

Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical/surgical (M/S) benefits. This generally means that financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements, such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage.

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Concurrent Review is defined as “a clinical review of an extension of previously approved, ongoing course of treatment over a period of time or number of treatments conducted during an inpatient stay or ongoing ambulatory care. It is sometimes called a “continued stay review.”” The *Optum National Policy Definitions List* defines a Concurrent (Review) Request as “a request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care.” Concurrent Review does not involve onsite reviews.

Concurrent Review is a component of the Plan’s Utilization Management (UM) program that helps ensure members receive appropriate coverage based on their specific clinical status and health care needs. The process is designed to achieve optimal clinical outcomes by applying objective, evidence-based clinical criteria, and nationally recognized guidelines and best practices. Concurrent Review is a UM process that involves applying the benefit plan language and/or clinical criteria to make the most appropriate clinical coverage benefit determination.

This document includes the following information:

- The Concurrent Review process for M/S and MH/SUD inpatient services
- The description of the NQTL and application (Step 1)
- Factors used to determine which services are subject to the NQTL (Step 2)
- Evidentiary standards and sources used to define, trigger, and/or implicate a factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

This analysis refers to the following attachments:

- *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions* - M/S policy that defines Concurrent Review
- *Optum National Policy Definitions List* - MH/SUD policy that defines Concurrent Review

Concurrent Review – In-Network Inpatient Non-Quantitative Treatment Limitation (NQTL) Analysis

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- *Utilization Management Program Description (UMPD) of United HealthCare Services, Inc. and UnitedHealthcare Insurance Company* - Summarizes the philosophy, structure and standards that govern UHC's medical management, UM and utilization review responsibilities and functions
- *Management of Behavioral Health Benefits Policy* - Describes the mechanisms and processes designed to promote consistency in the management of behavioral health benefits and to ensure that members receive appropriate, high quality behavioral health services in a timely manner
- *Schedule of Benefits - SBN23-Medical-INS-BIND-2021-Choice Plus-LG-GA-UHIC* - Plan document that outlines member responsibilities
- *Core Principles and Practices* - MH/SUD policy that outlines the Core Principles and Practices that should be used by personnel in their interactions with members, authorized member representatives, practitioners and facilities, related to the management of behavioral health benefits, coverage determinations and appeals/grievances of non-coverage determinations
- *Performance Assessment and Incentives* - M/S policy confirming that clinical reviewers are not incented to make denials for financial reasons
- *2023 UnitedHealthcare Provider Administrative Guide* – Informs M/S providers of the Concurrent Review process. The *UnitedHealthcare Provider Administrative Guide* can be accessed on the website <https://www.uhcprovider.com/en/admin-guides.html>
- *September 2023 Optum National Network Manual* - Informs MH/SUD providers of the Concurrent Review process. The *Optum National Network Manual* can be accessed on the website <https://public.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/optum-network-manual.html>

The Plan concludes that the Concurrent Review requirements for M/S and MH/SUD are comparable and applied no more stringently for MH/SUD in-network (INN) inpatient benefits both “as written” and “in operation.”

Process

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Concurrent Review is defined as “a clinical review of an extension of previously approved, ongoing course of treatment over a period of time or number of treatments conducted during an inpatient stay or ongoing ambulatory care. It is sometimes called “continued stay review.”” The *Optum National Policy Definitions List* defines a Concurrent (Review) Request as “a request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care.”

The Plan structures inpatient Concurrent Review processes to be compliant with all applicable federal and state laws. Concurrent Review is governed at both the state and federal level, which includes consumer protections such as external review for adverse benefit determinations after internal appeals options are exhausted.

The Plan delegates management of MH/SUD inpatient services, including Concurrent Review for MH/SUD inpatient services, to United Behavioral Health d/b/a Optum Behavioral Health (OBH), its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor.

Concurrent Review of M/S inpatient admissions consists of the following:

Initial Concurrent Review. The Plan requires INN facilities and providers to timely notify the Plan (e.g., within 24 hours) of an unplanned (e.g., urgent/emergent) inpatient admission. Provider notification triggers the inpatient Concurrent Review process. Providers can notify the Plan through the secure provider portal (www.uhcprovider.com), their connected electronic medical record, by telephone, or by fax (where required).

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The Plan confirms receipt of the Concurrent Review request. Non-clinical staff confirm member eligibility and benefit coverage upon receipt of the notification. Non-clinical staff may approve coverage requests in scenarios where the member's plan documents allow and if a clinical review is not required. Non-clinical staff will also approve a coverage request if the facility's contract does not allow for clinical reviews. Non-clinical staff refer coverage requests that they cannot approve to initial clinical reviewers.

First Level Clinical Review/Initial Review. Clinical reviewers (nurses or physicians) consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether the inpatient admission is medically necessary by reviewing the member's clinical information, the applicable clinical criteria or guidelines, and the Plan benefit terms. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs to determine whether the applicable clinical criteria are met or may access clinical information in the provider's electronic medical record (EMR) if the provider has given the Plan access. The clinical reviewer may approve the admission based on their review.

Second Level Clinical Review/Peer Review. The initial clinical reviewer refers cases to a second level/peer clinical reviewer if the case cannot be approved. Peer clinical reviewers (physician or mid-level practitioner) consult clinical criteria when making clinical coverage benefit determinations. Peer clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs. Only qualified peer clinical reviewers (e.g., Medical Director) can issue adverse benefit determinations. The peer clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. If a peer clinical reviewer issues an adverse benefit determination, then the Plan timely communicates the adverse benefit determination, including appeal rights, and offers a peer-to-peer conversation consistent with state and federal requirements.

Adverse Benefit Determination. For M/S, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction, or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when benefits are exhausted. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials. Modified coverage requests that are approved are recorded as partial denials.

Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based medical clinical policies and clinical criteria from third party sources such as InterQual® or MCG® guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that inpatient Concurrent Review determinations are appropriate.

Per the M/S policy entitled, *Performance Assessment and Incentives*, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons.

M/S generally structures UM processes to comply with federal Employee Retirement Income Security Act of 1974 (ERISA) requirements, NCQA UM standards, and state law where applicable.

Concurrent Review of MH/SUD Inpatient Admissions consists of the following:

The Plan delegates management of MH/SUD inpatient services, including Concurrent Review, to United Behavioral Health d/b/a OBH, its delegated MH/SUD MBHO vendor.

Initial Concurrent Review. All INN inpatient admissions are subject to the Concurrent Review process. The Plan requires INN providers and facilities to timely notify the Plan of MH/SUD inpatient admissions. INN facilities must notify the Plan within one business day after an admission unless a longer period is required by contract or state-specific requirements. Provider notification triggers the inpatient Concurrent Review process. Providers notify the Plan of the need for additional days/services by telephone.

As described in the *Management of Behavioral Health Benefits Policy*, upon receipt of admission notification, non-clinical staff confirm member eligibility and benefit coverage. Non-clinical staff may approve cases that do not require clinical evaluation or interpretation based on the member's diagnosis and the clinical information submitted by providers. Non-clinical staff refer cases that they cannot approve to initial clinical reviewers.

First Level Clinical Review/Initial Review. Clinical decisions are made by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse benefit determinations are made by Medical Directors. Clinical reviewers consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether an inpatient admission is medically necessary by reviewing the member's clinical information, the applicable clinical criteria or guidelines, and the Plan benefit terms. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for certification, related diagnostic results, and history of related treatment and services to determine whether the applicable clinical criteria are met. The clinical reviewer may approve the admission based on their review.

Second Level Clinical Review/Peer Review. The initial clinical reviewer refers cases to a peer clinical reviewer for a peer-to-peer discussion if the case cannot be approved. The requesting provider is offered the opportunity to discuss the case with the peer clinical reviewer, consistent with state and federal requirements before an adverse benefit determination is issued. Only qualified peer clinical reviewers (e.g., Medical Directors) can issue adverse benefit determinations. Peer clinical reviewers apply clinical criteria to member clinical information to determine coverage for an inpatient admission. If the requesting provider fails to complete the peer-to-peer discussion, the peer clinical reviewer makes a determination based on the information available. If a peer clinical reviewer issues an adverse benefit determination, (e.g., the admission is not medically necessary and is not approved), then the Plan timely communicates the adverse benefit determination, including appeal rights, to the member and provider consistent with applicable state, federal, and accreditation requirements.

Adverse Benefit Determination. For MH/SUD, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination, or failure to provide or make payment (in whole or in part), of a benefit. Adverse benefit determinations are recorded as a clinical denial when it is based on clinical criteria and member clinical information.

Clinical Criteria. Initial clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based behavioral clinical policies or use clinical criteria from third party sources such as American Society of Addiction Medicine (ASAM) Criteria®, Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System-Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) and Early Childhood Service Intensity Instrument (ECSII) guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure inpatient Concurrent Review determinations are appropriate.

Per the MH/SUD policy entitled, *Core Principles and Practices*, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons.

MH/SUD generally structures UM processes to comply with federal ERISA requirements and state law, where applicable.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- Concurrent Review

Benefit Classification(s)

- INN, inpatient

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHIC)

Plan Terms/Source Document(s)

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Concurrent Review is defined as “a clinical review of an extension of previously approved, ongoing course of treatment over a period of time or number of treatments conducted during an inpatient stay or ongoing ambulatory care. It is sometimes called a “continued stay review.”” Concurrent Review does not involve onsite reviews.

The *Optum National Policy Definitions List* defines a Concurrent (Review) Request as “a request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care.”

The Plan’s *Schedule of Benefits* notify members of Concurrent Review requirements.

“The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.”

The *2023 UnitedHealthcare Care Provider Administrative Guide* notifies providers of the Concurrent Review requirements. INN providers are required to comply with UM protocols established by the Plan:

We determine the medical necessity of inpatient admissions through either concurrent or retrospective review. We require you to comply with our requests:

- For information, documents or discussions related to our reviews and discharge planning. This includes primary and secondary diagnosis, clinical information, treatment plan, admission order, patient status, discharge planning needs, barriers to discharge and discharge date. When available, provide access to electronic medical records (EMR).
- From our interdisciplinary care coordination team and/or Medical Director. This includes our requests that you help us engage our members directly face-to-face or by phone.
 - If you receive the request before 1 p.m. local time:
 - › Supply all requested information within 4 hours
 - If you receive our request after 1 p.m. local time:
 - › Provide the information within the same business day, but no later than 12 p.m. local time the next business

day

The *Optum National Network Manual*, September 1, 2023, Edition notifies providers of the Concurrent Review requirements. INN providers are required to comply with UM protocols established by the Plan:

In most cases, inpatient admissions will be directed only to participating hospitals and attending psychiatrists.

All inpatient and sub-acute level of care admissions require notification or pre-authorization by the network provider or facility. Optum requires notification within one business day after an admission for a facility to request a pre-authorization unless a longer period is required by contract or state specific requirements. This includes, but is not limited to, mental health or substance abuse disorder services delivered as inpatient treatment, partial/day hospitalization or residential treatment.

