



TO: Georgia Office of Commissioner of Insurance and Safety Fire
DATE: December 29, 2023
RE: Humana Insurance Company – 2023 Georgia NQTL Comparative Analyses

To Whom It May Concern:

Enclosed please find Humana's Non-Quantitative Treatment Limit Comparative Analyses for the state of Georgia, dated as of December 29, 2023. This chart is provided in order to demonstrate compliance with the Mental Health Parity and Addiction Act (MHPAEA) of 2008 as required by the new filing requirements established by HB 1013, the Mental Health Parity Act.

If there are any questions, please feel free to contact me the below.

Sincerely,

Cyndi Magruder, JD

Compliance Lead | MHPAEA Compliance

cmagruder@humana.com

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.
<p>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.</p> <p>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.</p>	
Column 1 - Prompt	Column 2 - All Classifications
Benefit/Service(s) to which the coding edits apply.	<p>The following benefits/services are subject to coding edits:</p> <p>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.</p> <p>Claim volume out of scope includes, but is not limited to:</p> <ul style="list-style-type: none">• Secondary payer• Real Time• Pharmacy• Inpatient facility
Step 1: Describe the NQTL's requirements and associated procedures	<p><u>Overview of Humana's coding edits</u></p> <p>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.</p>
Step 2: Describe the reason for applying the NQTL (Factors Applied)	<p>Humana enforces code editing to services rendered in order to:</p> <ul style="list-style-type: none">• 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 <p>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.</p>

Step 3: Identify and describe evidentiary standards and other evidence relied upon	<p>Humana policy exeprts and coding edit vendors develop code editing policies based upon the following evidentiary standards including, but not limited to:</p> <ul style="list-style-type: none">• 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 <p>These evidentiary standards apply across all services/items for Medical/Surgical (M/S) and Mental Health/ Substance Use Disorder (MH/SUD).</p>
Step 4: Processes and strategies used to design NQTL as written	<p><u>Comparative Analysis - Process as Written</u></p> <p>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).</p> <p>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:</p> <ul style="list-style-type: none">• Claims Process Organization• Provider Contracting• Member Group Contracting• Provider Markets• RMDs• Coders• Pharmacists• Compliance <p>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.</p>
Step 5: Processes in implementation of NQTL in operation	<p><u>Comparative Analysis - Process In Operation</u></p> <p>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.</p>

Step 6: Summary conclusion of how plan has determined overall compliance	<p><u>Summary Conclusions</u></p> <p>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.</p> <p>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.</p>
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<i>Code Edit Policy Type</i>	<i>Description</i>
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 modifier	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 modifier	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 modifier	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 modifier	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	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	<p>There are two different types of diagnosis to procedure edits</p> <p>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.</p>
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	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 v	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 Nec	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 Modifier	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 Procedure	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 Components	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. 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.						
Provider Reimbursement	This NQTL addresses the processes, factors, and evidentiary standards by which Humana reimburses providers								
Inpatient 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	Emergency Benefits			
Step 1: Describe the NQTL's requirements and associated procedures	Humana, MHSUD and MS 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. NNO has an extensive training program for its contracting teams.	For both medical/surgical and MHSUD 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) 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 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 Optum) 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 MHSUD 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 MHSUD—billed by the provider type.	For physicians and professionals rendering services subject to the Georgia state law: Pursuant to the provisions of Georgia state law, for both MH/SUD and medical/surgical benefits, Humana followed Georgia procedures to apply the greater of: • The verifiable median amount paid by all eligible health insurance issuers for similar services, • The most recent verifiable amount agreed to by the non-network provider and Humana, or • An amount we deemed appropriate given the complexity and circumstances of the services For physicians and professionals not rendering services subject to the Georgia state law: 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 schedules are determined as described in the In-Network response. 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). These rates apply to all claims, both MH/SUD and medical/surgical.	The NQTL is out-of-network provider reimbursement as applicable to emergency services and applies to all emergency MHSUD benefits and medical/surgical benefits. Emergency services for both MHSUD benefits and medical/surgical benefits are paid in accordance with the Georgia state law.			The NQTL is out-of-network provider reimbursement as applicable to emergency services and applies to all emergency MHSUD benefits and medical/surgical benefits. Emergency services for both MHSUD benefits and medical/surgical benefits are paid in accordance with the Georgia state law.
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 MHSUD 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 MHSUD 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.	For both MH/SUD and medical surgical benefits, the provider reimbursement was in accordance with the requirements of the Georgia state law for post stabilization services or services received by a non-network provider while the member was at a network facility, unless the member chose to receive services from a non-network provider and provided consent to obtain such services. Humana's payment to the provider under these circumstances is based upon the maximum allowable fee for a covered expense. Under the Georgia state law, there can be three factors: the verifiable median amount paid by all eligible health insurance issuers for similar services, the most recent verifiable amount agreed to by the non-network provider and Humana, or an amount we deemed appropriate given the complexity and circumstances of the services. The maximum allowable fee reimbursement is the greater of these considerations. The maximum allowable fee for all other covered expenses is the lesser of: • The fee charged by the provider for the services; • The fee that has been negotiated with the provider, whether directly or through one or more intermediaries or shared savings contracts for the services; • The fee established by us by comparing rates from one or more regional or national databases or schedules for the same or similar services from a geographical area determined by us; • The fee based upon rates negotiated by us or other payors with one or more network providers in a geographic area determined by us for the same or similar services; • The fee 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; or • The fee based on a percentage determined by us of the fee Medicare allows for the same or similar services provided in the same geographic area.	For both MHSUD and medical surgical benefits, the provider reimbursement was in accordance with the requirements of Georgia state law. Maximum allowable fee for a covered expense for the following services in the state of Georgia: • Emergency care services provided by non-network providers. • Services you receive from a non-network provider while you are at a network facility, unless you choose to receive services from a non-network provider and you provide your written and oral consent to obtain such services; and • Post stabilization services when: -The attending qualified provider determines you are not able to travel by non-medical transportation to obtain services from a network provider; and -You do not provide your consent to the non-network provider to obtain such services. is the greater of: • The verifiable median amount paid by all eligible health insurance issuers for similar services; • The most recent verifiable amount agreed to by the non-network provider and us for the same service during the time the provider was a network provider; or • A higher amount we deem appropriate given the complexity and circumstances of the services.			For both MHSUD and medical surgical benefits, the provider reimbursement was in accordance with the requirements of Georgia state law. Maximum allowable fee for a covered expense for the following services in the state of Georgia: • Emergency care services provided by non-network providers. • Services you receive from a non-network provider while you are at a network facility, unless you choose to receive services from a non-network provider and you provide your written and oral consent to obtain such services; and • Post stabilization services when: -The attending qualified provider determines you are not able to travel by non-medical transportation to obtain services from a network provider; and -You do not provide your consent to the non-network provider to obtain such services. is the greater of: • The verifiable median amount paid by all eligible health insurance issuers for similar services; • The most recent verifiable amount agreed to by the non-network provider and us for the same service during the time the provider was a network provider; or • A higher amount we deem appropriate given the complexity and circumstances of the 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 reports 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.	For physicians and professionals rendering services subject to Georgia state law: For both MH/SUD and medical/surgical benefits, Humana's development of the maximum allowable fee is based on the three factors outlined in the Georgia state law and used for provider reimbursement. The development of MAF is based upon the criteria outlined in the law. For other physicians and professionals not rendering services subject to the Georgia state law: 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.	For both MHSUD and medical/surgical benefits, Humana's development of MAF is based on the requirements outlined in the Georgia state law and is used for provider reimbursement. The development of MAF is based upon the verifiable median amount paid by all eligible health insurance issuers for similar services; the most recent verifiable amount agreed to by the non-network provider and us for the same service during the time the provider was a network provider; or a higher amount we deem appropriate given the complexity and circumstances of the services.			For both MHSUD and medical/surgical benefits, Humana's development of MAF is based on the requirements outlined in the Georgia state law and is used for provider reimbursement. The development of MAF is based upon the verifiable median amount paid by all eligible health insurance issuers for similar services; the most recent verifiable amount agreed to by the non-network provider and us for the same service during the time the provider was a network provider; or a higher amount we deem appropriate given the complexity and circumstances of the services.
Step 4: Processes and strategies used to design NQTL as written	Uniform policies and procedures describing methodologies and factors apply to all MHSUD 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 MHSUD and medical/surgical services.	Uniform policies and procedures describing methodologies and factors apply to all MHSUD 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 MHSUD benefits billed by the applicable facility.	The factors listed above, as applied using the standards above, are used to establish reimbursement rates for professional providers of all MH/SUD and medical/surgical services.	The same reimbursement method using the standard mentioned above is applied to both MH/SUD and medical/surgical services for each provider type.			The same reimbursement method using the standard mentioned above is applied to both MH/SUD and medical/surgical services for each provider type.
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.	For other physicians and professionals rendering services subject to the Georgia state law: Humana followed Georgia state law provisions for both medical/surgical and MHSUD out of network services (for both inpatient and outpatient services) For other physicians and professionals not rendering services subject to the Georgia state law: 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 Plan followed Georgia state law provisions for both medical/surgical and MH/SUD out of network emergency services (for both inpatient and outpatient services)			The Plan followed Georgia state law provisions for both medical/surgical and MH/SUD out of network emergency services (for both inpatient and outpatient services)
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 MHSUD benefits.	Humana complies with MHPAEA by applying reimbursement rates to out-of-network providers using uniform policies, procedures, and processes across medical/surgical and MHSUD benefits.	Humana complies with MHPAEA by applying reimbursement rates to in-network providers using uniform policies, procedures, and processes across medical/surgical and MHSUD benefits.	Humana complies with MHPAEA by applying reimbursement rates to out-of-network providers using uniform policies, procedures, and processes across medical/surgical and MHSUD 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 MHSUD benefits.			Humana complies with MHPAEA by applying reimbursement rates to out-of-network providers using uniform policies, procedures, and processes across medical/surgical and MHSUD benefits.

NQTL Name <i>(as noted in NQTL List)</i>	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.		
Network Admittance	This NQTL addresses the processes, factors, and evidentiary standards for which Humana admits providers to the network		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.		
Column 1 - Prompt	Inpatient Benefits Column 2 - In network	Column 3 - out-of-network	Outpatient Benefits Column 4 - In network	Column 5 - Out-of-network	Emergency Column 6 - E
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. M/S and MH/SUD contracting teams follow the same policy and procedure. Humana's M/S 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. M/S and MH/SUD contracting teams follow the same policy and procedure.	N/A	N/A
Step 2: Describe the reason for applying the NQTL	N/A	N/A	MH/SUD requires access and adequacy, credentialing standards and rate acceptance for network admittance. M/S network admittance factors include adequacy, credentialing standards and efficiency and effectiveness described as follows for network admittance. Humana's M/S 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 Humana uses its National Network Operations Policy 702-044 or state specific as required for monitoring its networks for member access for M/S and MH/SUD.	N/A	N/A
Step 3: Identify and describe evidentiary standards and other evidence relied upon	N/A	N/A	Network reviews are performed: *On a quarterly basis *As part of the annual access plan process *Upon a major termination	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 M/S as they do not apply the Efficiency and Effectiveness factor.	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 M/S as they do not apply the Efficiency and Effectiveness. MH/SUD and M/S use adequacy/access, credentialing and reimbursement factors in a comparable manner.	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

NQTL Name <i>(as noted in NQTL List)</i>	Plan's Description of NQTL
Provider Credentialing	This NQTL addresses the processes, factors, and evidentiary standards for which Humana credentials providers
<p>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 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/ 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.</p> <p>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 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 requests you are required to keep the contents of this Humana Template NQTL comparative analysis confidential as it is the proprietary information of Humana.</p>	
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	<p><u>Medical/Surgical (M/S) and Mental Health/Substance Use Disorder (MH/SUD):</u></p> <p>Humana's Credentialing and Recredentialing Policy defines the credentialing and recredentialing process for selecting and evaluating licensed and independent practitioners and 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.</p> <p>Elements described in Humana's Credentialing and Recredentialing Policy include:</p> <ul style="list-style-type: none">• Types of Practitioners to Credential and Recredential• Verification Sources for Credentialing and Recredentialing• Education and Training• Telehealth 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	<p><u>Medical/Surgical (M/S) and Mental Health/Substance Use Disorder (MH/SUD):</u></p> <p>Humana credentials and recredentials providers in order to:</p> <ul style="list-style-type: none">• 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	<p><u>Medical/Surgical (M/S) and Mental Health/Substance Use Disorder (MH/SUD):</u></p> <p>Humana's credentialing and recredentialing requirements are supported by the following evidence:</p> <ul style="list-style-type: none">• 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	<p><u>Medical/Surgical (M/S) and Mental Health/Substance Use Disorder (MH/SUD):</u></p> <p>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.</p>

Step 5: Processes in implementation of NQTL in operation	<p><u>Medical/Surgical (M/S) and Mental Health/Substance Use Disorder (MH/SUD):</u></p> <p>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.</p> <p>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.</p> <p>The credentialing program undergoes weekly auditing to monitor quality and adherence to policy as applied to all provider types.</p> <p>The credentialing program undergoes quarterly auditing to monitor systems performance and processing.</p>
Step 6: Summary conclusion of how plan or issuer has determined overall compliance	<p><u>Medical/Surgical (M/S) and Mental Health/Substance Use Disorder (MH/SUD):</u></p> <p>Humana's written and implemented practices, processes, factors, and evidentiary standards used to define provider credentialing apply across all services/items and are not different between Medical/Surgical and Mental Health/Substance Use Disorder.</p> <p>Therefore, Humana concludes that the processes, strategies, and evidentiary standards used in applying the provider credentialing NQTL to Mental Health and Substance Use Disorders 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 services.</p>

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 of authorization.
<p>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 used for 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 should be on an as applied 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 vary. A general comparative analysis is appropriate in all regards.</p> <p>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, you agree 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 NQTL comparative analysis confidential as it is the proprietary information of Humana.</p>	
Column 1 - Prompt	
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	<p>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.</p> <p>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 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 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 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</p> <p>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) c information needed to complete the review.</p> <p>If the case is approved, the pharmacist must then provide the appropriate approval duration and approval notes based on the approval comment template.</p> <p>Pharmacists will add additional comments if approving/denying outside of policy based off compendia, clinical judgement, and additional research, providing clinical rationale for the denied cases will proceed to the Regional Medical Director (RMD) for final sign off before the notification letter is distributed to prescriber and patient.</p> <p>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 t 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 day</p> <p>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 p 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.</p> <p>Reviews for office-administered authorizations will be resolved within 72hrs for expedited requests and 15 days for standard.</p> <p>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</p>
Step 2: Describe the reason for applying the NQTL (Factors Applied)	<p>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 li</p> <ul style="list-style-type: none">• 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• 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• 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 <p>The current medical literature is used to support the implementation of all prior authorization criteria.</p>

