rendered?
 - Is a surgical procedure or other procedure scheduled?
- B. We want to ensure appropriate care coordination occurs and that the Non-Par facility and Par facility and attending physicians agree that care can be safely transitioned. To do that we need to consider the following:
 - Determine the anticipated length of stay from medical record review or the admitting physician and through the concurrent review process and use of Plan criteria.
- C. When member is considered stable by the treating physician and more than one (1) additional inpatient day is anticipated, the Utilization Management (UM) designee works with the facility discharge planner or Care Management personnel to transfer the member's care to a participating facility and physician as soon as possible.
 - Note: If a single case agreement (SCA) is reached with the Non-Par facility this eliminates the need to transfer the member. The SCA should be discussed with the facility by the Plan Contracting department. Documentation on the SCA should indicate that the facility is reimbursed at 100% of Payor Fee Schedule Rates and agree that the member is not balance billed. (Refer to HIM.UM.17 Single Case Agreements Policy.)

II. Member Notice of Transfer:

Once it has been determined to transfer the member to a Par facility, specific steps need to occur to ensure the member is notified. With Par facilities we can work closely with the hospital staff but for Non-Par facilities follow the below steps.

- A. If hospital designee is not willing to discuss transfer with the member, a Plan representative is to discuss transfer with member and educate member on benefits of transferring to a participating facility.
- B. Transfer Steps
 - A list of participating facility options is provided to the member or designated representative when possible. (Refer to HIM.UM.01.08 – Use of Out-of-Network Providers and Steerage for search process.)
 - If the member agrees to the transfer, the admitting physician is consulted and an order to transfer the member is obtained by the facility personnel along with arrangements to transport.
 - A physician on staff at the receiving facility is contacted by hospital discharge planner to admit the member.
 - The UM designee should request that a copy of the member's medical record be transported with the member and provided to the admitting facility.
 - Mode of transportation is per the discharge physician's orders.
- C. Member Refuses Transfer
 - If a member refuses to transfer, the Member is provided "Refusal to Transfer" Letter. This letter is sent to the Non-Par hospital with a request the hospital provide a copy of the notice to member upon receipt.
 - The letter outlines benefit coverage implications for the member and the Non-Par facility based on the refusal to transfer.
 - This is based on a review of the Summary of Benefits and Coverage (SBC) and assures that the member is aware of the potential non coverage cost sharing, deductible and co-pay responsibilities that result while inpatient at a non-participating facility. (Refer to Evidence of Coverage (EOC))

III. When Health Status is Considered Unstable:

- A. Monitor member's health status throughout the concurrent review process.
- B. UM designee notifies Plan's Contracting department as soon as possible of the need for a Single Case Agreement while member remains inpatient in unstable condition at the non-participating facility.
- C. As soon as the member is stable, consideration should be given to transferring the member to a participating facility following the steps outlined in Section I if an additional length of stay is anticipated to be greater than one (1) day.

REFERENCES:
HIM.UM.17 Single Case Agreements
HIM.UM.01.08 – Use of Out-of-Network Providers and Steerage

ATTACHMENTS: N/A

SUPPORT/HELP: N/A

REVISION LOG

REVISION TYPE	REVISION SUMMARY	DATE APPROVED & PUBLISHED
Annual Review	Updated approval titles; no substantive change	02/16
Annual Review	No substantive content changes.	01/17
Annual Review	Additional language added throughout the policy and transfer steps added. Refusal to Transfer Letter added to policy.	01/18
Annual Review	No substantive content changes.	02/19
Ad Hoc Review	Reimbursement language revised to reflect the removal of Medicare from the Payor Fee Schedule. New language Payor Fee Schedule.	12/19
Annual Review	No substantive changes.	12/20
Annual Review	No substantive changes.	01/22
Ad Hoc Review	Policy was accidentally retired 04/22. Review is to re-publish. Updated policy ID to <i>IFP.UM.01.09</i> from <i>HIM.UM.01.09</i> . No content changes to policy.	05/22

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, the Company's P&P management software, is considered equivalent to a signature.