Network providers are solely responsible for completing prior notification or obtaining preauthorization prior to providing inpatient or sub-acute level of care services. This includes timely provision of information necessary for concurrent review of continued stay or ongoing care requests prior to the delivery of services.

Should a provider fail to obtain or otherwise follow the required administrative procedures for notification or pre-authorization, Optum may, in accordance with applicable law, apply a reduction of payment to the network provider up to 100% of provider's reimbursement rate. Network provider payment reductions for failure to complete notification or obtain pre-authorization are solely the network provider's liability (i.e., the member cannot be billed for these reductions in payment).

The role of the Plan's delegate, United Behavioral Health d/b/a OBH, is discussed in the *UMPD*:

"United Behavioral Health (UBH) performs the review of requests for coverage of behavioral health services (i.e., substance abuse, and mental health requests for services). UBH provides comprehensive behavioral health care delivery for members through a network of behavioral health practitioners, ancillary care providers, hospitals and other facilities.

For mental health, substance-related disorder services, and wraparound services, UBH uses its Clinical Criteria (see below), behavioral clinical policies, and best practice guidelines to make coverage determinations. UBH adopts externally-developed clinical criteria, and creates internally-developed Clinical Criteria, where appropriate, based on its assessment of relevant guidance. UBH develops clinical criteria that supersedes its standard set or adopts externally-developed clinical criteria when required to do so by contract or regulation.

- Clinical Criteria (Level of Care Utilization System-LOCUS) – Standardized level of care assessment tool developed by the American Association of Community Psychiatrists used to make clinical determinations and placement decisions for mental health disorder benefits for adults ages 19 and older when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (Child and Adolescent Level of Care/Service Intensity Utilization System-CALOCUS-CASII) - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry (AACAP) and the American Association for Community Psychiatry (AACP) used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children and adolescents ages 6-18 when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (Early Childhood Service Intensity Instrument-ECSII) - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children ages 0-5 when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (State or Contract Specific Level of Care Guidelines) - Criteria used to make medical necessity

determinations for mental health disorder benefits when there are explicit mandates or contractual requirements.

- Clinical Criteria (American Society of Addiction Medicine [ASAM]) - Criteria developed by the American Society of Addiction Medicine used to make clinical determinations for substance-related disorder benefits.
- Clinical Criteria (Optum Developed)
 - Optum Behavioral Clinical Policies: Criteria that stem from evaluation of new services or treatments or new applications of existing services or treatments and are used to make clinical determinations regarding proven or unproven services and treatments.

Licensed practitioners conduct all reviews with a focus on measurable outcome goals and objectives for treatment. A senior UBH Medical Director is responsible for directing and implementing behavioral health utilization management programs. A referral is sent to UBH when a member is identified as potentially benefiting from behavioral health services during a “medical event.”

The UBH UM Program is staffed by clinical, non-clinical and administrative personnel. All clinical denials or adverse decisions are made by board certified psychiatrists, or, if the health plans choose, by a panel of other appropriate health care service reviewers. If the health plan chooses to use a panel to make adverse decisions, the panel contains at least one physician who is board certified in psychiatry. When the health care service under review is a mental health or substance abuse service, the adverse decision is made by a licensed physician who is board certified in psychiatry. All potential clinical denials are referred to a physician who is board certified in psychiatry for final determination. An evaluation of the overall effectiveness of the Behavioral Health UM Program is conducted annually to determine how well resources have been deployed to improve UM activities and the clinical care and service provided to members.”

The Plan’s terms require services to be medically necessary for coverage. INN providers are required to comply with the Plan’s UM protocols including complying with Concurrent Review requirements.

Step 2 – Factors Used in the Design and Application of the NQTL

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

The Plan relies on the following factor to determine which INN inpatient services are subject to initial Concurrent Review (design). This factor applies to M/S and MH/SUD for the following:

- I. M/S: General Hospital, SNF, AIR, LTACH
- II. MH/SUD: Inpatient and residential facilities

- All M/S and MH/SUD Inpatient Admissions – Initial Concurrent Review (Qualitative)

The Plan relies on the following factor to determine which INN inpatient services are subject to ongoing Concurrent Review (design). This factor applies to M/S and MH/SUD for the following:

- I. M/S: General Hospital, Specialty Hospital, SNF, AIR, LTACH
- II. MH/SUD: Inpatient and residential facilities

- All M/S and MH/SUD Inpatient Admission Requests for Additional Days – Ongoing Concurrent Review (Qualitative)

The factors apply to M/S and MH/SUD services. The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL. All Concurrent Reviews are subject to Clinical Appropriateness and must have medical necessity criteria.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below is the evidentiary standard and source used to define, trigger, and/or implicate the factor used in designing and applying the Plan's initial Concurrent Review requirement to INN inpatient services. This evidentiary standard and source apply to the following:

- I. M/S: General Hospital, Specialty Hospital, SNF, AIR, LTACH
- II. MH/SUD: Inpatient and residential facilities

Factor – All M/S and MH/SUD Inpatient Admissions – Initial Concurrent Review includes all inpatient admissions.

The Plan's evidentiary standard and source apply to M/S and MH/SUD services and are defined in a qualitative manner.

Below is the evidentiary standard and source used to define, trigger, and/or implicate the factor used in designing and applying the Plan's ongoing Concurrent Review requirement to INN inpatient services. This evidentiary standard and source apply to the following:

- I. M/S: General Hospital, Specialty Hospital, SNF, AIR, LTACH
- II. MH/SUD: Inpatient and residential facilities

Factor – All M/S and MH/SUD Inpatient Admission Requests for Additional Days – Ongoing Concurrent Review

The Plan's evidentiary standard and source apply to M/S and MH/SUD services and are defined in a qualitative manner.

The factors and evidentiary standards used as the basis for subjecting MH/SUD INN inpatient services to Concurrent Review are comparable to, and applied no more stringently than, the factors used as the basis for subjecting M/S INN inpatient benefits to Concurrent Review "as written" and "in operation." The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL.

Step 4 – NQTL "As Written" and "In Operation" Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The findings of the Plan's comparative analyses confirmed the strategies, processes, factors, evidentiary standards, and source information used to determine the MH/SUD INN inpatient services subject to initial and ongoing Concurrent Review were comparable to, and applied no more stringently than, the strategies, processes, factors, evidentiary standards, and source information used to determine the M/S INN inpatient services subject to initial and ongoing Concurrent Review "as written."

The Plan found the factors used to subject INN MH/SUD inpatient services to initial and ongoing Concurrent Review were comparable to and applied no more stringently than the factors used to subject INN M/S inpatient services to initial and ongoing Concurrent Review "in operation." All M/S and MH/SUD inpatient admissions were subject to initial Concurrent Review. All M/S and MH/SUD inpatient admissions were subject to ongoing Concurrent Review if coverage of additional days was requested after initial Concurrent Review approved days expired.

Conclusions

The Plan reviewed the M/S and MH/SUD Concurrent Review operational policies and procedures and concluded the methodology used to determine which MH/SUD INN inpatient services are subject to Concurrent Review "as written" were comparable to, and applied no more stringently than, the methodology used to determine which M/S INN inpatient services are subject to Concurrent Review "as written." Additionally, the Plan concluded that how Concurrent Review is applied to MH/SUD INN inpatient services was comparable to, and applied no more stringently than, how Concurrent Review is applied to M/S INN inpatient services "as written."

The Plan reviewed the M/S and MH/SUD processes, including responsibility for submission, timeframes for submission and review, notification to members and providers, clinical standards for review, and staff qualifications and concluded how the Plan conducts Concurrent Review for MH/SUD INN inpatient services "in operation" was comparable to, and applied no more stringently than, how the Plan conducts Concurrent Review for M/S INN inpatient services "in operation."

Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical/surgical (M/S) benefits. This generally means that financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements, such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage.

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

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This document includes the following information:

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The Plan concludes that the Concurrent Review requirements for M/S and MH/SUD are comparable and applied no more stringently for MH/SUD in-network (INN) inpatient benefits both “as written” and “in operation.”

Process

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The Plan delegates management of MH/SUD inpatient services, including Concurrent Review for MH/SUD inpatient services, to United Behavioral Health d/b/a Optum Behavioral Health (OBH), its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor.

Concurrent Review of M/S inpatient admissions consists of the following:

Initial Concurrent Review. The Plan requires INN facilities and providers to timely notify the Plan (e.g., within 24 hours) of an unplanned (e.g., urgent/emergent) inpatient admission. Provider notification triggers the inpatient Concurrent Review process. Providers can notify the Plan through the secure provider portal (www.uhcprovider.com), their connected electronic medical record, by telephone, or by fax (where required).

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The Plan confirms receipt of the Concurrent Review request. Non-clinical staff confirm member eligibility and benefit coverage upon receipt of the notification. Non-clinical staff may approve coverage requests in scenarios where the member's plan documents allow and if a clinical review is not required. Non-clinical staff will also approve a coverage request if the facility's contract does not allow for clinical reviews. Non-clinical staff refer coverage requests that they cannot approve to initial clinical reviewers.

First Level Clinical Review/Initial Review. Clinical reviewers (nurses or physicians) consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether the inpatient admission is medically necessary by reviewing the member's clinical information, the applicable clinical criteria or guidelines, and the Plan benefit terms. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs to determine whether the applicable clinical criteria are met or may access clinical information in the provider's electronic medical record (EMR) if the provider has given the Plan access. The clinical reviewer may approve the admission based on their review.

Second Level Clinical Review/Peer Review. The initial clinical reviewer refers cases to a second level/peer clinical reviewer if the case cannot be approved. Peer clinical reviewers (physician or mid-level practitioner) consult clinical criteria when making clinical coverage benefit determinations. Peer clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs. Only qualified peer clinical reviewers (e.g., Medical Director) can issue adverse benefit determinations. The peer clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. If a peer clinical reviewer issues an adverse benefit determination, then the Plan timely communicates the adverse benefit determination, including appeal rights, and offers a peer-to-peer conversation consistent with state and federal requirements.

Adverse Benefit Determination. For M/S, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction, or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when benefits are exhausted. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials. Modified coverage requests that are approved are recorded as partial denials.

Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based medical clinical policies and clinical criteria from third party sources such as InterQual® or MCG® guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that inpatient Concurrent Review determinations are appropriate.

Per the M/S policy entitled, *Performance Assessment and Incentives*, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons.

M/S generally structures UM processes to comply with federal Employee Retirement Income Security Act of 1974 (ERISA) requirements, NCQA UM standards, and state law where applicable.

Concurrent Review of MH/SUD Inpatient Admissions consists of the following:

The Plan delegates management of MH/SUD inpatient services, including Concurrent Review, to United Behavioral Health d/b/a OBH, its delegated MH/SUD MBHO vendor.

