Current as of April 2022

NQTL Name	Plan's Description of NQTL
Medical Necessity Criteria	This NQTL addresses the processes, factors, and evidentiary standards defining Humana's criteria for performing Medical Necessity Reviews. Development and application of Medical Necessity criteria are the primary focus within this NQTL analysis. Processes to perform a medical necessity review are also addressed.

	Inpatient Benefits	**Outpatient Benefits**	**Emergency Benefits**
Step 1: Describe the NQTL's requirements and associated procedures	**Establishment of Medical Necessity Criteria (Medical/Surgical (M/S) and Mental Health/Substance Use Disorder (MH/SUD)** Humana establishes medical necessity criteria for inpatient services; these criteria are reassessed as needed by Humana's Corporate Medical Director leadership team. Annually, at minimum, the hierarchy of clinical decision making/medical necessity guidelines are reviewed by Medical Director and Operations leadership via Policy Review Committees. For inpatient Medical/Surgical and Mental Health services, Humana has selected MCG® guidelines as the primary medical necessity guidelines. MCG® guidelines have been selected as they are based on clinically validated best practices that support optimal clinical decision-making. Humana partners with MCG® at least annually to review its guidelines. For initial inpatient reviews, MCG guidelines are applied on primary diagnosis are applied to determine medical necessity. To determine appropriate length of stay for the initial review, MCG's Goal Length of Stay (GLOS) and Benchmark Length of Stay (BLOS) criteria are utilized. When a provider or facility wishes to extend the number of days initially authorized, the provider/facility is instructed to submit an subsequent request for continued stay. For these extended stay reviews, MCG's Optimal Recovery Course and Extended Stay Criteria are used to determine additional length of stay. MCG's process to develop and maintain its proprietary guidelines is as follows, per its website. ... In addition to MCG guidelines, Humana may also apply other considerations to its Inpatient medical necessity reviews, such as weekend/holiday timing, specific guidelines within individual provider contracts, and clinical judgment as appropriate. Further details may be found in "Factors" and "Evidentiary Standards" below. For inpatient Substance Use Disorder (SUD), Humana has selected ASAM criteria as the primary medical necessity guidelines. ASAM criteria have been selected as they are based on clinically validated best practices that support optimal clinical decision-making. Oversight and revision of the ASAM criteria is a collaborative process between ASAM leadership and the Steering Committee of the Coalition for National Clinical Criteria. Review follows ASAM criteria for applicable levels of care across the continuum as written using the definition of medical necessity from each of six dimensions. **Medical Necessity Review Processes - Medical/Surgical (M/S)** When a member or provider/facility submits a request that requires Medical Necessity Review, a licensed clinician (for example, a Registered Nurse) may approve the request if it meets Humana's established medical necessity guidelines. If the licensed clinician cannot approve the request based on his/her review of the clinical criteria and the documentation obtained to support the request, the request is forwarded to a licensed, board-certified physician for the medical necessity review against the same criteria. A determination is then rendered and the member or provider/facility are notified of the determination per state and federal notification requirements. **Medical Necessity Review Processes - Mental Health/Substance Use Disorder (MH/SUD)** When a member or provider/facility submits a request that requires Medical Necessity Review, a licensed clinician (for example, a Registered Nurse or Licensed Clinical Social Worker) may approve the request if it meets Humana's established	**Establishment of Medical Necessity Criteria (Medical/Surgical (M/S) and Mental Health/Substance Use Disorder (MH/SUD)** Humana establishes medical necessity criteria for outpatient services; these criteria are reassessed as needed by Humana's Corporate Medical Director leadership team. Annually, at minimum, the hierarchy of clinical decision making/medical necessity guidelines are reviewed by Medical Director and Operations leadership via Policy Review Committees. For Outpatient services, Humana utilizes the following clinical review criteria: • Federal and state mandates • Member's Certificates of Coverage • Humana internal medical coverage policies • ASAM for Substance Use Disorder • Relevant medical research/literature, in the absence of other criteria or guidelines Humana's internal coverage policies are developed and maintained by a dedicated team of Clinical Policy experts, under the leadership of a licensed, board-certified Corporate Medical Director. Underlying factors and criteria used to develop these internal coverage policies are captured in Steps 2 and 3 below. The policies are updated and reviewed annually, at minimum, by a Policy Review Committee comprised of physicians with various specialties and other health plan leadership. External physician groups or societies may be consulted as well. The internal coverage policies, generally speaking, address services not covered by MCG criteria; so they primarily address outpatient services and items. In terms of the medical necessity review process itself, Humana may apply other considerations to its outpatient medical necessity reviews, such as weekend/holiday timing, specific guidelines within individual provider contracts, and clinical judgment as appropriate. Further details may be found in Steps 2 and 3 below. For outpatient Substance Use Disorder (SUD), Humana has selected ASAM criteria as the primary medical necessity guidelines. ASAM criteria have been selected as they are based on clinically validated best practices that support optimal clinical decision-making. Oversight and revision of the ASAM criteria is a collaborative process between ASAM leadership and the Steering Committee of the Coalition for National Clinical Criteria. Review follows ASAM criteria for applicable levels of care across the continuum as written using the definition of medical necessity from each of six dimensions. **Medical Necessity Review Processes - Medical/Surgical (M/S)** When a member or provider/facility submits a request that requires Medical Necessity Review, a licensed clinician (for example, a Registered Nurse) may approve the request if it meets Humana's established medical necessity guidelines. If the licensed clinician cannot approve the request based on his/her review of the clinical criteria and the documentation obtained to support the request, the request is forwarded to a licensed, board-certified physician for the medical necessity review against the same criteria. A determination is then rendered and the member or provider/facility are notified of the determination per state and federal notification requirements. **Medical Necessity Review Processes - Mental Health/Substance Use Disorder (MH/SUD)**	**Medical/Surgical (M/S) Process** Neither a referral nor an authorization is required for members to access emergency services (either in-network or out-of-network) if they present with an emergency medical condition as defined under the "any prudent layperson" law. Emergency Services claims may be subject to review by a licensed board-certified Medical Director when submitted. The intent of the review is to ensure the services rendered were truly emergent in nature. **Mental Health (MH)/Substance Use Disorder (SUD) Process** Neither a referral nor an authorization is required for members to access emergency services (either in-network or out-of-network) if they present with an emergency medical condition as defined under the "any prudent layperson" law. Emergency Services claims may be subject to review by a licensed board-certified Medical Director when submitted. The intent of the review is to ensure the services rendered were truly emergent in nature.
Step 2: Describe the reason for applying the NQTL (Factors Applied)	**Medical/Surgical (M/S) Factors** The underlying factors driving MCG® medical necessity and length of stay guidelines are determined and maintained by MCG®; its website is accessible here: https://www.mcg.com/ Per MCG's website, the following are examples of factors utilized to develop and maintain their guidelines: • Published professional literature meeting quality, utility, and relevance standards (see evidentiary standards for further details) • Utilization analysis using claims-based databases to confirm the reasonability and clinical appropriateness of care guidelines' utilization goals and objectives. In addition to MCG guidelines as written, Humana clinicians and medical directors may apply clinical judgment, as appropriate, through the medical necessity review process. Note also that state/federal regulations and contractual requirements take precedence over clinical guidelines and are taken into consideration through the utilization review process. **Mental Health (MH) / Substance Use Disorder (SUD) Factors** The underlying factors driving MCG® medical necessity and length of stay guidelines are determined and maintained by MCG®; its website is accessible here: https://www.mcg.com/, and ASAM, its website is accessible here: https://www.asam.org. Per MCG's website, the following are examples of factors utilized to develop and maintain their guidelines: • Published professional literature meeting quality, utility, and relevance standards (see evidentiary standards for further details) • Utilization analysis using claims-based databases to confirm the reasonability and clinical appropriateness of care guidelines' utilization goals and objectives. In addition to MCG guidelines as written, Humana clinicians and medical directors may apply clinical judgment, as appropriate, through the medical necessity review process. Note also that state/federal regulations and contractual requirements take precedence over clinical guidelines and are taken into consideration through the utilization review process.	**Medical/Surgical (M/S) Factors** For Medical/Surgical Outpatient services, Humana utilizes internally developed coverage policies. Factors used in the development of outpatient medical necessity criteria (Humana Medical Coverage Policies) include: • The technology must be approved by the FDA if applicable; • The clinical evidence must permit conclusions to be made concerning the effect of health outcomes; • The technology must improve the net health outcome; • The improvement must be attainable outside of investigational settings. **Mental Health (MH) / Substance Use Disorder (SUD) Factors** For Mental Health, Humana utilizes internally developed coverage polices. Factors used in the development of outpatient medical necessity criteria (Humana Medical Coverage Policies) include: • The technology must be approved by the FDA if applicable; • The clinical evidence must permit conclusions to be made concerning the effect of health outcomes; • The technology must improve the net health outcome; • The improvement must be attainable outside of investigational settings. Substance Use Disorder utilizes ASAM for Outpatient services. The underlying factors driving ASAM criteria are determined and maintained by ASAM. Its website is accessible here: https://www.asam.org.	**Medical/Surgical (M/S) Factors** When determining which claims are considered Emergency Services, Humana's definition of emergency care and the prudent layperson standard are applied. Emergency Care is defined as - Services provided to an individual for a Bodily Injury or Sickness with acute symptoms of sufficient severity such that a prudent layperson would expect the absence of immediate medical attention to result in: • Placing their health in serious jeopardy, or • Serious impairment to bodily functions, or • Serious dysfunction of any bodily organ or part. Additional considerations applied within the clinical review may include the patient's perceived pain level, vital signs, and presenting symptoms. Length of time symptoms have been present is not, in isolation, a driving factor for the determination. All relevant facts of the case are reviewed comprehensively to determine the appropriateness of the use of Emergency Services. **Mental Health (MH) / Substance Use Disorder (SUD) Factors** When determining which claims are considered Emergency Services, Humana's definition of emergency care and the prudent layperson standard are applied. Emergency Care is defined as - Services provided to an individual for a Bodily Injury or Sickness with acute symptoms of sufficient severity such that a prudent layperson would expect the absence of immediate medical attention to result in: • Placing their health in serious jeopardy, or • Serious impairment to bodily functions, or • Serious dysfunction of any bodily organ or part. Additional considerations applied within the clinical review may include the patient's perceived pain level, vital signs, and presenting symptoms. Length of time symptoms have been present is not, in isolation, a driving factor for the determination. All relevant facts of the case are reviewed comprehensively to determine the appropriateness of the use of Emergency Services.
Step 3: Identify and describe evidentiary standards and other evidence relied upon	**Medical/Surgical (M/S) Evidentiary Standards** The underlying evidentiary standards driving MCG® medical necessity and length of stay guidelines are determined and maintained by MCG®; its website is accessible here: https://www.mcg.com/ Per MCG's website, the following are examples of evidentiary standards supporting its clinical guidelines: • Published professional literature – preference is given to publications that: o Are designed with rigorous scientific methodology. o Are published in higher-quality journals (i.e., journals that are read and cited most often within their field). o Address an aspect of specific importance to the guideline in question (e.g., admission criteria, length of stay). o Represent an update or contain new data or information not reflected in the current guideline. • Authoritative sources and evidence are graded according to the level of authoritativeness, as follows: o (EG 1) Evidence Grade 1: Meta-analyses, Randomized controlled trials with meta-analysis, Randomized controlled trials, Systematic reviews o (EG 2) Evidence Grade 2: Observational studies (cohort studies, case series with historical or literature controls), Published guidelines, Statements in published articles or textbooks o (EG 3) Evidence Grade 3: Unpublished data (large database analyses, written protocols or outcomes reports from large practices, expert practitioner reports **Mental Health (MH) / Substance Use Disorder (SUD) Evidentiary Standards** For Mental Health, the underlying evidentiary standards driving MCG® medical necessity and length of stay guidelines are determined and maintained by MCG®; its website is accessible here: https://www.mcg.com/. Per MCG's website, the following are examples of evidentiary standards supporting its clinical guidelines: • Published professional literature – preference is given to publications that: o Are designed with rigorous scientific methodology. o Are published in higher-quality journals (i.e., journals that are read and cited most often within their field). o Address an aspect of specific importance to the guideline in question (e.g., admission criteria, length of stay). o Represent an update or contain new data or information not reflected in the current guideline. • Authoritative sources and evidence are graded according to the level of authoritativeness, as follows: o (EG 1) Evidence Grade 1: Meta-analyses, Randomized controlled trials with meta-analysis, Randomized controlled trials, Systematic reviews o (EG 2) Evidence Grade 2: Observational studies (cohort studies, case series with historical or literature controls), Published guidelines, Statements in published articles or textbooks o (EG 3) Evidence Grade 3:Unpublished data (large database analyses, written protocols or outcomes reports from large practices, expert practitioner reports For Substance Use Disorder, the underlying evidentiary standards driving ASAM criteria are determined and maintained by ASAM, its website accessible here: https://www.asam.org. Review follows ASAM criteria for: • Applicable levels of care across the continuum 2.1: Intensive Outpatient Services 2.5: Partial Hospitalization Services	**Medical/Surgical (M/S) Evidentiary Standards** In addition to the medical necessity considerations outlined in the "Factors" column, the following criteria are established as it pertains to requirements for clinical evidence used to develop Humana Medical Coverage Policies: • The clinical evidence must permit conclusions to be made concerning the effect on health outcomes. o The evidence should consist of well-designed and well-conducted investigations published in peer-reviewed medical journals in the English language. The quality of the body of studies and the consistency of the results are considered in evaluating the evidence. o The evidence should demonstrate that the technology can alter the physiological state related to a disease, injury, illness or condition. In addition, there should be evidence or a convincing argument based on established medical facts that such alteration affects the health outcomes as compared to treatment with other interventions to at least an equal extent (when information is available). o Opinions and assessments by US national medical associations, consensus panels or other technology evaluation bodies are evaluated according to the scientific quality of the supporting evidence and rationale. **Mental Health (MH)/Substance Use Disorder (SUD) Evidentiary Standards** In addition to the medical necessity considerations outlined in the "Factors" column, the following criteria are established as it pertains to requirements for clinical evidence used to develop Humana Medical Coverage Policies: • The clinical evidence must permit conclusions to be made concerning the effect on health outcomes. o The evidence should consist of well-designed and well-conducted investigations published in peer-reviewed medical journals in the English language. The quality of the body of studies and the consistency of the results are considered in evaluating the evidence. o The evidence should demonstrate that the technology can alter the physiological state related to a disease, injury, illness or condition. In addition, there should be evidence or a convincing argument based on established medical facts that such alteration affects the health outcomes as compared to treatment with other interventions to at least an equal extent (when information is available). o Opinions and assessments by US national medical associations, consensus panels or other technology evaluation bodies are evaluated according to the scientific quality of the supporting evidence and rationale. For Substance Use Disorder, the underlying evidentiary standards driving ASAM criteria are determined and maintained by ASAM, its website accessible here: https://www.asam.org. Review follows ASAM criteria for: • Applicable levels of care across the continuum 2.1: Intensive Outpatient Services	**Medical/Surgical (M/S) Evidentiary Standards** The definition of Emergency Care and the Prudent Layperson standard are driven from applicable state and federal regulatory requirements, including 42 CFR 438.114 Emergency and Post Stabilization Services. **Mental Health (MH)/Substance Use Disorder (SUD) Evidentiary Standards** The definition of Emergency Care and the Prudent Layperson standard are driven from applicable state and federal regulatory requirements, including 42 CFR 438.114 Emergency and Post Stabilization Services.
Step 4: Processes and strategies used to design NQTL as written	**Comparative Analysis - Process as Written** The factors and evidentiary standards used to develop processes for medical necessity reviews are outlined in steps 2 and 3 above. In policy, Humana has memorialized the Clinical Review process, which outlines Medical Necessity review processes and criteria. This is a singular policy comprehensively capturing M/S and MH/SUD medical necessity reviews. Humana has established associate-level processes and procedures for performing medical necessity reviews - which outline how to perform medical necessity reviews according to the approved hierarchy and clinical decision making criteria.	**Comparative Analysis - Process as Written** The factors and evidentiary standards used to develop processes for medical necessity reviews are outlined in steps 2 and 3 above. In policy, Humana has memorialized the Clinical Review process, which outlines Medical Necessity review processes and criteria. This is a singular policy comprehensively capturing M/S and MH/SUD medical necessity reviews. Humana has memorialized its process to develop and maintain Humana Medical Coverage Policies according to established criteria. Humana has established associate-level processes and procedures for performing medical necessity reviews - which outline how to perform medical necessity reviews according to the approved hierarchy and clinical decision making criteria.	**Comparative Analysis - Process as Written** The factors and evidentiary standards used to develop Humana's Medical Necessity Criteria NQTL are outlined in steps 2 and 3 above. As noted, Humana does not apply Prior Authorization requirements to Medical/Surgical or Mental Health/Substance Use Disorder Emergency Services. However, for both M/S and MH/SUD, emergency services *claims* may be reviewed (against comparable criteria) when submitted by a provider or facility.
Step 5: Processes in implementation of NQTL in operation	**Comparative Analysis - Process in Operation** • In operation, associates follow written processes and procedures for performing medical necessity reviews. Rationale for approving or denying is required to be thoroughly documented with each review. Mechanisms such as outreach for additional clinical information and peer-to-peer consultation with treating physicians may be performed as part of the Medical Necessity Review process. • In operation, medical necessity reviews resulting in an approval may be performed by licensed clinicians - such as Registered Nurses for M/S reviews and Licensed Clinical Social Workers for MH/SUD reviews. Medical Necessity reviews resulting in a denial or partial approval must be performed by licensed board-certified physicians of an appropriate specialty. • Upon publication of a new MCG edition, Humana performs educational and training sessions for internal review staff; policies and procedures are updated if required. • Humana's primary clinical documentation system platform is integrated with an MCG online interface, which promotes consistency in application of MCG criteria	**Comparative Analysis - Process in Operation** • In operation, associates follow written processes and procedures for performing medical necessity reviews. Rationale for approving or denying is required to be thoroughly documented with each review. Mechanisms such as outreach for additional clinical information and peer-to-peer consultation with treating physicians may be performed as part of the Medical Necessity Review process. • In operation, medical necessity reviews resulting in an approval may be performed by licensed clinicians - such as Registered Nurses for M/S reviews and Licensed Clinical Social Workers for MH/SUD reviews. Medical Necessity reviews resulting in a denial or partial approval must be performed by licensed board-certified physicians of an appropriate specialty. • Development and maintenance of all Humana Medical Coverage Policies involves the support of comparably licensed clinicians who are fully dedicated to policy research and maintenance. Additionally, physicians of various specialties are responsible for review and approval of policies upon development and upon re-review, which occurs annually at minimum. • Development of Humana's Coverage Policies may involve consultation from outside entities as necessary.	**Comparative Analysis - Process in Operation** • As noted, Humana does not require authorization for Medical/Surgical or Mental Health/Substance Use Disorder Emergency Services. Emergency Services claims may be subject to review by a licensed board-certified Medical Director when submitted. The intent of the review is to ensure the services rendered were truly emergent in nature. • In practice, Humana Medical Directors review claims using the Humana-approved definition of emergency care (inclusive of the Prudent Layperson Standard) to ensure consistency in reviews of Emergency Services claims. • Humana's claims platforms are configured not to require prior authorization for emergency services claims.
Step 6: Summary conclusion of how plan has determined overall compliance	**Summary Conclusions** As outlined in steps 4 and 5, Humana's written and operationalized practices for the Medical Necessity Criteria NQTL for Inpatient MH/SUD are comparable to the written and operationalized practices for Inpatient M/S. For medical necessity reviews of services in the Inpatient classification, Humana utilizes MCG® guidelines as the primary source of medical necessity criteria for both M/S and MH services. For medical necessity reviews of SUD services in the Inpatient classification, Humana utilizes ASAM criteria as the source of medical necessity criteria. Clinical reviews for M/S and MH/SUD are performed by reviewers with comparable credentials. The processes as designed are supported by policies, procedures, and practices. In addition to comparing written and operational practices, Humana uses data to perform stringency assessments to ensure that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL are no more stringently applied in operation. The assessment consists of a review of adverse decision rates, timeliness of decisions, and appeal overturn rates for M/S and MH/SUD services. Based on reviews performed by Humana Operational Leaders to date, there is no evidence to indicate that the processes, strategies, and evidentiary standards are applied more stringently in operation to the MH/SUD Medical Necessity NQTL than the M/S Medical Necessity NQTL. Therefore, Humana concludes that the processes, strategies, and evidentiary standards used in applying the Medical Necessity Criteria NQTL to Mental Health and Substance Use Disorder are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the Medical Necessity Criteria NQTL to Medical/Surgical reviews in the Inpatient Classification.	**Summary Conclusions** As outlined in steps 4 and 5, Humana's written and operationalized practices for the Medical Necessity Criteria NQTL for MH/SUD Outpatient are comparable to the written and operationalized practices for M/S. For medical necessity reviews of services in the Outpatient classification, Humana utilizes its internal Humana Medical Coverage Policies as the primary source of medical necessity criteria for both M/S and MH services. For medical necessity reviews of SUD services in the Outpatient classification, Humana utilizes ASAM criteria as the source of medical necessity criteria. Clinical reviews for M/S and MH/SUD are performed by reviewers with comparable credentials. The processes as designed are supported by policies, procedures, and practices. In addition to comparing written and operational practices, Humana uses data to perform stringency assessments to ensure that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL are no more stringently applied in operation. The assessment consists of a review of adverse decision rates, timeliness of decisions, and appeal overturn rates for M/S and MH/SUD services. Based on reviews performed by Humana Operational Leaders to date, there is no evidence to indicate that the processes, strategies, and evidentiary standards are applied more stringently in operation to the MH/SUD Medical Necessity NQTL than the M/S Medical Necessity NQTL. Therefore, Humana concludes that the processes, strategies, and evidentiary standards used in applying the Medical Necessity Criteria NQTL to Mental Health and Substance Use Disorder are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the Medical Necessity Criteria NQTL to Medical/Surgical	**Summary Conclusions** As outlined in steps 4 and 5, Humana's written and operationalized practices for the Medical Necessity Criteria NQTL for Medical/Surgical. As noted, Emergency Services require neither prior authorization, but Emergency Services claims may be subject to review against the Prudent Layperson standard when submitted by the provider/facility. The processes as designed are supported by policies, procedures, and practices. Therefore, Humana concludes that the processes, strategies, and evidentiary standards used in applying the Medical Necessity Criteria NQTL to Mental Health and Substance Use Disorder are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the Medical Necessity Criteria NQTL to Medical/Surgical.