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 has been 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 indications, 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:

- 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 to ensure continued compliance with the Federal Mental Health Parity and Addiction Equity Act by monitoring formulary design and prior authorization requirements for medical/surgical drug classes. 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 literature, 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	<p>The P&T policy and procedure outlines the following details.</p> <p>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 pharmaceuticals. The committee oversees the 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 quality of care. The committee's purview pertains to drugs, biologics, and select non-drug products.</p> <p>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 needed. The 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 issues. In addition to reviewing 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 revision.</p> <p>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. 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 organization. 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.</p> <p>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 and Privileging Policy. Members are reviewed 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 licensed in the United States or one of its Territories as a physician or pharmacist with good standing.</p> <p>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 at the start of each meeting. Product sponsor representatives are specifically excluded from P&T Committee membership and from attending P&T Committee meetings.</p> <p>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 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 recommendations to 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 edits. Coverage 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 use of direct to consumer messaging, the P&T Committee will communicate these changes to members as per state specific timelines.</p> <p>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, 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 relevance 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 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, and references are also provided to these areas to ensure that decisions involving coverage and clinical policies are operationalized and displayed as intended.</p>
Step 5: Processes in implementation of NQTL in operation	<p>The Pharmacy and Therapeutics (P&T) Committee applies the same processes and strategies across all therapeutic classes, including peer clinical review, consultations with experts, and the 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 decision.</p>
Step 6: Summary conclusion of how plan has determined overall compliance	<p>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 criteria 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 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 drug class.</p>

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.
<p>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 used for 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 an “as applied” 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 vary. A general comparative analysis is appropriate in all regards.</p> <p>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, you must 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 NQTL comparative analysis confidential as it is the proprietary information of Humana.</p>	
Column 1 - Prompt	Column 2 - Prescription Drugs
Step 1: Describe the NQTL’s requirements and associated procedures	<p>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).</p> <p>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 NQTL exceptions, the pharmacist will also review for Supporting Statement. After the medication information is reviewed, the clinical information provided is assessed. The pharmacist must verify the 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 EOCs relevant to the current request, and claims history information available in PAHub.</p> <p>Each case is to be reviewed for compendia support.</p> <p>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.</p> <p>If the case is approved, the pharmacist must then provide the appropriate approval duration and approval notes based on the approval comment template.</p> <p>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.</p> <p>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.</p> <p>Humana will make coverage determinations as expeditiously as the member’s health condition requires.</p> <p>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 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.</p> <p>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 is notified 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.</p> <p>Reviews for office-administered authorizations will be resolved within 72hrs for expedited requests and 15 days for standard.</p> <p>Humana follows the ERISA standards for timeliness along with State / Federal guidelines. Humana follows the most stringent guidance for these reviews.</p> <p>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 for certain states.</p>

Step 2: Describe the reason for applying the NQTL (Factors Applied)	<p>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:</p> <ul style="list-style-type: none">• 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• 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 not warranted• The Pharmacy and Therapeutics Committee develops coding edit criteria• The criteria is implemented and supported by needed processes <p>The current medical literature and /or cost benefit analysis is used to support the implementation of all coding edit criteria.</p>
Step 3: Identify and describe evidentiary standards and other evidence relied upon	<p>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 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 indications, 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:</p> <ul style="list-style-type: none">- 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 <p>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 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.</p> <p>Pharmacy and Therapeutics Committee coverage decisions may include the following activities to support an evidence based review process:</p> <ul style="list-style-type: none">• Assessing peer-reviewed medical literature including randomized clinical trials (especially drug comparison studies), undisputed articles in medical journals, generally accepted medical pharmacoeconomic studies, and outcomes research data.• Employing published practice guidelines, developed by an acceptable evidence-based process.• Reviewing the AMCP Formulary Dossier. <p>When reviewing coding edits requirements for drugs used for Medical/surgical conditions, Humana utilizes the following references (including but not limited to):</p> <ul style="list-style-type: none">- 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 <p>When reviewing coding edits requirements for drugs used for mental health conditions, Humana utilizes the following references (including but not limited to):</p> <ul style="list-style-type: none">- 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 <p>Humana applies coding edits for substance use disorder based upon the following references (including but not limited to):</p> <ul style="list-style-type: none">- Guidelines and or position statements published by the American Society of Addiction Medicine (ASAM)- Advisory consultations with external psychiatrists/physicians who specialize in the treatment of substance use disorders and internal mental health professionals (including psychiatrists)

Step 4: Processes and strategies used to design NQTL as written	<p>The P&T policy and procedure outlines the following details.</p> <p>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 pharmaceuticals for the 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 quality of care. This responsibility pertains to drugs, biologics, and select non-drug products.</p> <p>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 needed. The 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 issues. In addition to 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 revision.</p> <p>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. 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 organization. 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.</p> <p>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. This occurs 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 licensed in the United States or one of its Territories as a physician or pharmacist with good standing.</p> <p>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. Product sponsor representatives are specifically excluded from P&T Committee membership and from attending P&T Committee meetings.</p> <p>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 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 recommendations to 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 edits. This 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 area of consumer messaging, the P&T Committee will communicate these changes to members as per state specific timelines.</p> <p>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, clinical 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 coverage are shared 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. These are shared with the areas charged with consumer messaging to ensure accurate display of drug coverage and policy requirements. Other relevant files, spreadsheets, databases, and reports are provided to these areas to ensure that decisions involving coverage and clinical policies are operationalized and displayed as intended.</p>
Step 5: Processes in implementation of NQTL in operation	<p>Humana applies the same processes and strategies across all therapeutic classes, including peer clinical review, consultations with expert reviewers, clinical rationale used in approval, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.</p>
Step 6: Summary conclusion of how plan has determined overall compliance	<p>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 medical/surgical drugs and medical/surgical drugs. All Drugs or biologicals are reviewed to determine need for coding edits based upon the same criteria. Humana uses the same and comparable evidence 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.</p>

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.
<p>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 used for 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 should be on an “as applied” 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 vary. A general comparative analysis is appropriate in all regards.</p> <p>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, you agree 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 NQTL comparative analysis confidential as it is the proprietary information of Humana.</p>	
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 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 has been 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 uses, but are not 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:

- 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 to ensure 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 practice, 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	<p>The P&T policy and procedure outlines the following details.</p> <p>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 pharmaceuticals. The committee oversees the 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 quality of care. The committee's jurisdiction pertains to drugs, biologics, and select non-drug products.</p> <p>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 needed. The 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 issues. In addition to reviewing 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 when a change is warranted for review.</p> <p>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. 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 organization. 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.</p> <p>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. This verification occurs 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 licensed in the United States or one of its Territories as a physician or pharmacist with good standing.</p> <p>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 at the start of each meeting. Product sponsor representatives are specifically excluded from P&T Committee membership and from attending P&T Committee meetings.</p> <p>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 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 a recommendation to 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 edits. The review 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 review process and consumer messaging, the P&T Committee will communicate these changes to members as per state specific timelines.</p> <p>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, 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 relevance are discussed 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. The minutes are shared with the areas charged with consumer messaging to ensure accurate display of drug coverage and policy requirements. Other relevant files, spreadsheets, databases, and documents are provided to these areas to ensure that decisions involving coverage and clinical policies are operationalized and displayed as intended.</p>
Step 5: Processes in implementation of NQTL in operation	<p>The Pharmacy and Therapeutics (P&T) Committee applies the same processes and strategies across all therapeutic classes, including peer clinical review, consultations with experts, and the 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 decision.</p>
Step 6: Summary conclusion of how plan has determined overall compliance	<p>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 consistent 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.</p>

NQTL Name	Plan's Description of NQTL
RX Experimental	This NQTL addresses the processes, factors, and evidentiary standards driving the list of experimental drugs for which Humana requires members of authorization.
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Column 1 - Prompt	Column 2 - Prescription Drugs
Benefit/Service(s) which have been subject to review to determine if they are experimental or investigational.	<p>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 the Standards below.</p> <p>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.</p>

Step 1: Describe the NQTL’s requirements and associated procedures	<p>For drugs not yet FDA approved, they are excluded by benefit along with other approved drugs that may be specifically mentioned in the benefit language. The P&T role is then to determine if the drug is covered under the member's plan as defined by policy for medically-accepted use. This is mainly supported by (1) HHS approved compendia, and (2) peer-reviewed journals. When a drug is requested for treatment of a member, the pharmacist must review the clinical information provided for experimental investigational use, a experimental treatment review request can be initiated by a member, provider, or pharmacist.</p> <p>When a experimental treatment 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 drug 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 and clinical information provided is assessed. The pharmacist must review all clinical information provided by the prescriber. The pharmacist must utilize all information available to the pharmacist 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.</p> <p>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) category. The pharmacist will request the 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.</p> <p>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. Denied cases will proceed to the Regional Medical Director (RMD) for final sign off before the notification letter is distributed to prescriber and patient.</p> <p>Humana will make coverage determinations as expeditiously as the member's health condition requires.</p> <p>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 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.</p> <p>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.</p> <p>Reviews for office-administered authorizations will be resolved within 72hrs for expedited requests and 15 days for standard.</p> <p>Humana follows the ERISA standards for timeliness along with State / Federal guidelines. Humana follows the most stringent guidance for these reviews.</p> <p>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.</p>
Step 2: Describe the reason for applying the NQTL (Factors Applied)	<p>Drugs or biologics used for experimental treatment are reviewed based on specific issues that include, but are not limited to, the following:</p> <ul style="list-style-type: none">• 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• 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 not warranted• The Pharmacy and Therapeutics Committee develops experimental treatment criteria• The criteria is implemented and supported by needed processes <p>Review ensures consistent evidence-based review of pharmaceuticals for currently accepted medical conditions for coverage on the formulary for Humana members. Formulary coverage is determined by the member's plan and the benefits allowed by the member's plan.</p>

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 has been 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 indications, but are not 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 additional review:

- 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 review to experimental treatment drugs. The application of medical necessity limits to experimental drugs is a standardized process across all therapeutic classes. Humana ensures continued compliance with the Federal Mental Health Parity and Addiction Equity Act by monitoring experimental treatment drugs used for all classes and indications 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 practice, pharmacoeconomic studies, and outcomes research data.
- Employing published practice guidelines, developed by an acceptable evidence-based process.
- Reviewing the AMCP Formulary Dossier.

When reviewing experimental treatment 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 experimental treatment 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

Step 4: Processes and strategies used to design NQTL as written	<p>The P&T policy and procedure outlines the following details.</p> <p>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 pharmaceuticals. The committee oversees the 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 quality of care. The committee's purview pertains to drugs, biologics, and select non-drug products.</p> <p>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 needed. The 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 issues. For all 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 when a change is warranted for review.</p> <p>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. 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 organization. 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.</p> <p>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. This occurs 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 licensed in the United States or one of its Territories as a physician or pharmacist with good standing.</p> <p>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 at the start of each meeting. Product sponsor representatives are specifically excluded from P&T Committee membership and from attending P&T Committee meetings.</p> <p>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 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 a recommendation to 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 edits. This may involve positive or negative changes to the Formulary such as drug coverage, tier placement, or clinical edits (e.g. experimental treatment, step therapy, quantity limits). Through consumer messaging, the P&T Committee will communicate these changes to members as per state specific timelines.</p> <p>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, clinical edits, experimental treatment, 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 reimbursement 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 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, and references are also provided to these areas to ensure that decisions involving coverage and clinical policies are operationalized and displayed as intended.</p>
Step 5: Processes in implementation of NQTL in operation	<p>The Pharmacy and Therapeutics (P&T) Committee applies the same processes and strategies across all therapeutic classes, including peer clinical review, consultations with experts, and the 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 decision.</p>
Step 6: Summary conclusion of how plan has determined overall compliance	<p>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 expert review procedures for both MH/SUD drugs and medical/surgical drugs. Humana uses the same and comparable evidentiary standards to establish the experimental treatment (medical necessity) for both MH/SUD and medical/surgical drugs. Processes for review of both MH/SUD benefits and medical/surgical benefits are applied the same irrespective of therapeutic area.</p>

NQTL Name	Plan's Description of NQTL
RX Fail First (Step Therapy)	This NQTL addresses the processes, factors, and evidentiary standards driving the list of services and items for which Humana requires step therapy.
<p>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 used for 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 must be made on an "as applied" 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 not be identified in a general comparative analysis is appropriate in all regards.</p> <p>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, you must 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 NQTL comparative analysis confidential as it is the proprietary information of Humana.</p>	
Column 1 - Prompt	Column 2 - Prescription Drugs
Benefit/Service(s) which require the beneficiary to have tried and failed a lower level of care prior to coverage.	A list of all covered prescription drugs requiring step therapy (fail first) may be found on the group's formulary drug list.

Step 1: Describe the NQTL’s requirements and associated procedures	<p>When a drug denies for Step Therapy Required at point-of-sale, a step therapy review request can be initiated by a member, provider, or pharmacist.</p> <p>When a step therapy 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 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 received, the 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, 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 the system.</p> <p>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) category until the information needed to complete the review.</p> <p>If the case is approved, the pharmacist must then provide the appropriate approval duration and approval notes based on the approval comment template.</p> <p>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. Denied cases will proceed to the Regional Medical Director (RMD) for final sign off before the notification letter is distributed to prescriber and patient.</p> <p>Humana will make coverage determinations as expeditiously as the member’s health condition requires.</p> <p>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, 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.</p> <p>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 oral, then the written notification will be mailed within three calendar days of the oral notification.</p> <p>Reviews for office-administered authorizations will be resolved within 72hrs for expedited requests and 15 days for standard.</p> <p>Humana follows the ERISA standards for timeliness along with State / Federal guidelines. Humana follows the most stringent guidance for these reviews.</p> <p>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 for use.</p>
Step 2: Describe the reason for applying the NQTL (Factors Applied)	<p>After drugs and biologics are approved by the FDA, the Pharmacy and Therapeutics Committee reviews the new entities for their necessity to determine need for step therapy criteria.</p> <ul style="list-style-type: none">• The drug is only effective in a limited population that would preclude the drug from being used as first line therapy, therefore broad or first- line use of the drug is ill advised• 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 <p>Selection of the first and second line drugs takes place after careful review of medical literature, manufacturer product information, and consultation with medical professionals. The goal is to ensure that the protocols reflect the most current and appropriate drug therapy treatment guidelines.</p>

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 has been 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 indications, but are not 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:

- 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 step therapy requirements to some prescription drugs. The application of step therapy edits is a standardized process across all therapeutic categories. Humana ensures compliance with the Federal Mental Health Parity and Addiction Equity Act by monitoring formulary design and step therapy 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 literature, pharmacoeconomic studies, and outcomes research data.
- Employing published practice guidelines, developed by an acceptable evidence-based process.
- Reviewing the AMCP Formulary Dossier.