Initial Concurrent Review. All INN inpatient admissions are subject to the Concurrent Review process. The Plan requires INN providers and facilities to timely notify the Plan of MH/SUD inpatient admissions. INN facilities must notify the Plan within one business day after an admission unless a longer period is required by contract or state-specific requirements. Provider notification triggers the inpatient Concurrent Review process. Providers notify the Plan of the need for additional days/services by telephone.

As described in the *Management of Behavioral Health Benefits Policy*, upon receipt of admission notification, non-clinical staff confirm member eligibility and benefit coverage. Non-clinical staff may approve cases that do not require clinical evaluation or interpretation based on the member's diagnosis and the clinical information submitted by providers. Non-clinical staff refer cases that they cannot approve to initial clinical reviewers.

First Level Clinical Review/Initial Review. Clinical decisions are made by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse benefit determinations are made by Medical Directors. Clinical reviewers consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether an inpatient admission is medically necessary by reviewing the member's clinical information, the applicable clinical criteria or guidelines, and the Plan benefit terms. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for certification, related diagnostic results, and history of related treatment and services to determine whether the applicable clinical criteria are met. The clinical reviewer may approve the admission based on their review.

Second Level Clinical Review/Peer Review. The initial clinical reviewer refers cases to a peer clinical reviewer for a peer-to-peer discussion if the case cannot be approved. The requesting provider is offered the opportunity to discuss the case with the peer clinical reviewer, consistent with state and federal requirements before an adverse benefit determination is issued. Only qualified peer clinical reviewers (e.g., Medical Directors) can issue adverse benefit determinations. Peer clinical reviewers apply clinical criteria to member clinical information to determine coverage for an inpatient admission. If the requesting provider fails to complete the peer-to-peer discussion, the peer clinical reviewer makes a determination based on the information available. If a peer clinical reviewer issues an adverse benefit determination, (e.g., the admission is not medically necessary and is not approved), then the Plan timely communicates the adverse benefit determination, including appeal rights, to the member and provider consistent with applicable state, federal, and accreditation requirements.

Adverse Benefit Determination. For MH/SUD, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination, or failure to provide or make payment (in whole or in part), of a benefit. Adverse benefit determinations are recorded as a clinical denial when it is based on clinical criteria and member clinical information.

Clinical Criteria. Initial clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based behavioral clinical policies or use clinical criteria from third party sources such as American Society of Addiction Medicine (ASAM) Criteria®, Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System-Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) and Early Childhood Service Intensity Instrument (ECSII) guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure inpatient Concurrent Review determinations are appropriate.

Per the MH/SUD policy entitled, *Core Principles and Practices*, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons.

MH/SUD generally structures UM processes to comply with federal ERISA requirements and state law, where applicable.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- Concurrent Review

Benefit Classification(s)

- INN, inpatient

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHIC)

Plan Terms/Source Document(s)

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Concurrent Review is defined as “a clinical review of an extension of previously approved, ongoing course of treatment over a period of time or number of treatments conducted during an inpatient stay or ongoing ambulatory care. It is sometimes called a “continued stay review.”” Concurrent Review does not involve onsite reviews.

The *Optum National Policy Definitions List* defines a Concurrent (Review) Request as “a request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care.”

The Plan’s *Schedule of Benefits* notify members of Concurrent Review requirements.

“The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.”

The *2023 UnitedHealthcare Care Provider Administrative Guide* notifies providers of the Concurrent Review requirements. INN providers are required to comply with UM protocols established by the Plan:

We determine the medical necessity of inpatient admissions through either concurrent or retrospective review. We require you to comply with our requests:

- For information, documents or discussions related to our reviews and discharge planning. This includes primary and secondary diagnosis, clinical information, treatment plan, admission order, patient status, discharge planning needs, barriers to discharge and discharge date. When available, provide access to electronic medical records (EMR).
- From our interdisciplinary care coordination team and/or Medical Director. This includes our requests that you help us engage our members directly face-to-face or by phone.
 - If you receive the request before 1 p.m. local time:
 - › Supply all requested information within 4 hours
 - If you receive our request after 1 p.m. local time:
 - › Provide the information within the same business day, but no later than 12 p.m. local time the next business

day

The *Optum National Network Manual*, September 1, 2023, Edition notifies providers of the Concurrent Review requirements. INN providers are required to comply with UM protocols established by the Plan:

In most cases, inpatient admissions will be directed only to participating hospitals and attending psychiatrists.

All inpatient and sub-acute level of care admissions require notification or pre-authorization by the network provider or facility. Optum requires notification within one business day after an admission for a facility to request a pre-authorization unless a longer period is required by contract or state specific requirements. This includes, but is not limited to, mental health or substance abuse disorder services delivered as inpatient treatment, partial/day hospitalization or residential treatment.

Network providers are solely responsible for completing prior notification or obtaining preauthorization prior to providing inpatient or sub-acute level of care services. This includes timely provision of information necessary for concurrent review of continued stay or ongoing care requests prior to the delivery of services.

Should a provider fail to obtain or otherwise follow the required administrative procedures for notification or pre-authorization, Optum may, in accordance with applicable law, apply a reduction of payment to the network provider up to 100% of provider's reimbursement rate. Network provider payment reductions for failure to complete notification or obtain pre-authorization are solely the network provider's liability (i.e., the member cannot be billed for these reductions in payment).

The role of the Plan's delegate, United Behavioral Health d/b/a OBH, is discussed in the *UMPD*:

"United Behavioral Health (UBH) performs the review of requests for coverage of behavioral health services (i.e., substance abuse, and mental health requests for services). UBH provides comprehensive behavioral health care delivery for members through a network of behavioral health practitioners, ancillary care providers, hospitals and other facilities.

For mental health, substance-related disorder services, and wraparound services, UBH uses its Clinical Criteria (see below), behavioral clinical policies, and best practice guidelines to make coverage determinations. UBH adopts externally-developed clinical criteria, and creates internally-developed Clinical Criteria, where appropriate, based on its assessment of relevant guidance. UBH develops clinical criteria that supersedes its standard set or adopts externally-developed clinical criteria when required to do so by contract or regulation.

- Clinical Criteria (Level of Care Utilization System-LOCUS) – Standardized level of care assessment tool developed by the American Association of Community Psychiatrists used to make clinical determinations and placement decisions for mental health disorder benefits for adults ages 19 and older when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (Child and Adolescent Level of Care/Service Intensity Utilization System-CALOCUS-CASII) - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry (AACAP) and the American Association for Community Psychiatry (AACP) used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children and adolescents ages 6-18 when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (Early Childhood Service Intensity Instrument-ECSII) - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children ages 0-5 when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (State or Contract Specific Level of Care Guidelines) - Criteria used to make medical necessity

determinations for mental health disorder benefits when there are explicit mandates or contractual requirements.

- Clinical Criteria (American Society of Addiction Medicine [ASAM]) - Criteria developed by the American Society of Addiction Medicine used to make clinical determinations for substance-related disorder benefits.
- Clinical Criteria (Optum Developed)
 - Optum Behavioral Clinical Policies: Criteria that stem from evaluation of new services or treatments or new applications of existing services or treatments and are used to make clinical determinations regarding proven or unproven services and treatments.

Licensed practitioners conduct all reviews with a focus on measurable outcome goals and objectives for treatment. A senior UBH Medical Director is responsible for directing and implementing behavioral health utilization management programs. A referral is sent to UBH when a member is identified as potentially benefiting from behavioral health services during a “medical event.”

The UBH UM Program is staffed by clinical, non-clinical and administrative personnel. All clinical denials or adverse decisions are made by board certified psychiatrists, or, if the health plans choose, by a panel of other appropriate health care service reviewers. If the health plan chooses to use a panel to make adverse decisions, the panel contains at least one physician who is board certified in psychiatry. When the health care service under review is a mental health or substance abuse service, the adverse decision is made by a licensed physician who is board certified in psychiatry. All potential clinical denials are referred to a physician who is board certified in psychiatry for final determination. An evaluation of the overall effectiveness of the Behavioral Health UM Program is conducted annually to determine how well resources have been deployed to improve UM activities and the clinical care and service provided to members.”

The Plan’s terms require services to be medically necessary for coverage. INN providers are required to comply with the Plan’s UM protocols including complying with Concurrent Review requirements.

Step 2 – Factors Used in the Design and Application of the NQTL

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

The Plan relies on the following factor to determine which INN inpatient services are subject to initial Concurrent Review (design). This factor applies to M/S and MH/SUD for the following:

- I. M/S: General Hospital, SNF, AIR, LTACH
- II. MH/SUD: Inpatient and residential facilities

- All M/S and MH/SUD Inpatient Admissions – Initial Concurrent Review (Qualitative)

The Plan relies on the following factor to determine which INN inpatient services are subject to ongoing Concurrent Review (design). This factor applies to M/S and MH/SUD for the following:

- I. M/S: General Hospital, Specialty Hospital, SNF, AIR, LTACH
- II. MH/SUD: Inpatient and residential facilities

- All M/S and MH/SUD Inpatient Admission Requests for Additional Days – Ongoing Concurrent Review (Qualitative)

The factors apply to M/S and MH/SUD services. The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL. All Concurrent Reviews are subject to Clinical Appropriateness and must have medical necessity criteria.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below is the evidentiary standard and source used to define, trigger, and/or implicate the factor used in designing and applying the Plan's initial Concurrent Review requirement to INN inpatient services. This evidentiary standard and source apply to the following:

- I. M/S: General Hospital, Specialty Hospital, SNF, AIR, LTACH
- II. MH/SUD: Inpatient and residential facilities

Factor – All M/S and MH/SUD Inpatient Admissions – Initial Concurrent Review includes all inpatient admissions.

The Plan's evidentiary standard and source apply to M/S and MH/SUD services and are defined in a qualitative manner.

Below is the evidentiary standard and source used to define, trigger, and/or implicate the factor used in designing and applying the Plan's ongoing Concurrent Review requirement to INN inpatient services. This evidentiary standard and source apply to the following:

- I. M/S: General Hospital, Specialty Hospital, SNF, AIR, LTACH
- II. MH/SUD: Inpatient and residential facilities

Factor – All M/S and MH/SUD Inpatient Admission Requests for Additional Days – Ongoing Concurrent Review

The Plan's evidentiary standard and source apply to M/S and MH/SUD services and are defined in a qualitative manner.

The factors and evidentiary standards used as the basis for subjecting MH/SUD INN inpatient services to Concurrent Review are comparable to, and applied no more stringently than, the factors used as the basis for subjecting M/S INN inpatient benefits to Concurrent Review "as written" and "in operation." The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL.

Step 4 – NQTL "As Written" and "In Operation" Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The findings of the Plan's comparative analyses confirmed the strategies, processes, factors, evidentiary standards, and source information used to determine the MH/SUD INN inpatient services subject to initial and ongoing Concurrent Review were comparable to, and applied no more stringently than, the strategies, processes, factors, evidentiary standards, and source information used to determine the M/S INN inpatient services subject to initial and ongoing Concurrent Review "as written."