NQTL Name	Plan's Description of NQTL
Preauthorization	This NQTL addresses the processes, factors, and evidentiary standards driving the list of services and items for which Humana requires members or providers to obtain authorization. Processes, factors, and evidentiary standards with respect to Humana's medical necessity review processes are covered in the Medical Necessity Criteria NQTL analysis.	This Humana Template NQTL comparative analysis is made available for informational purposes only and covers some of the primary NQTLs in the Humana Plan Template. It is not intended and should not be construed as providing legal advice. Each plan's situation can be highly fact specific and does not address plan customizations. The federal agencies interpreting MHPAEA have emphasized that any MHPAEA analysis is on a plan-by-plan basis and not on the overall "book of business" of any issuer or third-party administrator/ASO. Also, NQTLs are evaluated on an "as applied" basis. Therefore, specific utilization abnormalities may impact whether this general comparative analysis is appropriate to all regards. As noted, a plan's NQTL comparative analysis must be made available to participants, beneficiaries, providers and governmental agencies upon request. As a condition of use of this NQTL analysis, we require that you notify us whenever you provide a copy of this NQTL analysis pursuant to a request from such an individual or entity. Except for such requests you are required to keep the contents of this Humana Template NQTL comparative analysis confidential as it is the proprietary information of Humana.

	Inpatient Benefits In-Network	Inpatient Benefits Out-Of-Network	Outpatient Benefits In-Network	Outpatient Benefits Out-Of-Network	Emergency Benefits
List of Benefits requiring Preauthorization	The following benefits require authorization, per Humana's Preauthorization List (PAL): • Acute Hospital (includes Inpatient Hospice) • Acute Rehab Facilities • Long-term Acute Care • Skilled Nursing Facilities • Spinal and Musculoskeletal Surgeries • Transplant • Mental Health, Substance Use Disorders - Inpatient hospitalization, Residential Treatment	The following benefits require authorization, per Humana's Preauthorization List (PAL): • Acute Hospital (includes Inpatient Hospice) • Acute Rehab Facilities • Long-term Acute Care • Skilled Nursing Facilities • Spinal and Musculoskeletal Surgeries • Transplant • Mental Health, Substance Use Disorders - Inpatient hospitalization, Residential Treatment	The following benefits require authorization, per Humana's Preauthorization List (PAL), www.humana.com/pal. Mental Health/Substance Use Disorder Services • Applied Behavioral Analysis • Transcranial Magnetic Stimulation • Partial Hospitalization Medical/Surgical Services • Outpatient surgeries • Stimulators • Chemotherapy, symptom management and specialty drugs • Diagnostic procedures • Diagnostic and cardiac imaging • Chiropractic Therapy • Pain management procedures • Durable Medical Equipment • Home Health • Infertility testing and treatment • Outpatient therapies (radiation, Hyperbaric oxygen, Negative pressure wound, rehabilitative, immunotherapy) • Genetic Testing • Prosthetics	The following benefits require authorization, per Humana's Preauthorization List (PAL), www.humana.com/pal. Mental Health/Substance Use Disorder Services • Applied Behavioral Analysis • Transcranial Magnetic Stimulation • Partial Hospitalization Medical/Surgical Services • Outpatient surgeries • Stimulators • Chemotherapy, symptom management and specialty drugs • Diagnostic procedures • Diagnostic and cardiac imaging • Chiropractic Therapy • Pain management procedures • Durable Medical Equipment • Home Health • Infertility testing and treatment • Outpatient therapies (radiation, Hyperbaric oxygen, Negative pressure wound, rehabilitative, immunotherapy) • Genetic Testing • Prosthetics	Humana does not require Preauthorization for Emergency Services.
Step 1: Describe the NQTL's requirements and associated procedures	Overview of Humana's Preauthorization List (PAL)	Overview of Humana's Preauthorization List (PAL)	Overview of Humana's Preauthorization List (PAL)	Overview of Humana's Preauthorization List (PAL)	Medical/Surgical (M/S) Process
Step 2: Describe the reason for applying the NQTL (Factors Applied)	Medical/Surgical (M/S) Factors	Medical/Surgical (M/S) Factors	Medical/Surgical (M/S) Factors	Medical/Surgical (M/S) Factors	Medical/Surgical (M/S) Factors
Step 3: Identify and describe evidentiary standards and other evidence relied upon	Medical/Surgical (M/S) Evidentiary Standards	Medical/Surgical (M/S) Evidentiary Standards	Medical/Surgical (M/S) Evidentiary Standards	Medical/Surgical (M/S) Evidentiary Standards	Medical/Surgical (M/S) Evidentiary Standards
Step 4: Processes and strategies used to design NQTL as written	Comparative Analysis - Process as Written	Comparative Analysis - Process as Written	Comparative Analysis - Process as Written	Comparative Analysis - Process as Written	Comparative Analysis - Process as Written
Step 5: Processes in implementation of NQTL in operation	Comparative Analysis - Process in Operation	Comparative Analysis - Process in Operation	Comparative Analysis - Process in Operation	Comparative Analysis - Process in Operation	Comparative Analysis - Process in Operation
Step 6: Summary conclusion of how plan has determined overall compliance	Summary Conclusions	Summary Conclusions	Summary Conclusions	Summary Conclusions	Summary Conclusions

Plan's Description of NQTL

This Humana Template NQTL comparative analysis is made available for informational purposes only and covers some of the primary NQTLs in the Humana Plan Template. It is not intended and should not be construed as providing legal advice. Each plan's situation can be highly fact specific and does not address plan customizations. The federal agencies interpreting MHPAEA have emphasized that any MHPAEA analysis is on a plan by plan basis and not on the overall "book of business" of any insurer or third-party administrator/ASO. Also, NQTLs are evaluated on an "as applied" basis. Therefore, specific utilization abnormalities may impact whether this general comparative analysis is appropriate in all regards.

NQTL Name					
Concurrent Review	This NQTL addresses the processes, factors, and evidentiary standards prompting Humana to perform a Concurrent Review. Processes, factors, and evidentiary standards with respect to Humana's medical necessity review processes (including managing length of stay for inpatient reviews) are covered in the Medical Necessity Criteria NQTL analysis.	As noted, a plan's NQTL comparative analysis must be made available to participants, beneficiaries, providers and governmental agencies upon request. As a condition of use of this NQTL comparative analysis, we require that you notify us whenever you provide a copy of this NQTL analysis pursuant to a request from such an individual or entity. Except for such requests you are required to keep the contents of this Humana Template NQTL comparative analysis confidential as it is the proprietary information of Humana.			

	Inpatient Benefits In-Network	Inpatient Benefits Out-Of-Network	Outpatient Benefits In-Network	Outpatient Benefits Out-Of-Network	Emergency Benefits
List of Benefits that may be subject to Concurrent Review	Humana's Preauthorization List (PAL) is the driving factor as to which services/items may be subject to concurrent review. For further details on how the PAL is developed, and the underlying factors/evidentiary standards, and services included on the PAL, please see Humana's Preauthorization NQTL analysis.	Humana's Preauthorization List (PAL) is the driving factor as to which services/items may be subject to concurrent review. For further details on how the PAL is developed, and the underlying factors/evidentiary standards, and services included on the PAL, please see Humana's Preauthorization NQTL analysis.	Humana's Preauthorization List (PAL) is the driving factor as to which services/items may be subject to concurrent review. For further details on how the PAL is developed, and the underlying factors/evidentiary standards, and services included on the PAL, please see Humana's Preauthorization NQTL analysis.	Humana's Preauthorization List (PAL) is the driving factor as to which services/items may be subject to concurrent review. For further details on how the PAL is developed, and the underlying factors/evidentiary standards, and services included on the PAL, please see Humana's Preauthorization NQTL analysis.	Humana does not require Preauthorization for Emergency Services. Therefore, concurrent review is neither required nor performed.
Step 1: Describe the NQTL's requirements and associated procedures	Medical/Surgical (MS) Concurrent Review Process ... Mental Health (MH) / Substance Use Disorder (SUD) Concurrent Review Process ...	Medical/Surgical (MS) Concurrent Review Process ... Mental Health (MH) / Substance Use Disorder (SUD) Concurrent Review Process ...	Medical/Surgical (MS) Concurrent Review Process ... Mental Health (MH) / Substance Use Disorder (SUD) Concurrent Review Process ...	Medical/Surgical (MS) Concurrent Review Process ... Mental Health (MH) / Substance Use Disorder (SUD) Concurrent Review Process ...	Medical/Surgical (MS) Process ... Mental Health (MH)/Substance Use Disorder (SUD) Process ...
Step 2: Describe the reason for applying the NQTL (Factors Applied)	Medical/Surgical (MS) Factors — Factors driving initiation of concurrent review; Factors driving medical necessity review of concurrent requests. Mental Health (MH) / Substance Use Disorder Factors.	Medical/Surgical (MS) Factors — Factors driving initiation of concurrent review; Factors driving medical necessity review of concurrent requests. Mental Health (MH) / Substance Use Disorder Factors.	Medical/Surgical (MS) Factors — Factors driving initiation of concurrent review; Factors driving medical necessity review of concurrent requests. Mental Health (MH) / Substance Use Disorder Factors.	Medical/Surgical (MS) Factors — Factors driving initiation of concurrent review; Factors driving medical necessity review of concurrent requests. Mental Health (MH) / Substance Use Disorder Factors.	Medical/Surgical (MS) Process ... Mental Health (MH)/Substance Use Disorder (SUD) Process ...
Step 3: Identify and describe evidentiary standards and other evidence relied upon	Medical/Surgical (MS) Evidentiary Standards — Evidentiary Standards driving initiation of concurrent review; Evidentiary Standards driving medical necessity review of concurrent requests. Mental Health (MH) / Substance Use Disorder Evidentiary Standards.	Medical/Surgical (MS) Evidentiary Standards. Mental Health (MH) / Substance Use Disorder Evidentiary Standards.	Medical/Surgical (MS) Evidentiary Standards. Mental Health (MH) / Substance Use Disorder Evidentiary Standards.	Medical/Surgical (MS) Evidentiary Standards. Mental Health (MH) / Substance Use Disorder Evidentiary Standards.	Medical/Surgical (MS) Evidentiary Standards. Mental Health (MH)/Substance Use Disorder (SUD) Evidentiary Standards.
Step 4: Processes and strategies used to design NQTL as written	Comparative Analysis - Process as Written — The factors and evidentiary standards used to develop processes for inpatient in-network concurrent review are outlined in steps 2 and 3 above. In policy, Humana has memorialized the Concurrent Review process. These policies comprehensively capture M/S and MH/SUD operational processes and clinical reviews. Humana has also established associate-level processes and procedures for performing concurrent review.	Comparative Analysis - Process as Written — (inpatient out-of-network)	Comparative Analysis - Process as Written — (outpatient in-network)	Comparative Analysis - Process as Written — (outpatient out-of-network)	Comparative Analysis - Process as Written
Step 5: Processes in implementation of NQTL in operation	Comparative Analysis - Process in Operation	Comparative Analysis - Process in Operation	Comparative Analysis - Process in Operation	Comparative Analysis - Process in Operation	Comparative Analysis - Process in Operation
Step 6: Summary conclusion of how plan has determined overall compliance	Summary Conclusions	Summary Conclusions	Summary Conclusions	Summary Conclusions	Summary Conclusions

NQTL Name	Plan's Description of NQTL				
Retrospective Review	This NQTL addresses the processes, factors, and evidentiary standards prompting Humana to perform a Retrospective Review. Processes, factors, and evidentiary standards with respect to Humana's medical necessity review processes are covered in the Medical Necessity Criteria NQTL analysis.	This Humana Template NQTL comparative analysis is made available for informational purposes only and covers some of the primary NQTLs in the Humana Plan Template. It is not intended and should not be construed as providing legal advice. Each plan's situation can be highly fact specific and does not address plan customizations. The federal agencies interpreting MHPAEA have emphasized that any MHPAEA analysis is on a plan by plan basis and not on the overall "book of business" of any insurer or third-party administrator/ASO. Also, NQTLs are evaluated on an "as applied" basis. Therefore, specific utilization abnormalities may impact whether this general comparative analysis is appropriate in all regards.