When reviewing step therapy 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 step therapy 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

When reviewing step therapy requirements for drugs used for substance use disorder, Humana utilizes 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	<p>The P&T policy and procedure outlines the following details.</p> <p>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 pharmaceuticals. The committee oversees the 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 quality of care. The committee's purview pertains to drugs, biologics, and select non-drug products.</p> <p>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 needed. The 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 issues. For all 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 when a change is warranted for review.</p> <p>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. 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 organization. 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.</p> <p>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. This occurs 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 licensed in the United States or one of its Territories as a physician or pharmacist with good standing.</p> <p>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 at the start of each meeting. Product sponsor representatives are specifically excluded from P&T Committee membership and from attending P&T Committee meetings.</p> <p>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 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 a recommendation to 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 edits. This 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 use of direct to consumer messaging, the P&T Committee will communicate these changes to members as per state specific timelines.</p> <p>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, 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 relevance 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 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, and references are also provided to these areas to ensure that decisions involving coverage and clinical policies are operationalized and displayed as intended.</p>
Step 5: Processes in implementation of NQTL in operation	<p>The Pharmacy and Therapeutics (P&T) Committee applies the same processes and strategies across all therapeutic classes, including peer clinical review, consultations with experts, and the 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 decision.</p>
Step 6: Summary conclusion of how plan has determined overall compliance	<p>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 step therapy process for MH/SUD drugs and medical/surgical drugs. All Drugs or biologicals are reviewed to determine need for step therapy based upon the same criteria. Humana uses the same and common criteria to establish the step therapy protocols. Processes for review of both MH/SUD benefits and medical/surgical benefits are applied the same irrespective of therapeutic area.</p>

NQTL Name	Plan's Description of NQTL
RX Formulary Design	This NQTL addresses the processes, factors, and evidentiary standards driving the list of services and items covered on Humana's formulary.
<p>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 used for 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 made on an individual 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 vary. A general comparative analysis is appropriate in all regards.</p> <p>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, you agree that you will 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 NQTL comparative analysis confidential as it is the proprietary information of Humana.</p>	
Column 1 - Prompt	Column 2 - Prescription Drugs
Step 1: Describe the NQTL’s requirements and associated procedures	<p>Humana utilizes a tiered benefit design. The process by which medications are placed in a tier is a standardized process consistent across all therapeutic categories, including medical/surgical. Rx5/5-tier drug list/formulary places drugs in tiers based on generic/brand status and cost of medication. Lowest and low cost generics are placed in drug tiers 1 and 2, and brands in tiers 3 and 4; and specialty drugs (both branded and generic) are placed in tier 5. Rx4/4-tier drug list/formulary places drugs in tiers based on cost. Tiers are graduated so that the least expensive drugs fall into lower tiers and higher cost drugs are placed in higher tiers. Rx3/3-tier drug list/formulary places drugs in tiers based on cost, except in the case of certain generics, so that the least expensive drugs fall into the lower 2 tiers and higher cost drugs are placed in the highest tier (tier 3). Generic drugs, however, are required to be placed at tier 1 unless otherwise specified in the application (NDA), non-FDA approved, or over-the-counter (OTC).</p> <p>Pharmacy & Therapeutics is responsible for the review of drugs approved by the FDA and the inclusion/exclusion of therapeutic classes in the formulary on an annual basis:</p> <ul style="list-style-type: none">• Corporate Pharmacy Management identifies new drugs or biologics in order to facilitate timely review by the P&T Committee.• After the FDA approves new chemical or biologic entities or abbreviated new drug applications (ANDAs) and these products become available in pharmacies, Corporate Pharmacy Management initiates the listing of new drug products from the prescription claims processor for review. Additional information regarding the pending release of new drug or biological products is obtained from the manufacturer, Corporate Pharmacy Management pipeline review and the regular review of various sources, such as the Pink Sheets, the Internet, the FDA, and the drug manufacturers.• Corporate Pharmacy Management, on behalf of the P&T Committee, assigns drugs or biologics to the appropriate tier or coverage level. If a clinical review of new medications or therapeutic classes is requested by the P&T Committee, it is conducted utilizing an evidence based medicine approach. Acquisition costs and financial incentives are considered within the context of medical management as part of the delivery of quality medical care without compromising clinical integrity. <p>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. 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 medical community. 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.</p> <p>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 and Privileging Policy 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 licensed in the United States or one of its Territories as a physician or pharmacist with good standing.</p> <p>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 at each meeting. Members will not be allowed to vote on any agenda item for which there is a conflict but are allowed to participate in the discussion. All voting members must also sign a statement of no conflict or disclosure of conflict verifying either no conflict or disclosure of conflict if it exists at least annually. Any consideration of voting for members who have stated a conflict of interest will be made with consultation of the Compliance and Ethics and Compliance office prior to granting of such privilege.</p>

Step 2: Describe the reason for applying the NQTL (Factors Applied)	<p>P&T coverage decisions involve basing formulary system decisions on a thorough evaluation of the benefits, risks and potential outcomes for consumers; risks encompass adverse reactions and medication errors, such as those caused by confusing product names or labels).</p> <p>Pharmacy & Therapeutics is responsible for the review of drugs approved by the FDA and the inclusion/exclusion of therapeutic classes in the formulary on an annual basis:</p> <p>Medications are reviewed in the following areas for which a coverage and formulary inclusion determination will be made:</p> <ul style="list-style-type: none">a. Safetyb. Efficacy (solely and in comparison to current formulary agents)c. Place in therapy (solely and in comparison to current formulary agents)d. Side effect profilee. Adverse drug reaction reportsf. Current utilization trendsg. Cost versus Benefit
Step 3: Identify and describe evidentiary standards and other evidence relied upon	<p>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 has been 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 indications, 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:</p> <p>American Hospital Formulary Service Drug Information (AHFS DI)</p> <ul style="list-style-type: none">- Truven Health Analytics Micromedex DrugDEX- National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium- Elsevier/Gold Standard Clinical Pharmacology- Wolters Kluwer Lexi Drugs <p>Formulary design is a standardized process across all therapeutic categories. Humana ensures continued compliance with the Federal Mental Health Parity and Addiction Equity Act through the Pharmacy and Therapeutics Committee.</p> <p>Pharmacy and Therapeutics Committee coverage decisions may include the following activities to support an evidence based review process:</p> <ul style="list-style-type: none">• Assessing peer-reviewed medical literature including randomized clinical trials (especially drug comparison studies), undisputed articles in medical journals, generally accepted medical pharmacoeconomic studies, and outcomes research data.• Employing published practice guidelines, developed by an acceptable evidence-based process.• Reviewing the AMCP Formulary Dossier. <p>When designing formularies with respect to drugs used for Medical/surgical conditions, Humana utilizes the following references (including but not limited to):</p> <ul style="list-style-type: none">- 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 <p>When designing formularies with respect to drugs used for mental health conditions, Humana utilizes the following references (including but not limited to):</p> <ul style="list-style-type: none">- 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 <p>Humana selects and tiers preferred products for substance use disorder based upon the following references (including but not limited to):</p> <ul style="list-style-type: none">- Guidelines and or position statements published by the American Society of Addiction Medicine (ASAM)- Advisory consultations with external psychiatrists/physicians who specialize in the treatment of substance use disorders and internal mental health professionals (including psychiatrists)

Step 4: Processes and strategies used to design NQTL as written	<p>The P&T policy and procedure outlines the following details.</p> <p>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 pharmaceuticals. The committee oversees the 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 quality of care. The committee's jurisdiction pertains to drugs, biologics, and select non-drug products.</p> <p>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 needed. The 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 issues. In addition to 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 when a change is warranted for review.</p> <p>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. 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 organization. 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.</p> <p>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. This occurs 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 licensed in the United States or one of its Territories as a physician or pharmacist with good standing.</p> <p>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 at the start of each meeting. Product sponsor representatives are specifically excluded from P&T Committee membership and from attending P&T Committee meetings.</p> <p>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 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 a recommendation to 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 edits. This may involve positive or negative changes to the Formulary such as drug coverage, tier placement, or clinical edits (e.g. formulary design, step therapy, quantity limits). Through the use of direct-to-consumer messaging, the P&T Committee will communicate these changes to members as per state specific timelines.</p> <p>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, formulary design, 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 are discussed 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. Policies are shared with the areas charged with consumer messaging to ensure accurate display of drug coverage and policy requirements. Other relevant files, spreadsheets, databases, and reports are provided to these areas to ensure that decisions involving coverage and clinical policies are operationalized and displayed as intended.</p>
Step 5: Processes in implementation of NQTL in operation	<p>The Pharmacy and Therapeutics (P&T) Committee applies the same processes and strategies across all therapeutic classes, including peer clinical review, consultations with experts, and the 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 decision.</p>
Step 6: Summary conclusion of how plan has determined overall compliance	<p>Consistent with 45 CFR 146.136 (c)(iv)(4), Humana applies pharmacy non-quantitative treatment limitations uniformly across all therapeutic areas. Humana applies a consistent review process for consideration of coverage within a formulary based on the clinical profile. Humana utilizes the same formulary design procedures for both MH/SUD drugs and medical/surgical drugs. All drugs are reviewed for formulary design based upon the same criteria. Humana uses the same and comparable evidentiary standards to establish the formulary design. Processes for review of medical and medical/surgical benefits are applied the same irrespective of therapeutic area.</p>

Current as of Dec 2023

NQTL Name

Medical Necessity Criteria

Step 1: Describe the NQTL's requirements and associated procedures

**Step 2: Describe the
reason for applying the
NQTL (Factors Applied)**

Step 3: Identify and describe evidentiary standards and other evidence relied upon

Step 4: Processes and strategies used to design NQTL as written

**Step 5: Processes in
implementation of NQTL
in operation**

**Step 6: Summary
conclusion of how plan
has determined overall
compliance**

Plan's Description of NQTL

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 In-Network Benefits Benefits

Humana's Commercial medical necessity process is consistent for all fully insured commercial plans.

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. See reference "HCO-CL-01-012 Utilization and Approval of Clinical Review Criteria".

For Inpatient services, Humana utilizes the following clinical review criteria:

- Federal and state mandates
- Member's Certificates of Coverage
- MCG (M/S and MH)
- ASAM (Substance Use Disorder)
- Relevant medical research/literature, in the absence of other criteria or guidelines

For inpatient Medical/Surgical and Mental Health services, Humana has selected MCG® guidelines as the medical necessity guidelines for initial reviews as well as subsequent reviews as applicable. MCG® guidelines have been selected as they are based on unbiased, clinically validated best practices that support optimal clinical decision-making. Humana partners with MCG® at least annually to review its guidelines. MCG guidelines based 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 a 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.

- For each guideline, the published professional literature (the National Library of Medicine database via the PubMed search engine) is systematically queried at least annually using specially developed, customized, tested, proprietary search strings.
- A MCG clinical editor evaluates all new evidence and updates the guideline as needed to ensure its continued clinical validity.
- On an annual basis, each guideline undergoes external review by clinically active experts (e.g., board-certified

Medical/Surgical (M/S) Factors

As stated in Step 1, Humana utilizes MCG® guidelines for inpatient M/S or MH medical necessity reviews. 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

As stated in Step 1, Humana utilizes MCG® guidelines for inpatient M/S or MH medical necessity reviews. 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) 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:

Comparative Analysis - Process as Written

The factors and evidentiary standards used to develop processes for medical necessity for Inpatient reviews are outlined above. In policy, Humana has memorialized the Clinical Review process, which outlines Medical Necessity review processes and criteria. The *HCO-CL-01-012 Utilization and Approval of Clinical Review Criteria* 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

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. There is no variation in these processes between M/S and MH/SUD reviews.

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. Timely notifications of determinations are completed within state and federal requirements.

Humana performs Inter-rater Reliability (IRR) Testing to evaluate consistency with which all clinicians working in Utilization Management apply criteria in decision making. The purpose is to evaluate the reliability in applying criteria and identify inconsistencies across teams, departments, and classifications. If inconsistencies are identified, Humana provides additional education and training to associates as needed.

Summary Conclusions

As outlined above, Humana's written and operationalized practices for the Medical Necessity Criteria NQTL for Inpatient In-Network MH/SUD are comparable to the written and operationalized practices for Inpatient In-Network M/S. For medical necessity reviews of services in the Inpatient In-Network classification, Humana utilizes MCG® guidelines as the source of medical necessity criteria for both M/S and MH services. For medical necessity reviews of SUD services in the Inpatient In-Network 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

This Humana Template NQTL comparative analysis is made available for informational purposes only and construed as providing legal advice. Each plan's situation can be highly fact specific and does not address analysis is on a plan by plan basis and not on the overall "book of business" of any insurer or third-party. 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, etc. We require that you notify us whenever you provide a copy of this NQTL analysis pursuant to a request from Humana. Humana Template NQTL comparative analysis confidential as it is the proprietary information of Humana.

Inpatient Out-of-Network Benefits

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. See reference "*HCO-CL-01-012 Utilization and Approval of Clinical Review Criteria*".

For Inpatient services, Humana utilizes the following clinical review criteria:

- Federal and state mandates
- Member's Certificates of Coverage
- MCG (M/S and MH)
- ASAM (Substance Use Disorder)
- Relevant medical research/literature, in the absence of other criteria or guidelines

For inpatient Medical/Surgical and Mental Health services, Humana has selected MCG® guidelines as the medical necessity guidelines for initial reviews as well as subsequent reviews as applicable. MCG® guidelines have been selected as they are based on unbiased, clinically validated best practices that support optimal clinical decision-making. Humana partners with MCG® at least annually to review its guidelines. MCG guidelines are based on primary diagnosis and 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 a 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.

- For each guideline, the published professional literature (the National Library of Medicine database via the PubMed search engine) is systematically queried at least annually using specially developed, customized, tested, proprietary search strings.
- A MCG clinical editor evaluates all new evidence and updates the guideline as needed to ensure its continued clinical validity.
- On an annual basis, each guideline undergoes external review by clinically active experts (e.g., board-certified specialist physicians without stated financial conflicts of interest) to confirm the clinical appropriateness, accuracy,

As stated in Step 1, Humana utilizes MCG® guidelines for inpatient M/S or MH medical necessity reviews. 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) Factors

As stated in Step 1, Humana utilizes MCG® guidelines for inpatient M/S or MH medical necessity reviews. 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.

Substance Use Disorder (SUD) Factors

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) 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

The factors and evidentiary standards used to develop processes for medical necessity for Inpatient reviews are outlined above. In policy, Humana has memorialized the Clinical Review process, which outlines Medical Necessity review processes and criteria. The *HCO-CL-01-012 Utilization and Approval of Clinical Review Criteria* 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. See “2023 Commercial UMPD” pages 17-18 starting with “Clinical Criteria and Guidelines”.