POLICY AND PROCEDURE

POLICY NAME: Timeliness of UM Decisions and Notifications	POLICY ID: IFP.UM.05
BUSINESS UNIT: Please refer to system of record – Archer	FUNCTIONAL AREA: Utilization Management
EFFECTIVE DATE: 01/2014	PRODUCT: Marketplace
REVIEWED/REVISED DATE: 2/7/14; 2/27/14; 5/22/14; 6/25/14; 10/10/14; 03/31/15; 05/29/15; 08/15; 10/15; 10/16; 10/17; 6/18; 7/18; 9/18; 8/19; 8/20; 10/20; 12/20; 10/21; 02/22; 05/22; 11/22	
REGULATOR MOST RECENT APPROVAL DATE: N/A	

POLICY STATEMENT:

This policy provides the timelines in place for providers to notify the Plan of a service request and for the Plan to make utilization management decisions and notifications to the member and provider.

PURPOSE:

To ensure utilization management (UM) decisions are made in a timely manner to accommodate the clinical urgency of the situation and to minimize any disruption in the provision of health care.

SCOPE:

This policy applies to Ambetter Health Insurance Marketplace Population Health and Clinical Operations

POLICY:

Timeframes apply to all non-behavioral healthcare, behavioral healthcare and pharmacy UM decisions, *whether the request is based on benefits or medical necessity*. Review by an appropriate practitioner (as outlined in the CC.UM.04 – Appropriate UM Professionals policy) is not required for requests for medical services that are specifically excluded from the member’s benefit plan, or exceed the limitations or restrictions outlined in the benefit plan. All relevant information related to UM requests are documented in the clinical documentation system.

DEFINITIONS:

Concurrent Review Decision: any review for an extension of previously approved ongoing course of treatment over a period or number of treatments. If a request to extend a course of treatment beyond the period or number of treatments previously approved by the Plan does not meet the definition of urgent care, the request may be handled as a new request and decided within the time frame appropriate for the type of decision (i.e., preservice or postservice).

Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairments of bodily functions, or serious dysfunction of any bodily organ or part.

Medical Necessity: Covered services that are prescribed based on generally accepted medical practices considering conditions at the time of treatment. Medically Necessary services are: appropriate and consistent with the diagnosis of the treating provider and the omission of such could adversely affect the member’s medical condition; compatible with the standards of acceptable medical practice in the community; provided in a safe, appropriate, cost-effective setting given the nature of the diagnosis and severity of the symptoms; not provided solely for the convenience of the member, the physician, or the facility providing the care; those for which there are no other effective and more conservative or substantially less costly treatment, service or setting available.

Medical Necessity Determinations: A decision on services that are, or that could be considered, covered benefits.

Post-Stabilization Services: Covered services related to an Emergency Medical Condition, provided after a member is stabilized, to maintain the stabilized condition, or to improve or resolve the member’s condition.

Postservice Decision: any review of care or services that have already been received (e.g., retrospective review).

Preservice Decision: any case or service that the Plan must approve, in part or in whole, in advance of a member obtaining medical care or services. Pre-authorization and pre-certification are preservice claims.

Prior Authorization: Authorization granted in advance of the rendering of a service after appropriate medical review. When related to an inpatient admission, this process may also be referred to as pre-certification.

Retrospective Review: the initial review for medical necessity of services delivered to a member, but for which authorization and/or timely Plan notification was not obtained.

Timeliness of Notification: 24 hours is equivalent to one (1) calendar day and 72 hours is equivalent of three (3) calendar days.

Time of Receipt: when the request is made to the Plan in accordance with reasonable filing procedures, regardless of whether the organization has all the information necessary to make the decision at the time of the request. Time of receipt for urgent requests does not have to occur during normal business hrs.