The Plan found the factors used to subject INN MH/SUD inpatient services to initial and ongoing Concurrent Review were comparable to and applied no more stringently than the factors used to subject INN M/S inpatient services to initial and ongoing Concurrent Review "in operation." All M/S and MH/SUD inpatient admissions were subject to initial Concurrent Review. All M/S and MH/SUD inpatient admissions were subject to ongoing Concurrent Review if coverage of additional days was requested after initial Concurrent Review approved days expired.

Conclusions

The Plan reviewed the M/S and MH/SUD Concurrent Review operational policies and procedures and concluded the methodology used to determine which MH/SUD INN inpatient services are subject to Concurrent Review "as written" were comparable to, and applied no more stringently than, the methodology used to determine which M/S INN inpatient services are subject to Concurrent Review "as written." Additionally, the Plan concluded that how Concurrent Review is applied to MH/SUD INN inpatient services was comparable to, and applied no more stringently than, how Concurrent Review is applied to M/S INN inpatient services "as written."

The Plan reviewed the M/S and MH/SUD processes, including responsibility for submission, timeframes for submission and review, notification to members and providers, clinical standards for review, and staff qualifications and concluded how the Plan conducts Concurrent Review for MH/SUD INN inpatient services "in operation" was comparable to, and applied no more stringently than, how the Plan conducts Concurrent Review for M/S INN inpatient services "in operation."

Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical/surgical (M/S) benefits. This generally means that the financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements, such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage.

Specific NQTL

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Concurrent Review is defined as “a clinical review of an extension of previously approved, ongoing course of treatment over a period of time or number of treatments conducted during an inpatient stay or ongoing ambulatory care. It is sometimes called a “continued stay review.”” The *Optum National Policy Definitions List* defines a Concurrent (Review) Request as “a request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care. Concurrent Review does not involve onsite reviews.”

Concurrent Review is a component of the Plan’s Utilization Management (UM) program that helps members receive appropriate coverage based on their specific clinical status and health care needs. The process is designed to achieve optimal clinical outcomes by applying objective, evidence-based clinical criteria and nationally recognized guidelines and best practices.

This document includes the following information:

- The description of the NQTL and process

This analysis refers to the following attachments:

- *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions* - M/S policy that defines Concurrent Review
- *Optum National Policy Definitions List* - MH/SUD policy that defines Concurrent Review

Process

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Concurrent Review is defined as: “a clinical review of an extension of previously approved, ongoing course of treatment over a period of time or number of treatments conducted during an inpatient stay or ongoing ambulatory care. It is sometimes called “continued stay review.”” The *Optum National Policy Definitions List* defines a Concurrent (Review) Request as: “a request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care.”

The Plan structures outpatient Concurrent Review processes to be compliant with all applicable federal and state laws. Concurrent Review is governed at both the state and federal level, which includes consumer protections such as external review for adverse benefit determinations after internal appeals options are exhausted.

The Plan delegates management of MH/SUD outpatient services, including Concurrent Review to United Behavioral Health d/b/a Optum Behavioral Health (OBH), its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor.

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Concurrent Review of M/S and MH/SUD outpatient services consists of the following:

The Plan requires INN M/S providers to timely request coverage of additional units of service or extensions of time for services previously approved in Prior Authorization. The Plan reclassifies M/S and MH/SUD outpatient Concurrent Review coverage requests as preservice/Prior Authorization requests. The Plan follows the outpatient Prior Authorization process for these requests and uses the outpatient Prior Authorization process to review requests for coverage of additional units of service or extensions of time for previously approved services.

Refer to the INN outpatient Prior Authorization NQTL for a description of the process, factors, evidentiary standards, and comparability of processes “in writing” and “in operation.”

Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical/surgical (M/S) benefits. This generally means that the financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements, such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage.

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Concurrent Review is defined as “a clinical review of an extension of previously approved, ongoing course of treatment over a period of time or number of treatments conducted during an inpatient stay or ongoing ambulatory care. It is sometimes called a “continued stay review.”” The *Optum National Policy Definitions List* defines a Concurrent (Review) Request as “a request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care.” Concurrent Review does not involve onsite reviews.

Concurrent Review is a component of the Plan’s Utilization Management (UM) program that helps ensure members receive appropriate coverage based on their specific clinical status and health care needs. The process is designed to achieve optimal clinical outcomes by applying objective, evidence-based clinical criteria and nationally recognized guidelines and best practices. Concurrent Review is a UM process that involves applying the benefit plan language and/or clinical criteria to make the most appropriate clinical coverage benefit determination.

This document includes the following information:

- The Concurrent Review process for M/S and MH/SUD outpatient services
- The description of the NQTL and application (Step 1)
- Factors used to determine which services are subject to the NQTL (Step 2)
- Evidentiary standards and sources used to define, trigger, and or implicate a factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

This analysis refers to the following attachments:

- *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions* - M/S policy that defines Concurrent Review
- *Optum National Policy Definitions List* - MH/SUD policy that defines Concurrent Review
- *Utilization Management Program Description (UMPD) of United HealthCare Services, Inc. and UnitedHealthcare Insurance Company* - Summarizes the philosophy, structure and standards that govern UHC’s medical management, UM and utilization review responsibilities and functions
- *Management of Behavioral Health Benefits Policy* - Describes the mechanisms and processes designed to promote

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consistency in the management of behavioral health benefits and to ensure that members receive appropriate, high quality behavioral health services in a timely manner

- *Certificates of Coverage (COC23-INS-BIND-2021-LG-GA-UHIC)* - Plan document that explains covered services, terms, conditions, and limitations of the member's policy
- *Schedule of Benefits - SBN23-Medical-INS-BIND-2021-Choice Plus-LG-GA-UHIC* - Plan document that outlines member responsibilities
- *Core Principles and Practices* - MH/SUD policy that outlines the core principles and practices that should be used by personnel in their interactions with members, authorized member representatives, practitioners and facilities, related to the management of behavioral health benefits, coverage determinations and appeals/grievances of non-coverage determinations
- *Performance Assessment and Incentives* - M/S policy confirming that clinical reviewers are not incented to make denials for financial reasons
- *2023 UnitedHealthcare Provider Administrative Guide* – Informs M/S providers of the Prior Authorization process. The *UnitedHealthcare Provider Administrative Guide* can be accessed on the website <https://www.uhcprovider.com/en/admin-guides.html>
- *September 2023 Optum National Network Manual* - Informs MH/SUD providers of the Prior Authorization process. The *Optum National Network Manual* can be accessed on the website <https://public.providerexpress.com/content/openprovr/us/en/clinical-resources/guidelines-policies/optum-network-manual.html>

The Plan concludes that the Concurrent Review requirements for M/S and MH/SUD are comparable and applied no more stringently for MH/SUD in-network (INN) outpatient benefits both “as written” and “in operation.”

Process

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Concurrent Review is defined as: “a clinical review of an extension of previously approved, ongoing course of treatment over a period of time or number of treatments conducted during an inpatient stay or ongoing ambulatory care. It is sometimes called “continued stay review.”” The *Optum National Policy Definitions List* defines a Concurrent (Review) Request as: “a request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care.”

The Plan structures outpatient Concurrent Review processes to be compliant with all applicable federal and state requirements, Concurrent Review is governed at both the state and federal level, which includes consumer protections such as external review for adverse benefit determinations after internal appeals options are exhausted.

The Plan delegates management of MH/SUD outpatient services, including Concurrent Review to United Behavioral Health d/b/a Optum Behavioral Health (OBH), its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor.

The Plan has national committees that approve M/S and MH/SUD outpatient services to be subject to Concurrent Review. Additionally, the Plan has a standard process for assessing the services that are subjected to Concurrent Review and whether they should be retained or removed from the list of services that are subject to Concurrent Review.

Concurrent Review of M/S outpatient services consists of the following:

The Plan requires INN M/S providers to submit a Concurrent Review request for outpatient services that are described in Step 1 of this NQTL. The INN provider's submission of a request (notification) triggers the Concurrent Review process.

The Plan requires INN M/S providers to timely request coverage of additional units of service or extensions of time for services previously approved in Prior Authorization. The Plan reclassifies M/S outpatient Concurrent Review coverage requests as preservice/Prior Authorization requests. The Plan follows the outpatient Prior Authorization process for these requests and

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uses the outpatient Prior Authorization process to review requests for coverage of additional units of service or extensions of time for previously approved services.

INN providers may submit Prior Authorization requests through the secure provider portal (www.uhcprovider.com), their connected electronic medical record, by telephone, or by fax (where required). Members may submit Prior Authorization requests by phone, fax, or mail, in accordance with Plan requirements. Providers and members communicate basic information to create a case. As outlined in the *UnitedHealthcare Care Provider Administrative Guide*, providers must submit advance notification with supporting documentation as soon as possible, but at least two weeks before the planned service, unless otherwise stated. The provider's submission of a request (notification) triggers the Prior Authorization process.

The Plan confirms receipt of the Prior Authorization request. Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. Non-clinical staff may administratively deny coverage if member benefits are exhausted. Non-clinical staff review cases to ensure availability of accurate and thorough case information. Non-clinical staff may approve coverage requests in scenarios where the member's plan documents allow and if a clinical review is not required. Requests that are submitted through the secure provider portal may also be approved based on the benefit plan coverage criteria, member diagnosis, and the clinical information submitted. Non-clinical staff refer cases that they cannot approve or administratively deny to initial clinical reviewers for medical necessity review.

First Level Clinical Review/Initial Review. Clinical reviewers (nurses) consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs to determine whether the applicable clinical criteria are met. The clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. The clinical reviewer can approve cases that meet applicable clinical criteria.

Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Peer clinical reviewers (physician or mid-level practitioner) consult clinical criteria when making clinical coverage benefit determinations. Peer clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs. The peer clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If a peer clinical reviewer issues an adverse benefit determination, then the Plan communicates the adverse benefit determination, including appeal rights, and offers a peer-to-peer conversation consistent with state and federal requirements.

Adverse Benefit Determination. For M/S, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction, or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when member benefits are exhausted. Modified coverage requests that are approved are recorded as partial denials.

Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based medical clinical policies or use clinical criteria from third party sources such as InterQual® or MCG® guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that outpatient Concurrent Review determinations are appropriate.

Per the M/S policy entitled, *Performance Assessment and Incentives*, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons.

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M/S generally structures UM processes to comply with federal Employee Retirement Income Security Act of 1974 (ERISA) requirements, and state law, where applicable.

Concurrent Review of MH/SUD outpatient services consists of the following:

The Plan delegates management of MH/SUD outpatient services, including Concurrent Review, to United Behavioral Health d/b/a OBH, its delegated MH/SUD MBHO vendor.

The Plan requires INN MH/SUD providers to submit a Concurrent Review request for outpatient services. Provider notification triggers the outpatient Concurrent Review process. Outpatient Concurrent Review begins when INN provider requests coverage for additional units of service and/or periods of time beyond those initially authorized by the Plan.