As noted, a plan's NQTL comparative analysis must be made available to participants, beneficiaries, providers and governmental agencies upon request. As a condition of use of this NQTL comparative analysis, we require that you notify us whenever you provide a copy of this NQTL analysis pursuant to a request from such an individual or entity. Except for such requests you are required to keep the contents of this Humana Template NQTL comparative analysis confidential as it is the proprietary information of Humana. | | | |

	Inpatient Benefits In-Network	**Inpatient Benefits Out-Of-Network**	**Outpatient Benefits In-Network**	**Outpatient Benefits Out-Of-Network**	**Emergency Benefits**
List of Benefits that may be subject to Retrospective Review	Humana will conduct a pre-claim retrospective review in the following situations: • The requested services requires authorization per Humana's PAL • The authorization request contains unlisted/unspecified code(s)/service(s) • The requested service has little to no indications per evidentiary standards • The requested service is considered experimental/investigational	Humana will conduct a pre-claim retrospective review in the following situations: • The requested services requires authorization per Humana's PAL • The authorization request contains unlisted/unspecified code(s)/service(s) • The requested service has little to no indications per evidentiary standards • The requested service is considered experimental/investigational	Humana will conduct a retrospective review in the following situations: • The requested services require authorization per Humana's PAL • The authorization request contains unlisted/unspecified code(s)/service(s) • The requested service has little to no indications per evidentiary standards • The requested service is considered experimental/investigational	Humana will conduct a retrospective review in the following situations: • The requested services require authorization per Humana's PAL • The authorization request contains unlisted/unspecified code(s)/service(s) • The requested service has little to no indications per evidentiary standards • The requested service is considered experimental/investigational	Neither a referral nor a Preauthorization is required for members to access emergency services (either in-network or out-of-network).
Step 1: Describe the NQTL's requirements and associated procedures	**Medical/Surgical (M/S) Retrospective Review Process** Humana conducts retrospective review when a member or provider submits an authorization request for a service, after service has been rendered, but before a claim has been submitted. When a member or provider/facility submits a request for a service, after the service has been rendered (i.e., member has been discharged from the facility) but before a claim has been submitted, a licensed clinician (for example, a Registered Nurse) may approve the Inpatient request if deemed medically necessary. For information related to medical necessity criteria, refer to the Medical Necessity Criteria NQTL comparative analysis. If the licensed clinician cannot approve the request based on his/her review of the clinical criteria, the request is forwarded to a licensed, board-certified physician for medical necessity review against the same criteria. A determination is then rendered and the member and/or provider/facility are notified of the determination per state and federal notification requirements. **Mental Health (MH) / Substance Use Disorder (SUD) Retrospective Review Process** Humana conducts retrospective review when a member or provider submits an authorization request for a service, after service has been rendered, but before a claim has been submitted. When a member or provider/facility submits a request for a service, after the service has been rendered (i.e., member has been discharged from the facility) but before a claim has been submitted, a licensed clinician (for example, a Licensed Clinical Social Worker) may approve the Inpatient request if deemed medically necessary. For information related to medical necessity criteria, refer to the Medical Necessity Criteria NQTL comparative analysis. If the licensed clinician cannot approve the request based on his/her review of the clinical criteria, the request is forwarded to a licensed, board-certified physician for medical necessity review against the same criteria. A determination is then rendered and the member and/or provider/facility are notified of the determination per state and federal notification requirements.	**Medical/Surgical (M/S) Retrospective Review Process** Humana conducts retrospective review when a member or provider submits an authorization request for a service, after service has been rendered, but before a claim has been submitted. When a member or provider/facility submits a request for a service, after the service has been rendered (i.e., member has been discharged from the facility) but before a claim has been submitted, a licensed clinician (for example, a Registered Nurse) may approve the Inpatient request if deemed medically necessary. For information related to medical necessity criteria, refer to the Medical Necessity Criteria NQTL comparative analysis. If the licensed clinician cannot approve the request based on his/her review of the clinical criteria, the request is forwarded to a licensed, board-certified physician for medical necessity review against the same criteria. A determination is then rendered and the member and/or provider/facility are notified of the determination per state and federal notification requirements. **Mental Health (MH) / Substance Use Disorder (SUD) Retrospective Review Process** Humana conducts retrospective review when a member or provider submits an authorization request for a service, after service has been rendered, but before a claim has been submitted. When a member or provider/facility submits a request for a service, after the service has been rendered (i.e., member has been discharged from the facility) but before a claim has been submitted, a licensed clinician (for example, a Licensed Clinical Social Worker) may approve the Inpatient request if deemed medically necessary. For information related to medical necessity criteria, refer to the Medical Necessity Criteria NQTL comparative analysis. If the licensed clinician cannot approve the request based on his/her review of the clinical criteria, the request is forwarded to a licensed, board-certified physician for medical necessity review against the same criteria. A determination is then rendered and the member and/or provider/facility are notified of the determination per state and federal notification requirements.	**Medical/Surgical (M/S) Retrospective Review Process** Humana conducts retrospective review when a member or provider submits an authorization request for a service, after service has been rendered, but before a claim has been submitted. When a member or provider/facility submits a request for a service, after the service has been rendered (i.e., member has already received the specified service/item) but before a claim has been submitted, a licensed clinician (for example, a Registered Nurse) may approve the request if deemed medically necessary. For information related to medical necessity criteria, refer to the Medical Necessity Criteria NQTL comparative analysis. If the licensed clinician cannot approve the request based on his/her review of the clinical criteria, the request is forwarded to a licensed, board-certified physician for medical necessity review against the same criteria. A determination is then rendered and the member and/or provider/facility are notified of the determination per state and federal notification requirements. **Mental Health (MH) / Substance Use Disorder (SUD) Retrospective Review Process** Humana conducts retrospective review when a member or provider submits an authorization request for a service, after service has been rendered, but before a claim has been submitted. When a member or provider/facility submits a request for a service, after the service has been rendered (i.e., member has already received the specified service/item) but before a claim has been submitted, a licensed clinician (for example, a Licensed Clinical Social Worker) may approve the request if deemed medically necessary. For information related to medical necessity criteria, refer to the Medical Necessity Criteria NQTL comparative analysis. If the licensed clinician cannot approve the request based on his/her review of the clinical criteria, the request is forwarded to a licensed, board-certified physician for medical necessity review against the same criteria. A determination is then rendered and the member and/or provider/facility are notified of the determination per state and federal notification requirements.	**Medical/Surgical (M/S) Retrospective Review Process** Humana conducts retrospective review when a member or provider submits an authorization request for a service, after service has been rendered, but before a claim has been submitted. When a member or provider/facility submits a request for a service, after the service has been rendered (i.e., member has already received the specified service/item) but before a claim has been submitted, a licensed clinician (for example, a Registered Nurse) may approve the request if deemed medically necessary. For information related to medical necessity criteria, refer to the Medical Necessity Criteria NQTL comparative analysis. If the licensed clinician cannot approve the request based on his/her review of the clinical criteria, the request is forwarded to a licensed, board-certified physician for medical necessity review against the same criteria. A determination is then rendered and the member and/or provider/facility are notified of the determination per state and federal notification requirements. **Mental Health (MH) / Substance Use Disorder (SUD) Retrospective Review Process** Humana conducts retrospective review when a member or provider submits an authorization request for a service, after service has been rendered, but before a claim has been submitted. When a member or provider/facility submits a request for a service, after the service has been rendered (i.e., member has already received the specified service/item) but before a claim has been submitted, a licensed clinician (for example, a Licensed Clinical Social Worker) may approve the request if deemed medically necessary. For information related to medical necessity criteria, refer to the Medical Necessity Criteria NQTL comparative analysis. If the licensed clinician cannot approve the request based on his/her review of the clinical criteria, the request is forwarded to a licensed, board-certified physician for medical necessity review against the same criteria. A determination is then rendered and the member and/or provider/facility are notified of the determination per state and federal notification requirements.	**Medical/Surgical (M/S) Process** Neither a referral nor an authorization is required for members to access emergency services (either in-network or out-of-network) if they present with an emergency medical condition as defined under the "any prudent layperson" law. Emergency Services claims may be subject to review by a licensed board-certified Medical Director when submitted/billed by the provider/facility. The intent of the review is to ensure the services rendered were truly emergent in nature. **Mental Health (MH)/Substance Use Disorder (SUD) Process** Neither a referral nor an authorization is required for members to access emergency services (either in-network or out-of-network) if they present with an emergency medical condition as defined under the "any prudent layperson" law. Emergency Services claims may be subject to review by a licensed board-certified Medical Director when submitted/billed by the provider/facility. The intent of the review is to ensure the services rendered were truly emergent in nature.
Step 2: Describe the reason for applying the NQTL (Factors Applied)	**Medical/Surgical (M/S) Factors** **Factors driving initiation of retrospective review** Humana will conduct a retrospective review in the following situations: - The requested service/item requires authorization per Humana's PAL (for details regarding the factors underlying the PAL, please see Humana's Preauthorization NQTL analysis), or - The request contains an unspecified/unlisted code, or - The service/item has little or no evidentiary standards, or - The service/item is considered experimental or investigational, or **Factors driving medical necessity review of retrospective requests** Factors driving retrospective review Medical Necessity determinations for Inpatient requests are outlined in Medical Necessity Criteria NQTL Comparative Analysis. **Mental Health (MH) / Substance Use Disorder (SUD) Factors** **Factors driving initiation of retrospective review** Humana will conduct a retrospective review in the following situations: - The requested service/item requires authorization per Humana's PAL (for details regarding the factors underlying the PAL, please see Humana's Preauthorization NQTL analysis), or - The request contains an unspecified/unlisted code, or - The service/item has little or no evidentiary standards, or - The service/item is considered experimental or investigational, or **Factors driving medical necessity review of retrospective requests** Factors driving retrospective review Medical Necessity determinations for Inpatient requests are outlined in Medical Necessity Criteria NQTL Comparative Analysis.	**Medical/Surgical (M/S) Factors** **Factors driving initiation of retrospective review** Humana will conduct a retrospective review in the following situations: - The requested service/item requires authorization per Humana's PAL (for details regarding the factors underlying the PAL, please see Humana's Preauthorization NQTL analysis), or - The request contains an unspecified/unlisted code, or - The service/item has little or no evidentiary standards, or - The service/item is considered experimental or investigational, or **Factors driving medical necessity review of retrospective requests** Factors driving retrospective review Medical Necessity determinations for Inpatient requests are outlined in Medical Necessity Criteria NQTL Comparative Analysis. **Mental Health (MH) / Substance Use Disorder (SUD) Factors** **Factors driving initiation of retrospective review** Humana will conduct a retrospective review in the following situations: - The requested service/item requires authorization per Humana's PAL (for details regarding the factors underlying the PAL, please see Humana's Preauthorization NQTL analysis), or - The request contains an unspecified/unlisted code, or - The service/item has little or no evidentiary standards, or - The service/item is considered experimental or investigational, or **Factors driving medical necessity review of retrospective requests** Factors driving retrospective review Medical Necessity determinations for Inpatient requests are outlined in Medical Necessity Criteria NQTL Comparative Analysis.	**Medical/Surgical (M/S) Factors** **Factors driving initiation of retrospective review** Humana will conduct a retrospective review in the following situations: - The requested service/item requires authorization per Humana's PAL (for details regarding the factors underlying the PAL, please see Humana's Preauthorization NQTL analysis), or - The request contains an unspecified/unlisted code, or - The service/item has little or no evidentiary standards, or - The service/item is considered experimental or investigational, or **Factors driving medical necessity review of retrospective requests** Factors driving retrospective review Medical Necessity determinations for outpatient requests are outlined in Medical Necessity Criteria NQTL Comparative Analysis. **Mental Health (MH) / Substance Use Disorder (SUD) Factors** **Factors driving initiation of retrospective review** Humana will conduct a retrospective review in the following situations: - The requested service/item requires authorization per Humana's PAL (for details regarding the factors underlying the PAL, please see Humana's Preauthorization NQTL analysis), or - The request contains an unspecified/unlisted code, or - The service/item has little or no evidentiary standards, or - The service/item is considered experimental or investigational, or **Factors driving medical necessity review of retrospective requests** Factors driving retrospective review Medical Necessity determinations for outpatient requests are outlined in Medical Necessity Criteria NQTL Comparative Analysis.	**Medical/Surgical (M/S) Factors** **Factors driving initiation of retrospective review** Humana will conduct a retrospective review in the following situations: - The requested service/item requires authorization per Humana's PAL (for details regarding the factors underlying the PAL, please see Humana's Preauthorization NQTL analysis), or - The request contains an unspecified/unlisted code, or - The service/item has little or no evidentiary standards, or - The service/item is considered experimental or investigational, or **Factors driving medical necessity review of retrospective requests** Factors driving retrospective review Medical Necessity determinations for outpatient requests are outlined in Medical Necessity Criteria NQTL Comparative Analysis. **Mental Health (MH) / Substance Use Disorder (SUD) Factors** **Factors driving initiation of retrospective review** Humana will conduct a retrospective review in the following situations: - The requested service/item requires authorization per Humana's PAL (for details regarding the factors underlying the PAL, please see Humana's Preauthorization NQTL analysis), or - The request contains an unspecified/unlisted code, or - The service/item has little or no evidentiary standards, or - The service/item is considered experimental or investigational, or **Factors driving medical necessity review of retrospective requests** Factors driving retrospective review Medical Necessity determinations for outpatient requests are outlined in Medical Necessity Criteria NQTL Comparative Analysis.	**Medical/Surgical (M/S) Factors** When determining which claims are considered Emergency Services, Humana's definition of emergency care and the prudent layperson standard are applied. Emergency Care is defined as - Services provided to an individual for a Bodily Injury or Sickness with acute symptoms of sufficient severity such that a prudent layperson would expect the absence of immediate medical attention to result in: • Placing their health in serious jeopardy, or • Serious impairment to bodily functions, or • Serious dysfunction of any bodily organ or part. Additional considerations applied on a case-by-case basis may include the patient's perceived pain level, vital signs, and presenting symptoms. All relevant facts of the case are reviewed comprehensively to determine the appropriateness of the use of Emergency Services. **Mental Health (MH) / Substance Use Disorder (SUD) Factors** When determining which claims are considered Emergency Services, Humana's definition of emergency care and the prudent layperson standard are applied. Emergency Care is defined as - Services provided to an individual for a Bodily Injury or Sickness with acute symptoms of sufficient severity such that a prudent layperson would expect the absence of immediate medical attention to result in: • Placing their health in serious jeopardy, or • Serious impairment to bodily functions, or • Serious dysfunction of any bodily organ or part. Additional considerations applied on a case-by-case basis may include the patient's perceived pain level, vital signs, and presenting symptoms. All relevant facts of the case are reviewed comprehensively to determine the appropriateness of the use of Emergency Services.
Step 3: Identify and describe evidentiary standards and other evidence relied upon	**Medical/Surgical (M/S) Evidentiary Standards** **Evidentiary Standards driving initiation of retrospective review** No additional details. **Factors driving medical necessity review of retrospective requests** Factors driving retrospective review Medical Necessity determinations for Inpatient requests are outlined in Medical Necessity Criteria NQTL Comparative Analysis. **Mental Health (MH) / Substance Use Disorder (SUD) Evidentiary Standards** **Evidentiary Standards driving initiation of retrospective review** No additional details. **Factors driving medical necessity review of retrospective requests** Factors driving retrospective review Medical Necessity determinations for Inpatient requests are outlined in Medical Necessity Criteria NQTL Comparative Analysis.	**Medical/Surgical (M/S) Evidentiary Standards** **Evidentiary Standards driving initiation of retrospective review** No additional details. **Factors driving medical necessity review of retrospective requests** Factors driving retrospective review Medical Necessity determinations for Inpatient requests are outlined in Medical Necessity Criteria NQTL Comparative Analysis. **Mental Health (MH) / Substance Use Disorder (SUD) Evidentiary Standards** **Evidentiary Standards driving initiation of retrospective review** No additional details. **Factors driving medical necessity review of retrospective requests** Factors driving retrospective review Medical Necessity determinations for Inpatient requests are outlined in Medical Necessity Criteria NQTL Comparative Analysis.	**Medical/Surgical (M/S) Evidentiary Standards** **Evidentiary Standards driving initiation of retrospective review** No additional details. **Factors driving medical necessity review of retrospective requests** Factors driving retrospective review Medical Necessity determinations for Inpatient requests are outlined in Medical Necessity Criteria NQTL Comparative Analysis. **Mental Health (MH) / Substance Use Disorder (SUD) Evidentiary Standards** **Evidentiary Standards driving initiation of retrospective review** No additional details. **Factors driving medical necessity review of retrospective requests** Factors driving retrospective review Medical Necessity determinations for Inpatient requests are outlined in Medical Necessity Criteria NQTL Comparative Analysis.	**Medical/Surgical (M/S) Evidentiary Standards** **Evidentiary Standards driving initiation of retrospective review** No additional details. **Factors driving medical necessity review of retrospective requests** Factors driving retrospective review Medical Necessity determinations for Inpatient requests are outlined in Medical Necessity Criteria NQTL Comparative Analysis. **Mental Health (MH) / Substance Use Disorder (SUD) Evidentiary Standards** **Evidentiary Standards driving initiation of retrospective review** No additional details. **Factors driving medical necessity review of retrospective requests** Factors driving retrospective review Medical Necessity determinations for Inpatient requests are outlined in Medical Necessity Criteria NQTL Comparative Analysis.	**Medical/Surgical (M/S) Evidentiary Standards** The definition of Emergency Care and the Prudent Layperson standard are driven from applicable state and federal regulatory requirements, including 42 CFR 438.114 Emergency and Post Stabilization Services. **Mental Health (MH)/Substance Use Disorder (SUD) Evidentiary Standards** The definition of Emergency Care and the Prudent Layperson standard are driven from applicable state and federal regulatory requirements, including 42 CFR 438.114 Emergency and Post Stabilization Services.
Step 4: Processes and strategies used to design NQTL as written	**Comparative Analysis - Process as Written** The factors and evidentiary standards used to develop processes for Inpatient in-network retrospective review are outlined in steps 2 and 3 above. In policy, Humana has memorialized the Retrospective Review process. These policies comprehensively capture M/S and MH/SUD operational processes and clinical reviews. Humana has also established associate-level processes and procedures for performing retrospective reviews.	**Comparative Analysis - Process as Written** The factors and evidentiary standards used to develop processes for Inpatient out-of-network retrospective review are outlined in steps 2 and 3 above. In policy, Humana has memorialized the Retrospective Review process. These policies comprehensively capture M/S and MH/SUD operational processes and clinical reviews. Humana has also established associate-level processes and procedures for performing retrospective reviews.	**Comparative Analysis - Process as Written** The factors and evidentiary standards used to develop processes for Outpatient in-network retrospective review are outlined in steps 2 and 3 above. In policy, Humana has memorialized the Retrospective Review process. These policies comprehensively capture M/S and MH/SUD operational processes and clinical reviews. Humana has also established associate-level processes and procedures for performing retrospective reviews.	**Comparative Analysis - Process as Written** The factors and evidentiary standards used to develop processes for Outpatient out-of-network retrospective review are outlined in steps 2 and 3 above. In policy, Humana has memorialized the Retrospective Review process. These policies comprehensively capture M/S and MH/SUD operational processes and clinical reviews. Humana has also established associate-level processes and procedures for performing retrospective reviews.	**Comparative Analysis - Process as Written** The factors and evidentiary standards used to develop Humana's Retrospective Review NQTL are outlined in steps 2 and 3 above. As noted, Humana does not apply Preauthorization requirements to Medical/Surgical or Mental Health/Substance Use Disorder Emergency Services. However, for both M/S and MH/SUD, emergency services claims may be reviewed (against comparable criteria) when submitted by a provider or facility.
Step 5: Processes in implementation of NQTL in operation	**Comparative Analysis - Process in Operation** • In operation, associates follow written processes and procedures for performing retrospective reviews. Rationale for approving or denying is required to be thoroughly documented with each review. Mechanisms such as outreach for additional clinical information and peer-to-peer consultation with treating physicians may be performed as part of the review process. • In operation, retrospective reviews resulting in an approval may be performed by licensed clinicians - such as Registered Nurses for M/S reviews and Licensed Clinical Social Workers for MH/SUD reviews. Retrospective medical necessity reviews resulting in a denial or partial approval must be performed by licensed board-certified physicians.	**Comparative Analysis - Process in Operation** • In operation, associates follow written processes and procedures for performing retrospective reviews. Rationale for approving or denying is required to be thoroughly documented with each review. Mechanisms such as outreach for additional clinical information and peer-to-peer consultation with treating physicians may be performed as part of the review process. • In operation, retrospective reviews resulting in an approval may be performed by licensed clinicians - such as Registered Nurses for M/S reviews and Licensed Clinical Social Workers for MH/SUD reviews. Retrospective medical necessity reviews resulting in a denial or partial approval must be performed by licensed board-certified physicians.	**Comparative Analysis - Process in Operation** • In operation, associates follow written processes and procedures for performing retrospective reviews. Rationale for approving or denying is required to be thoroughly documented with each review. Mechanisms such as outreach for additional clinical information and peer-to-peer consultation with treating physicians may be performed as part of the review process. • In operation, retrospective reviews resulting in an approval may be performed by licensed clinicians - such as Registered Nurses for M/S reviews and Licensed Clinical Social Workers for MH/SUD reviews. Retrospective medical necessity reviews resulting in a denial or partial approval must be performed by licensed board-certified physicians.	**Comparative Analysis - Process in Operation** • In operation, associates follow written processes and procedures for performing retrospective reviews. Rationale for approving or denying is required to be thoroughly documented with each review. Mechanisms such as outreach for additional clinical information and peer-to-peer consultation with treating physicians may be performed as part of the review process. • In operation, retrospective reviews resulting in an approval may be performed by licensed clinicians - such as Registered Nurses for M/S reviews and Licensed Clinical Social Workers for MH/SUD reviews. Retrospective medical necessity reviews resulting in a denial or partial approval must be performed by licensed board-certified physicians.	**Comparative Analysis - Process in Operation** • As noted, Humana does not require authorization for Medical/Surgical or Mental Health/Substance Use Disorder Emergency Services. Emergency Services claims may be subject to medical necessity review by a licensed board-certified Medical Director when submitted. The intent of the review is to ensure the services rendered were truly emergent in nature. • In practice, Humana Medical Directors review claims using the Humana-approved definition of emergency care (inclusive of the Prudent Layperson Standard) to ensure consistency in reviews of Emergency Services claims. • Humana's claims platforms are configured not to require Preauthorization for emergency services claims.
Step 6: Summary conclusion of how plan has determined overall compliance	**Summary Conclusions** As outlined in steps 4 and 5, Humana's written and operationalized practices for the Retrospective Review NQTL for Inpatient in-network MH/SUD are comparable to the written and operationalized practices for M/S. Processes, factors, and evidentiary standards used to determine which services require/prompt Retrospective Review are not differentiated between Medical/Surgical and Mental Health/Substance Use Disorder. Retrospective review for M/S and MH/SUD are performed by reviewers with comparable credentials. The processes are designed and supported by policies, procedures, and practices. In addition to comparing written and operational practices, Humana uses data to perform stringency assessments to ensure that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL are no more stringently applied in operation. The assessment consists of a review of adverse decision rates, timeliness of decisions, and appeal overturn rates for M/S and MH/SUD services. Based on reviews performed by Humana Operational Leaders to date, there is no evidence to indicate that the processes, strategies, and evidentiary standards are applied more stringently in operation to the MH/SUD Retrospective Review NQTL than the M/S Retrospective Review NQTL. Therefore, Humana concludes that the processes, strategies, and evidentiary standards used in applying the Retrospective Review NQTL to Mental Health and Substance Use Disorder are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the Retrospective Review NQTL to Medical/Surgical.	**Summary Conclusions** As outlined in steps 4 and 5, Humana's written and operationalized practices for the Retrospective Review NQTL for Inpatient out-of-network MH/SUD are comparable to the written and operationalized practices for M/S. Processes, factors, and evidentiary standards used to determine which services require/prompt Retrospective Review are not differentiated between Medical/Surgical and Mental Health/Substance Use Disorder. Retrospective review for M/S and MH/SUD are performed by reviewers with comparable credentials. The processes are designed and supported by policies, procedures, and practices. In addition to comparing written and operational practices, Humana uses data to perform stringency assessments to ensure that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL are no more stringently applied in operation. The assessment consists of a review of adverse decision rates, timeliness of decisions, and appeal overturn rates for M/S and MH/SUD services. Based on reviews performed by Humana Operational Leaders to date, there is no evidence to indicate that the processes, strategies, and evidentiary standards are applied more stringently in operation to the MH/SUD Retrospective Review NQTL than the M/S Retrospective Review NQTL. Therefore, Humana concludes that the processes, strategies, and evidentiary standards used in applying the Retrospective Review NQTL to Mental Health and Substance Use Disorder are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the Retrospective Review NQTL to Medical/Surgical.	**Summary Conclusions** As outlined in steps 4 and 5, Humana's written and operationalized practices for the Retrospective Review NQTL for Outpatient in-network MH/SUD are comparable to the written and operationalized practices for M/S. Processes, factors, and evidentiary standards used to determine which services require/prompt Retrospective Review are not differentiated between Medical/Surgical and Mental Health/Substance Use Disorder. Retrospective review for M/S and MH/SUD are performed by reviewers with comparable credentials. The processes are designed and supported by policies, procedures, and practices. In addition to comparing written and operational practices, Humana uses data to perform stringency assessments to ensure that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL are no more stringently applied in operation. The assessment consists of a review of adverse decision rates, timeliness of decisions, and appeal overturn rates for M/S and MH/SUD services. Based on reviews performed by Humana Operational Leaders to date, there is no evidence to indicate that the processes, strategies, and evidentiary standards are applied more stringently in operation to the MH/SUD Retrospective Review NQTL than the M/S Retrospective Review NQTL. Therefore, Humana concludes that the processes, strategies, and evidentiary standards used in applying the Retrospective Review NQTL to Mental Health and Substance Use Disorder are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the Retrospective Review NQTL to Medical/Surgical.	**Summary Conclusions** As outlined in steps 4 and 5, Humana's written and operationalized practices for the Retrospective Review NQTL for Outpatient out-of-network MH/SUD are comparable to the written and operationalized practices for M/S. Processes, factors, and evidentiary standards used to determine which services require/prompt Retrospective Review are not differentiated between Medical/Surgical and Mental Health/Substance Use Disorder. Retrospective review for M/S and MH/SUD are performed by reviewers with comparable credentials. The processes are designed and supported by policies, procedures, and practices. In addition to comparing written and operational practices, Humana uses data to perform stringency assessments to ensure that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL are no more stringently applied in operation. The assessment consists of a review of adverse decision rates, timeliness of decisions, and appeal overturn rates for M/S and MH/SUD services. Based on reviews performed by Humana Operational Leaders to date, there is no evidence to indicate that the processes, strategies, and evidentiary standards are applied more stringently in operation to the MH/SUD Retrospective Review NQTL than the M/S Retrospective Review NQTL. Therefore, Humana concludes that the processes, strategies, and evidentiary standards used in applying the Retrospective Review NQTL to Mental Health and Substance Use Disorder are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the Retrospective Review NQTL to Medical/Surgical.	**Summary Conclusions** As outlined in steps 4 and 5, Humana's written and operationalized practices for the Retrospective Review NQTL for Emergency Services are comparable to the written and operationalized practices for Medical/Surgical. Processes, factors, and evidentiary standards used to determine which services require/prompt Retrospective Review are not differentiated between Medical/Surgical and Mental Health/Substance Use Disorder. As noted, Emergency Services require neither referral nor preauthorization, but Emergency Services claims may be subject to review against the Prudent Layperson standard when submitted by the provider/facility. The processes are designed and supported by policies, procedures, and practices. Therefore, Humana concludes that the processes, strategies, and evidentiary standards used in applying the Retrospective Review NQTL to Mental Health and Substance Use Disorder are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the Retrospective Review NQTL to Medical/Surgical.