Urgent Care: any request for care or treatment with respect to which the application of the time periods for making nonurgent care determinations:

- Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment, or jeopardize safety of the member or others due to the member's psychological state, **or**
- In the opinion of a practitioner with knowledge of the member's medical or behavioral health condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.

A request made while a member is in the process of receiving care is an urgent concurrent request if the care requested meets the definition of urgent, even if the Plan did not previously approve the earlier care.

PROCEDURE:

Timeliness of Provider Notification to Plan

- For all pre-scheduled services requiring prior authorization, participating providers must notify the Plan within the timeframe outlined in the state specific provider manual prior to the requested service date.
- Prior authorization is *not required* for emergent or urgent care services. Post-stabilization services *do not require* authorization. Once the member's emergency medical condition is stabilized, certification for hospital admission or authorization for follow-up care is required as stated above.
- Facilities are required to notify the Plan of all inpatient admissions within **one (1) business day** following the admission.

Timeliness of UM Decision Making and Notifications (Refer to Plan Specific Evidence of Coverage)

All timeframes are maximum timeframes; UM decisions should be made as expeditiously as the member's health condition requires. Ambetter Health Insurance Marketplace UM timeframes are determined by NCQA guidelines or state guidelines (whichever are the more stringent timeframes). If the state is silent, NCQA guidelines are applied. (Refer to plan specific Evidence of Coverage). Time of receipt is when the request is made by the member or the member's representative to the Plan according to the Plan's filing procedures, regardless of whether the Plan has all the information necessary to make the decision and whether the Plan is open for business on the date/time the request is received. The date/time of receipt is documented for all requests.

Reasonable attempts (minimum of one attempt) are made in all cases to obtain complete clinical information; Plans may elect to make additional outreach attempts to obtain clinical information for urgent or complex requests, or to meet state requirements or business needs. Administrative denials for lack of clinical information are *not* issued for any requests where insufficient information has been received if at minimum, a diagnosis is included with the request. For denials due to insufficient clinical information, the decision is a medical necessity decision, and the denial notice must describe the specific information needed to make the decision (e.g., history and physical exam documentation, lab values, current nursing notes, etc.).

All notifications of UM decisions are documented in the clinical documentation system; notification by telephone includes the date and time of the notification, as well as who was notified of the decision. When verbally notifying the practitioner of any approval, staff gives the authorization number, authorization dates, and number of units and must recite the "disclaimer": "Authorization is not a guarantee of benefits or payment. Payment of benefits is subject to any subsequent review of medical information or records, patient's eligibility on the date the service is rendered and any other contractual provisions of the Plan."

The date of written notification of a UM denial decision is the date included in the date field of the UM denial or appeal notification letter. When the organization uses electronic notification for denial or appeal determinations, the written notification date is the date the notification is entered into the electronic system.

I. Nonurgent, Pre-Service Decisions (standard prior authorization)

- A. Determinations for nonurgent, preservice prior authorization requests are made within timeframes noted in the plan specific Evidence of Coverage not to exceed 15 calendar days from receipt of the request.
- B. If a determination cannot be made due to lack of necessary information, the UM designee makes at least one (1) documented attempt (or per state regulation), to obtain the additional information within the original timeframe.
 - If there is no response or continued lack of necessary information, a determination is made based on the available information.
 - If the request for authorization is approved, the utilization nurse or designee notifies the requesting practitioner of the approval by telephone, or fax, with the member being notified in writing, as outlined in the attachment, not to exceed the original determination period.

- In all cases the requesting or treating/attending practitioner must be notified. The facility (e.g., hospital, rehabilitation facility, etc.) or other treating practitioner (e.g., DME, medical equipment company, physical therapy group, etc.) is also notified, as applicable.