INN providers may submit authorization requests through the secure provider portal (www.providerexpress.com), by telephone, or by fax (where required). Members may submit authorization requests by telephone, fax, or mail, in accordance with Plan requirements. Intensive Outpatient Program (IOP) providers notify the Plan of the need for additional days/services by telephone and Partial Hospitalization Program (PHP) providers notify the Plan of the need for additional days/services by telephone or the secure provider portal.

As described in the *Management of Behavioral Health Benefits Policy*, the Plan confirms receipt of the Concurrent Review request. Non-clinical staff confirm member eligibility and benefit coverage. Non-clinical staff may approve cases that do not require clinical evaluation or interpretation based on the member's diagnosis and the clinical information submitted by providers. Non-clinical staff refer cases that they cannot approve to the initial clinical reviewers.

First Level Clinical Review/Initial Review. Clinical decisions are made by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse benefit determinations are made by Medical Directors or psychologists. Clinical reviewers consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether a service is medically necessary by reviewing the member's clinical information, the applicable clinical criteria or guidelines, and the Plan benefit terms. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for certification, related diagnostic results, and history of related treatment and services. The clinical reviewer may approve cases that meet applicable clinical criteria.

Second Level Clinical Review/Peer Review. The initial clinical reviewer refers cases to a peer clinical reviewer for a peer-to-peer discussion if the case cannot be approved. The requesting provider is offered the opportunity to discuss the case with the peer clinical reviewer, consistent with state and federal requirements before an adverse benefit determination is issued. Only qualified peer clinical reviewers (e.g., Medical Directors or psychologists) can issue adverse benefit determinations. Peer clinical reviewers apply clinical criteria to member clinical information to determine coverage for additional units of service during an extended period of time. If the requesting provider fails to complete the peer-to-peer discussion, the peer clinical reviewer makes a determination based on the information available. If a peer clinical reviewer issues an adverse benefit determination, (e.g., that numbers of treatments or extensions of time are not authorized), then the Plan timely communicates the adverse benefit determination, including appeal rights, to the member and provider consistent with applicable state and federal requirements.

Adverse Benefit Determination. For MH/SUD, an adverse benefit determination is recorded as a clinical denial when it is based on clinical criteria and member clinical information.

IOP Practice Management. The Plan identifies INN MH/SUD IOP facilities and clinics that demonstrate effective performance based on readmission rates, lengths of stay, and post-discharge outcomes for inclusion in Practice Management. INN MH/SUD facilities or clinics that meet these performance criteria do not have to obtain Prior Authorization for IOP services.

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Instead, the facilities submit claims post-service, which the Plan pays.

Platinum Designation. The Plan offers a Platinum Designation program to INN MH/SUD PHP providers based on facilities' quantitative practice patterns (effectiveness and efficiency benchmarks). The Platinum Designation program's effectiveness and efficiency benchmarks include targeted 30- and 90-day readmission rates, 7- and 30-day follow up after hospitalization, outlier length of stay, and outlier behavioral health episode spend. INN MH/SUD providers that meet the Platinum Designation are required to notify the Plan of admissions to PHP and provide member information. The Plan covers the first 17 days of admission to PHP without review. Facilities notify the Plan if additional days are needed. The Plan evaluates INN MH/SUD facilities' performance annually as described in the *Optum National Network Manual*.

Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity clinical coverage determinations on objective, evidence-based behavioral clinical policies or use clinical criteria from third-party sources such as, American Society of Addiction Medicine (ASAM) Criteria®, Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System-Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) and Early Childhood Service Intensity Instrument (ECSII) guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that outpatient Concurrent Review determinations are appropriate.

Per the MH/SUD policy entitled, *Core Principles and Practices*, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse clinical coverage benefit determinations (clinical denials) for financial reasons.

MH/SUD generally structures UM processes to comply with federal ERISA requirements and state law, where applicable.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- Concurrent Review

Benefit Classification(s)

- INN, outpatient

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHIC)

Plan Terms/Source Document(s)

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Concurrent Review is defined as “A clinical review of an extension of previously approved, ongoing course of treatment over a period of time or number of treatments conducted during an inpatient stay or ongoing ambulatory care. It is sometimes called a “continued stay review.””

The *Optum National Policy Definitions List* defines a Concurrent (Review) Request as “a request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care.”

The Plan's *Schedule of Benefits* notify members of Concurrent Review requirements.

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“The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.”

The *2023 UnitedHealthcare Care Provider Administrative Guide* notifies providers of the Concurrent Review requirements. INN providers are required to comply with UM protocols established by the Plan:

“We determine the medical necessity of inpatient admissions through either concurrent or retrospective review. We require you to comply with our requests:

- For information, documents or discussions related to our reviews and discharge planning. This includes primary and secondary diagnosis, clinical information, treatment plan, admission order, patient status, discharge planning needs, barriers to discharge and discharge date. When available, provide access to electronic medical records (EMR).
- From our interdisciplinary care coordination team and/or Medical Director. This includes our requests that you help us engage our members directly face-to-face or by phone.
 - If you receive the request before 1 p.m. local time:
 - › Supply all requested information within 4 hours
 - If you receive our request after 1 p.m. local time:
 - › Provide the information within the same business day, but no later than 12 p.m. local time the next business day”

The *Optum National Network Manual*, September 1, 2023 Edition notifies providers of the Concurrent Review requirements. INN providers are required to comply with UM protocols established by the Plan:

“In most cases, inpatient admissions will be directed only to participating hospitals and attending psychiatrists.

All inpatient and sub-acute level of care admissions require notification or pre-authorization by the network provider or facility. Optum requires notification within one business day after an admission for a facility to request a pre-authorization unless a longer period is required by contract or state specific requirements. This includes, but is not limited to, mental health or substance abuse disorder services delivered as inpatient treatment, partial/day hospitalization or residential treatment.

Network providers are solely responsible for completing prior notification or obtaining preauthorization prior to providing inpatient or sub-acute level of care services. This includes timely provision of information necessary for concurrent review of continued stay or ongoing care requests prior to the delivery of services.

Should a provider fail to obtain or otherwise follow the required administrative procedures for notification or pre-authorization, Optum may, in accordance with applicable law, apply a reduction of payment to the network provider up to 100% of provider's reimbursement rate. Network provider payment reductions for failure to complete notification or obtain pre-authorization are solely the network provider's liability (i.e., the member cannot be billed for these reductions in payment).”

The role of the Plan's delegate, United Behavioral Health d/b/a OBH, is discussed in the *UMPD*:

“United Behavioral Health (UBH) performs the review of requests for coverage of behavioral health services (i.e., substance abuse, and mental health requests for services). UBH provides comprehensive behavioral health care delivery for members through a network of behavioral health practitioners, ancillary care providers, hospitals and other facilities.

For mental health, substance-related disorder services, and wraparound services, UBH uses its Clinical Criteria (see below), behavioral clinical policies, and best practice guidelines to make coverage determinations. UBH adopts externally-developed clinical criteria, and creates internally-developed Clinical Criteria, where appropriate, based on its assessment of

relevant guidance. UBH develops clinical criteria that supersedes its standard set or adopts externally-developed clinical criteria when required to do so by contract or regulation.

- Clinical Criteria (Level of Care Utilization System-LOCUS) – Standardized level of care assessment tool developed by the American Association of Community Psychiatrists used to make clinical determinations and placement decisions for mental health disorder benefits for adults ages 19 and older when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (Child and Adolescent Level of Care/Service Intensity Utilization System-CALOCUS-CASII) - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry (AACAP) and the American Association for Community Psychiatry (AAP) used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children and adolescents ages 6-18 when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (Early Childhood Service Intensity Instrument-ECSII) - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children ages 0-5 when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (American Psychological Association Psychological and Neuropsychological Billing and Coding Guide) - Comprehensive billing and coding guide developed by the APA used for making medical necessity determinations for behavioral health psychological and neuropsychological testing services.
- Clinical Criteria (State or Contract Specific Level of Care Guidelines) – Criteria used to make medical necessity determinations for mental health disorder benefits when there are explicit mandates or contractual requirements.
- Clinical Criteria (American Society of Addiction Medicine [ASAM]) - Criteria developed by the American Society of Addiction Medicine used to make clinical determinations for substance-related disorder benefits.
- Clinical Criteria (Medicare Required Criteria): Centers for Medicaid and Medicare (CMS) National and Local Coverage Determinations (NCDs/LCDs) - Summary document of Criteria used to make medical necessity determinations for Medicare benefits.
- Clinical Criteria (Optum Developed)
 - Optum Behavioral Clinical Policies: Criteria that stem from evaluation of new services or treatments or new applications of existing services or treatments and are used to make clinical determinations regarding proven or unproven services and treatments.
 - Optum Supplemental Clinical Criteria: Criteria used to make clinical determinations for Applied Behavior Analysis, Electroconvulsive Therapy and Extended Outpatient Sessions.
 - Optum's Supplement to the APA Psychological and Neuropsychological Testing Billing and Coding Guide: Additional criteria used regarding provider qualifications, coverage rationale, limitations, and developmental testing.

Licensed practitioners conduct all reviews with a focus on measurable outcome goals and objectives for treatment. A senior UBH Medical Director is responsible for directing and implementing behavioral health utilization management programs. A referral is sent to UBH when a member is identified as potentially benefiting from behavioral health services during a “medical event”.

The UBH UM Program is staffed by clinical, non-clinical and administrative personnel. All clinical denials or adverse decisions are made by board certified psychiatrists, or, if the health plans choose, by a panel of other appropriate health care service reviewers. If the health plan chooses to use a panel to make adverse decisions, the panel contains at least one physician who is board certified in psychiatry. When the health care service under review is a mental health or substance abuse service, the adverse decision is made by a licensed physician who is board certified in psychiatry. All potential clinical denials are referred to a physician who is board certified in psychiatry for final determination. An evaluation of the overall effectiveness of the Behavioral Health UM Program is conducted annually to determine how well resources have been deployed to improve UM activities and the clinical care and service provided to members.”

The Plan's terms require services to be medically necessary for coverage. INN providers are required to comply with the Plan's UM protocols including complying with Concurrent Review requirements.

Step 2 – Factors Used in the Design and Application of the NQTL

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FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

When Surest (Bind) plans first launched in 2016, the Plans were designed to offer a simpler and more transparent way for people to access the system. The Plan included coverage for services with the option to buy-up specific benefits based on member need.

In 2022, UnitedHealthcare acquired Surest (Bind) and agreed to adopt the existing list of services that had been identified to be subject to Concurrent Review. Clinical Appropriateness is presently the factor that is determinative in imposing the Concurrent Review limitation. At this time, the Plan is assessing the value of managing the services, the consistency of adherence to evidence-based guidelines, and volume of services utilized to further refine which INN outpatient services are subject to Concurrent Review.