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. There is no variation in these processes between M/S and MH/SUD reviews.

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. Timely notifications of determinations are completed within state and federal requirements.

Humana performs Inter-rater Reliability (IRR) Testing to evaluate consistency with which all clinicians working in Utilization Management apply criteria in decision making. The purpose is to evaluate the reliability in applying criteria and identify inconsistencies across teams, departments, and classifications. If inconsistencies are identified, Humana provides additional education and training to associates as needed.

Summary Conclusions

As outlined above, Humana's written and operationalized practices for the Medical Necessity Criteria NQTL for Inpatient Out-of-Network MH/SUD are comparable to the written and operationalized practices for Inpatient Out-of-Network M/S. For medical necessity reviews of services in the Inpatient Out-of-Network classification, Humana utilizes MCG® guidelines as the source of medical necessity criteria for both M/S and MH services. For medical necessity reviews of SUD services in the Inpatient Out-of-Network 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

covers some of the primary NQTLs in the Humana Plan Template. It is not intended and should not be s plan customizations. The federal agencies interpreting MHPAEA have emphasized that any MHPAEA administrator/ASO. Also, NQTLs are evaluated on an “as applied” basis. Therefore, specific utilization

ders and governmental agencies upon request. As a condition of use of this NQTL comparative analysis, m such an individual or entity. Except for such requests you are required to keep the contents of this

Outpatient In-Network Benefits

Humana’s Commercial medical necessity process is consistent for all fully insured commercial plans. 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. See reference “*HCO-CL-01-012 Utilization and Approval of Clinical Review Criteria*”.

For Outpatient services, Humana utilizes the following clinical review criteria:

- Federal and state mandates
- Member’s Certificates of Coverage
- Humana Internal Medical Coverage Policies (M/S and MH)
- MCG (M/S and MH)
- ASAM (SUD)
- Relevant medical research/literature, in the absence of other criteria or guidelines

Humana’s internal medical 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 the steps below as well as the reference “*Development and Maintenance of Humana Medical Coverage Policies*”. The medical coverage policies are updated and reviewed annually, at minimum, by a policy review committee comprised of physicians with various specialties and other health plan leadership. See reference “*TAF Voting Members*” for a list of the physicians and specialties. External physician groups or societies may be consulted as well. The internal coverage policies are utilized for outpatient services and items.

Additionally, Humana utilizes MCG® guidelines for medical necessity for outpatient reviews as applicable. MCG® guidelines have been selected as they are based on unbiased, clinically validated best practices that support optimal clinical decision-making. Humana partners with MCG® at least annually to review its guidelines.

MCG’s process to develop and maintain its proprietary guidelines is as follows, per its website.

- For each guideline, the published professional literature (the National Library of Medicine database via the PubMed search engine) is systematically queried at least annually using specially developed, customized,

The factors identified in the design and application of Medical Necessity are listed below. Please see “*Development and Maintenance of Humana Medical Coverage Policies*”. Please refer to MCG and ASAM regarding weight of factors utilizing their respective criteria.

Medical/Surgical (M/S) Factors

For Medical/Surgical Outpatient services, Humana utilizes internally developed coverage policies. No factor is given more weight than another factor. 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.

Please also see reference “*Development and Maintenance of Humana Medical Coverage Policies*”.

The underlying factors driving MCG® medical necessity 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 Humana Medical Coverage Policies and 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) Factors

For Mental Health, Humana utilizes internally developed coverage policies. No factor is given more weight than another factor. 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;
-

Medical/Surgical (M/S) Evidentiary Standards

In addition to the medical necessity considerations outlined under “Factors”, 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. Please also see reference “*Development and Maintenance of Humana Medical Coverage Policies*”.

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)

Comparative Analysis - Process as Written

The factors and evidentiary standards used to develop processes for outpatient medical necessity reviews are outlined in the steps above. In policy, Humana has memorialized the clinical review process, which outlines medical necessity review processes and criteria. The *HCO-CL-01-012 Utilization and Approval of Clinical Review Criteria* is a singular policy comprehensively capturing M/S and MH/SUD medical necessity reviews. Also in policy, Humana has memorialized its process to develop and maintain Humana Medical Coverage Policies according to standards outlined above. Humana has established associate-level processes and procedures for

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. There is no variation in these processes between M/S and MH/SUD reviews.

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. Timely notifications of determinations are completed within state and federal requirements.

Development and maintenance of all Humana Medical Coverage Policies involves the support of 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. See reference "*TAF Voting Members*". Development of Humana's Coverage Policies may involve consultation from outside entities as necessary.

Summary Conclusions

As outlined above, Humana's written and operationalized practices for the Medical Necessity Criteria NQTL for Outpatient In-Network MH/SUD are comparable to the written and operationalized practices for Outpatient In-Network M/S. For medical necessity reviews of services in the Outpatient In-Network classification, Humana utilizes its internal Humana Medical Coverage Policies and MCG guidelines as the source of medical necessity criteria for both M/S and MH services. For medical necessity reviews of SUD services in the Outpatient In-Network 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 includes 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

Outpatient Out-of-Network Benefits

Humana's Commercial medical necessity process is consistent for all fully insured commercial plans. 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. See reference "*HCO-CL-01-012 Utilization and Approval of Clinical Review Criteria*".

For Outpatient services, Humana utilizes the following clinical review criteria:

- Federal and state mandates
- Member's Certificates of Coverage
- Humana Internal Medical Coverage Policies (M/S and MH)
- MCG (M/S and MH)
- ASAM (SUD)
- Relevant medical research/literature, in the absence of other criteria or guidelines

Humana's internal medical 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 the steps below as well as the reference "*Development and Maintenance of Humana Medical Coverage Policies*". The medical coverage policies are updated and reviewed annually, at minimum, by a policy review committee comprised of physicians with various specialties and other health plan leadership. See reference "*TAF Voting Members*" for a list of the physicians and specialties. External physician groups or societies may be consulted as well. The internal coverage policies are utilized for outpatient services and items.

Additionally, Humana utilizes MCG® guidelines for medical necessity for outpatient reviews as applicable. MCG® guidelines have been selected as they are based on unbiased, clinically validated best practices that support optimal clinical decision-making. Humana partners with MCG® at least annually to review its guidelines.

MCG's process to develop and maintain its proprietary guidelines is as follows, per its website.

- For each guideline, the published professional literature (the National Library of Medicine database via the PubMed search engine) is systematically queried at least annually using specially developed, customized,

The factors identified in the design and application of Medical Necessity are listed below. Please see *“Development and Maintenance of Humana Medical Coverage Policies”*. Please refer to MCG and ASAM regarding weight of factors utilizing their respective criteria.

Medical/Surgical (M/S) Factors

For Medical/Surgical Outpatient services, Humana utilizes internally developed coverage policies. No factor is given more weight than another factor. 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.

Please also see reference *“Development and Maintenance of Humana Medical Coverage Policies”*.

The underlying factors driving MCG® medical necessity 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 Humana Medical Coverage Policies and 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) Factors

For Mental Health, Humana utilizes internally developed coverage policies. No factor is given more weight than another factor. 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;
-

Medical/Surgical (M/S) Evidentiary Standards

In addition to the medical necessity considerations outlined under “Factors”, 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. Please also see reference “*Development and Maintenance of Humana Medical Coverage Policies*”.

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)

Comparative Analysis - Process as Written

The factors and evidentiary standards used to develop processes for outpatient medical necessity reviews are outlined in the steps above. In policy, Humana has memorialized the clinical review process, which outlines medical necessity review processes and criteria. The *HCO-CL-01-012 Utilization and Approval of Clinical Review Criteria* is a singular policy comprehensively capturing M/S and MH/SUD medical necessity reviews. Also in policy, Humana has memorialized its process to develop and maintain Humana Medical Coverage Policies according to standards outlined above. Humana has established associate-level processes and procedures for

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. There is no variation in these processes between M/S and MH/SUD reviews.

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. Timely notifications of determinations are completed within state and federal requirements.

Development and maintenance of all Humana Medical Coverage Policies involves the support of 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. See reference "*TAF Voting Members*". Development of Humana's Coverage Policies may involve consultation from outside entities as necessary.

Summary Conclusions

As outlined above, Humana's written and operationalized practices for the Medical Necessity Criteria NQTL for Outpatient Out-of-Network MH/SUD are comparable to the written and operationalized practices for Outpatient Out-of-Network M/S. For medical necessity reviews of services in the Outpatient Out-of-Network classification, Humana utilizes its internal Humana Medical Coverage Policies and MCG guidelines as the source of medical necessity criteria for both M/S and MH services. For medical necessity reviews of SUD services in the Outpatient Out-of-Network 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 includes 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

Emergency Benefits

Medical/Surgical (M/S) Process

Humana does not perform medical necessity review on Emergency Services. Humana does not require an authorization or notification for members to access emergency services (either in-network or out-of-network). Emergency Services claims for both MH/SUD and M/S may be subject to review by a licensed board-certified Medical Director when submitted. The intent of the review is to ensure the medical condition and/or situation meets Humana's definition of "Emergency Care" (which is aligned with the Prudent Layperson Standard).

Mental Health (MH)/Substance Use Disorder (SUD) Process

Humana does not perform medical necessity review on Emergency Services. Humana does not require an authorization or notification for members to access emergency services (either in-network or out-of-network). Emergency Services claims for both MH/SUD and M/S may be subject to review by a licensed board-certified Medical Director when submitted. The intent of the review is to ensure the medical condition and/or situation meets Humana's definition of "Emergency Care" (which is aligned with the Prudent Layperson Standard).

Medical/Surgical (M/S) Factors

Humana's definition of Emergency Care (inclusive of the Prudent Layperson Standard) 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

Humana's definition of Emergency Care (inclusive of the Prudent Layperson Standard) 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.

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.

Comparative Analysis - Process as Written

For both M/S and MH/SUD, emergency services claims may be reviewed against the same emergency care and the prudent layperson standard.

Comparative Analysis - Process in Operation

Medical/Surgical and Mental Health/Substance Use Disorder Emergency Services reviews are performed by a licensed board-certified Medical Director when submitted. The intent of the review is to ensure the medical condition and/or situation meets Humana's definition of "Emergency Care" (which is aligned with the Prudent Layperson Standard). 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.

Summary Conclusions

As outlined above, Humana's written and operationalized practices for the Medical Necessity Review NQTL for Emergency Services for MH/SUD are comparable to the written and operationalized practices for Medical/Surgical. Emergency Services claims for both MH/SUD and M/S may be subject to review against Humana's Emergency Care definition (inclusive of 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 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 NQTL to Medical/Surgical in the Emergency Benefit Classification.

Current as of Dec 2023

[illegible]

Preauthorization

List of Benefits requiring Preauthorization

**Step 1: Describe the
NQTL's requirements and
associated procedures**

**Step 2: Describe the
reason for applying the
NQTL (Factors Applied)**

Step 3: Identify and describe evidentiary standards and other evidence relied upon

Step 4: Processes and strategies used to design NQTL as written

**Step 5: Processes in
implementation of NQTL
in operation**

**Step 6: Summary
conclusion of how plan
has determined overall
compliance**

Plan's Description of NQTL

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.*

Inpatient Benefits In-Network

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

Overview of Humana's Preauthorization List (PAL)

The Preauthorization List (PAL) represents services and items for which Humana requires authorization. The PAL determines which covered services identified in the member's Certificate of Coverage and Schedule of Benefits require utilization review, whether prospectively, concurrently, or retrospectively. The PAL includes Medical, Surgical, Mental Health, and Substance Use Disorder services and items. The full PAL is available on Humana's website, www.humana.com/pal. Only specific services found on the PAL require clinical review and must be reviewed by a licensed clinician.

Humana's Commercial PAL is consistent for all fully insured commercial plans.

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Humana has a PAL Core Team, which consists of representation across M/S and MH/SUD domains - Operational Leaders, Policy Researchers, and Medical Directors. See reference "PAL Core Team". The PAL Committee is responsible for reviewing and discussing clinical rationale, data analysis, and staffing /consumer impacts for proposed additions/removals of PAL services and items while applying them against a standardized set of criteria – see further details in the "Factors" and "Evidentiary Standards" sections of this document. See reference "HUM-HCO 05-013 Evaluation of PAL Additions and Removals" for specific steps and guidelines for the PAL Program.

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Medical/Surgical (M/S) Preauthorization Review Process

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The factors identified in the design and application of Prior Authorization are listed below. No factor is given more weight than another factor. Please see *"HUM-HCO 05-013 Evaluation of PAL Additions and Removals"*.

Medical/Surgical (M/S) Factors

When determining what services or items may be added or removed from Humana's PAL, the following factors are considered as part of the assessment process:

- Net Savings
- Quality of care
- Under or Over Utilization
- Cost of Episode
- New/Emerging Technology

See "Evidentiary Standards" below for further details behind each of these factors as well as reference *"HUM-HCO 05-013 Evaluation of PAL Additions and Removals"*.

Mental Health (MH)/Substance Use Disorder (SUD) Factors

When determining what services or items may be added or removed from Humana's PAL, the following factors may be considered.

- Net Savings
- Quality of care
- Under or Over Utilization
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Medical/Surgical (M/S) Evidentiary Standards

When determining what services may be added or removed from Humana's PAL, the following evidentiary standards are considered as part of the assessment process.

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 - o Gross savings minus administrative costs
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- **New/Emerging Technology:** New and emerging technologies and services are evaluated through Humana's internal Technology Assessment process and/or any qualified internal clinical area at Humana, which includes an annual evaluation of published, peer-reviewed literature and standards of care. As the result of the assessment process, a physician and/ or physician panel has determined there is insufficient evidence to support the safety and efficacy of this service for limited indications of this service. See reference "*Development and Maintenance of Humana Medical Coverage Policies*".

Humana utilizes a PAL Dashboard that provides claims and data analysis for services being reviewed for addition/removal from PAL. See Reference "*Quantitative Threshold Research*" for sources utilized to support established thresholds and factors.

Comparative Analysis - Process as Written

The factors and evidentiary standards used to develop the Prior Authorization NQTL and Humana's PAL for Inpatient In-Network are outlined above. In writing, the services requiring Prior Authorization in the Inpatient In-Network Classification are captured in Humana's PAL, found at humana.com/pal, which is a publicly available webpage for both members and providers. Humana's PAL is a singular document inclusive of both M/S and MH/SUD benefits. The PAL processes, factors, and evidentiary standards are memorialized in Humana Clinical Operations policies, which are published internally and reviewed at minimum on an annual basis. There is no variation to the Prior Authorization process as written between M/S and MH/SUD benefits. Policies are updated more frequently, as needed, based on changes to the processes and requirements. See reference "*HUM-HCO 05.013 Evaluation of PAL Additions and Removals*" for Humana's written policy regarding the PAL program.