Note: notification is sent to the member's PCP if the requesting or treating/attending practitioner cannot be identified, or per state contract guidelines

- C. If the request lacks clinical information, or the Plan is unable to make a decision due to matters beyond its control, it may extend the decision timeframe once, not to exceed 15 calendar days under the following conditions:

- Within the original request turn-around time (TAT) noted in the Plan specific Evidence of Coverage, the member or member's authorized representative is notified of the specific information needed to make the decision, the extension and the expected date the determination is made, and the organization gives the member or the member's authorized representative at least 45 calendar days to provide the information.
- The extension period, within which a decision must be made by the organization, begins on the sooner of:
 - The date when the organization receives the member's response (even if not all the information is provided), or
 - The last date of the time period given to the member to supply the information, even if no response is received from the member or the member's authorized representative.
- Notification must be in writing and include the reason for the delay and the member's right to file an expedited grievance if they disagree with the extension.
- The extension period begins on the date the Plan receives member/member authorized representative's response (regardless or not if all information is included), or no response is received by the end of the period given to supply the information.

- D. If the determination results in a denial, reduction or termination of coverage, the Medical Director or designee may notify the practitioner orally within one (1) business day after the decision is made, not to exceed the original determination period.

- A written or electronic notice of the decision, including reason, right to a peer-to-peer discussion, right to appeal and the appeal process is issued to the treating physician, PCP, facility and member (or as dictated by state requirements) within three (3) calendar days of the –notification, not to exceed the original determination period. The facility (e.g., hospital, rehabilitation facility, etc.) or other treating practitioner (e.g., DME, medical equipment company, physical therapy group, etc.) is also notified, as applicable. Requirements for adverse determination/denial letters are outlined in policy CC.UM.07.

Note: Notification is sent to the member's PCP if the treating physician cannot be identified, or per state contract guidelines.

Texas renewal process (House Bill 3041- Refer to Attachment)

II. Urgent Pre-Service Decisions (Urgent Prior Authorization)

- A. Determinations for urgent preservice care are issued within timeframes noted in the Plan specific Evidence of Coverage from date of receipt of the request for service, not to exceed three (3) calendar days, from receipt of the request.
- If an urgent preservice request is received that does not meet the definition of "urgent", the Plan may reclassify the request as nonurgent, following the process in section 2.D. below.
- B. Where allowed, a one-time extension as noted in the Plan specific Evidence of Coverage not to exceed 48 hours may be implemented if additional information is necessary prior to issuing a determination.
- Within 24 hours of the receipt of the request, the Plan notifies the member (or the member's authorized representative) and/or requesting practitioner in writing of the need for an extension and the specific information necessary to make the decision.
 - A specified time frame for submission of the additional information, of at least 48 hours, must be given.
 - The Plan makes a decision within 48-hrs of receiving the additional information (even if the information is incomplete) or within 48-hrs of the end of the specified period given to supply the additional information (even if no response is received), whichever is earlier.

- The Plan may deny the request if all necessary information is not provided within this timeframe. The appeal process may be initiated at this time if desired.
 - Reasonable attempts are made in all cases to obtain complete clinical information. Administrative denials for lack of clinical information are not issued for any requests where insufficient information has been received if at minimum, a diagnosis is included with the request. For denials due to insufficient clinical information, the decision is a medical necessity decision, and the denial notice must describe the specific information needed to make the decision (e.g., lab values, current nursing notes, etc.).
 - Extending the timeframe past 48 hours must be requested by member or if the member voluntarily agrees to the extension.
 - If the request is approved, the UM designee notifies the requesting or treating/attending practitioner of the decision by telephone, or fax, along with the member via written notice, within 72 hours/three (3) calendar days after the decision is made, not to exceed the original determination period or subsequent extension.
 - In all cases the requesting or treating/attending practitioner must be notified. The facility (e.g., hospital, rehabilitation facility, etc.) or other treating practitioner (e.g., DME, medical equipment company, physical therapy group, etc.) is also notified, as applicable.