The Plan relies on the following factor to determine which INN outpatient services are added to the list of services subject to Concurrent Review. This factor applies to M/S and MH/SUD for the following:

- I. M/S: INN outpatient Services
 - II. MH/SUD: INN outpatient Services
- Clinical Appropriateness (Qualitative)

Applies to M/S and MH/SUD services.

Meeting Clinical Appropriateness is determinative in imposing the limitation.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below is the evidentiary standard and source used to define, trigger, and/or implicate the factor used to add services to the list of services subject to outpatient Concurrent Review. This evidentiary standard and source apply to benefits for the following:

- I. M/S: INN outpatient services
- II. MH/SUD: INN outpatient services

Factor – Clinical Appropriateness

The factor and evidentiary standard used as the basis for subjecting MH/SUD INN outpatient benefits to Concurrent Review are comparable to, and applied no more stringently than, the factor and evidentiary standard used as the basis for subjecting M/S INN outpatient benefits to Concurrent Review "as written" and "in operation."

Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer

ultimately relied upon each expert's evaluations in setting recommendations regarding both.

As Written

In Operation

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan's or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The findings of the Plan's comparative analyses confirmed the strategies, processes, factor, evidentiary standard, and source information used to determine the MH/SUD INN outpatient services subject to Concurrent Review were comparable to, and applied no more stringently than, the strategies, processes, factor, evidentiary standard, and source information used to determine the M/S INN outpatient services subject to Concurrent Review "as written."

The Plan found the factor used to add MH/SUD INN outpatient services on the list of services subject to Concurrent Review was comparable to, and applied no more stringently than, the factor used to add M/S INN outpatient services on the list of services subject to Concurrent Review. INN M/S and MH/SUD outpatient services that met the applicable factor(s) were subject to Concurrent Review "in operation."

Conclusions

The Plan reviewed the M/S and MH/SUD Concurrent Review operational policies and procedures and concluded the methodology used to determine which MH/SUD INN outpatient services are subject to Concurrent Review "as written" were comparable to, and applied no more stringently than, the methodology used to determine which M/S INN outpatient services are subject to Concurrent Review "as written." Additionally, the Plan concluded that how Concurrent Review is applied to MH/SUD INN outpatient services was comparable to, and applied no more stringently than, how Concurrent Review is applied to M/S INN outpatient services "as written."

The Plan reviewed the M/S and MH/SUD processes, including responsibility for submission, timeframes for submission and review, notification to members and providers, clinical standards for review, staff qualifications and IRR assessment results and concluded how the Plan conducts Concurrent Review for MH/SUD INN outpatient services "in operation" was comparable to, and applied no more stringently than, how the Plan conducts Concurrent Review for M/S INN outpatient services "in operation."

Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical/surgical (M/S) benefits. This generally means that financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements, such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage.

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Concurrent Review is defined as “a clinical review of an extension of previously approved, ongoing course of treatment over a period of time or number of treatments conducted during an inpatient stay or ongoing ambulatory care. It is sometimes called a “continued stay review.”” The *Optum National Policy Definitions List* defines a Concurrent (Review) Request as “a request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care.” Concurrent Review does not involve onsite reviews.

Concurrent Review is a component of the Plan’s Utilization Management (UM) program that helps ensure members receive appropriate coverage based on their specific clinical status and health care needs. The process is designed to achieve optimal clinical outcomes by applying objective, evidence-based clinical criteria, and nationally recognized guidelines and best practices. Concurrent Review is a UM process that involves applying the benefit plan language and/or clinical criteria to make the most appropriate clinical coverage benefit determination.

This document includes the following information:

- The Concurrent Review process for both M/S and MH/SUD inpatient services
- The description of the NQTL and application (Step 1)
- Factors used to determine which services are subject to the NQTL (Step 2)
- Evidentiary standards and sources used to define, trigger, and or implicate a factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

This analysis refers to the following attachments:

- *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions* - M/S policy that defines Concurrent Review
- *Optum National Policy Definitions List* - MH/SUD policy that defines Concurrent Review

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- *Utilization Management Program Description (UMPD) of United HealthCare Services, Inc. and UnitedHealthcare Insurance Company* - summarizes the philosophy, structure and standards that govern UHC's medical management, UM and utilization review responsibilities and functions
- *Management of Behavioral Health Benefits Policy* - Describes the mechanisms and processes designed to promote consistency in the management of behavioral health benefits and to ensure that members receive appropriate, high quality behavioral health services in a timely manner.
- *Schedule of Benefits - SBN23-Medical-INS-BIND-2021-Choice Plus-LG-GA-UHIC* - Plan document that outlines member responsibilities
- *Core Principles and Practices* - MH/SUD policy that outlines the Core Principles and Practices that should be used by personnel in their interactions with members, authorized member representatives, practitioners and facilities, related to the management of behavioral health benefits, coverage determinations and appeals/grievances of non-coverage determinations
- *Performance Assessment and Incentives* - M/S policy confirming that clinical reviewers are not incented to make denials for financial reasons

The Plan concludes that the Concurrent Review requirements for M/S and MH/SUD are comparable and applied no more stringently for MH/SUD out-of-network (OON) inpatient benefits both "as written" and "in operation."

Process

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Concurrent Review is defined as "a clinical review of an extension of previously approved, ongoing course of treatment over a period of time or number of treatments conducted during an inpatient stay or ongoing ambulatory care. It is sometimes called "continued stay review." The *Optum National Policy Definitions List* defines a Concurrent (Review) Request as "a request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care."

The Plan structures inpatient Concurrent Review processes to be compliant with all applicable federal and state laws. Concurrent Review is governed at both the state and federal level, which includes consumer protections such as external review for adverse benefit determinations after internal appeals options are exhausted.

The Plan delegates management of MH/SUD inpatient services, including Concurrent Review for MH/SUD inpatient services, to United Behavioral Health d/b/a Optum Behavioral Health (OBH), its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor.

Concurrent Review of M/S Inpatient Admissions consists of the following:

Initial Concurrent Review. Members are required to ensure that OON facilities and providers timely notify the Plan (e.g., within 24 hours) of an unplanned (e.g., urgent/emergent) inpatient admission. Notification triggers the inpatient Concurrent Review process. OON facilities can notify the Plan by telephone or fax (where required).

The Plan confirms receipt of the Concurrent Review request. Non-clinical staff confirm member eligibility and benefit coverage upon receipt of the notification. Non-clinical staff may approve coverage requests in scenarios where the member's plan documents allow and if a clinical review is not required. Non-clinical staff refer coverage requests that they cannot approve to initial clinical reviewers.

First Level Clinical Review/Initial Review. Clinical reviewers (nurses or physicians) consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether the inpatient admission is medically

necessary by reviewing the member's clinical information, the applicable clinical criteria or guidelines, and the Plan benefit terms. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs to determine whether the applicable clinical criteria are met. The clinical reviewer may approve the admission based on their review.

Second Level Clinical Review/Peer Review. The initial clinical reviewer refers cases to a second level/peer clinical reviewer if the case cannot be approved. Peer clinical reviewers (physician or mid-level practitioner) consult clinical criteria when making clinical coverage benefit determinations. Peer clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs. Only qualified peer clinical reviewers (e.g., Medical Director) can issue adverse benefit determinations. The peer clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. If a peer clinical reviewer issues an adverse benefit determination, then the Plan timely communicates the adverse benefit determination, including appeal rights, and offers a peer-to-peer conversation consistent with state and federal requirements.

Adverse Benefit Determination. For M/S, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction, or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when benefits are exhausted. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials. Modified coverage requests that are approved are recorded as partial denials.

The Plan follows the initial Concurrent Review clinical review process when conducting ongoing Concurrent Reviews.

Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based medical clinical policies and clinical criteria from third party sources such as InterQual® or MCG® guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that inpatient Concurrent Review determinations are appropriate.

M/S generally structures UM processes to comply with federal Employee Retirement Income Security Act of 1974 (ERISA) requirements, NCQA UM standards, and state law where applicable.

Concurrent Review of MH/SUD Inpatient Admissions consists of the following:

The Plan delegates management of MH/SUD inpatient services, including Concurrent Review, to United Behavioral Health d/b/a OBH, its delegated MH/SUD MBHO vendor.

Initial Concurrent Review. All OON inpatient admissions are subject to the Concurrent Review process. The Plan requires that members ensure that OON providers and facilities timely notify the Plan of inpatient admissions. Notification triggers the inpatient Concurrent Review process. Providers notify the Plan of the need for additional days/services by telephone.

As described in the *Management of Behavioral Health Benefits Policy*, upon receipt of admission notification, non-clinical staff confirm member eligibility and benefit coverage. Non-clinical staff may approve cases that do not require clinical evaluation or interpretation based on the member's diagnosis and the clinical information submitted by providers. Non-clinical staff refer cases that they cannot approve to initial clinical reviewers.

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First Level Clinical Review/Initial Review. Clinical decisions are made by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse benefit determinations are made by Medical Directors. Clinical reviewers consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether an inpatient admission is medically necessary by reviewing the member's clinical information, the applicable clinical criteria or guidelines, and the Plan benefit terms. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for certification, related diagnostic results, and history of related treatment and services to determine whether the applicable clinical criteria are met. The clinical reviewer may approve the admission based on their review.

Second Level Clinical Review/Peer Review. The initial clinical reviewer refers cases to a peer clinical reviewer for a peer-to-peer discussion if the case cannot be approved. The requesting provider is offered the opportunity to discuss the case with the peer clinical reviewer, consistent with state and federal requirements before an adverse benefit determination is issued. Only qualified peer clinical reviewers (e.g., Medical Directors) can issue adverse benefit determinations. Peer clinical reviewers apply clinical criteria to member clinical information to determine coverage for an inpatient admission. If the requesting provider fails to complete the peer-to-peer discussion, the peer clinical reviewer makes a determination based on the information available. If a peer clinical reviewer issues an adverse benefit determination, (e.g., the admission is not medically necessary and is not approved), then the Plan timely communicates the adverse benefit determination, including appeal rights, to the member and provider consistent with applicable state and federal requirements.

Adverse Benefit Determination. For MH/SUD, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination or failure to provide or make payment (in whole or in part), of a benefit. Adverse benefit determinations are recorded as a clinical denial when it is based on clinical criteria and member clinical information.

Clinical Criteria. Initial clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based behavioral clinical policies or use clinical criteria from third party sources such as American Society of Addiction Medicine (ASAM) Criteria®, Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System-Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) and Early Childhood Service Intensity Instrument (ECSII) guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure inpatient Concurrent Review determinations are appropriate.

MH/SUD generally structures UM processes to comply with federal ERISA requirements and state law, where applicable.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- Concurrent Review

Benefit Classification(s)

- OON, inpatient

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHIC)

Plan Terms/Source Document(s)

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Concurrent Review is defined as “a clinical review of an extension of previously approved, ongoing course of treatment over a period of time or number of treatments conducted during an inpatient stay or ongoing ambulatory care. It is sometimes called a “continued stay review.”” Concurrent Review does not involve onsite reviews.