Current as of April 2022

NQTL Name	Plan's Description of NQTL
Experimental & Investigational Definition	This NQTL addresses the definition that Humana has established and applies for Experimental & Investigational services as it pertains to coverage and Medical Necessity Review. *Processes, factors, and evidentiary standards with respect to Humana's medical necessity review processes are covered in the Medical Necessity Criteria NQTL analysis.*

Column 1 - Prompt	Column 2 - All Classifications
Step 1: Describe the NQTL's requirements and associated procedures	Humana has developed a singular definition of Experimental & Investigational - which applies consistently across all services/items, for both Medical/Surgical (M/S) and Mental Health/Substance Use Disorder (MH/SUD). The definition of E&I is developed by Clinical Policy SMEs and reviewed/approved by Medical Director leadership. The definition and the sources relied upon are outlined in Factors and Evidentiary Standards below. For transparency, E&I is also defined in each member's Evidence of Coverage (EOC) and limitations in coverage of E&I services are outlined.

Step 2: Describe the reason for applying the NQTL (Factors Applied)	**Humana's established definition of Experimental & Investigational is as follows - The same definition applies across all services/items, for both Medical/Surgical (M/S) and Mental Health / Substance Use Disorder (MH/SUD)**
	
	Experimental or investigational or for research purposes means a biological product, device, treatment or procedure that meets any one of the following criteria:
	☐ Cannot be lawfully marketed without the final approval of the United States Food and Drug Administration (FDA) and which lacks such final FDA approval for the use or proposed use, unless:
	   o found to be accepted for that use in the most recently published edition of the United States Pharmacopeia-Drug Information for Healthcare Professional (USP-DI) or in the most recently published edition of the American Hospital Formulary Service (AHFS) Drug Information, or
	   o identified as safe, widely used and generally accepted as effective for that use as reported in nationally recognized peer reviewed medical literature published in the English language as of the date of service; or
	   o is mandated by state law;
	☐ Is a device required to receive Premarket Approval (PMA) or 510(k) approval by the FDA but has not received a PMA or 510(k) approval;
	☐ Is not identified as safe, widely used and generally accepted as effective for the proposed use as reported in nationally recognized peer reviewed medical literature published in the English language as of the date of service;
	☐ Is the subject of a National Cancer Institute (NCI) Phase I, II or III trial or a treatment protocol comparable to a NCI Phase I, II or III trial, or any trial not recognized by NCI regardless of phase; or
	☐ Is identified as not covered by the Centers for Medicare and Medicaid Services (CMS) Medicare Coverage Issues Manual, a CMS Operational Policy Letter or a CMS National Coverage Decision, except as required by state or federal law.

Step 3: Identify and describe evidentiary standards and other evidence relied upon	Evidentiary Standards supporting the definition of Experimental & Investigational are outlined in the row above. As noted, the evidentiary standards include: - United States Food and Drug Administration (FDA) approval list(s) - United States Pharmacopeia-Drug Information for Healthcare Professional (USP-DI) - Nationally recognized peer reviewed medical literature as of the date of service - National Cancer Institute trials - CMS manuals, and other state/federal guidelines
Step 4: Processes and strategies used to design NQTL as written	**Comparative Analysis - Process as Written** The factors and evidentiary standards used to develop Humana's Experimental and Investigational NQTL are listed above in steps 2 and 3. In policy, a singular definition of Experimental & Investigational applies across all services/items, for both Medical/Surgical (M/S) and Mental Health / Substance Use Disorder (MH/SUD)

Step 5: Processes in implementation of NQTL in operation	**Comparative Analysis - Process in Operation** • The definition of Experimental & Investigational is reviewed, at minimum, annually as a result of standardized policy review processes. Additionally, ad hoc committees of Medical Director leadership and Operational leaders may revisit the definition on an as-needed basis. Processes and strategies may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.
Step 6: Summary conclusion of how plan has determined overall compliance	**Summary Conclusions** As outlined in steps 4 and 5, Humana's written and operationalized practices for the Experimental and & Investigational Definition NQTL MH/SUD are comparable to the written and operationalized practices for M/S. Processes, factors, and evidentiary standards used to define E&I are not differentiated between Medical/Surgical and Mental Health/Substance Use Disorder; Humana has established a singular definition of Experimental & Investigational across all services/items. In addition to comparing written and operational practices, Humana uses data to perform stringency assessments to ensure that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL are no more stringently applied in operation. The assessment consists of a review of adverse decision rates, timeliness of decisions, and appeal overturn rates for M/S and MH/SUD services. Based on reviews performed by Humana Operational Leaders to date, there is no evidence to indicate that the processes, strategies, and evidentiary standards are applied more stringently in operation to the MH/SUD Concurrent Review NQTL than the M/S Concurrent Review NQTL. Therefore, Humana concludes that the processes, strategies, and evidentiary standards used in applying the Experimental & Investigational NQTL to Mental Health and Substance Use Disorder are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the Experimental & Investigational NQTL to Medical/Surgical.