Note: Notification is sent to the member's PCP if the requesting or treating/attending practitioner cannot be identified, or per state contract guidelines.
 - Member notification of urgent preservice approvals is not required as the attending or treating practitioner is acting as the member's representative; members may also be notified of urgent preservice authorization approvals, as mandated by state contract requirement or business needs.
- C. If the determination results in a denial, reduction or termination of an urgent pre-service request, the Medical Director or designee may notify the practitioner orally within one (1) business day of the determination not to exceed the original determination period or subsequent extension, and issue a written or electronic notice of the decision including reason, right to a peer-to-peer discussion, right to appeal and the appeal process to the treating practitioner, PCP, facility and member within three (3) calendar days after the notification.
- Note:** Notification is sent to the member's PCP if the treating practitioner cannot be identified, or per state contract guidelines.
- D. If an urgent preservice request is received that does not meet the definition of "urgent", the Plan may reclassify the request as nonurgent.
- Post service requests (i.e., service have already been received by the member) are not considered urgent requests and the post service/retrospective review timeframe is followed.
 - UM staff contacts the requesting practitioner to verify if the request is urgent; if the requesting practitioner agrees the request is not urgent and can be handled as a nonurgent preservice request, the agreement by the practitioner is documented and the process for nonurgent preservice requests are followed.
 - If the requesting practitioner does not agree that the request can be handled as a nonurgent request and does not provide additional clinical information to support the urgency of the request, the case is sent to the Medical Director for review. The Medical Director uses their discretion to:
 - Reclassify the request as nonurgent based on the information received.
 - Follow the above process for urgent preservice requests based on the information received.
 - Initiate a peer-to-peer discussion with the practitioner to resolve whether the request meets the definition of urgent.

III. Urgent Concurrent Decisions/Notification (Urgent Continued Stay)

- A. An urgent concurrent review is a request for services made while the member is in the process of receiving the care; typically associated with inpatient care or ongoing ambulatory care. Determinations for urgent concurrent continued stay review are issued within timeframes stated on the Plan specific Evidence of Coverage not to exceed 24 hours/1 calendar day from receipt of the request.

- B. When the organization has procedures for ongoing concurrent review of urgent care that was approved initially, the notification period begins on the day of the review. The organization documents the date of the ongoing review and the decision notification in the UM denial file.
- C. If the request to extend a course of ongoing ambulatory treatment beyond the period or number of treatments previously approved does not meet the definition of “urgent care”, the request may be handled as a new request and be handled under the applicable time frame (i.e., pre-service or post-service request).
- The Plan considers the content of the request when determining if an outpatient concurrent request meets the definition of “urgent care” and determines whether applying nonurgent timeframes could lead to adverse health consequences for the member and/or cause an unnecessary disruption in case.
- D. Where allowed, the Plan may extend the timeframe for making urgent concurrent decisions in the following situations:
- If the request to extend urgent concurrent care is not made at least 24 hours prior to the expiration of the prescribed period or number of treatments, the Plan may treat it as an urgent pre-service decision and make the decision within 72 hours/3 calendar days. (Refer to the Plan specific Evidence of Coverage)
 - If the request to approve additional days for urgent concurrent review is related to care not previously approved by the Plan documents that it made at least one attempt and was unable to obtain needed clinical information within the initial 24 hours after the request for coverage of additional days, the Plan has up to 72 hours to make the decision.
 - The Plan contacts the member who voluntarily agrees to extend the decision-making time frame. This contact is documented in the documentation system.
- E. If ongoing care is approved, the UM designee notifies the requesting practitioner of the decision by telephone, fax, or email, along with the member via written notification, within 24 hours/ one (1) calendar day of the request.
- In all cases the requesting or treating/attending practitioner must be notified. The facility (e.g., hospital, rehabilitation facility, etc.) or other treating practitioner (e.g., DME, medical equipment company, physical therapy group, etc.) is also notified, as applicable.
- Note:** Notification is sent to the member’s PCP if the treating practitioner cannot be identified, or per state guidelines.
- F. If the determination results in a denial, reduction or termination of coverage, the UM designee provides electronic or written (i.e., email, fax, notice via EMR system, or mail) notification of the denial to the requesting or treating/attending practitioner, not to exceed the original 24 hours/one (1) calendar day timeframe. The UM designee provides written or electronic notice of the decision including reason, right to a peer-to-peer discussion, right to appeal and the appeal process to the member within three (3) calendar days after the notification.
- In all cases the requesting or treating/attending practitioner must be notified. The facility (e.g., hospital, rehabilitation facility, etc.) or other treating practitioner (e.g., DME, medical equipment company, physical therapy group, etc.) is also notified, as applicable. Requirements for adverse determination/denial letters are outlined in policy CC.UM.07.
 - Note: Notification is sent to the member’s PCP if the treating practitioner cannot be identified, or per state guidelines.
 - For inpatient urgent concurrent denials, the Plan may inform the hospital Utilization Review (UR) Department staff of the decision, with the understanding that UR staff informs the attending/treating practitioner.
 - Oral notification of the denial to the requesting or treating/attending practitioner may be provided for urgent concurrent requests within 24 hours/1 calendar day of the request. Although not required, oral notification of the denial to the requesting or treating/attending practitioner is recommended for urgent concurrent requests.
 - The written or electronic notice of the decision must be issued no later than three (3) calendar days after the oral notification if the oral notification is given directly to the requesting practitioner (or member if appropriate); voicemail is not an acceptable form of oral notification to allow for an additional three (3) calendar days to send written or electronic notification.