Comparative Analysis - Process In Operation

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Summary Conclusions

As outlined in the steps above, Humana's written and operationalized practices for the Prior Authorization NQTL for MH/SUD are comparable to the written and operationalized practices for M/S. Processes, factors, and evidentiary standards used to determine which services require Prior Authorization are not differentiated between Medical/Surgical and Mental Health/Substance Use Disorder. Humana establishes a singular inclusive list of benefits requiring Prior Authorization. The processes as designed are supported by policies, procedures, and practices. This is evidenced by reference "*HUM-HCO 05-013 Evaluation of PAL Additions and Removals*".

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 PriorAuthorization NQTL than the M/S Prior Authorization NQTL. Please see "*Georgia Stringency Assessment 2023*".

This Humana Template NQTL comparative analysis is made available for informational purposes only and construed as providing legal advice. Each plan's situation can be highly fact specific and does not address a plan's situation. This analysis is on a plan by plan basis and not on the overall "book of business" of any insurer or third-party administrator. Plan specific 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 other interested parties. We require that you notify us whenever you provide a copy of this NQTL analysis pursuant to a request from a participant, beneficiary, provider, or other interested party.

Inpatient Benefits Out-Of-Network

The following benefits require authorization, per Humana's Preauthorization List (PAL)

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Medical/Surgical (M/S) Factors

When determining what services or items may be added or removed from Humana's PAL, the following factors are considered as part of the assessment process:

- Net Savings
- Quality of care
- Under or Over Utilization
- Cost of Episode
- New/Emerging Technology

See "Evidentiary Standards" below for further details behind each of these factors as well as reference *"HUM-HCO 05-013 Evaluation of PAL Additions and Removals"*.

Mental Health (MH)/Substance Use Disorder (SUD) Factors

When determining what services or items may be added or removed from Humana's PAL, the following factors may be considered.

- Net Savings
- Quality of care
- Under or Over Utilization
- Cost of Episode
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When determining what services may be added or removed from Humana's PAL, the following evidentiary standards are considered as part of the assessment process.

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Comparative Analysis - Process as Written

The factors and evidentiary standards used to develop the Prior Authorization NQTL and Humana's PAL for Inpatient Out-of-Network are outlined above. In writing, the services requiring Prior Authorization in the Inpatient Out-of-Network Classification are captured in Humana's PAL, found at humana.com/pal, which is a publicly available webpage for both members and providers. Humana's PAL is a singular document inclusive of both M/S and MH/SUD benefits. The PAL processes, factors, and evidentiary standards are memorialized in Humana Clinical Operations policies, which are published internally and reviewed at minimum on an annual basis. There is no variation to the Prior Authorization process as written between M/S and MH/SUD benefits. Policies are updated more frequently, as needed, based on changes to the processes and requirements. See reference "*HUM.HCO.05.013 Evaluation of PAL Additions and Removals*" for Humana's written policy regarding the PAL

Comparative Analysis - Process In Operation

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Summary Conclusions

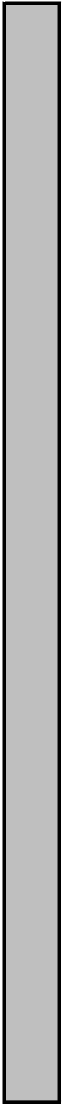
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ers some of the primary NQTLs in the Humana Plan Template. It is not intended and should not be in customizations. The federal agencies interpreting MHPAEA have emphasized that any MHPAEA nistrator/ASO. Also, NQTLs are evaluated on an “as applied” basis. Therefore, specific utilization

and governmental agencies upon request. As a condition of use of this NQTL comparative analysis, we an individual or entity. Except for such requests you are required to keep the contents of this Humana

Outpatient Benefits In-Network

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
- Chiropractic Therapy
- Diagnostic procedures
- Diagnostic and cardiac imaging
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- Durable Medical Equipment
- Home Health
- Infertility testing and treatment
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- Cost of Episode
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Mental Health (MH)/Substance Use Disorder (SUD) Factors

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Summary Conclusions

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 - o Increase in the cost of care by 5% or more over a two year period or month over month cost increase in a 12 month period.
 - o Variability in the cost per episode of a given condition when there is a demonstrated cost range greater than or equal to 30% in a 12 month claim sample
- **New/Emerging Technology:** New and emerging technologies and services are evaluated through Humana's internal Technology Assessment process and/or any qualified internal clinical area at Humana, which includes an annual evaluation of published, peer-reviewed literature and standards of care. As the result of the assessment process, a physician and/ or physician panel has determined there is insufficient evidence to support the safety and efficacy of this service for limited indications of this service. See reference "*Development and Maintenance of Humana Medical Coverage Policies*".

Humana utilizes a PAL Dashboard that provides claims and data analysis for services being reviewed for addition/removal from PAL. See Reference "*Quantitative Threshold Research*" for sources utilized to support established thresholds and factors.

Comparative Analysis - Process as Written

The factors and evidentiary standards used to develop the Prior Authorization NQTL and Humana's PAL for Outpatient Out-of-Network are outlined above. In writing, the services requiring Prior Authorization in the Outpatient Out-of-Network Classification are captured in Humana's PAL, found at humana.com/pal, which is a publicly available webpage for both members and providers. Humana's PAL is a singular document inclusive of both M/S and MH/SUD benefits. The PAL processes, factors, and evidentiary standards are memorialized in Humana Clinical Operations policies, which are published internally and reviewed at minimum on an annual basis. There is no variation to the Prior Authorization process as written between M/S and MH/SUD benefits. Policies are updated more frequently, as needed, based on changes to the processes and requirements. See reference "*HLIM HCO 05-013 Evaluation of PAL Additions and Removals*" for Humana's written policy regarding the PAL

Comparative Analysis - Process In Operation

In operation, the PAL Core Team follows the documented policy "*HUM-HCO 05-013 Evaluation of PAL Additions and Removals*" when determining PAL additions/removals. The PAL Core Team, comprised of clinical and operational leaders from across the organization, meets monthly to review and discuss clinical rationale, data analysis, and staffing /consumer impacts for proposed additions/removals. To effectuate a PAL change, Core Team representatives must agree at a rate of 80% or more. There is no variation between M/S and MH/SUD proposed additions/removals. The PAL Core Team consists of representation across M/S and MH/SUD domains - Operational Leaders, Policy Researchers, and Medical Directors. See reference titled, "*PAL Core Team*" for list of specific PAL Core Team members.

Summary Conclusions

As outlined in the steps above, Humana's written and operationalized practices for the Prior Authorization NQTL for MH/SUD are comparable to the written and operationalized practices for M/S. Processes, factors, and evidentiary standards used to determine which services require Prior Authorization are not differentiated between Medical/Surgical and Mental Health/Substance Use Disorder. Humana establishes a singular inclusive list of benefits requiring Prior Authorization. The processes as designed are supported by policies, procedures, and practices. This is evidenced by reference "*HUM-HCO 05-013 Evaluation of PAL Additions and Removals*".

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 PriorAuthorization NQTL than the M/S Prior Authorization NQTL. Please see "*Georgia Stringency Assessment 2023*".

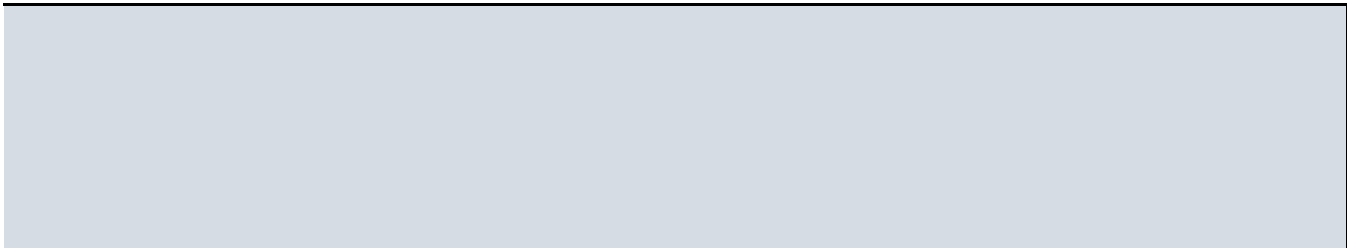












Emergency Benefits

Humana does not require Preauthorization for Emergency Services.



Humana does not require Preauthorization for Emergency Services.

Humana does not require or perform preauthorization for Emergency Services

Humana does not require or perform preauthorization for Emergency Services

Comparative Analysis - Process as Written

Humana does not require or perform preauthorization for Emergency Services

Summary Conclusions

Humana does not require or perform preauthorization for Emergency Services

Summary Conclusions

Humana does not require or perform preauthorization for Emergency Services

Current as of Dec 2023

NQTL Name
Concurrent Review
List of Benefits that may be subject to Concurrent Review

**Step 1: Describe the
NQTL's requirements and
associated procedures**

**Step 2: Describe the
reason for applying the
NQTL (Factors Applied)**

Step 3: Identify and describe evidentiary standards and other evidence relied upon

Step 4: Processes and strategies used to design NQTL as written

**Step 5: Processes in
implementation of NQTL
in operation**

**Step 6: Summary
conclusion of how plan
has determined overall
compliance**

Plan's Description of NQTL

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.*

Inpatient Benefits In-Network

The following benefits require authorization, per Humana's Preauthorization List (PAL) and could be subject to Concurrent Review:

- 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

Humana's Preauthorization List (PAL) is the driving factor as to which services/items may be subject to concurrent review.

Overview of Humana's Preauthorization List (PAL)

The Preauthorization List (PAL) represents services and items for which Humana requires authorization, including concurrent review. The PAL determines which covered services identified in the member's Certificate of Coverage and Schedule of Benefits require utilization review, whether prospectively, concurrently, or retrospectively. The PAL includes Medical, Surgical, Mental Health, and Substance Use Disorder services and items. The full PAL is available on Humana's website, www.humana.com/pal. Only specific services found on the PAL require clinical review and must be reviewed by a licensed clinician.

Humana's Commercial PAL is consistent for all fully insured commercial plans.

Humana's PAL program was developed to increase the quality of care provided for members and promote optimal treatment options and site of service, while controlling costs to the healthcare delivery system. Services identified with potential quality of care concerns, including over-utilization, under-utilization, or new/emerging technology, may be added to the PAL if the factor requirements described in steps below are met. This allows Humana to focus on improving quality of care provided to members, facilitates the receipt of appropriate services, and improves treatment decisions and health outcomes. See "*2023 Commercial UMPD*", page 13 and section titled "*Preauthorization and Notification List*".

Humana has a PAL Core Team, which consists of representation across M/S and MH/SUD domains - Operational Leaders, Policy Researchers, and Medical Directors. See reference "*PAL Core Team*". The PAL Committee is responsible for reviewing and discussing clinical rationale, data analysis, and staffing /consumer impacts for proposed additions/removals of PAL services and items while applying them against a standardized set of criteria – see further details in the "Factors" and "Evidentiary Standards" sections of this document. See reference "*HUM-HCO 05-013 Evaluation of PAL Additions and Removals*" for specific steps and guidelines for the PAL Program.

Humana's participating (contracted) providers are alerted of PAL additions or removals prior to implementation.

Medical/Surgical (M/S) Concurrent Review Process

Humana conducts a concurrent review when a member or provider submits a request for a service or item that

Factors driving initiation of concurrent review

The factors identified in the design and application of Concurrent Review are listed below. No factor is given more weight than another factor. Please see "*HUM-HCO 05-013 Evaluation of PAL Additions and Removals*".

Medical/Surgical (M/S) Factors

As noted above, Humana's Preauthorization List (PAL) is the driving factor as to which services/items may be subject to concurrent review. The services requiring authorization, per Humana's PAL, are listed above. Therefore, the factors driving initiation of concurrent review are the same as prior authorization and retrospective review:

- Net Savings
- Quality of care
- Under or Over Utilization
- Cost of Episode
- New/Emerging Technology

See "Evidentiary Standards" below for further details behind each of these factors as well as reference "*HUM-HCO 05-013 Evaluation of PAL Additions and Removals*".

Mental Health (MH)/Substance Use Disorder (SUD) Factors

As noted above, Humana's Preauthorization List (PAL) is the driving factor as to which services/items may be subject to concurrent review. The services requiring authorization, per Humana's PAL, are listed above. Therefore, the factors driving initiation of concurrent review are the same as prior authorization and retrospective review:

- Net Savings
- Quality of care
- Under or Over Utilization
- Cost of Episode
- New/Emerging Technology

See "Evidentiary Standards" below for further details behind each of these factors as well as reference "*HUM-*

Medical/Surgical (M/S) Evidentiary Standards

Evidentiary Standards driving initiation of concurrent review

As noted above, Humana's Preauthorization List (PAL) is the driving factor as to which services/items may be subject to concurrent review. The services requiring authorization, per Humana's PAL, are listed above. Therefore, the evidentiary standards driving the initiation of concurrent review are the same as prior authorization and retrospective review:

- Net Savings
 - o Gross savings minus administrative costs
- Quality Of Care:
 - o Adverse event (AE) (any untoward medical occurrence) in a selection of individuals for procedures/services identified in at least 10% of the episodes in a 12 month data sample.
 - o Greater than or equal to 10% of the episodes for a specific disease/condition do not appear from data to be performed based on evidence based standard in a 12 month sample of data
- Under or Over Utilization:
 - o Utilization is equal of greater than 5% above average/expected utilization as indicated by clinical literature or Humana claim research.
 - o Utilization is equal to or less than 5% below average/expected utilization as indicated by clinical literature or Humana claim research, or specific pathways are not being followed at least 5% of the time as identified in at least 3 months of claims data
- Cost of Episode:
 - o Increase in the cost of care by 5% or more over a two year period or month over month cost increase in a 12 month period.
 - o Variability in the cost per episode of a given condition when there is a demonstrated cost range greater than or equal to 30% in a 12 month claim sample
- New/Emerging Technology: New and emerging technologies and services are evaluated through Humana's internal Technology Assessment process and/or any qualified internal clinical area at Humana, which includes an annual evaluation of published, peer-reviewed literature and standards of care. As the result of the assessment process, a physician and/ or physician panel has determined there is insufficient evidence to support the safety and efficacy of this service for limited indications of this service. See reference "*Development and Maintenance of Humana Medical Coverage Policies*".