The *Optum National Policy Definitions List* defines a Concurrent (Review) Request as “a request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care.”

The Plan’s *Schedule of Benefits* notify members of Concurrent Review requirements.

“The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.”

The role of the Plan’s delegate, United Behavioral Health d/b/a OBH, is discussed in the *UMPD*:

“United Behavioral Health (UBH) performs the review of requests for coverage of behavioral health services (i.e., substance abuse, and mental health requests for services). UBH provides comprehensive behavioral health care delivery for members through a network of behavioral health practitioners, ancillary care providers, hospitals and other facilities.

For mental health, substance-related disorder services, and wraparound services, UBH uses its Clinical Criteria (see below), behavioral clinical policies, and best practice guidelines to make coverage determinations. UBH adopts externally-developed clinical criteria, and creates internally-developed Clinical Criteria, where appropriate, based on its assessment of relevant guidance. UBH develops clinical criteria that supersedes its standard set or adopts externally-developed clinical criteria when required to do so by contract or regulation.

- **Clinical Criteria (Level of Care Utilization System-LOCUS)** – Standardized level of care assessment tool developed by the American Association of Community Psychiatrists used to make clinical determinations and placement decisions for mental health disorder benefits for adults ages 19 and older when State or Contract Specific Level of Care Guidelines do not apply.
- **Clinical Criteria (Child and Adolescent Level of Care/Service Intensity Utilization System-CALOCUS-CASII)** - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry (AACAP) and the American Association for Community Psychiatry (AACP) used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children and adolescents ages 6-18 when State or Contract Specific Level of Care Guidelines do not apply.
- **Clinical Criteria (Early Childhood Service Intensity Instrument-ECSII)** - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children ages 0-5 when State or Contract Specific Level of Care Guidelines do not apply.
- **Clinical Criteria (State or Contract Specific Level of Care Guidelines)** - Criteria used to make medical necessity determinations for mental health disorder benefits when there are explicit mandates or contractual requirements.
- **Clinical Criteria (American Society of Addiction Medicine [ASAM])** - Criteria developed by the American Society of Addiction Medicine used to make clinical determinations for substance-related disorder benefits.
- **Clinical Criteria (Optum Developed)**
 - Optum Behavioral Clinical Policies: Criteria that stem from evaluation of new services or treatments or new applications of existing services or treatments and are used to make clinical determinations regarding proven or unproven services and treatments.

Licensed practitioners conduct all reviews with a focus on measurable outcome goals and objectives for treatment. A senior UBH Medical Director is responsible for directing and implementing behavioral health utilization management programs. A referral is sent to UBH when a member is identified as potentially benefiting from behavioral health services during a “medical event.”

The UBH UM Program is staffed by clinical, non-clinical and administrative personnel. All clinical denials or adverse decisions are made by board certified psychiatrists, or, if the health plans choose, by a panel of other appropriate health care service reviewers. If the health plan chooses to use a panel to make adverse decisions, the panel contains at least one physician who is board certified in psychiatry. When the health care service under review is a mental health or substance abuse service, the adverse decision is made by a licensed physician who is board certified in psychiatry. All potential clinical denials are referred to a physician who is board certified in psychiatry for final determination. An evaluation of the overall effectiveness of the Behavioral Health UM Program is conducted annually to determine how well resources have been deployed to improve UM activities and the clinical care and service provided to members.”

The Plan’s terms require services to be medically necessary for coverage.

Step 2 – Factors Used in the Design and Application of the NQTL

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

The Plan relies on the following factor to determine which OON inpatient services are subject to initial Concurrent Review (design). This factor applies to M/S and MH/SUD for the following:

- I. M/S: General Hospital, Specialty Hospital, SNF, AIR, LTACH
- II. MH/SUD: Inpatient and residential facilities

- **All M/S and MH/SUD Inpatient Admissions – Initial Concurrent Review (Qualitative)**

The Plan relies on the following factor to determine which OON inpatient services are subject to ongoing Concurrent Review (design). This factor applies to M/S and MH/SUD for the following:

- I. M/S: General Hospital, Specialty Hospital, SNF, AIR, LTACH
- II. MH/SUD: Inpatient and residential facilities

- **All M/S and MH/SUD Inpatient Admissions Request for Additional Days – Ongoing Concurrent Review (Qualitative)**

The factors apply to M/S and MH/SUD services. The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL. All Concurrent Reviews are subject to Clinical Appropriateness and must have medical necessity criteria.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below is the evidentiary standard and source used to define, trigger, and/or implicate the factor used in designing and applying the Plan's initial Concurrent Review requirement to OON inpatient services. This evidentiary standard and source apply to the following:

- I. M/S: General Hospital, Specialty Hospital, SNF, AIR, LTACH
- II. MH/SUD: Inpatient and residential facilities

Factor – All M/S and MH/SUD Inpatient Admissions – Initial Concurrent Review includes all inpatient admissions.

- The Plan's evidentiary standard and source that define and/or trigger the factor are provider notification of an inpatient admission

The Plan's evidentiary standard and source apply to M/S and MH/SUD services and are defined in a qualitative manner.

Below is the evidentiary standard and source used to define, trigger, and/or implicate the factors used in designing and applying the Plan's ongoing Concurrent Review requirement to OON inpatient services. This evidentiary standard and source apply to the following:

- I. M/S: General Hospital, Specialty Hospital, SNF, AIR, LTACH
- II. MH/SUD: Inpatient and residential facilities

Factor – All M/S and MH/SUD Inpatient Admissions Request for Additional Days – Ongoing Concurrent Review includes all inpatient admissions for which a provider requests coverage of additional days.

- The Plan's evidentiary standard and source that define and/or trigger the factor is an inpatient admission for which a provider requests coverage of additional days

The Plan's evidentiary standard and source apply to M/S and MH/SUD services and is defined in a qualitative manner.

The factors and evidentiary standards used as the basis for subjecting MH/SUD OON inpatient services to Concurrent Review are comparable to, and applied no more stringently than, the factors used as the basis for subjecting M/S OON inpatient benefits to Concurrent Review "as written" and "in operation." The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL.

Step 4 – NQTL "As Written" and "In Operation" Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The findings of the Plan's comparative analyses confirmed the strategies, processes, factors, evidentiary standards, and source information used to determine the MH/SUD OON inpatient services subject to initial and ongoing Concurrent Review were comparable to, and applied no more stringently than, the strategies, processes, factors, evidentiary standards, and source information used to determine the M/S OON inpatient services subject to initial and ongoing Concurrent Review "as written."

Conclusions

The Plan reviewed the M/S and MH/SUD Concurrent Review operational policies and procedures and concluded the methodology used to determine which MH/SUD OON inpatient services are subject to Concurrent Review "as written" were comparable to, and applied no more stringently than, the methodology used to determine which M/S OON inpatient services are subject to Concurrent Review "as written." Additionally, the Plan concluded that how Concurrent Review is applied to MH/SUD OON inpatient services was comparable to, and applied no more stringently than, how Concurrent Review is applied to M/S OON inpatient services "as written."

The Plan reviewed the M/S and MH/SUD processes, including responsibility for submission, timeframes for submission and review, notification to members and providers, clinical standards for review, and staff qualifications and concluded how the Plan conducts Concurrent Review for MH/SUD OON inpatient services "in operation" was comparable to, and applied no more stringently than, how the Plan conducts Concurrent Review for M/S OON inpatient services "in operation."

Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical/surgical (M/S) benefits. This generally means that the financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements, such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage.

Specific NQTL

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Concurrent Review is defined as: “a clinical review of an extension of previously approved, ongoing course of treatment over a period of time or number of treatments conducted during an inpatient stay or ongoing ambulatory care. It is sometimes called a “continued stay review.”” The *Optum National Policy Definitions List* defines a Concurrent (Review) Request as “a request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care. Concurrent Review does not involve onsite reviews.”

Concurrent Review is a component of the Plan’s Utilization Management (UM) program that helps members receive appropriate coverage based on their specific clinical status and health care needs. The process is designed to achieve optimal clinical outcomes by applying objective, evidence-based clinical criteria and nationally recognized guidelines and best practices.

This document includes the following information:

- The description of the NQTL and process

This analysis refers to the following attachments:

- *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions* – M/S policy that defines Concurrent Review
- *Optum National Policy Definitions List* – MH/SUD policy that defines Concurrent Review

Process

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Concurrent Review is defined as “a clinical review of an extension of previously approved, ongoing course of treatment over a period of time or number of treatments conducted during an inpatient stay or ongoing ambulatory care. It is sometimes called “continued stay review.”” The *Optum National Policy Definitions List* defines a Concurrent (Review) Request as “a request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care.”

The Plan structures outpatient Concurrent Review processes to be compliant with all applicable federal and state laws. Concurrent Review is governed at both the state and federal level, which includes consumer protections such as external review for adverse benefit determinations after internal appeals options are exhausted.

The Plan delegates management of MH/SUD outpatient services, including Concurrent Review to United Behavioral Health d/b/a Optum Behavioral Health (OBH), its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor.

Concurrent Review of M/S and MH/SUD outpatient services consists of the following:

The Plan requires members, or OON M/S providers on the member's behalf, to timely request coverage of additional units of service or extensions of time for services previously approved in Prior Authorization. The Plan reclassifies M/S and MH/SUD outpatient Concurrent Review coverage requests as preservice/Prior Authorization requests. The Plan follows the outpatient Prior Authorization process for these requests and uses the outpatient Prior Authorization process to review requests for coverage of additional units of service or extensions of time for previously approved services.

Refer to the OON outpatient Prior Authorization NQTL for a description of the process, factors, evidentiary standards, and comparability of processes "in writing" and "in operation."

Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical/surgical (M/S) benefits. This generally means that the financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements, such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage.

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Concurrent Review is defined as “a clinical review of an extension of previously approved, ongoing course of treatment over a period of time or number of treatments conducted during an inpatient stay or ongoing ambulatory care. It is sometimes called a “continued stay review.”” The *Optum National Policy Definitions List* defines a Concurrent (Review) Request as “a request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care. Concurrent Review does not involve onsite reviews.”

Concurrent Review is a component of the Plan’s Utilization Management (UM) program that helps ensure members receive appropriate coverage based on their specific clinical status and health care needs. The process is designed to achieve optimal clinical outcomes by applying objective, evidence-based clinical criteria and nationally recognized guidelines and best practices. Concurrent Review is a UM process that involves applying the benefit plan language and/or clinical criteria to make the most appropriate clinical coverage benefit determination.