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NQTL Name	Plan's Description of NQTL
Coding Edits	This NQTL addresses the processes, factors, and evidentiary standards driving the list of services and items for which Humana requires requiring providers to limit bill codes that could otherwise be applicable.

Column 1 - Prompt	
	Column 2 - All Classifications
Benefit/Service(s) to which the coding edits apply.	**The following benefits/services are subject to coding edits:** Professional and outpatient medical claims are eligible for code edit review and edit application. Eligible services include Medical/Surgical (M/S) or Mental Health/Substance Use Disorder (MH/SUD). Code editing may be applied to current or previous allowed claim volume based on eligibility criteria, as defined by claims payment systems, line of business and claim type. Claim volume out of scope includes, but is not limited to: • Secondary payer • Real Time • Pharmacy • Inpatient facility
Step 1: Describe the NQTL's requirements and associated procedures	Overview of Humana's coding edits Application of and conformity of coding edits apply irrespective to whether a service is Medical/Surgical (M/S) or Mental Health/Substance Use Disorder (MH/SUD) and Humana applies similar criteria for the same purposes. These edits include, but are not limited to, units of service, unbundling, mutually exclusive and incidental procedures, pre/post-op surgical periods, modifier usage, multiple surgery reduction, add-on codes, cosmetic, and assistant surgeon. The current list of policies are listed below this analysis.
Step 2: Describe the reason for applying the NQTL (Factors Applied)	Humana enforces code editing to services rendered in order to: • Remain compliant with all Federal and State regulations • Maintain compliance with clinical and regulatory guidelines • Ensure consistent and appropriate processing of claims, based on services billed • Utilize funds appropriately In order to adjudicate claims accurately and in a timely manner, Humana will identify inappropriately coded claims and, when possible, reimburse using the correct code. Humana will do so based only upon known facts, such as member demographic information or service location. When the correct code cannot clearly be identified, the claim will be returned to the health care provider for correction and resubmission, if applicable.

Step 3: Identify and describe evidentiary standards and other evidence relied upon	Humana policy experts and coding edit vendors develop code editing policies based upon the following evidentiary standards including, but not limited to: • CPT Coding Rules in the CPT Manual • HCPCS Coding Rules • ICD-10 Coding Rules • CPT Assistant • Principles of CPT Coding • AMA Coding with Modifiers • AMA Errata (published coding errors/changes that were left out of the update) • MPFS status codes and other indicators (E.g. bilateral designation, multiple surgery, etc.) • OPPS payment status indicator if facility DP • OCE edits • NCD and/or LCDs • Medicare Manuals • Critical Access Hospital rules in the Medicare Manuals • Medical Learning Network updates or CMS transmittals • Humana Medicare MCP Policy on the topic • DME MAC website, Supplier Manual, DME LCDs • HEDIS Measures and Star ratings • Health Care Reform provisions that effect Medicare • State Mandates These evidentiary standards apply across all services/items for Medical/Surgical (M/S) and Mental Health/ Substance Use Disorder (MH/SUD).
Step 4: Processes and strategies used to design NQTL as written	**Comparative Analysis - Process as Written** Humana code edit policies, noted above, are reviewed at a minimum annually, by vendor and Humana coding experts. Policy reviews may result in the implementation of new code editing policies or modification of existing code editing policies. Policy reviews are performed for all polices applicable to Medical/Surgical (M/S) and Mental Health/ Substance Use Disorder (MH/SUD). Stakeholder approval is required for any and all changes to code edit policy, including new and existing policies. Stakeholders include but are not limited to representation from each of the following areas: • Claims Process Organization • Provider Contracting • Member Group Contracting • Provider Markets • RMDs • Coders • Pharmacists • Compliance Humana post notifications of upcoming changes to www.Humana.com on the first Friday of each month. These notifications inform providers that Humana plans to make a change to our code editing rules or claim payment processes. Previously published notifications are available online for at least five years. A notification may be removed after five years, or sooner if the notice no longer applies.
Step 5: Processes in implementation of NQTL in operation	**Comparative Analysis - Process In Operation** Humana routinely monitors and/or audits the performance of code edit policies and collaborates with stakeholders to facilitate effective provider code submissions and addresses policy changes with all expediency to ensure accurate claims payment. Additionally, as noted in Step 4, Humana code edit policies are reviewed at minimum annually to adhere to published protocols and policy updates as dictated by the source of the applicable policy.
Step 6: Summary conclusion of how plan has determined overall compliance	**Summary Conclusions** Humana's written and implemented practices, processes, factors, and evidentiary standards used to define code editing policies apply across all services/items and are not differentiated between Medical/Surgical and Mental Health/Substance Use Disorder. Therefore, Humana concludes that the processes, strategies, and evidentiary standards used in applying the code editing NQTL to Mental Health and Substance Use Disorder are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the code editing NQTL to Medical/Surgical.

Code Edit Policy Type	*Description*
Age	Some procedure codes and/or diagnosis codes are specific to certain age ranges. When one of these procedures is billed for a member outside that age range it is denied.

Assistant at surgery	There are specific guidelines related to assistant at surgery services. Some services do not require an assistant. Providers acting as assistants are required to append a specific modifier based on their certification. When claims are billed without following these requirements, the services are denied or have the modifier changed.
Bilateral	Some bilateral CPT or HCPCS codes have billing requirements to be submitted with modifier 50. When one of these codes is billed without the required modifier it is denied.
Billed with inappropriate modifie	Based on AMA and CMS guidelines when a procedure is billed with a modifier considered inappropriate for the service the code is denied.
Billed with inappropriate modifie	Based on AMA and CMS guidelines when a procedure is billed with a modifier and/or place of service considered inappropriate for the service the code is denied.
Billed without appropriate modif	Some CPT or HCPCS codes have billing requirements to be submitted with a specific modifier. When one of these codes is billed without the required modifier it is denied.
Billed without appropriate modif	Some CPT or HCPCS codes have billing requirements to be submitted with a specific modifier and/or diagnosis. When one of these codes is billed without the required modifier and/or diagnosis it is denied.
Blood Product	There are specific guidelines related to the billing of blood products and blood storage. When claims are billed without following these requirements, the services are denied. .
Bundling	Some services are considered included or integral to the primary procedure. When these component services are billed separately they will be bundled into the comprehensive procedure code and not allowed separately.
Co Surgeon	When two surgeons perform a procedure during the same surgical setting, they are referred to as co surgeons (modifier 62). These services are only covered when the procedures are approved for co surgeons.
Condition Codes	A condition code identifies a condition relating to a facility bill that may affect claim processing. There are specific guidelines around condition codes. When these guidelines are not followed, the services are denied.
Date of Death/Occurrence Code F	Services billed for deceased members require applicable occurrence codes and/or date of death to be allowed. Claims billed without applicable occurrence codes and/or date of death will deny. .
Diagnosis Frequency	Based on the Florida Medicaid Practitioners Handbook, when a procedure code is billed with units exceeding the frequency limit allowed per associated diagnosis, the additional units will be denied.
Diagnosis to Procedure	There are two different types of diagnosis to procedure edits A procedure could be denied because it is not typically expected with the diagnosis billed. Or a procedure could be denied because it is billed without an expected diagnosis. Historical diagnoses may be considered.
Diagnosis Validity	The ICD9 and ICD10 books include direction on what constitutes a valid diagnosis, and in what position that diagnosis may be billed. When claims are billed with an invalid diagnosis, or a diagnosis in an invalid position, the services are denied. .
DME - Clinical	Based on Humana policy, AMA or CMS guidelines a service that is experimental, investigational, exceeds clinical guidelines, not FDA approved or for research purposes is not covered.
DME - Coding	There are specific guidelines related to rental, replacement, repair, maintenance, accessories, etc. for the billing of Durable Medical Equipment. When claims are billed without following these requirements, the services are denied. .
DME Coverage Criteria	The Way This DME Was Billed Does Not Meet The CMS LCD Specific Coverage Criteria. The Member Is Not Responsible For Payment.
Drugs & Biologicals - Age	Drugs and biologicals are sometimes only appropriate for patients in certain age groups. Our editing enforces the age restrictions dictated by the FDA-approved package insert/prescribing information, Humana coverage policies or other approved sources.
Drugs & Biologicals – Billed with I	When a drug and/or biological code is billed with a specific diagnosis and place of service combination, the service billed will be denied if the place of service is inappropriate. These edits are based on a number of different references and are meant to account for the average person in the average situation.
Drugs & Biologicals - Billed witho	Some drug and/or biological codes have billing requirements to be submitted with a specific modifier. When one of these codes is billed without the required modifier it is denied.
Drugs & Biologicals - Coding	There are specific guidelines related to drug and biologicals. When claims are billed without following these requirements, the services are denied. .
Drugs & Biologicals - Diagnosis to	Drugs and biologicals are sometimes only appropriate to treat certain indications. Our editing enforces the diagnosis to procedure billing dictated by the FDA-approved package insert/prescribing information, Humana coverage policies or other approved sources.

Drugs & Biologicals - Frequency	When a drug and/or biological code is billed exceeding the frequency limit, the service billed will be denied. These edits are based on a number of different references and are meant to account for the average person in the average situation.
Drugs & Biologicals - Frequency w	When a drug and/or biological code is billed exceeding the frequency limit with specific diagnosis, the service billed will be denied. These edits are based on a number of different references and are meant to account for the average person in the average situation.
Drugs & Biologicals - Incompatibl	Drugs and biologicals are sometimes only appropriate to administer using certain procedures. Our editing enforces the administration procedure billing dictated by the FDA-approved package insert/prescribing information, Humana coverage policies or other approved sources.
Drugs & Biologicals - Max Units	When a code is billed with units exceeding the daily maximum, the excess units are denied. These edits are based on a number of different references and are meant to account for the average person in the average situations.
Drugs & Biologicals - Missing Nee	Some drugs and biologicals require a primary service to be performed. When the primary service has not been billed or allowed the drug or biological is also denied.
Drugs & Biologicals - Procedure to	Some drugs and biologicals require a corresponding procedure to be performed. When the corresponding procedure has not been billed or allowed the drug or biological is denied.
Drugs & Biologicals - Wastage (M	When a drug and/or biological code is billed with modifier JW (wastage) and the units exceed the limit for wastage, the excess units are denied.
Duplicate	Duplicate claim lines are identified via variety of criteria. When services are billed that match the criteria of a duplicate rule, the service is denied.
Duplicate/Quality Control Interpr	Interpretation of EKG or X-rays performed in specific settings are allowed per Humana policy. Subsequent interpretation(s) billed on the same date of service without appropriate modifiers will deny as duplicates.
Frequency	When a code is billed exceeding the frequency limit, the additional units billed will be denied. These edits are based on a number of different references and are meant to account for the average person in the average situation.
Gender	Some procedure codes are specific to a gender. When the gender is inconsistent with the service based on member information, the service is denied. Claims for transgender members are excluded based on condition code and/or modifier.
Global OB	Global obstetric care codes include antepartum, delivery and postpartum services. When one of these services are billed separately (in addition to a global obstetric care code), the individual service is denied.
Global Surgery	Payment for the surgical procedure includes the preoperative, intra-operative, and post-operative services. When these services are billed separately during the global surgery period they will be denied.
Inappropriate Bill Type	These edits are based on bill type guidelines. Services performed outside the scope of these guidelines are denied. .
Inappropriate Claim Type	These edits are based on claim type guidelines. Services performed outside the scope of these guidelines are denied. .
Inappropriate Provider Specialty/	These edits are based on provider specialty or type guidelines. Services performed outside the scope of the provider's specialty or type are denied.
Incompatible Procedure to Modif	Based on definition, some procedure codes and modifiers billed are inconsistent with each other. When incompatible procedure and modifiers are billed together, the service is denied. .
Incompatible Procedure to Proce	Based on definition, some codes cannot be billed together because they represent services that are inconsistent with each other. Example, power wheelchair accessory billed with a manual wheelchair. When incompatible services are billed together, the lesser service is denied. .
Inconsistent Modifier	When a modifier is inconsistent with information in member history, the service is denied. Example, modifier 78 (return to operating room) is billed, but there is no prior surgery in member history. .
Invalid Service	Based on CMS, certain services are considered not valid for Medicare purposes. When one of these services is billed it is denied.
LCD - exceeds coverage	When a code is billed but the member has exceeded the frequency limit for that service per guidance within an LCD/NCD policy. The guidance within an LCD/NCD is meant to account for the average person in the average situation.
LCD - reasonable and necessary	When a service is billed without a diagnosis on the claim that meets medical necessity per guidance within an LCD/NCD policy.

Max Units	When a code is billed with units exceeding the daily maximum, the excess units are denied. These edits are based on a number of different references and are meant to account for the average person in the average situations.
Multiple E/Ms	In general, only 1 evaluation and management service is allowed per day by the same provider. If multiple E/Ms are billed, and no modifier is appended to represent a significant, separately identifiable service, the lesser service is denied.
Multiple Technical/Professional C	Some services can be billed globally or as individual professional and technical components. Only 1 unit of each component, or 1 unit of global, is allowed. If any combination of codes is billed representing more than 1 professional or 1 technical component, the excess is denied.
Never Event	Services are not allowed if the wrong procedure was performed on a patient or the service was performed on the same date as a wrong procedure performed.
New Patient E/M	A new patient evaluation and management service is only appropriate to be billed for patients that meet the AMA definition of a new patient. When a provider bills a new patient visit for a member that does not meet the definition of new patient it is denied. .
Not Covered	Based on CMS, Humana coverage policies, etc., certain services are considered not covered. When one of these services is billed it is denied. .
Partial Hospitalization Policy	Some services are applicable only to the Partial Hospitalization Program. When these services are billed with a condition code representing partial hospitalization, they are denied. .
PCI (duplicate)	When the same service is billed by multiple providers, it is reviewed for possible duplication. Some services cannot be billed multiple times on the same day and are denied.
PCI (modifier validation)	Some modifiers (like 25 and 59) prompt additional payment and are therefore subject to misuse/abuse. Information on the claim, in member history, and in provider history is reviewed to determine if the modifier usage is supported. If it appears the modifier has been misused, the service is denied.
Place of Service	Some services can only be performed in certain places of service. When a procedure is billed for an inappropriate place of service, based on AMA or CMS guidance, it is denied.
Primary procedure not processed	Some services require a primary service to be performed. When the primary service has not been billed or allowed the subsequent service will also deny. .
Procedure Code Guideline Policy	These edits are based on AMA procedure code definitions and guidelines. Billing scenarios that do not meet procedure code billing requirements will deny. .
Recode	A recode is when the procedure code is changed to a different procedure code that more accurately describes the services rendered. This is determined based on member history, member information, and details on the claim. Recodes are a 1 to 1 relationship (i.e., male vs female code).
Revenue Code Policy	These rules enforce revenue code guidelines. When revenue codes are billed with a procedure that does not match the revenue code the service will be denied. Or If a revenue code requires a procedure code to also be billed a denial will invoke when no procedure is billed. Or if a revenue code conflicts with another revenue code billed on the same date of service it will deny. .
Secondary Interpretation	Interpretation of EKG or X-rays performed in specific settings are allowed per Humana policy. Subsequent interpretation(s) billed on the same date of service without appropriate modifiers will deny with support documentation, or applicable modifiers indicating the service is separate and distinct and supports the diagnosis and treatment of the member.
Specialty	Taxonomy Is Not Approved For Services Billed Under Illinois Medicaid Guidelines.
Team Surgery	When a group of surgeons perform multiple surgeries in the same surgical setting, it is referred to as Team Surgery (modifier 66). These services are only covered when the procedures are approved for team surgery.