IV. Post-Service Decisions (Retrospective Review, refer to the Plan specific Evidence of Coverage)

- A. The Ambetter Health Insurance Marketplace Health Plan makes retrospective review decisions for services as outlined in UM.05.01-Retrospective Review for Services Requiring Authorization policy. Medical necessity post-service decisions and subsequent written member and practitioner notification occur no later than 30 calendar days from receipt of the request.
- B. If the request lacks clinical information, the organization may extend the nonurgent post service time frame up to 15 calendar days, under the following conditions:
 - Before the end of the time frame the organization asks the member or the member’s representative for the information necessary to make the decision, and
 - The organization gives the member or the member’s authorized representative at least 45 calendar days to provide the information.
 - The extension period, within which a decision must be made by the organization, begins on the sooner of:
 - The date when the organization receives the member’s response (even if not all the information is provided), or
 - The last date of the period given to the member to supply the information, even if no response is received from the member or the member’s authorized representative.
 - The organization may deny the request if it does not receive the information within the time frame, and the member may appeal the denial.

V. Notice of Action for Previously Approved Services

- A. When a service request for ongoing treatment(s) for a previously approved service request is received, the Plan reviews medical necessity criteria for the continuation and extent of these ongoing services (i.e., Rehab Therapy Services).
- B. If the determination results in a termination, suspension, or reduction of a previously approved treatment request, the Medical Director or designee notifies the practitioner and member in accordance with the notification standards as stated herein and issue a written or electronic notification notice at least 10 days before the intended Action.

REFERENCES:

UM.04 – Appropriate UM Professionals
UM.15 – Oversight of Delegated UM
UM.05.01 - Retrospective Review for Services Requiring Authorization
UM.07 – Adverse Determination (Denial) Letters
IFP.UM.08 – Appeal of UM Decisions
NCQA Health Plan Standards and Guidelines for the Accreditation of Health Plans
Plan Specific Evidence of Coverage

ATTACHMENTS:

Ambetter Alabama Celtic Insurance Company
Ambetter Texas Superior Health Plan Addendum
Ambetter Arizona Complete Health Addendum
Ambetter Tennessee Celtic Insurance Company Addendum
Western Sky Community Care Addendum