Comparative Analysis - Process as Written

The factors and evidentiary standards used to develop the Concurrent Review NQTL are outlined above. In writing, the services requiring authorization, including concurrent review, in the Inpatient In-Network Classification are captured in Humana's PAL, found at humana.com/pal, which is a publicly available webpage for both members and providers. Humana's PAL is a singular document inclusive of both M/S and MH/SUD benefits. The PAL processes, factors, and evidentiary standards are memorialized in Humana Clinical Operations policies, which are published internally and reviewed at minimum on an annual basis. There is no variation to the concurrent review process as written between M/S and MH/SUD benefits. Policies are updated more frequently, as needed, based on changes to the processes and requirements. See reference "*HUM-HCO 05-013 Evaluation of PAL Additions and Removals*" for Humana's written policy regarding the PAL program.

Comparative Analysis - Process in Operation

In operation, the PAL Core Team, follows the documented policy "*HUM-HCO 05-013 Evaluation of PAL Additions and Removals*" when determining PAL additions/removals. The PAL Core Team, comprised of clinical and operational leaders from across the organization, meets monthly to review and discuss clinical rationale, data analysis, and staffing /consumer impacts for proposed additions/removals. To effectuate a PAL change, Core Team representatives must agree at a rate of 80% or more. There is no variation between M/S and MH/SUD proposed additions/removals. The PAL Core Team consists of representation across M/S and MH/SUD domains - Operational Leaders, Policy Researchers, and Medical Directors. See reference titled, "*PAL Core Team*" for list of specific PAL Core Team members.

Step 1 above provides details as to how benefits are identified for clinical review (including concurrent review), the type of associate performing the review and qualifications needed. Timely notifications of determinations are completed within state and federal requirements. These details of operation are consistent across M/S and

Summary Conclusions

As outlined in the steps above, Humana's written and operationalized practices for the Concurrent Review NQTL for MH/SUD are comparable to the written and operationalized practices for M/S. Processes, factors, and evidentiary standards used to determine which services require concurrent review are not differentiated between Medical/Surgical and Mental Health/Substance Use Disorder. Humana establishes a singular inclusive list of benefits requiring authorization, including concurrent review. The processes as designed are supported by policies, procedures, and practices. This is evidenced by reference "*HUM-HCO 05-013 Evaluation of PAL Additions and Removals*".

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. Please see "*Georgia Stringency Assessment 2023*".

This Humana Template NQTL comparative analysis is made available for informational purposes only and customizations. The federal agencies interpreting MHPAEA have emphasized that any MHPAEA analysis is 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, or such an individual or entity. Except for such requests you are required to keep the contents of this Humana

Inpatient Benefits Out-Of-Network

The following benefits require authorization, per Humana's Preauthorization List (PAL) and could be subject to Concurrent Review:

- 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

Humana's Preauthorization List (PAL) is the driving factor as to which services/items may be subject to concurrent review.

Overview of Humana's Preauthorization List (PAL)

The Preauthorization List (PAL) represents services and items for which Humana requires authorization, including concurrent review. The PAL determines which covered services identified in the member's Certificate of Coverage and Schedule of Benefits require utilization review, whether prospectively, concurrently, or retrospectively. The PAL includes Medical, Surgical, Mental Health, and Substance Use Disorder services and items. The full PAL is available on Humana's website, www.humana.com/pal. Only specific services found on the PAL require clinical review and must be reviewed by a licensed clinician.

Humana's Commercial PAL is consistent for all fully insured commercial plans.

Humana's PAL program was developed to increase the quality of care provided for members and promote optimal treatment options and site of service, while controlling costs to the healthcare delivery system. Services identified with potential quality of care concerns, including over-utilization, under-utilization, or new/emerging technology, may be added to the PAL if the factor requirements described in steps below are met. This allows Humana to focus on improving quality of care provided to members, facilitates the receipt of appropriate services, and improves treatment decisions and health outcomes. See "*2023 Commercial UMPD*", page 13 and section titled "*Preauthorization and Notification List*".

Humana has a PAL Core Team, which consists of representation across M/S and MH/SUD domains - Operational Leaders, Policy Researchers, and Medical Directors. See reference "*PAL Core Team*". The PAL Committee is responsible for reviewing and discussing clinical rationale, data analysis, and staffing /consumer impacts for proposed additions/removals of PAL services and items while applying them against a standardized set of criteria – see further details in the "Factors" and "Evidentiary Standards" sections of this document. See reference "*HUM-HCO 05-013 Evaluation of PAL Additions and Removals*" for specific steps and guidelines for the PAL Program.

Humana's participating (contracted) providers are alerted of PAL additions or removals prior to implementation.

Medical/Surgical (M/S) Concurrent Review Process

Humana conducts a concurrent review when a member or provider submits a request for a service or item that

Factors driving initiation of concurrent review

The factors identified in the design and application of Concurrent Review are listed below. No factor is given more weight than another factor. Please see "*HUM-HCO 05-013 Evaluation of PAL Additions and Removals*".

Medical/Surgical (M/S) Factors

As noted above, Humana's Preauthorization List (PAL) is the driving factor as to which services/items may be subject to concurrent review. The services requiring authorization, per Humana's PAL, are listed above. Therefore, the factors driving initiation of concurrent review are the same as prior authorization and retrospective review:

- Net Savings
- Quality of care
- Under or Over Utilization
- Cost of Episode
- New/Emerging Technology

See "Evidentiary Standards" below for further details behind each of these factors as well as reference "*HUM-HCO 05-013 Evaluation of PAL Additions and Removals*".

Mental Health (MH)/Substance Use Disorder (SUD) Factors

As noted above, Humana's Preauthorization List (PAL) is the driving factor as to which services/items may be subject to concurrent review. The services requiring authorization, per Humana's PAL, are listed above. Therefore, the factors driving initiation of concurrent review are the same as prior authorization and retrospective review:

- Net Savings
- Quality of care
- Under or Over Utilization
- Cost of Episode
- New/Emerging Technology

See "Evidentiary Standards" below for further details behind each of these factors as well as reference "*HUM-*

Medical/Surgical (M/S) Evidentiary Standards

Evidentiary Standards driving initiation of concurrent review

As noted above, Humana's Preauthorization List (PAL) is the driving factor as to which services/items may be subject to concurrent review. The services requiring authorization, per Humana's PAL, are listed above. Therefore, the evidentiary standards driving the initiation of concurrent review are the same as prior authorization and retrospective review:

- Net Savings
 - o Gross savings minus administrative costs
- Quality Of Care:
 - o Adverse event (AE) (any untoward medical occurrence) in a selection of individuals for procedures/services identified in at least 10% of the episodes in a 12 month data sample.
 - o Greater than or equal to 10% of the episodes for a specific disease/condition do not appear from data to be performed based on evidence based standard in a 12 month sample of data
- Under or Over Utilization:
 - o Utilization is equal of greater than 5% above average/expected utilization as indicated by clinical literature or Humana claim research.
 - o Utilization is equal to or less than 5% below average/expected utilization as indicated by clinical literature or Humana claim research, or specific pathways are not being followed at least 5% of the time as identified in at least 3 months of claims data
- Cost of Episode:
 - o Increase in the cost of care by 5% or more over a two year period or month over month cost increase in a 12 month period.
 - o Variability in the cost per episode of a given condition when there is a demonstrated cost range greater than or equal to 30% in a 12 month claim sample
- New/Emerging Technology: New and emerging technologies and services are evaluated through Humana's internal Technology Assessment process and/or any qualified internal clinical area at Humana, which includes an annual evaluation of published, peer-reviewed literature and standards of care. As the result of the assessment process, a physician and/ or physician panel has determined there is insufficient evidence to support the safety and efficacy of this service for limited indications of this service. See reference "*Development and Maintenance of Humana Medical Coverage Policies*".

Comparative Analysis - Process as Written

The factors and evidentiary standards used to develop the Concurrent Review NQTL are outlined above. In writing, the services requiring authorization, including concurrent review, in the Inpatient Out-of-Network Classification are captured in Humana's PAL, found at humana.com/pal, which is a publicly available webpage for both members and providers. Humana's PAL is a singular document inclusive of both M/S and MH/SUD benefits. The PAL processes, factors, and evidentiary standards are memorialized in Humana Clinical Operations policies, which are published internally and reviewed at minimum on an annual basis. There is no variation to the concurrent review process as written between M/S and MH/SUD benefits. Policies are updated more frequently, as needed, based on changes to the processes and requirements. See reference "*HUM-HCO 05-013 Evaluation of PAL Additions and Removals*" for Humana's written policy regarding the PAL program.

Comparative Analysis - Process in Operation

In operation, the PAL Core Team, follows the documented policy "*HUM-HCO 05-013 Evaluation of PAL Additions and Removals*" when determining PAL additions/removals. The PAL Core Team, comprised of clinical and operational leaders from across the organization, meets monthly to review and discuss clinical rationale, data analysis, and staffing /consumer impacts for proposed additions/removals. To effectuate a PAL change, Core Team representatives must agree at a rate of 80% or more. There is no variation between M/S and MH/SUD proposed additions/removals. The PAL Core Team consists of representation across M/S and MH/SUD domains - Operational Leaders, Policy Researchers, and Medical Directors. See reference titled, "*PAL Core Team*" for list of specific PAL Core Team members.

Step 1 above provides details as to how benefits are identified for clinical review (including concurrent review), the type of associate performing the review and qualifications needed. Timely notifications of determinations are completed within state and federal requirements. These details of operation are consistent across M/S and

Summary Conclusions

As outlined in the steps above, Humana's written and operationalized practices for the Concurrent Review NQTL for MH/SUD are comparable to the written and operationalized practices for M/S. Processes, factors, and evidentiary standards used to determine which services require concurrent review are not differentiated between Medical/Surgical and Mental Health/Substance Use Disorder. Humana establishes a singular inclusive list of benefits requiring authorization, including concurrent review. The processes as designed are supported by policies, procedures, and practices. This is evidenced by reference "*HUM-HCO 05-013 Evaluation of PAL Additions and Removals*".

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. Please see "*Georgia Stringency Assessment 2023*".

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ers some of the primary NQTLs in the Humana Plan Template. It is not intended and should not be construed as a plan by plan basis and not on the overall “book of business” of any insurer or third-party administrator/A

and governmental agencies upon request. As a condition of use of this NQTL comparative analysis, we re
emplate NQTL comparative analysis confidential as it is the proprietary information of Humana.

Outpatient Benefits In-Network

The following benefits require authorization, per Humana’s Preauthorization List (PAL), www.humana.com/pal and could be subject to Concurrent Review:

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
- Chiropractic Therapy
- Diagnostic procedures
- Diagnostic and cardiac imaging
- 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's Preauthorization List (PAL) is the driving factor as to which services/items may be subject to concurrent review.

Overview of Humana's Preauthorization List (PAL)

The Preauthorization List (PAL) represents services and items for which Humana requires authorization, including concurrent review. The PAL determines which covered services identified in the member's Certificate of Coverage and Schedule of Benefits require utilization review, whether prospectively, concurrently, or retrospectively. The PAL includes Medical, Surgical, Mental Health, and Substance Use Disorder services and items. The full PAL is available on Humana's website, www.humana.com/pal. Only specific services found on the PAL require clinical review and must be reviewed by a licensed clinician.

Humana's Commercial PAL is consistent for all fully insured commercial plans.

Humana's PAL program was developed to increase the quality of care provided for members and promote optimal treatment options and site of service, while controlling costs to the healthcare delivery system. Services identified with potential quality of care concerns, including over-utilization, under-utilization, or new/emerging technology, may be added to the PAL if the factor requirements described in steps below are met. This allows Humana to focus on improving quality of care provided to members, facilitates the receipt of appropriate services, and improves treatment decisions and health outcomes. See *"2023 Commercial UMPD"*, page 13 and section titled *"Preauthorization and Notification List"*.

Humana has a PAL Core Team, which consists of representation across M/S and MH/SUD domains - Operational Leaders, Policy Researchers, and Medical Directors. See reference *"PAL Core Team"*. The PAL Committee is responsible for reviewing and discussing clinical rationale, data analysis, and staffing /consumer impacts for proposed additions/removals of PAL services and items while applying them against a standardized set of criteria – see further details in the "Factors" and "Evidentiary Standards" sections of this document. See reference *"HUM-HCO 05-013 Evaluation of PAL Additions and Removals"* for specific steps and guidelines for the PAL Program.

Humana's participating (contracted) providers are alerted of PAL additions or removals prior to implementation.

Medical/Surgical (M/S) Concurrent Review Process

Factors driving initiation of concurrent review

The factors identified in the design and application of Concurrent Review are listed below. No factor is given more weight than another factor. Please see “*HUM-HCO 05-013 Evaluation of PAL Additions and Removals*”.

Medical/Surgical (M/S) Factors

As noted above, Humana's Preauthorization List (PAL) is the driving factor as to which services/items may be subject to concurrent review. The services requiring authorization, per Humana's PAL, are listed above. Therefore, the factors driving initiation of concurrent review are the same as prior authorization and retrospective review:

- Net Savings
- Quality of care
- Under or Over Utilization
- Cost of Episode
- New/Emerging Technology

See “Evidentiary Standards” below for further details behind each of these factors as well as reference “*HUM-HCO 05-013 Evaluation of PAL Additions and Removals*”.

Mental Health (MH)/Substance Use Disorder (SUD) Factors

As noted above, Humana's Preauthorization List (PAL) is the driving factor as to which services/items may be subject to concurrent review. The services requiring authorization, per Humana's PAL, are listed above. Therefore, the factors driving initiation of concurrent review are the same as prior authorization and retrospective review:

- Net Savings
- Quality of care
- Under or Over Utilization
- Cost of Episode
- New/Emerging Technology

See “Evidentiary Standards” below for further details behind each of these factors as well as reference “*HUM-*

Medical/Surgical (M/S) Evidentiary Standards

Evidentiary Standards driving initiation of concurrent review

As noted above, Humana's Preauthorization List (PAL) is the driving factor as to which services/items may be subject to concurrent review. The services requiring authorization, per Humana's PAL, are listed above. Therefore, the evidentiary standards driving the initiation of concurrent review are the same as prior authorization and retrospective review:

- Net Savings
 - Gross savings minus administrative costs
- Quality Of Care:
 - Adverse event (AE) (any untoward medical occurrence) in a selection of individuals for procedures/services identified in at least 10% of the episodes in a 12 month data sample.
 - Greater than or equal to 10% of the episodes for a specific disease/condition do not appear from data to be performed based on evidence based standard in a 12 month sample of data
- Under or Over Utilization:
 - Utilization is equal or greater than 5% above average/expected utilization as indicated by clinical literature or Humana claim research.
 - Utilization is equal to or less than 5% below average/expected utilization as indicated by clinical literature or Humana claim research, or specific pathways are not being followed at least 5% of the time as identified in at least 3 months of claims data
- Cost of Episode:
 - Increase in the cost of care by 5% or more over a two year period or month over month cost increase in a 12 month period.
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- New/Emerging Technology: New and emerging technologies and services are evaluated through Humana's internal Technology Assessment process and/or any qualified internal clinical area at Humana, which includes an annual evaluation of published, peer-reviewed literature and standards of care. As the result of the assessment process, a physician and/ or physician panel has determined there is insufficient evidence to support the safety and efficacy of this service for limited indications of this service. See reference "*Development and Maintenance of Humana Medical Coverage Policies*".