NQTL Name	Plan's Description of NQTL	This Humana Template NQTL comparative analysis is made available for informational purposes only and covers some of the primary NQTLs in the Humana Plan Template. It is not intended and should not be construed as providing legal advice. Each plan's situation can be highly fact specific and does not address plan customizations. The federal agencies interpreting MHPAEA have emphasized that any MHPAEA analysis is on a plan by plan basis and not on the overall "book of business" of any insurer or third-party administrator/ASO. Also, NQTLs are evaluated on an "as applied" basis. Therefore, specific utilization abnormalities may impact whether this general comparative analysis is appropriate in all regards.
Provider Reimbursement	This NQTL addresses the processes, factors, and evidentiary standards by which Humana reimburses providers	As noted, a plan's NQTL comparative analysis must be made available to participants, beneficiaries, providers and governmental agencies upon request. As a condition of use of this NQTL comparative analysis, we require that you notify us whenever you provide a copy of this NQTL analysis pursuant to a request from such an individual or entity. Except for each request you are required to keep the contents of this Humana Template NQTL comparative analysis confidential as it is the proprietary information of Humana.

		Inpatient Benefits		Outpatient Benefits			Emergency Benefits	
Column 1 - Prompt	**Column 2 - In network**	**Column 3 - Out-of-network**	**Column 4 - In network**	**Column 5 - Out-of-network Facility-Based**	**Column 6 - Out-of-network Physician/Professional and Other**	**Column 7 - Out-of-network Facility-Based**	**Column 8 - Out-of-network Physician/Professional and Other**	
Step 1: Describe the NQTL's requirements and associated procedures	Humana, MH/SUD and M/S rates are determined by obtaining analytics such as access and adequacy standards/requirements, claims analysis, Medicare pricing, a combination of resources, including Humana's coordination of benefit (COB) information as well as purchased vendor information, such as Hewitt. Contracting team members hold a bachelor's degree or higher; NINO has an extensive training program for its contracting teams.	For both medical/surgical and MH/SUD benefits, out-of-network reimbursement (for both inpatient and outpatient services) is established based on the facility type. Using Medicare data, Humana establishes a Maximum Allowable Fee (MAF) for all hospitals, including Critical Access Hospitals, LTAC, Psychiatric and Inpatient Rehab, are based on each facility's cost-to-charge ratio plus seventeen percent. As institutional Medicare providers, each fiscal year, hospitals are required to submit cost reports to CMS. Humana uses these data to ascertain the overall cost of providing services to our members in a specific geographic area. Humana applies the overall cost ratio obtained from CMS (via Option) to the billed charges for a particular claim to determine the average cost of the service(s) billed under that claim. Humana then applies a seventeen percent markup to the overall cost calculation. In summary, Humana's MAF rate is seventeen percent above the average health care provider's costs. Rates are updated several times per year as Optum's updates are made available to Humana. This methodology applies to all diagnoses and services billed by the facility. In keeping with the uniform approach of establishing reimbursement based on the facility billing services, in the infrequent event that an inpatient benefit is billed by a non-hospital facility, reimbursement for that facility is determined based on the process described in Column 5 for outpatient facility-based out-of-network benefits.	In-network outpatient reimbursement rates are negotiated by Humana's contracting teams, which use as a starting point a set of fee schedules developed as described here.	For both medical/surgical and MH/SUD benefits, out-of-network reimbursement (for both inpatient and outpatient services) is established based on the facility type. For any facility type, a Maximum Allowable Fee (MAF) is determined, usually using one of two reimbursement methodologies. For facilities that file a Medicare cost report, a cost-plus-percentage methodology generally applies. Most facilities that do not file Medicare cost reports are reimbursed based on the average in-network rate for the facility type. Using Medicare data, Humana establishes a MAF that applies to each inpatient out-of-network claim. The MAF for all hospitals, including Critical Access Hospitals, LTAC, Psychiatric and Inpatient Rehab, are based on each facility's cost to charge ratio (CCR) plus seventeen percent. As institutional Medicare providers, each fiscal year, hospitals are required to submit cost reports to CMS. CMS applies a calculation to determine the CCR. The CCR is the ratio between a hospital's expenses and their charges. Humana applies a seventeen percent markup to the overall cost to charge ratio. In summary, Humana's MAF rate is seventeen percent above the average health care provider's costs. Rates are updated several times per year as Optum's updates are made available to Humana. In general, the reimbursement rates for non-hospital facilities (such as dialysis centers, outpatient psych clinics, residential treatment centers, and substance abuse facilities) is based on the average in-network reimbursement rate for similar services (determined based on revenue codes), adjusted by geography (CBSA) where appropriate. Ambulatory Surgical Centers are reimbursed at 100% of Medicare. These methodologies apply to all diagnoses and services—whether medical/surgical or MH/SUD—billed by the provider type.	The same reimbursement methodology is used for both inpatient and outpatient services provided by physicians and ancillary providers (such as DME suppliers or laboratories). Out-of-network reimbursement generally is determined using fee schedules. Within the fee schedule, geographical area and procedural code categories generally are considered. Humana's fee schedule percentages are determined as described in Column 4. The applicable fee schedules are developed for the initial purpose of serving as the starting point for negotiations with in-network providers (using the factors set forth for in-network reimbursement), and they are updated periodically to reflect market realities. These rates apply to all claims, both MH/SUD and medical/surgical.	For both medical/surgical and MH/SUD benefits, out-of-network reimbursement (for both inpatient and outpatient services) is established based on the facility type. For any facility type, a Maximum Allowable Fee (MAF) is determined, using one of three reimbursement methodologies required by the Patient Protection Affordable Care Act. The three methodologies are the in-network median rate, the Medicare rate or the out-of-network rate. These methodologies apply to all emergent services—whether medical/surgical or MH/SUD—billed by the provider type.	For both medical/surgical and MH/SUD benefits, out-of-network reimbursement is established for any professional service rendered in an emergency room setting. A Maximum Allowable Fee (MAF) is determined, using one of three reimbursement methodologies required by the Patient Protection Affordable Care Act. The three methodologies are the in-network median rate, the Medicare rate or the out-of-network rate. These rates apply to all claims, both MH/SUD and medical/surgical.
Step 2: Describe the reason for applying the NQTL	Humana contracting applies the following factors: • Service type • Provider specialty • Level of provider expertise • Geographic location • Demand for services • Supply of providers • Medicare reimbursement rates • Programs that review quality • Comparison of rates from one or more regional or national databases or schedules for the same or similar services • Provider Practice Size • Site of service	Reimbursement rates for medical/surgical and for MH/SUD benefits are based upon the provider's cost for providing the same or similar services as reported by such provider in its most recent publicly available Medicare cost report submitted to the Centers for Medicare & Medicaid Services (CMS) annually.	Humana contracting applies the following factors in establishing fee schedules: • Service type • Provider specialty • Level of provider expertise • Geographic location • Demand for services • Supply of providers • Medicare reimbursement rates • Programs that review quality • Comparison of rates from one or more regional or national databases or schedules for the same or similar services • Provider Practice Size • Site of service	For hospitals, reimbursement rates for medical/surgical and for MH/SUD benefits generally are based upon the provider's cost for providing the same or similar services as reported by such provider in its most recent publicly available Medicare cost report submitted to the Centers for Medicare & Medicaid Services (CMS) annually. For many non-hospital facilities , Medicare either does not collect or does not make available sufficient Medicare data to reliably determine the facilities' costs. Thus, the typical cost plus seventeen percent methodology is not applied.	As noted under Step 1, fee schedules used for in-network contracting are applied to determine out-of-network reimbursement. The following factors are used to establish the fee schedule: • Service type • Provider specialty • Level of provider expertise • Geographic location • Demand for services • Supply of providers • Medicare reimbursement rates • Programs that review quality • Comparison of rates from one or more regional or national databases or schedules for the same or similar services • Provider Practice Size • Site of service	This reimbursement is used in accordance with the Patient Protection Affordable Care Act. The maximum allowable fee for a covered expense for emergency care services provided by non-network providers in a hospital's emergency department is an amount equal to the greatest of: • The fee negotiated with network providers; • The fee calculated using the same method to determine maximum allowable fee for a covered expense, other than emergency care services provided by non-network providers; or • The fee paid by Medicare for the same services.	This reimbursement is used in accordance with the Patient Protection Affordable Care Act. The maximum allowable fee for a covered expense for emergency care services provided by non-network providers in a hospital's emergency department is an amount equal to the greatest of: • The fee negotiated with network providers; • The fee calculated using the same method to determine maximum allowable fee for a covered expense, other than emergency care services provided by non-network providers; or • The fee paid by Medicare for the same services.
Step 3: Identify and describe evidentiary standards and other evidence relied upon	In-network rates are developed applying the factors listed in Step 2 by obtaining analytics such as access and adequacy standards/requirements, claims analysis, a combination of resources, including Humana's coordination of benefit (COB) information as well as purchased vendor information, such as Hewitt. In addition, the following information may be applied for any particular provider: • Provider website • Google maps for service location, near public transportation • Member requests/nominations • SAMHSA/Medical Licensure Websites to fill adequacy gaps • Medicare Fee Schedules • Zelis Network 360	Sources of provider reimbursement are Medicare cost report data submitted to the Centers for Medicare & Medicaid Services (CMS). Medicare cost report data provides a reliable, objective standard on which to determine facility-based services.	Fee schedules are developed applying the factors listed in Step 2 by obtaining analytics such as access and adequacy standards/requirements, claims analysis, Medicare fee schedules, a combination of resources, including Humana's coordination of benefit (COB) information as well as purchased vendor information, such as Hewitt. In addition, the following information may be applied for any particular provider: • Provider website • Google maps for service location, near public transportation • Member requests/nominations • SAMHSA/Medical Licensure Websites to fill adequacy gaps • Zelis Network 360	Sources of provider reimbursement are Medicare cost reports submitted to the Centers for Medicare & Medicaid Services (CMS), the current Medicare Fee Schedule specific to ambulatory surgical centers. Medicare data provides a reliable, objective standard on which to determine facility-based services. Humana's own in-network rates are considered for the development of the out-of-network rates for non-hospital facilities, for which Medicare cost report data generally is unavailable	In the development of fee schedules, Humana applies analytics such as access and adequacy standards/requirements, claims analysis, Medicare fee schedules, HEDIS measures, and a combination of resources, including Humana's coordination of benefit (COB) information as well as purchased vendor information, such as Hewitt and Zelis Network 360.	Sources of provider reimbursement are Medicare cost reports submitted to the Centers for Medicare & Medicaid Services (CMS). Medicare data provides a reliable, objective standard on which to determine facility-based services. Humana's own in-network rates are considered for the development of the out-of-network rates.	Medicare data provides a reliable, objective standard on which to determine professional-based services. Humana's own in-network rates are considered for the development of the out-of-network rates for professional services.
Step 4: Processes and strategies used to design NQTL as written	Uniform policies and procedures describing methodologies and factors apply to all MH/SUD and medical/surgical contracting. Contracting teams consist of an RVP, Director and contractor(s). The qualifications of staff involved are the same.	The same reimbursement method is applied to both MH/SUD and medical/surgical services.	Uniform policies and procedures describing methodologies and factors apply to all MH/SUD and medical/surgical contracting. Contracting teams consist of an RVP, Director and contractor(s). The qualifications of staff involved are the same.	CMS generally does not provide CCR calculations for non-hospital facilities, so alternative methods were developed to assign a fair and reasonable out-of-network reimbursement rate. Although dialysis centers file Medicare cost reports, these non-hospital facilities occupy a unique position among providers due to market forces related to the need for dialysis. Due to these circumstances, a different approach was used to develop rates for non-hospital facilities. To determine reimbursement for facility-based outpatient, out-of-network claims, Humana applies objective factors as appropriate for the facility at issue. For almost all facilities that file Medicare cost reports, the standard hospital formula of cost plus seventeen percent is applied for the services billed. For facilities that do not file cost reports, reimbursement generally is based on the average in-network reimbursement for the services billed. Each methodology applies to both medical/surgical and MH/SUD benefits billed by the applicable facility.	The factors listed above, as applied using the standards above, are used to established reimbursement rates for professional providers of all MH/SUD and medical/surgical services.	The same reimbursement method is applied to both MH/SUD and medical/surgical services.	The factors listed above, as applied using the standards above, are used to established reimbursement rates for professional providers of all MH/SUD and medical/surgical services.
Step 5: Processes in implementation of NQTL in operation	Humana tested its network by reviewing the member's access to care compared to the state required access requirements. Additionally, Humana monitors access complaints/requests.	The operation of this NQTL follows as written: providers are reimbursed on a cost plus seventeen percent basis.	Humana tests its network by reviewing the member's access to care compared to the state required access requirements. Additionally, Humana monitors access complaints/requests.	Using the data readily available, reimbursement comparisons have suggested that the methodology used for non-hospital facilities (i.e., the average in-network reimbursement rate for the services billed) results in payment at least equivalent to, and potentially more generous than, rates that are based on Medicare reimbursement. Specifically, analysis of dialysis centers' reimbursement suggests that applying the average in-network reimbursement rate results in higher reimbursement for the services performed by the facility than would be paid under the alternative methodology.	The operation of this NQTL follows as written: out-of-network providers of any type of service are reimbursed on fee schedules established using the factors and standards described above.	The operation of this NQTL follows as written: The maximum allowable fee for a covered expense for emergency care services provided by non-network providers in a hospital's emergency department is an amount equal to the greatest of: • The fee negotiated with network providers; • The fee calculated using the same method to determine maximum allowable fee for a covered expense, other than emergency care services provided by non-network providers; or • The fee paid by Medicare for the same services.	The operation of this NQTL follows as written: out-of-network providers of any type of service are reimbursed on fee schedules established using the factors and standards described above.
Step 6: Summary conclusion of how plan or issuer has determined overall compliance	Humana complies with MHPAEA by applying reimbursement rates to in-network providers using uniform policies, procedures, and processes across medical/surgical and MH/SUD benefits.	Humana complies with MHPAEA by applying reimbursement rates to out-of-network providers using uniform policies, procedures, and processes across medical/surgical and MH/SUD benefits.	Humana complies with MHPAEA by applying reimbursement rates to in-network providers using uniform policies, procedures, and processes across medical/surgical and MH/SUD benefits.	Humana complies with MHPAEA by applying reimbursement rates to out-of-network providers using uniform policies, procedures, and processes across medical/surgical and MH/SUD benefits.	Humana complies with MHPAEA by applying reimbursement rates to out-of-network providers using uniform policies, procedures, and processes across medical/surgical and MH/SUD benefits.	Humana complies with MHPAEA by applying reimbursement rates to out-of-network providers using uniform policies, procedures, and processes across medical/surgical and MH/SUD benefits.	Humana complies with MHPAEA by applying reimbursement rates to out-of-network providers using uniform policies, procedures, and processes across medical/surgical and MH/SUD benefits.