ROLES & RESPONSIBILITIES: N/A

REGULATORY REPORTING REQUIREMENTS: N/A

REVISION LOG

REVISION TYPE	REVISION SUMMARY	DATE APPROVED & PUBLISHED
Ad Hoc Review	Embedded timeline attachment; misc. grammatical corrections.	02/14
Ad Hoc Review	Corrected hyperlink for attachment.	02/14
Ad Hoc Review	Changed reference for NCQA to current year; Removed reference to URAC as no longer applicable; Inserted disclaimer info and notification	0514

	documentation required in “B.1.f”, B.2.e” and “B.3.f”; Updated attachment and can be found in C360	
Ad Hoc Review	Update to attachment and Texas TAT.	06/14
Ad Hoc Review	Updated NCQA reference for 2015; Updated “B.1.f” referring to attachment; Updated TAT Grid (attachment)	10/14
Annual Review	Added bullet under “A.”, “Requests for prior authorization involving genetic.....”; Added “or per state regulation” under “B.1.d”; The statement “Reasonable attempts are made in all cases to obtain.....to make the decision (e.g. lab values, current nursing notes, etc.)” was added to “B.1.d, B.2.c, B.3.d. and B.4.b.”; The statement “Note: Notification is sent to the member’s PCP if the treating physician cannot be identified, or per state contract guidelines” was added to “B.1.f, B.2.f and B.3.g”; Added CP.MP.89, CP.MP.50 and CC.UM.05.01 to reference section; Removed Missouri from Ambetter UM TAT attachment in C360; Added “not to exceed the original determination period” to “B.1.f.”; Updated approver titles.	03/15
Ad Hoc Review	NCQA timeframes added to the TAT attachment.	05/15
Annual Review	Annual review, changed “case manager” to “care manager”; updated NCQA reference	08/15
Ad Hoc Review	Updated Arkansas TAT to attachment grid	10/15
Annual Review	Annual review: no revisions.	10/16
Ad Hoc Review	KS/MO/NV Turnaround Time added the TAT Attachment	10/17
Annual Review	Annual review, revisions made to reflect current NCQA standards.	06/18
Ad Hoc Review	Timelines attachment updated for WA to reflect Urgent TAT 2 calendar days per WA state regulation.	06/18
Ad Hoc Review	Additional revisions based on NQCA changes	07/18
Ad Hoc Review	Additional revisions made based on additional feedback from the quality team in reference to NCQA notification requirements.	09/18
Ad Hoc Review	TX addendum added to policy to reflect renewal of PA requests.	08/19
Annual Review	Annual review, revisions made based on feedback from the Compliance team in reference to notification requirements. p. 7. Bullet E. The UM designee provides written or electronic notice of the decision including reason, right to a peer-to-peer discussion, right to appeal and the appeal process to the member within three (3) calendar days after the oral notification.	08/20
Ad Hoc Review	Timeline attachment “ Ambetter Utilization Determination Timeframes ” updated.	10/20
Ad Hoc Review	Updated policy to reflect new NCQA 2020 language	12/20
Annual Review	Updated attachment “ <i>Ambetter Utilization Determination Timeframes.</i> ”	10/21
Ad Hoc Review	Removed attachment “ <i>Ambetter Utilization Determination Timeframes</i> ” and updated all references to attachment to point to the plan specific Evidence of Coverage. Added addendum for <i>Western Sky Community Care.</i>	02/22
Ad Hoc Review	Updated to meet the new 2022 NCQA standards. Changed policy ID to IFP.UM.05 from HIM.UM.05.	05/22
Ad Hoc Review	Updated addendum for TN.	06/22
Ad Hoc Review	Revised section <i>D</i> under <i>I. Nonurgent, Pre-Service Decisions (standard prior authorization.)</i> for clarity.	08/22
Ad Hoc Review	Added addendums for Ambetter Alabama Celtic Insurance Company and updated addendum for Western Sky Community Care.	11/22

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in the P&P management software is considered equivalent to a physical signature.