Comparative Analysis - Process as Written

The factors and evidentiary standards used to develop the Concurrent Review NQTL are outlined above. In writing, the services requiring authorization, including concurrent review, in the Outpatient In-Network Classification are captured in Humana's PAL, found at humana.com/pal, which is a publicly available webpage for both members and providers. Humana's PAL is a singular document inclusive of both M/S and MH/SUD benefits. The PAL processes, factors, and evidentiary standards are memorialized in Humana Clinical Operations policies, which are published internally and reviewed at minimum on an annual basis. There is no variation to the concurrent review process as written between M/S and MH/SUD benefits. Policies are updated more frequently, as needed, based on changes to the processes and requirements. See reference "*HUM-HCO 05-013 Evaluation of PAL Additions and Removals*" for Humana's written policy regarding the PAL program.

Comparative Analysis - Process in Operation

In operation, the PAL Core Team, follows the documented policy "*HUM-HCO 05-013 Evaluation of PAL Additions and Removals*" when determining PAL additions/removals. The PAL Core Team, comprised of clinical and operational leaders from across the organization, meets monthly to review and discuss clinical rationale, data analysis, and staffing /consumer impacts for proposed additions/removals. To effectuate a PAL change, Core Team representatives must agree at a rate of 80% or more. There is no variation between M/S and MH/SUD proposed additions/removals. The PAL Core Team consists of representation across M/S and MH/SUD domains - Operational Leaders, Policy Researchers, and Medical Directors. See reference titled, "*PAL Core Team*" for list of specific PAL Core Team members.

Step 1 above provides details as to how benefits are identified for clinical review (including concurrent review), the type of associate performing the review and qualifications needed. Timely notifications of determinations are completed within state and federal requirements. These details of operation are consistent across M/S and

Summary Conclusions

As outlined in the steps above, Humana's written and operationalized practices for the Concurrent Review NQTL for MH/SUD are comparable to the written and operationalized practices for M/S. Processes, factors, and evidentiary standards used to determine which services require concurrent review are not differentiated between Medical/Surgical and Mental Health/Substance Use Disorder. Humana establishes a singular inclusive list of benefits requiring authorization, including concurrent review. The processes as designed are supported by policies, procedures, and practices. This is evidenced by reference "*HUM-HCO 05-013 Evaluation of PAL Additions and Removals*".

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. Please see "*Georgia Stringency Assessment 2023*".

ed as providing legal advice. Each plan's situation can be highly fact specific and does not address plan SO. Also, NQTLs are evaluated on an "as applied" basis. Therefore, specific utilization abnormalities

require that you notify us whenever you provide a copy of this NQTL analysis pursuant to a request from

Outpatient Benefits Out-Of-Network

The following benefits require authorization, per Humana's Preauthorization List (PAL), www.humana.com/pal and could be subject to Concurrent Review:

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
- Chiropractic Therapy
- Diagnostic procedures
- Diagnostic and cardiac imaging
- 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's Preauthorization List (PAL) is the driving factor as to which services/items may be subject to concurrent review.

Overview of Humana's Preauthorization List (PAL)

The Preauthorization List (PAL) represents services and items for which Humana requires authorization, including concurrent review. The PAL determines which covered services identified in the member's Certificate of Coverage and Schedule of Benefits require utilization review, whether prospectively, concurrently, or retrospectively. The PAL includes Medical, Surgical, Mental Health, and Substance Use Disorder services and items. The full PAL is available on Humana's website, www.humana.com/pal. Only specific services found on the PAL require clinical review and must be reviewed by a licensed clinician.

Humana's Commercial PAL is consistent for all fully insured commercial plans.

Humana's PAL program was developed to increase the quality of care provided for members and promote optimal treatment options and site of service, while controlling costs to the healthcare delivery system. Services identified with potential quality of care concerns, including over-utilization, under-utilization, or new/emerging technology, may be added to the PAL if the factor requirements described in steps below are met. This allows Humana to focus on improving quality of care provided to members, facilitates the receipt of appropriate services, and improves treatment decisions and health outcomes. See "*2023 Commercial UMPD*", page 13 and section titled "*Preauthorization and Notification List*".

Humana has a PAL Core Team, which consists of representation across M/S and MH/SUD domains - Operational Leaders, Policy Researchers, and Medical Directors. See reference "*PAL Core Team*". The PAL Committee is responsible for reviewing and discussing clinical rationale, data analysis, and staffing /consumer impacts for proposed additions/removals of PAL services and items while applying them against a standardized set of criteria – see further details in the "Factors" and "Evidentiary Standards" sections of this document. See reference "*HUM-HCO 05-013 Evaluation of PAL Additions and Removals*" for specific steps and guidelines for the PAL Program.

Humana's participating (contracted) providers are alerted of PAL additions or removals prior to implementation.

Medical/Surgical (M/S) Concurrent Review Process

Factors driving initiation of concurrent review

The factors identified in the design and application of Concurrent Review are listed below. No factor is given more weight than another factor. Please see “*HUM-HCO 05-013 Evaluation of PAL Additions and Removals*”.

Medical/Surgical (M/S) Factors

As noted above, Humana's Preauthorization List (PAL) is the driving factor as to which services/items may be subject to concurrent review. The services requiring authorization, per Humana's PAL, are listed above. Therefore, the factors driving initiation of concurrent review are the same as prior authorization and retrospective review:

- Net Savings
- Quality of care
- Under or Over Utilization
- Cost of Episode
- New/Emerging Technology

See “Evidentiary Standards” below for further details behind each of these factors as well as reference “*HUM-HCO 05-013 Evaluation of PAL Additions and Removals*”.

Mental Health (MH)/Substance Use Disorder (SUD) Factors

As noted above, Humana's Preauthorization List (PAL) is the driving factor as to which services/items may be subject to concurrent review. The services requiring authorization, per Humana's PAL, are listed above. Therefore, the factors driving initiation of concurrent review are the same as prior authorization and retrospective review:

- Net Savings
- Quality of care
- Under or Over Utilization
- Cost of Episode
- New/Emerging Technology

Medical/Surgical (M/S) Evidentiary Standards

Evidentiary Standards driving initiation of concurrent review

As noted above, Humana's Preauthorization List (PAL) is the driving factor as to which services/items may be subject to concurrent review. The services requiring authorization, per Humana's PAL, are listed above. Therefore, the evidentiary standards driving the initiation of concurrent review are the same as prior authorization and retrospective review:

- Net Savings
 - Gross savings minus administrative costs
- Quality Of Care:
 - Adverse event (AE) (any untoward medical occurrence) in a selection of individuals for procedures/services identified in at least 10% of the episodes in a 12 month data sample.
 - Greater than or equal to 10% of the episodes for a specific disease/condition do not appear from data to be performed based on evidence based standard in a 12 month sample of data
- Under or Over Utilization:
 - Utilization is equal or greater than 5% above average/expected utilization as indicated by clinical literature or Humana claim research.
 - Utilization is equal to or less than 5% below average/expected utilization as indicated by clinical literature or Humana claim research, or specific pathways are not being followed at least 5% of the time as identified in at least 3 months of claims data
- Cost of Episode:
 - Increase in the cost of care by 5% or more over a two year period or month over month cost increase in a 12 month period.
 - Variability in the cost per episode of a given condition when there is a demonstrated cost range greater than or equal to 30% in a 12 month claim sample
- New/Emerging Technology: New and emerging technologies and services are evaluated through Humana's internal Technology Assessment process and/or any qualified internal clinical area at Humana, which includes an annual evaluation of published, peer-reviewed literature and standards of care. As the result of the assessment process, a physician and/ or physician panel has determined there is insufficient evidence to support the safety and efficacy of this service for limited indications of this service. See reference "*Development and Maintenance of Humana Medical Coverage Policies*".

Comparative Analysis - Process as Written

The factors and evidentiary standards used to develop the Concurrent Review NQTL are outlined above. In writing, the services requiring authorization, including concurrent review, in the Outpatient Out-of-Network Classification are captured in Humana's PAL, found at humana.com/pal, which is a publicly available webpage for both members and providers. Humana's PAL is a singular document inclusive of both M/S and MH/SUD benefits. The PAL processes, factors, and evidentiary standards are memorialized in Humana Clinical Operations policies, which are published internally and reviewed at minimum on an annual basis. There is no variation to the concurrent review process as written between M/S and MH/SUD benefits. Policies are updated more frequently, as needed, based on changes to the processes and requirements. See reference "*HUM-HCO 05-013 Evaluation of PAL Additions and Removals*" for Humana's written policy regarding the PAL program.

Comparative Analysis - Process in Operation

In operation, the PAL Core Team, follows the documented policy "*HUM-HCO 05-013 Evaluation of PAL Additions and Removals*" when determining PAL additions/removals. The PAL Core Team, comprised of clinical and operational leaders from across the organization, meets monthly to review and discuss clinical rationale, data analysis, and staffing /consumer impacts for proposed additions/removals. To effectuate a PAL change, Core Team representatives must agree at a rate of 80% or more. There is no variation between M/S and MH/SUD proposed additions/removals. The PAL Core Team consists of representation across M/S and MH/SUD domains - Operational Leaders, Policy Researchers, and Medical Directors. See reference titled, "*PAL Core Team*" for list of specific PAL Core Team members.

Step 1 above provides details as to how benefits are identified for clinical review (including concurrent review), the type of associate performing the review and qualifications needed. Timely notifications of determinations are completed within state and federal requirements. These details of operation are consistent across M/S and

Summary Conclusions

As outlined in the steps above, Humana's written and operationalized practices for the Concurrent Review NQTL for MH/SUD are comparable to the written and operationalized practices for M/S. Processes, factors, and evidentiary standards used to determine which services require concurrent review are not differentiated between Medical/Surgical and Mental Health/Substance Use Disorder. Humana establishes a singular inclusive list of benefits requiring authorization, including concurrent review. The processes as designed are supported by policies, procedures, and practices. This is evidenced by reference "*HUM-HCO 05-013 Evaluation of PAL Additions and Removals*".

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. Please see "*Georgia Stringency Assessment 2023*".











Emergency Benefits	
Humana does not perform concurrent review for Emergency Services.	

Humana does not perform concurrent review for Emergency Services.

Humana does not perform concurrent review for Emergency Services.

Humana does not perform concurrent review for Emergency Services.

Comparative Analysis - Process as Written

Humana does not perform concurrent review for Emergency Services.

Comparative Analysis - Process in Operation

Humana does not perform concurrent review for Emergency Services.

Summary Conclusions

Humana does not perform concurrent review for Emergency Services.

Current as of Dec 2023

NQTL Name
<p>Retrospective Review</p>
<p>List of Benefits that may be subject to Retrospective Review</p>

**Step 1: Describe the
NQTL's requirements and
associated procedures**

**Step 2: Describe the
reason for applying the
NQTL (Factors Applied)**

Step 3: Identify and describe evidentiary standards and other evidence relied upon

Step 4: Processes and strategies used to design NQTL as written

**Step 5: Processes in
implementation of NQTL
in operation**

**Step 6: Summary
conclusion of how plan
has determined overall
compliance**

Plan's Description of NQTL

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.*

Inpatient Benefits In-Network

The following benefits require authorization, per Humana's Preauthorization List (PAL) and could be subject to Retrospective Review:

- 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

Humana's Preauthorization List (PAL) is the driving factor as to which services/items may be subject to retrospective review.

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Factors driving initiation of retrospective review

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- Net Savings
- Quality of care
- Under or Over Utilization
- Cost of Episode
- New/Emerging Technology

See "Evidentiary Standards" below for further details behind each of these factors as well as reference "*HUM-HCO 05-013 Evaluation of PAL Additions and Removals*".

Mental Health (MH)/Substance Use Disorder (SUD) Factors

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Medical/Surgical (M/S) Evidentiary Standards

Evidentiary Standards driving initiation of retrospective review

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Comparative Analysis - Process as Written

The factors and evidentiary standards used to develop the retrospective Review NQTL are outlined above. In writing, the services requiring authorization, including retrospective review, in the Inpatient In-Network Classification are captured in Humana's PAL, found at humana.com/pal, which is a publicly available webpage for both members and providers. Humana's PAL is a singular document inclusive of both M/S and MH/SUD benefits. The PAL processes, factors, and evidentiary standards are memorialized in Humana Clinical Operations policies, which are published internally and reviewed at minimum on an annual basis. There is no variation to the

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Step 1 above provides details as to how benefits are identified for clinical review (including retrospective review), the type of associate performing the review and qualifications needed. Timely notifications of determinations are completed within state and federal requirements. These details of operation are consistent across M/S and

Summary Conclusions

As outlined in the steps above, Humana's written and operationalized practices for the Retrospective Review NQTL for MH/SUD are comparable to the written and operationalized practices for M/S. Processes, factors, and evidentiary standards used to determine which services require retrospective review are not differentiated between Medical/Surgical and Mental Health/Substance Use Disorder. Humana establishes a singular inclusive list of benefits requiring authorization, including retrospective review. The processes as designed are supported by policies, procedures, and practices. This is evidenced by reference "*HUM-HCO 05-013 Evaluation of PAL Additions and Removals*".

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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

This Humana Template NQTL comparative analysis is made available for informational purposes only and customizations. The federal agencies interpreting MHPAEA have emphasized that any MHPAEA analysis is 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, or such an individual or entity. Except for such requests you are required to keep the contents of this Humana

Inpatient Benefits Out-Of-Network

The following benefits require authorization, per Humana's Preauthorization List (PAL) and could be subject to Retrospective Review:

- 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

Humana's Preauthorization List (PAL) is the driving factor as to which services/items may be subject to retrospective review.

Overview of Humana's Preauthorization List (PAL)

The Preauthorization List (PAL) represents services and items for which Humana requires authorization, including retrospective review. The PAL determines which covered services identified in the member's Certificate of Coverage and Schedule of Benefits require utilization review, whether prospectively, concurrently, or retrospectively. The PAL includes Medical, Surgical, Mental Health, and Substance Use Disorder services and items. The full PAL is available on Humana's website, www.humana.com/pal. Only specific services found on the PAL require clinical review and must be reviewed by a licensed clinician.

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Factors driving initiation of retrospective review

The factors identified in the design and application of retrospective Review are listed below. No factor is given more weight than another factor. Please see “*HUM-HCO 05-013 Evaluation of PAL Additions and Removals*”.