Current as of December 2021

NQTL Name (as noted in NQTL List)	Plan's Description of NQTL						
Network Admittance	This NQTL addresses the processes, factors, and evidentiary standards for which Humana admits providers to the network						
	Inpatient Benefits		**Outpatient Benefits**			**Emergency Benefits**	**Prescription Drugs**
Column 1 - Prompt	Column 2 - In network	Column 3 - out-of-network	Column 4 - In network	Column 5 - Out-of-network		Column 6 - Emergency Benefits	Column 7 - Prescription Drugs
Step 1: Describe the NQTL's requirements and associated procedures	For the purpose of explanation IP Benefits will be explained using Hospital/Facility perspective and OP Benefits will be explained using Physician/Provider perspective. MIS and MH/SUD contracting teams follow the same policy and procedure. Humana's MIS and MH/SUD contract with hospitals/facilities that are willing to accept Humana's reimbursement and can meet Humana's credentialing standards, unless the network is uniquely configured around a specific health system.	N/A	For the purpose of explanation IP Benefits will be explained using Hospital/Facility perspective and OP Benefits will be explained using Physician/Provider perspective. MIS and MH/SUD contracting teams follow the same policy and procedure.	N/A		N/A	N/A
Step 2: Describe the reason for applying the NQTL	N/A	N/A	MH/SUD require access and adequacy, credentialing standards and rate acceptance for network admittance. MIS network admittance factors include adequacy, credentialing standards and efficiency and effectiveness described as follows for network admittance. Humana's MIS quality measurement framework is constructed as follows: **Measurement Level**-tax id; **Geographic Areas**-CBSA or HRR; **Peer Groups**-physicians in the surrounding geographic area who, based on patients treated, practice the same specialty or sub-specialty type; **Frequency of Evaluation**-updated annually; Minimum Volume Requirements-Effectiveness 30 eligible cases and at least 5 different Humana covered patients and Efficiency-minimum 20 episodes of care and at least 5 different Humana covered patients. **Physician Attribution**: Eligible cases and episodes of care are assigned to physician who significantly contribute to a patient's treatment; **Case-Mix Adjustment**-case mix adjustments are applied to enable accurate peer comparisons; **Statistical Credibility**: 90 percent confidence interval around the performance index	N/A		N/A	N/A
Step 3: Identify and describe evidentiary standards and other evidence relied upon	N/A	N/A	Humana uses its National Network Operations Policy 702-044 or state specific as required for monitoring its network for member access for MIS and MH/SUD. Network reviews are performed: *On a quarterly basis *As part of the annual access plan process *Upon a major termination	N/A		N/A	N/A
Step 4: Processes and strategies used to design NQTL as written	N/A	N/A	As written Humana's requirements for network admittance for MH/SUD are comparable to and no more stringent than MIS as they do not apply the Efficiency and Effectiveness factor.	N/A		N/A	N/A
Step 5: Processes in implementation of NQTL in operation	N/A	N/A	In operation, Humana's requirements for network admittance for MH/SUD are comparable to and no more stringent than MIS as they do not apply the Efficiency and Effectiveness. MH/SUD and MIS use adequacy/access, credentialing and reimbursement factors in a comparable manner.	N/A		N/A	N/A
Step 6: Summary conclusion of how plan or issuer has determined overall compliance	N/A	N/A	Humana's network admittance policy and procedure as written and in operation are no more stringent and are comparable.	N/A		N/A	N/A

NQTL Name (as noted in NQTL List)	Plan's Description of NQTL
Provider Credentialing	This NQTL addresses the processes, factors, and evidentiary standards for which Humana credentials providers

Column 1 - Prompt	Inpatient/Outpatient Benefits
	Column 2 - In network
Providers to which the credentialing requirements apply	**Medical/Surgical (M/S) and Mental Health/Substance Use Disorder (MH/SUD):** Practitioners are within the scope of credentialing if all criteria listed below are met: • Practitioners are licensed, certified or registered by the state to practice independently (without direction or supervision). • Practitioners have an independent relationship with Humana (an independent relationship exists when Humana directs its members to see a specific practitioner or group of practitioners, including all practitioners whom a member can select as primary care practitioners). • Practitioners provide care to members under Humana's medical, dental and vision benefits. Credentialing Criteria apply to practitioners in the following settings: • Individual or group practices • Organizational providers • Rental networks • Telehealth Unless otherwise required by applicable law, practitioners who do not require credentialing include: • Practitioners, including hospitalists and extenders (who are not individually contracted and who do not print in the directory) who practice exclusively in the inpatient setting and who provide care for members only as a result of members being directed to the hospital or another inpatient setting. This includes hospital-based anesthesiology, emergency medicine, hospitalist, neonatology, pathology and radiology providers. • Practitioners who practice exclusively in freestanding facilities and who provide care for members only as a result of their being directed to the facility • Pharmacists who work for a pharmacy benefits management (PBM) organization • Covering practitioners (e.g., locums tenens) who do not have an independent relationship with Humana • Practitioners who do not provide care for members in a treatment setting (e.g., board-certified consultants) • Rental network practitioners who are specifically for out-of-area care • Non-licensed applied behavior analysis (ABA) providers • Physician extenders who do not act as a primary care physician (PCP) and who do not print in the directory. This includes licensed practical nurses, nurse anesthetists, physician assistants (non-PCP), registered nurses and registered nurse first assistants, as well as surgical assistants and surgical first assistants.

Step 1: Describe the NQTL's requirements and associated procedures	**Medical/Surgical (M/S) and Mental Health/Substance Use Disorder (MH/SUD):** Humana's Credentialing and Recredentialing Policy defines the credentialing and recredentialing process for selecting and evaluating licensed and independent practitioners and assessing organizational providers who provide care to Humana members. Practitioners are required to complete an application for initial credentialing that includes a current, signed attestation regarding their health status and any history of loss or limitation of licensure or privileges. Upon receipt of the application, Humana verifies credentialing information and makes a credentialing decision. Humana formally recredentials participating practitioners and reassesses organizational providers at least every 36 months. Upon receipt of a complete credentialing application, the credentialing process should be completed within 30 days, or as required by state or federal regulations. Humana should notify the applicant in writing of the Credentials Committee's approval within 60 days. The Credentials Committee must notify a practitioner of a denial that is based upon Credentialing Criteria. The notice must inform the practitioner of the reasons for the denial and should provide notice of an opportunity to request reconsideration of the decision in writing within 30 days of the notice. Elements described in Humana's Credentialing and Recredentialing Policy include: • Types of Practitioners to Credential and Recredential • Verification Sources for Credentialing and Recredentialing • Decision-making Criteria for Credentialing and Recredentialing • Delegation of Credentialing and Recredentialing • Nondiscrimination in Credentialing and Recredentialing • Confidentiality of Credentialing Information and System Controls • Medical/Dental Director Responsibility • Practitioner Rights • Credentials Committee • Initial Credentialing and Sanction Information • Application and Attestation • Recredentialing and Sanction Information • Ongoing Monitoring and Interventions • Notification to Authorities and Practitioner Review Rights • Assessment of Organizational Providers
Step 2: Describe the reason for applying the NQTL	**Medical/Surgical (M/S) and Mental Health/Substance Use Disorder (MH/SUD):** Humana credentials and recredentials providers in order to: • Remain compliant with all state and federal regulations • Maintain accreditation status with NCQA • Enable selection of qualified practitioners and providers
Step 3: Identify and describe evidentiary standards and other evidence relied upon	**Medical/Surgical (M/S) and Mental Health/Substance Use Disorder (MH/SUD):** Humana's credentialing and recredentialing requirements are supported by the following evidence: • State and federal regulatory requirements • National accreditation standards including the National Committee for Quality Assurance (NCQA)
Step 4: Processes and strategies used to design NQTL as written	**Medical/Surgical (M/S) and Mental Health/Substance Use Disorder (MH/SUD):** The factors and evidentiary standards used to develop the process for provider credentialing are outlined in steps 2 and 3 above. Humana has documented the provider credentialing process in a singular policy which applies the same provider credentialing requirements and standards to both M/S and MH/SUD providers. Humana has established associate-level processes and procedures for performing provider credentialing according to the approved policy.
Step 5: Processes in implementation of NQTL in operation	**Medical/Surgical (M/S) and Mental Health/Substance Use Disorder (MH/SUD):** In operation, associates are required to follow Humana's Credentialing and Recredentialing Policy when credentialing and recredentialing participating providers. Rationale for approval or denial, is required to be thoroughly documented with each review and must be tracked in Humana's workflow system. All associates are trained and qualified to perform provider credentialing review for any provider type. All credentialing reviewers are required to complete Process and System training immediately upon hire as well as anytime there is a process change or a new requirement. The credentialing program undergoes weekly auditing to monitor quality and adherence to policy as applied to all provider types. The credentialing program undergoes quarterly auditing to monitor systems performance and processing.

| Step 6: Summary conclusion of how plan or issuer has determined overall compliance | **Medical/Surgical (M/S) and Mental Health/Substance Use Disorder (MH/SUD):** Humana's written and implemented practices, processes, factors, and evidentiary standards used to define provider credentialing apply across all services/items and are not differentiated between Medical/Surgical and Mental Health/Substance Use Disorder.

Therefore, Humana concludes that the processes, strategies, and evidentiary standards used in applying the provider credentialing NQTL to Mental Health and Substance Use Disorder are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the provider credentialing NQTL to Medical/Surgical. |

NQTL Name	Plan's Description of NQTL
RX Prior Authorization	This NQTL addresses the processes, factors, and evidentiary standards driving the list of services and items for which Humana requires members or providers to obtain RX authorization.

Column 1 - Prompt	Column 2 - Prescription Drugs
List of Benefits requiring Prior Authorization	A list of all covered prescription drugs requiring prior authorization may be found on the group's formulary drug list.
Step 1: Describe the NQTL's requirements and associated procedures	When a drug denies for Prior Authorization Required at point-of-sale, a prior authorization review request can be initiated by a member, provider, or pharmacist. When a prior authorization review request is received an Episode Of Care (EOC) is created. The Humana pharmacist must verify the member and plan information as well as the medication being requested, the quantity, edit type, PA Override codes, and Non-PA Override codes. For exceptions, the pharmacist will also review for Supporting Statement. After the medication information is reviewed, the clinical information provided is assessed. The pharmacist must review all clinical information provided by the prescriber. The pharmacist must utilize all information available to them at the time of review, including but not limited to; member EOC history for previous determinations, member EOC history for previous EOCs relevant to the current request, and claims history information available in PAHub. Each case is to be reviewed for compendia support. If additional information is needed to make a decision, the pharmacist will move the EOC to the NMI (need more information) queue to obtain ALL clinical information needed to complete the review. If the case is approved, the pharmacist must then provide the appropriate approval duration and approval notes based on the approval comment template. Pharmacists will add additional comments if approving/denying outside of policy based off compendia, clinical judgement, and additional research, providing clinical rationale for the decision. All Commercial denied cases will proceed to the Regional Medical Director (RMD) for final sign off before the notification letter is distributed to prescriber and patient. Humana will make coverage determinations as expeditiously as the member's health condition requires. Standard coverage determinations are to be decided (and parties notified) within 72 hours after receipt of the request. The member is notified by mail within 72 hours of receipt of the request and the physician or other prescriber notified by fax within 72 hours of receipt of the request. If the member's initial notification is orally, the written notification will be mailed within three calendar days of the oral notification. Expedited coverage determinations are to be decided (and parties notified) within 24 hours after receipt of the request. The member is notified by mail and the physician or other prescriber notified by fax within 24 hours of receipt of the request. If the member's initial notification is orally, the written notification will be mailed within three calendar days of the oral notification. Reviews for office-administered authorizations will be resolved within 72hrs for expedited requests and 15 days for standard. Humana follows the ERISA standards for timeliness along with State / Federal guidelines. Humana follows the most stringent guidance for these reviews. The prescribing physician or other prescriber may file an electronic, oral, or a written request for a standard or expedited coverage determination. State specific forms are available at Humana.com.
Step 2: Describe the reason for applying the NQTL (Factors Applied)	Drugs or biologics are reviewed to determine need for prior authorization criteria. The need for prior authorization criteria will be based on specific issues that include, but are not limited to, the following: • The drug requires special monitoring due to safety concerns • The drug is only effective in a limited population with specific indications that determine needed areas of use • Use of the drug outside of specific determined criteria would either foster adverse events or constitute investigational/experimental treatment as determined by medical literature and scientific evidence • The drug represents a high cost agent in a therapeutic area that contains alternate drug therapies of similar efficacy • The cost utility of the drug versus others in the same therapeutic area would preclude the drug from being used as first line therapy, therefore broad or first- line use of the drug is ill advised • The Pharmacy and Therapeutics Committee reviews and approves prior authorization criteria that is developed by clinical pharmacists • The criteria is implemented and supported by operational processes The current medical literature is used to support the implementation of all prior authorization criteria.

Step 3: Identify and describe evidentiary standards and other evidence relied upon	Medically-accepted indications are defined by CMS as those uses of a covered Part D drug which are approved under the Federal Food, Drug, and Cosmetic Act, or the use of which is supported by one or more citations included or approved for inclusion in any of the compendia described in section 1927(g)(1)(B)(i) of the Act. These compendia guide review of off-label and off-evidence prescribing and are subject to minimum evidence standards for each compendium. Currently this review includes the following references when applicable for all therapeutic classes and may be subject to change per CMS: - American Hospital Formulary Service-Drug Information (AHFS-DI) - Truven Health Analytics Micromedex DrugDEX - National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium - Elsevier/Gold Standard Clinical Pharmacology - Wolters Kluwer Lexi-Drugs Humana applies prior authorization requirements to some prescription drugs. The application of prior authorization edits is a standardized process across all therapeutic categories. Humana ensures continued compliance with the Federal Mental Health Parity and Addiction Equity Act by monitoring formulary design and prior authorization requirements for medical/surgical drugs through the Pharmacy and Therapeutics Committee. Pharmacy and Therapeutics Committee coverage decisions may include the following activities to support an evidence based review process: • Assessing peer-reviewed medical literature including randomized clinical trials (especially drug comparison studies), undisputed articles in medical journals, generally accepted medical textbooks, pharmacoeconomic studies, and outcomes research data. • Employing published practice guidelines, developed by an acceptable evidence-based process. • Reviewing the AMCP Formulary Dossier. When reviewing prior authorization requirements for drugs used for Medical/surgical conditions, Humana utilizes the following references (including but not limited to): - Advisory consultations with external physicians and medical specialists - Published clinical trials in various peer reviewed journals which may include the New England Journal of Medicine, and the Lancet - Clinical outcome posters presented at national clinical conferences When reviewing prior authorization requirements for drugs used for mental health conditions, Humana utilizes the following references (including but not limited to): - Guidelines and or position statements published by the American Psychiatric Association, - Advisory consultations with external psychiatrists and internal mental health professionals (including psychiatrists) - American Journal of Psychiatry - Published clinical trials in various peer reviewed journals which may include the New England Journal of Medicine, and the Lancet - Clinical outcome posters presented at national clinical conferences Humana selects preferred products for substance use disorder based upon the following references (including but not limited to): - Guidelines and or position statements published by the American Society of Addiction Medicine (ASAM)
Step 4: Processes and strategies used to design NQTL as written	The P&T policy and procedure outlines the following details. The Pharmacy and Therapeutics (P&T) Committee has a responsibility to review and make decisions about the appropriate use of drugs, biologicals, and select non-drug pharmacy related products including formulary development, clinical edits, and drug utilization review. The goal of the P&T Committee is to ensure that proper decisions are made regarding drug access and the overall value of the benefit as it pertains to drugs, biologics, and select non-drug products. The P&T Committee meets at least quarterly. Meetings are held via conference call, video conferencing, or at a designated site. Ad hoc meetings are also scheduled and convened as necessary. The P&T Committee may solicit votes through electronic means (e.g., email) from voting member(s) on urgent topics which require immediate attention to address clinical and/or operational needs. In accordance with internal standards and external regulatory requirements, all clinical review criteria and operational policies will be reviewed no less than once per year from date of original issue or last date of approval upon review. The corporate medical director of the P&T Committee and the director / manager of pharmacy and therapeutics, who serve as co-chairpersons, designate voting members of the P&T Committee. A majority of the voting members will be practicing physicians and/or practicing pharmacists. They will be chosen from various clinical specialties and with such experience to adequately represent the needs of enrollees. Those persons utilized as consultants on various issues are considered non-voting. Other non-voting stakeholders for relevant agenda items are invited at the discretion of P&T. All physician and pharmacist members of the P&T Committee must have primary source verification of their credentials (i.e.. license to practice) as per the applicable Humana Credentialing Policy at least once per year of tenure. This includes disclosure of exclusion from participation in federal health care programs. For purposes of P&T membership, members are considered to be practicing when licensed in the United States or one of its Territories as a physician or pharmacist with good standing. The voting members of the P&T Committee must be free of conflict of interest with any P&T agenda, pharmaceutical manufacturers, and must state any new potential conflicts of interest prior to discussion. Product sponsor representatives are specifically excluded from P&T Committee membership and from attending P&T Committee meetings. The process begins with the identification of a drug or drug issue such as a new drug release, new indication, generic availability, or safety signal. P&T then determines what type of review is needed. This may involve an individual drug review, class review, policy draft, or review of an existing policy. The issue is then sent to the proper committee which reviews the issue and makes the clinical decision such as P&T or its sub-committees. The Committee determines appropriateness of coverage through an evidence-based drug review. Ensuring access for appropriate use may require clinical policy. The decision may involve positive or negative changes to the Formulary such as drug coverage, tier placement, or clinical edits (e.g. prior authorization, step therapy, quantity limits). Through the areas charged with consumer messaging, the P&T Committee will communicate these changes to members as per state specific timelines. The minutes of any P&T Committee meeting serve to formally document its activities. The minutes include presentation summaries, positions, motions and decisions regarding coverage, policies, prior authorization, step therapy, and quantity limits. These minutes are shared with operational areas that build and enforce the intent of the decision. Issues of coding and clinical relevancy of policy are addressed through operational area feedback given to the Committee. This feedback from operations to P&T and its sub-committees after operationalization allows for refinement of existing policies. Decisions are also shared with the areas charged with consumer messaging to ensure accurate display of drug coverage and policy requirements. Other relevant files, spreadsheets, databases, and references are also provided to these areas to ensure that decisions involving coverage and clinical policies are operationalized and displayed as intended.

Step 5: Processes in implementation of NQTL in operation	The Pharmacy and Therapeutics (P&T) Committee applies the same processes and strategies across all therapeutic classes, including peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.
Step 6: Summary conclusion of how plan has determined overall compliance	Consistent with 45 CFR 146.136 (c)(iv)(4), Humana applies pharmacy non-quantitative treatment limitations uniformly across all therapeutic areas. Humana utilizes the same prior authorization procedures for both MH/SUD drugs and medical/surgical drugs. All Drugs or biologics are reviewed to determine need for prior authorization based upon the same criteria. Humana uses the same and comparable evidentiary standards to establish the prior authorization protocols. Processes for review of both MH/SUD benefits and medical/surgical benefits are applied the same irrespective of therapeutic area.