Medical/Surgical (M/S) Factors

As noted above, Humana's Preauthorization List (PAL) is the driving factor as to which services/items may be subject to retrospective review. The services requiring authorization, per Humana's PAL, are listed above. Therefore, the factors driving initiation of retrospective review are the same as prior authorization and concurrent review:

- Net Savings
- Quality of care
- Under or Over Utilization
- Cost of Episode
- New/Emerging Technology

See “Evidentiary Standards” below for further details behind each of these factors as well as reference “*HUM-HCO 05-013 Evaluation of PAL Additions and Removals*”.

Mental Health (MH)/Substance Use Disorder (SUD) Factors

As noted above, Humana's Preauthorization List (PAL) is the driving factor as to which services/items may be subject to retrospective review. The services requiring authorization, per Humana's PAL, are listed above. Therefore, the factors driving initiation of retrospective review are the same as prior authorization and concurrent review:

- Net Savings
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- Cost of Episode
- New/Emerging Technology

See “Evidentiary Standards” below for further details behind each of these factors as well as reference “*HUM-*

Medical/Surgical (M/S) Evidentiary Standards

Evidentiary Standards driving initiation of retrospective review

As noted above, Humana's Preauthorization List (PAL) is the driving factor as to which services/items may be subject to retrospective review. The services requiring authorization, per Humana's PAL, are listed above. Therefore, the evidentiary standards driving the initiation of retrospective review are the same as prior authorization and concurrent review:

- Net Savings
 - o Gross savings minus administrative costs
- Quality Of Care:
 - o Adverse event (AE) (any untoward medical occurrence) in a selection of individuals for procedures/services identified in at least 10% of the episodes in a 12 month data sample.
 - o Greater than or equal to 10% of the episodes for a specific disease/condition do not appear from data to be performed based on evidence based standard in a 12 month sample of data
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 - o Utilization is equal or greater than 5% above average/expected utilization as indicated by clinical literature or Humana claim research.
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Comparative Analysis - Process as Written

The factors and evidentiary standards used to develop the retrospective Review NQTL are outlined above. In writing, the services requiring authorization, including retrospective review, in the Inpatient Out-of-Network Classification are captured in Humana's PAL, found at humana.com/pal, which is a publicly available webpage for both members and providers. Humana's PAL is a singular document inclusive of both M/S and MH/SUD benefits. The PAL processes, factors, and evidentiary standards are memorialized in Humana Clinical Operations policies, which are published internally and reviewed at minimum on an annual basis. There is no variation to the

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Step 1 above provides details as to how benefits are identified for clinical review (including retrospective review), the type of associate performing the review and qualifications needed. Timely notifications of determinations are completed within state and federal requirements. These details of operation are consistent across M/S and

Summary Conclusions

As outlined in the steps above, Humana's written and operationalized practices for the Retrospective Review NQTL for MH/SUD are comparable to the written and operationalized practices for M/S. Processes, factors, and evidentiary standards used to determine which services require retrospective review are not differentiated between Medical/Surgical and Mental Health/Substance Use Disorder. Humana establishes a singular inclusive list of benefits requiring authorization, including retrospective review. The processes as designed are supported by policies, procedures, and practices. This is evidenced by reference "*HUM-HCO 05-013 Evaluation of PAL Additions and Removals*".

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. Please see "*Georgia Stringency Assessment 2023*".

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

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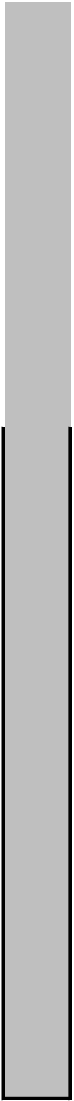
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rs some of the primary NQTLs in the Humana Plan Template. It is not intended and should not be construed as a plan by plan basis and not on the overall “book of business” of any insurer or third-party administrator/AS

and governmental agencies upon request. As a condition of use of this NQTL comparative analysis, we request that the NQTL comparative analysis be kept confidential as it is the proprietary information of Humana.

Outpatient Benefits In-Network

The following benefits require authorization, per Humana's Preauthorization List (PAL), www.humana.com/pal and could be subject to Retrospective Review:

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
- Chiropractic Therapy
- Diagnostic procedures
- Diagnostic and cardiac imaging
- Pain management procedures
- Durable Medical Equipment
- Home Health
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The factors identified in the design and application of retrospective Review are listed below. No factor is given more weight than another factor. Please see "*HUM-HCO 05-013 Evaluation of PAL Additions and Removals*".

Medical/Surgical (M/S) Factors

As noted above, Humana's Preauthorization List (PAL) is the driving factor as to which services/items may be subject to retrospective review. The services requiring authorization, per Humana's PAL, are listed above. Therefore, the factors driving initiation of retrospective review are the same as prior authorization and concurrent review:

- Net Savings
- Quality of care
- Under or Over Utilization
- Cost of Episode
- New/Emerging Technology

See "Evidentiary Standards" below for further details behind each of these factors as well as reference "*HUM-HCO 05-013 Evaluation of PAL Additions and Removals*".

Mental Health (MH)/Substance Use Disorder (SUD) Factors

As noted above, Humana's Preauthorization List (PAL) is the driving factor as to which services/items may be subject to retrospective review. The services requiring authorization, per Humana's PAL, are listed above. Therefore, the factors driving initiation of retrospective review are the same as prior authorization and concurrent review:

- Net Savings
- Quality of care
- Under or Over Utilization
- Cost of Episode
- New/Emerging Technology

See "Evidentiary Standards" below for further details behind each of these factors as well as reference "*HUM-*

Medical/Surgical (M/S) Evidentiary Standards

Evidentiary Standards driving initiation of retrospective review

As noted above, Humana's Preauthorization List (PAL) is the driving factor as to which services/items may be subject to retrospective review. The services requiring authorization, per Humana's PAL, are listed above. Therefore, the evidentiary standards driving the initiation of retrospective review are the same as prior authorization and concurrent review:

- Net Savings
 - o Gross savings minus administrative costs
- Quality Of Care:
 - o Adverse event (AE) (any untoward medical occurrence) in a selection of individuals for procedures/services identified in at least 10% of the episodes in a 12 month data sample.
 - o Greater than or equal to 10% of the episodes for a specific disease/condition do not appear from data to be performed based on evidence based standard in a 12 month sample of data
- Under or Over Utilization:
 - o Utilization is equal or greater than 5% above average/expected utilization as indicated by clinical literature or Humana claim research.
 - o Utilization is equal to or less than 5% below average/expected utilization as indicated by clinical literature or Humana claim research, or specific pathways are not being followed at least 5% of the time as identified in at least 3 months of claims data
- Cost of Episode:
 - o Increase in the cost of care by 5% or more over a two year period or month over month cost increase in a 12 month period.
 - o Variability in the cost per episode of a given condition when there is a demonstrated cost range greater than or equal to 30% in a 12 month claim sample
- New/Emerging Technology: New and emerging technologies and services are evaluated through Humana's internal Technology Assessment process and/or any qualified internal clinical area at Humana, which includes an annual evaluation of published, peer-reviewed literature and standards of care. As the result of the assessment process, a physician and/ or physician panel has determined there is insufficient evidence to support the safety and efficacy of this service for limited indications of this service. See reference "*Development and Maintenance of Humana Medical Coverage Policies*".

Comparative Analysis - Process as Written

The factors and evidentiary standards used to develop the Retrospective Review NQTL are outlined above. In writing, the services requiring authorization, including retrospective review, in the Outpatient In-Network Classification are captured in Humana's PAL, found at humana.com/pal, which is a publicly available webpage for both members and providers. Humana's PAL is a singular document inclusive of both M/S and MH/SUD benefits. The PAL processes, factors, and evidentiary standards are memorialized in Humana Clinical Operations policies, which are published internally and reviewed at minimum on an annual basis. There is no variation to the

Comparative Analysis - Process in Operation

In operation, the PAL Core Team, follows the documented policy "*HUM-HCO 05-013 Evaluation of PAL Additions and Removals*" when determining PAL additions/removals. The PAL Core Team, comprised of clinical and operational leaders from across the organization, meets monthly to review and discuss clinical rationale, data analysis, and staffing /consumer impacts for proposed additions/removals. To effectuate a PAL change, Core Team representatives must agree at a rate of 80% or more. There is no variation between M/S and MH/SUD proposed additions/removals. The PAL Core Team consists of representation across M/S and MH/SUD domains - Operational Leaders, Policy Researchers, and Medical Directors. See reference titled, "*PAL Core Team*" for list of specific PAL Core Team members.

Step 1 above provides details as to how benefits are identified for clinical review (including retrospective review), the type of associate performing the review and qualifications needed. Timely notifications of determinations are completed within state and federal requirements. These details of operation are consistent across M/S and

Summary Conclusions

As outlined in the steps above, Humana's written and operationalized practices for the Retrospective Review NQTL for MH/SUD are comparable to the written and operationalized practices for M/S. Processes, factors, and evidentiary standards used to determine which services require retrospective review are not differentiated between Medical/Surgical and Mental Health/Substance Use Disorder. Humana establishes a singular inclusive list of benefits requiring authorization, including retrospective review. The processes as designed are supported by policies, procedures, and practices. This is evidenced by reference "*HUM-HCO 05-013 Evaluation of PAL Additions and Removals*".

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. Please see "*Georgia Stringency Assessment 2023*".

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 appliedAs outlined in the steps above, Humana's written and operationalized practices for the Retrospective Review NQTL

and as providing legal advice. Each plan's situation can be highly fact specific and does not address plan SO. Also, NQTLs are evaluated on an "as applied" basis. Therefore, specific utilization abnormalities

require that you notify us whenever you provide a copy of this NQTL analysis pursuant to a request from

Outpatient Benefits Out-Of-Network

The following benefits require authorization, per Humana's Preauthorization List (PAL), www.humana.com/pal and could be subject to Retrospective Review:

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
- Chiropractic Therapy
- Diagnostic procedures
- Diagnostic and cardiac imaging
- 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's Preauthorization List (PAL) is the driving factor as to which services/items may be subject to retrospective review.

Overview of Humana's Preauthorization List (PAL)

The Preauthorization List (PAL) represents services and items for which Humana requires authorization, including retrospective review. The PAL determines which covered services identified in the member's Certificate of Coverage and Schedule of Benefits require utilization review, whether prospectively, concurrently, or retrospectively. The PAL includes Medical, Surgical, Mental Health, and Substance Use Disorder services and items. The full PAL is available on Humana's website, www.humana.com/pal. Only specific services found on the PAL require clinical review and must be reviewed by a licensed clinician.

Humana's Commercial PAL is consistent for all fully insured commercial plans.

Humana's PAL program was developed to increase the quality of care provided for members and promote optimal treatment options and site of service, while controlling costs to the healthcare delivery system. Services identified with potential quality of care concerns, including over-utilization, under-utilization, or new/emerging technology, may be added to the PAL if the factor requirements described in steps below are met. This allows Humana to focus on improving quality of care provided to members, facilitates the receipt of appropriate services and improves treatment decisions and health outcomes. See "*2023 Commercial UMPD*", page 13 and section titled "*Preauthorization and Notification List*".

Humana has a PAL Core Team, which consists of representation across M/S and MH/SUD domains - Operational Leaders, Policy Researchers, and Medical Directors. See reference "*PAL Core Team*". The PAL Committee is responsible for reviewing and discussing clinical rationale, data analysis, and staffing /consumer impacts for proposed additions/removals of PAL services and items while applying them against a standardized set of criteria – see further details in the "Factors" and "Evidentiary Standards" sections of this document. See reference "*HUM-HCO 05-013 Evaluation of PAL Additions and Removals*" for specific steps and guidelines for the PAL Program.

Factors driving initiation of retrospective review

The factors identified in the design and application of retrospective Review are listed below. No factor is given more weight than another factor. Please see “*HUM-HCO 05-013 Evaluation of PAL Additions and Removals*”.

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See “Evidentiary Standards” below for further details behind each of these factors as well as reference “*HUM-HCO 05-013 Evaluation of PAL Additions and Removals*”.

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Medical/Surgical (M/S) Evidentiary Standards

Evidentiary Standards driving initiation of retrospective review

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Comparative Analysis - Process as Written

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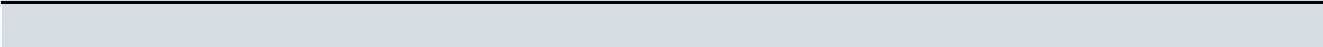
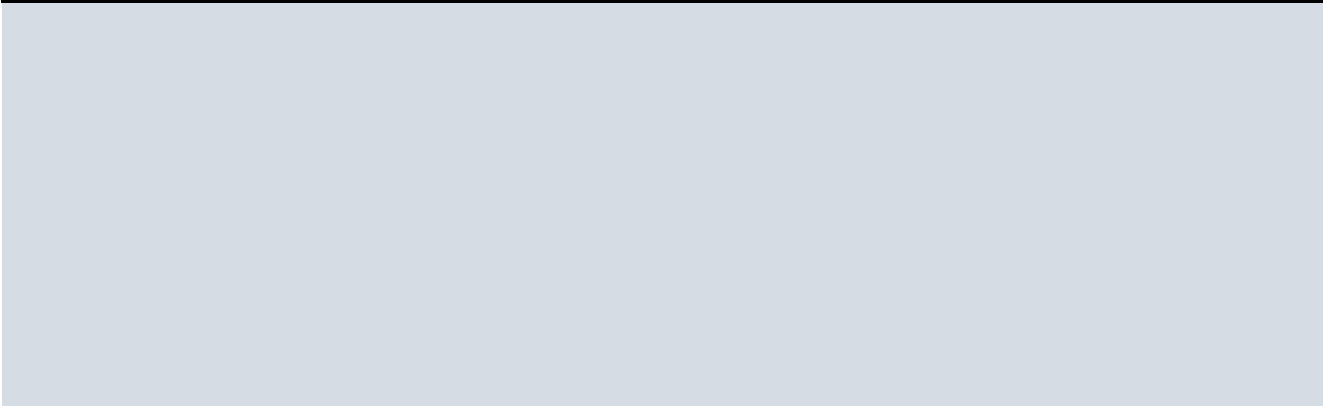
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Summary Conclusions

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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. Please see "*Georgia Stringency Assessment 2023*".

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



	Emergency Benefits
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	Humana does not perform retrospective review for Emergency Services.
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Humana does not perform retrospective review for Emergency Services.

Humana does not perform retrospective review for Emergency Services.

Humana does not perform retrospective review for Emergency Services.

Comparative Analysis - Process as Written

Humana does not perform retrospective review for Emergency Services.

Comparative Analysis - Process in Operation

Humana does not perform retrospective review for Emergency Services.

Summary Conclusions

Humana does not perform retrospective review for Emergency Services.