NQTL Name	Plan's Description of NQTL
RX Coding Edits	This NQTL addresses the processes, factors, and evidentiary standards driving the list of services and items for which Humana applies coding edits

Column 1 - Prompt	Column 2 - Prescription Drugs
Step 1: Describe the NQTL's requirements and associated procedures	Cases are filtered into the appropriate queues and the pharmacist selects the queue to work based on their work assignment or Line of Business (LOB). Once an EOC populates, the pharmacist must verify the member and plan information as well as the medication being requested, the quantity, edit type, PA Override codes, and Non-PA Override codes. For exceptions, the pharmacist will also review for Supporting Statement. After the medication information is reviewed, the clinical information provided is assessed. The pharmacist must review all clinical information provided by the prescriber. The pharmacist must utilize all information available to them at the time of review, including but not limited to; member EOC history for previous determinations, member EOC history for previous EOCs relevant to the current request, and claims history information available in PAHub. Each case is to be reviewed for compendia support. If additional information is needed to make a decision, the pharmacist will move the EOC to the NMI (need more information) queue to obtain ALL clinical information needed to complete the review. If the case is approved, the pharmacist must then provide the appropriate approval duration and approval notes based on the approval comment template. Pharmacists will add additional comments if approving/denying outside of policy based off compendia, clinical judgement, and additional research, providing clinical rationale for the decision. All Commercial denied cases will proceed to the Regional Medical Director (RMD) for final sign off before the notification letter is distributed to prescriber and patient. Humana will make coverage determinations as expeditiously as the member's health condition requires. Standard coverage determinations are to be decided (and parties notified) within 72 hours after receipt of the request. The member is notified by mail within 72 hours of receipt of the request and the physician or other prescriber notified by fax within 72 hours of receipt of the request. If the member's initial notification is orally, the written notification will be mailed within three calendar days of the oral notification. Expedited coverage determinations are to be decided (and parties notified) within 24 hours after receipt of the request. The member is notified by mail and the physician or other prescriber notified by fax within 24 hours of receipt of the request. If the member's initial notification is orally, the written notification will be mailed within three calendar days of the oral notification. Reviews for office-administered authorizations will be resolved within 72hrs for expedited requests and 15 days for standard. Humana follows the ERISA standards for timeliness along with State / Federal guidelines. Humana follows the most stringent guidance for these reviews. The prescribing physician or other prescriber may file an electronic, oral, or a written request for a standard or expedited coverage determination. State specific forms are available at Humana.com.
Step 2: Describe the reason for applying the NQTL (Factors Applied)	Drugs or biologics are reviewed to determine need for coding edit criteria. The need for coding edit criteria will be based on specific issues that include, but are not limited to, the following: • The drug requires special monitoring due to safety concerns • The drug is only effective in a limited population with specific indications that determine needed areas of use • Use of the drug outside of specific determined criteria would either foster adverse events or constitute investigational/experimental treatment as determined by medical literature and scientific evidence • The drug represents a high cost agent in a therapeutic area that contains alternate drug therapies of similar efficacy • The cost utility of the drug versus others in the same therapeutic area would preclude the drug from being used as first line therapy, therefore broad or first- line use of the drug is ill advised • The Pharmacy and Therapeutics Committee develops coding edit criteria • The criteria is implemented and supported by needed processes The current medical literature and /or cost benefit analysis is used to support the implementation of all coding edit criteria.

Step 3: Identify and describe evidentiary standards and other evidence relied upon	Medically-accepted indications are defined by CMS as those uses of a covered Part D drug which are approved under the Federal Food, Drug, and Cosmetic Act, or the use of which is supported by one or more citations included or approved for inclusion in any of the compendia described in section 1927(g)(1)(B)(i) of the Act. These compendia guide review of off-label and off-evidence prescribing and are subject to minimum evidence standards for each compendium. Currently this review includes the following references when applicable for all therapeutic classes and may be subject to change per CMS: - American Hospital Formulary Service-Drug Information (AHFS-DI) - Truven Health Analytics Micromedex DrugDEX - National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium - Elsevier/Gold Standard Clinical Pharmacology - Wolters Kluwer Lexi-Drugs Humana applies coding edits to some prescription drugs. The application of coding edits is a standardized process across all therapeutic categories. Humana ensures continued compliance with the Federal Mental Health Parity and Addiction Equity Act by monitoring formulary design and coding edits requirements for medical/surgical drugs through the Pharmacy and Therapeutics Committee. Pharmacy and Therapeutics Committee coverage decisions may include the following activities to support an evidence based review process: • Assessing peer-reviewed medical literature including randomized clinical trials (especially drug comparison studies), undisputed articles in medical journals, generally accepted medical textbooks, pharmacoeconomic studies, and outcomes research data. • Employing published practice guidelines, developed by an acceptable evidence-based process. • Reviewing the AMCP Formulary Dossier. When reviewing coding edits requirements for drugs used for Medical/surgical conditions, Humana utilizes the following references (including but not limited to): - Advisory consultations with external physicians and medical specialists - Published clinical trials in various peer reviewed journals which may include the New England Journal of Medicine, and the Lancet - Clinical outcome posters presented at national clinical conferences When reviewing coding edits requirements for drugs used for mental health conditions, Humana utilizes the following references (including but not limited to): - Guidelines and or position statements published by the American Psychiatric Association, - Advisory consultations with external psychiatrists and internal mental health professionals (including psychiatrists) - American Journal of Psychiatry - Published clinical trials in various peer reviewed journals which may include the New England Journal of Medicine, and the Lancet - Clinical outcome posters presented at national clinical conferences Humana applies coding edits for substance use disorder based upon the following references (including but not limited to): - Guidelines and or position statements published by the American Society of Addiction Medicine (ASAM)
Step 4: Processes and strategies used to design NQTL as written	The P&T policy and procedure outlines the following details. The Pharmacy and Therapeutics (P&T) Committee has a responsibility to review and make decisions about the appropriate use of drugs, biologicals, and select non-drug pharmacy related products including formulary development, clinical edits, and drug utilization review. The goal of the P&T Committee is to ensure that proper decisions are made regarding drug access and the overall value of the benefit as it pertains to drugs, biologics, and select non-drug products. The P&T Committee meets at least quarterly. Meetings are held via conference call, video conferencing, or at a designated site. Ad hoc meetings are also scheduled and convened as necessary. The P&T Committee may solicit votes through electronic means (e.g., email) from voting member(s) on urgent topics which require immediate attention to address clinical and/or operational needs. In accordance with internal standards and external regulatory requirements, all clinical review criteria and operational policies will be reviewed no less than once per year from date of original issue or last date of approval upon review. The corporate medical director of the P&T Committee and the director / manager of pharmacy and therapeutics, who serve as co-chairpersons, designate voting members of the P&T Committee. A majority of the voting members will be practicing physicians and/or practicing pharmacists. They will be chosen from various clinical specialties and with such experience to adequately represent the needs of enrollees. Those persons utilized as consultants on various issues are considered non-voting. Other non-voting stakeholders for relevant agenda items are invited at the discretion of P&T. All physician and pharmacist members of the P&T Committee must have primary source verification of their credentials (i.e.. license to practice) as per the applicable Humana Credentialing Policy at least once per year of tenure. This includes disclosure of exclusion from participation in federal health care programs. For purposes of P&T membership, members are considered to be practicing when licensed in the United States or one of its Territories as a physician or pharmacist with good standing. The voting members of the P&T Committee must be free of conflict of interest with any P&T agenda, pharmaceutical manufacturers, and must state any new potential conflicts of interest prior to discussion. Product sponsor representatives are specifically excluded from P&T Committee membership and from attending P&T Committee meetings. The process begins with the identification of a drug or drug issue such as a new drug release, new indication, generic availability, or safety signal. P&T then determines what type of review is needed. This may involve an individual drug review, class review, policy draft, or review of an existing policy. The issue is then sent to the proper committee which reviews the issue and makes the clinical decision such as P&T or its sub-committees. The Committee determines appropriateness of coverage through an evidence-based drug review. Ensuring access for appropriate use may require clinical policy. The decision may involve positive or negative changes to the Formulary such as drug coverage, tier placement, or clinical edits (e.g. coding edits, step therapy, quantity limits). Through the areas charged with consumer messaging, the P&T Committee will communicate these changes to members as per state specific timelines. The minutes of any P&T Committee meeting serve to formally document its activities. The minutes include presentation summaries, positions, motions and decisions regarding coverage, policies, coding edits, step therapy, and quantity limits. These minutes are shared with operational areas that build and enforce the intent of the decision. Issues of coding and clinical relevancy of policy are addressed through operational area feedback given to the Committee. This feedback from operations to P&T and its sub-committees after operationalization allows for refinement of existing policies. Decisions are also shared with the areas charged with consumer messaging to ensure accurate display of drug coverage and policy requirements. Other relevant files, spreadsheets, databases, and references are also provided to these areas to ensure that decisions involving coverage and clinical policies are operationalized and displayed as intended.

Step 5: Processes in implementation of NQTL in operation	Humana applies the same processes and strategies across all therapeutic classes, including peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.
Step 6: Summary conclusion of how plan has determined overall compliance	Consistent with 45 CFR 146.136 (c)(iv)(4), Humana applies pharmacy non-quantitative treatment limitations uniformly across all therapeutic areas. Humana utilizes the same coding edits for both MH/SUD drugs and medical/surgical drugs. All Drugs or biologics are reviewed to determine need for coding edits based upon the same criteria. Humana uses the same and comparable evidentiary standards to establish the coding edits. Processes for review of both MH/SUD benefits and medical/surgical benefits are applied the same irrespective of therapeutic area.

NQTL Name	Plan's Description of NQTL
RX Medical Necessity	This NQTL addresses the processes, factors, and evidentiary standards driving the list of drugs for which Humana requires medical necessity.

Column 1 - Prompt	Column 2 - Prescription Drugs
Step 1: Describe the NQTL's requirements and associated procedures	Utilization management tools and clinical edits such as medical necessity, step therapy, quantity limits, and coding edits are employed to ensure use when medically necessary.
Step 2: Describe the reason for applying the NQTL (Factors Applied)	Provides a mechanism for determining which drugs or biologics require clinical edits and drug utilization review. Clinical edits such as medical necessity, step therapy, and quantity limits are tools used to ensure appropriate use of drugs. This promotes safe, effective medication use while reducing cost when medically appropriate.
Step 3: Identify and describe evidentiary standards and other evidence relied upon	Medically-accepted indications are defined by CMS as those uses of a covered Part D drug which are approved under the Federal Food, Drug, and Cosmetic Act, or the use of which is supported by one or more citations included or approved for inclusion in any of the compendia described in section 1927(g)(1)(B)(i) of the Act. These compendia guide review of off-label and off-evidence prescribing and are subject to minimum evidence standards for each compendium. Currently this review includes the following references when applicable for all therapeutic classes and may be subject to change per CMS: - American Hospital Formulary Service-Drug Information (AHFS-DI) - Truven Health Analytics Micromedex DrugDEX - National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium - Elsevier/Gold Standard Clinical Pharmacology - Wolters Kluwer Lexi-Drugs Humana applies medical necessity requirements to some prescription drugs. The application of medical necessity edits is a standardized process across all therapeutic categories. Humana ensures continued compliance with the Federal Mental Health Parity and Addiction Equity Act by monitoring formulary design and medical necessity requirements for medical/surgical drugs through the Pharmacy and Therapeutics Committee. Pharmacy and Therapeutics Committee coverage decisions may include the following activities to support an evidence based review process: • Assessing peer-reviewed medical literature including randomized clinical trials (especially drug comparison studies), undisputed articles in medical journals, generally accepted medical textbooks, pharmacoeconomic studies, and outcomes research data. • Employing published practice guidelines, developed by an acceptable evidence-based process. • Reviewing the AMCP Formulary Dossier. When reviewing medical necessity requirements for drugs used for Medical/surgical conditions, Humana utilizes the following references (including but not limited to): - Advisory consultations with external physicians and medical specialists - Published clinical trials in various peer reviewed journals which may include the New England Journal of Medicine, and the Lancet - Clinical outcome posters presented at national clinical conferences When reviewing medical necessity requirements for drugs used for mental health conditions, Humana utilizes the following references (including but not limited to): - Guidelines and or position statements published by the American Psychiatric Association, - Advisory consultations with external psychiatrists and internal mental health professionals (including psychiatrists) - American Journal of Psychiatry - Published clinical trials in various peer reviewed journals which may include the New England Journal of Medicine, and the Lancet - Clinical outcome posters presented at national clinical conferences Humana selects preferred products for substance use disorder based upon the following references (including but not limited to): - Guidelines and or position statements published by the American Society of Addiction Medicine (ASAM)

Step 4: Processes and strategies used to design NQTL as written	The P&T policy and procedure outlines the following details. The Pharmacy and Therapeutics (P&T) Committee has a responsibility to review and make decisions about the appropriate use of drugs, biologicals, and select non-drug pharmacy related products including formulary development, clinical edits, and drug utilization review. The goal of the P&T Committee is to ensure that proper decisions are made regarding drug access and the overall value of the benefit as it pertains to drugs, biologics, and select non-drug products. The P&T Committee meets at least quarterly. Meetings are held via conference call, video conferencing, or at a designated site. Ad hoc meetings are also scheduled and convened as necessary. The P&T Committee may solicit votes through electronic means (e.g., email) from voting member(s) on urgent topics which require immediate attention to address clinical and/or operational needs. In accordance with internal standards and external regulatory requirements, all clinical review criteria and operational policies will be reviewed no less than once per year from date of original issue or last date of approval upon review. The corporate medical director of the P&T Committee and the director / manager of pharmacy and therapeutics, who serve as co-chairpersons, designate voting members of the P&T Committee. A majority of the voting members will be practicing physicians and/or practicing pharmacists. They will be chosen from various clinical specialties and with such experience to adequately represent the needs of enrollees. Those persons utilized as consultants on various issues are considered non-voting. Other non-voting stakeholders for relevant agenda items are invited at the discretion of P&T. All physician and pharmacist members of the P&T Committee must have primary source verification of their credentials (i.e.. license to practice) as per the applicable Humana Credentialing Policy at least once per year of tenure. This includes disclosure of exclusion from participation in federal health care programs. For purposes of P&T membership, members are considered to be practicing when licensed in the United States or one of its Territories as a physician or pharmacist with good standing. The voting members of the P&T Committee must be free of conflict of interest with any P&T agenda, pharmaceutical manufacturers, and must state any new potential conflicts of interest prior to discussion. Product sponsor representatives are specifically excluded from P&T Committee membership and from attending P&T Committee meetings. The process begins with the identification of a drug or drug issue such as a new drug release, new indication, generic availability, or safety signal. P&T then determines what type of review is needed. This may involve an individual drug review, class review, policy draft, or review of an existing policy. The issue is then sent to the proper committee which reviews the issue and makes the clinical decision such as P&T or its sub-committees. The Committee determines appropriateness of coverage through an evidence-based drug review. Ensuring access for appropriate use may require clinical policy. The decision may involve positive or negative changes to the Formulary such as drug coverage, tier placement, or clinical edits (e.g. medical necessity, step therapy, quantity limits). Through the areas charged with consumer messaging, the P&T Committee will communicate these changes to members as per state specific timelines. The minutes of any P&T Committee meeting serve to formally document its activities. The minutes include presentation summaries, positions, motions and decisions regarding coverage, policies, medical necessity, step therapy, and quantity limits. These minutes are shared with operational areas that build and enforce the intent of the decision. Issues of coding and clinical relevancy of policy are addressed through operational area feedback given to the Committee. This feedback from operations to P&T and its sub-committees after operationalization allows for refinement of existing policies. Decisions are also shared with the areas charged with consumer messaging to ensure accurate display of drug coverage and policy requirements. Other relevant files, spreadsheets, databases, and references are also provided to these areas to ensure that decisions involving coverage and clinical policies are operationalized and displayed as intended.
Step 5: Processes in implementation of NQTL in operation	The Pharmacy and Therapeutics (P&T) Committee applies the same processes and strategies across all therapeutic classes, including peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.
Step 6: Summary conclusion of how plan has determined overall compliance	Consistent with 45 CFR 146.136 (c)(iv)(4), Humana applies pharmacy non-quantitative treatment limitations uniformly across all therapeutic areas. Humana uses the same and comparable evidentiary standards to establish the medical necessity criteria. Processes for review of both MH/SUD benefits and medical/surgical benefits are applied the same irrespective of therapeutic area.