This document includes the following information:

- The Concurrent Review process for M/S and MH/SUD outpatient services
- The description of the NQTL and application (Step 1)
- Factors used to determine which services are subject to the NQTL (Step 2)
- Evidentiary standards and sources used to define, trigger and or implicate a factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

This analysis refers to the following attachments:

- *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions* – M/S policy that defines Concurrent Review
- *Optum National Policy Definitions List* – MH/SUD policy that defines Concurrent Review
- *Utilization Management Program Description (UMPD) of United HealthCare Services, Inc. and UnitedHealthcare Insurance Company* - Summarizes the philosophy, structure and standards that govern UHC’s medical management, UM and utilization review responsibilities and functions
- *Management of Behavioral Health Benefits Policy* - Describes the mechanisms and processes designed to promote

consistency in the management of behavioral health benefits and to ensure that members receive appropriate, high quality behavioral health services in a timely manner

- *Certificates of Coverage - COC23.INS.BIND.2021.LG.GA* - Plan document that explains covered services, terms, conditions, and limitations of the member's policy
- *Schedule of Benefits - SBN23-Medical-INS-BIND-2021-Choice Plus-LG-GA-UHIC* - Plan document that outlines member responsibilities
- *Core Principles and Practices* – MH/SUD policy that outlines the core principles and practices that should be used by personnel in their interactions with members, authorized member representatives, practitioners and facilities, related to the management of behavioral health benefits, coverage determinations and appeals/grievances of non-coverage determinations
- *Performance Assessment and Incentives* – M/S policy confirming that clinical reviewers are not incented to make denials for financial reasons

The Plan concludes that the Concurrent Review requirements for M/S and MH/SUD are comparable and applied no more stringently for MH/SUD out-of-network (OON) outpatient benefits both "as written" and "in operation."

Process

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Concurrent Review is defined as "a clinical review of an extension of previously approved, ongoing course of treatment over a period of time or number of treatments conducted during an inpatient stay or ongoing ambulatory care. It is sometimes called "continued stay review." The *Optum National Policy Definitions List* defines a Concurrent (Review) Request as "a request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care."

The Plan structures outpatient Concurrent Review processes to be compliant with all applicable federal and state requirements. Concurrent Review is governed at both the state and federal level, which includes consumer protections such as external review for adverse benefit determinations after internal appeals options are exhausted.

The Plan delegates management of MH/SUD outpatient services, including Concurrent Review to United Behavioral Health d/b/a Optum Behavioral Health(OBH), its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor.

The Plan has national committees that approve M/S and MH/SUD outpatient services to be subject to Concurrent Review. Additionally, the Plan has a standard process for assessing the services that are subjected to Concurrent Review and whether they should be retained or removed from the list of services that are subject to Concurrent Review. *Addendum A* includes a list of all service categories subject to outpatient Concurrent Review.

Concurrent Review of M/S outpatient services consists of the following:

Members are required to ensure that OON M/S providers submit clinical information for Concurrent Review for outpatient services that are described on *Addendum A*. The member's benefit plan document (e.g., *Schedule of Benefits*) identifies the services for which the member is responsible for obtaining Prior Authorization and by extension Concurrent Review. The OON provider can request Concurrent Review on behalf of the member.

The Plan requires members, or OON M/S providers on the member's behalf, to timely request coverage of additional units of service or extensions of time for services previously approved in Prior Authorization. The Plan reclassifies M/S outpatient Concurrent Review coverage requests as preservice/Prior Authorization requests. The Plan follows the outpatient Prior Authorization process for these requests and uses the outpatient Prior Authorization process to review requests for coverage of additional units of service or extensions of time for previously approved services.

Concurrent Review – Out-of-Network Outpatient Non-Quantitative Treatment Limitation (NQTL) Analysis

GA Surest - UnitedHealthcare Insurance Company

12/29/2023



Members may submit Prior Authorization requests by phone, fax, or mail, in accordance with Plan requirements. OON providers may submit authorization requests on behalf of the member by phone or by fax (where required). Providers and members communicate basic information to create a case. The member or OON provider's submission of a request (notification) triggers the Prior Authorization process.

The Plan confirms receipt of the Prior Authorization request. Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification and non-clinical staff may administratively deny coverage if member benefits are exhausted. Non-clinical staff review cases to ensure availability of accurate and thorough case information. Non-clinical staff may approve coverage requests in scenarios where the member's plan documents allow and if a clinical review is not required. Non-clinical staff refer cases that they cannot approve or administratively deny to the initial clinical reviewers for medical necessity review.

First Level Clinical Review/Initial Review. Clinical reviewers (nurses) consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs to determine whether the applicable clinical criteria are met. The clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. The clinical reviewer can approve cases that meet applicable clinical criteria.

Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Peer clinical reviewers (physician or mid-level practitioner) consult clinical criteria when making clinical coverage benefit determinations. Peer clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs. The peer clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If a peer clinical reviewer issues an adverse benefit determination, then the Plan communicates the adverse benefit determination, including appeal rights, and offers a peer-to-peer conversation consistent with state and federal requirements.

Adverse Benefit Determination. For M/S, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction, or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when member benefits are exhausted. Modified coverage requests that are approved are recorded as partial denials.

Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity benefit determinations on objective, evidence-based medical clinical policies or use clinical criteria from third party sources such as InterQual® or MCG® guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that outpatient Concurrent Review determinations are appropriate.

Per the M/S policy entitled, *Performance Assessment and Incentives*, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons.

M/S generally structures UM processes to comply with federal Employee Retirement Income Security Act of 1974 (ERISA) requirements, and state law, where applicable.

Concurrent Review of MH/SUD outpatient services consists of the following:

Concurrent Review – Out-of-Network Outpatient Non-Quantitative Treatment Limitation (NQTL) Analysis

GA Surest - UnitedHealthcare Insurance Company

12/29/2023



The Plan delegates management of MH/SUD outpatient services, including Concurrent Review, to United Behavioral Health d/b/a OBH, its delegated MH/SUD MBHO vendor.

Members are required to ensure that the rendering OON provider submits clinical information for Concurrent Review for outpatient services that are described in Step 1 of this NQTL. The OON provider must provide clinical information on the member's behalf. The member's benefit plan document (e.g., *Schedule of Benefits*) identifies the services for which the member is responsible for obtaining Concurrent Review. Provider notification triggers the outpatient Concurrent Review process. Concurrent Review begins when OON providers request coverage for additional units of service and/or periods of time beyond those initially authorized by the Plan.

Outpatient OON providers notify the Plan of the need for additional days/services by telephone or by fax (where required).

As described in the *Management of Behavioral Health Benefits Policy*, the Plan confirms receipt of the Concurrent Review request. Non-clinical staff confirm member eligibility and benefit coverage. Non-clinical staff may approve cases that do not require clinical evaluation or interpretation based on the member's diagnosis and the clinical information submitted by providers. Non-clinical staff refer cases that they cannot approve to the initial clinical reviewers.

First Level Clinical Review/Initial Review. Clinical decisions are made by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse benefit determinations are made by Medical Directors or psychologists. Clinical reviewers consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether a service is medically necessary by reviewing the member's clinical information, the applicable clinical criteria or guidelines, and the Plan benefit terms. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for certification, related diagnostic results, and history of related treatment and services. The clinical reviewer may approve cases that meet applicable clinical criteria.

Second Level Clinical Review/Peer Review. The initial clinical reviewer refers cases to a peer clinical reviewer for a peer-to-peer discussion if the case cannot be approved. The requesting provider is offered the opportunity to discuss the case with the peer clinical reviewer, consistent with state and federal requirements before an adverse determination is issued. Only qualified peer clinical reviewers (e.g., Medical Directors or psychologists) can issue adverse benefit determinations. Peer clinical reviewers apply clinical criteria to member clinical information to determine coverage for additional units of service during an extended period of time. If the requesting provider fails to complete the peer-to-peer discussion, the peer clinical reviewer makes a determination based on the information available. If a peer clinical reviewer issues an adverse benefit determination, (e.g., that numbers of treatments or extensions of time are not authorized), then the Plan timely communicates the adverse benefit determination, including appeal rights, to the member and provider consistent with applicable state and federal requirements.

Adverse Benefit Determination. For MH/SUD, an adverse benefit determination is recorded as a clinical denial when it is based on clinical criteria and member clinical information.

Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity clinical coverage determinations on objective, evidence-based behavioral clinical policies or use clinical criteria from third-party sources such as, American Society of Addiction Medicine (ASAM) Criteria®, Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System-Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) and Early Childhood Service Intensity Instrument (ECSII) guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that outpatient Concurrent Review determinations are appropriate.

Per the MH/SUD policy entitled, *Core Principles and Practices*, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse clinical coverage benefit determinations (clinical denials) for financial reasons.

MH/SUD generally structures UM processes to comply with federal ERISA requirements and state law, where applicable.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- Concurrent Review

Benefit Classification(s)

- OON, outpatient

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHC)

Plan Terms/Source Document(s)

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Concurrent Review is defined as “a clinical review of an extension of previously approved, ongoing course of treatment over a period of time or number of treatments conducted during an inpatient stay or ongoing ambulatory care. It is sometimes called a “continued stay review.””

The *Optum National Policy Definitions List* defines a Concurrent (Review) Request as “a request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care.”

The Plan’s *Schedule of Benefits* notify members of Concurrent Review requirements.

“The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.”

The role of the Plan’s delegate, United Behavioral Health d/b/a OBH, is discussed in the *UMPD*:

“United Behavioral Health (UBH) performs the review of requests for coverage of behavioral health services (i.e., substance abuse, and mental health requests for services). UBH provides comprehensive behavioral health care delivery for members through a network of behavioral health practitioners, ancillary care providers, hospitals and other facilities.

For mental health, substance-related disorder services, and wraparound services, UBH uses its Clinical Criteria (see below), behavioral clinical policies, and best practice guidelines to make coverage determinations. UBH adopts externally-developed clinical criteria, and creates internally-developed Clinical Criteria, where appropriate, based on its assessment of relevant guidance. UBH develops clinical criteria that supersedes its standard set or adopts externally-developed clinical criteria when required to do so by contract or regulation.

- **Clinical Criteria (Level of Care Utilization System-LOCUS)** – Standardized level of care assessment tool developed by the American Association of Community Psychiatrists used to make clinical determinations and placement decisions for mental health disorder benefits for adults ages 19 and older when State or Contract Specific Level of Care Guidelines do not apply.

- **Clinical Criteria (Child and Adolescent Level of Care/Service Intensity Utilization System-CALOCUS-CASII) -** Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry (AACAP) and the American Association for Community Psychiatry (AACP) used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children and adolescents ages 6-18 when State or Contract Specific Level of Care Guidelines do not apply.
- **Clinical Criteria (Early Childhood Service Intensity Instrument-ECSII) -** Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children ages 0-5 when State or Contract Specific Level of Care Guidelines do not apply.
- **Clinical Criteria (State or Contract Specific Level of Care Guidelines) -** Criteria used to make medical necessity determinations for mental health disorder benefits when there are explicit mandates or contractual requirements.
- **Clinical Criteria (American Society of Addiction Medicine [ASAM]) -** Criteria developed by the American Society of Addiction Medicine used to make clinical determinations for substance-related disorder benefits.
- **Clinical Criteria (Optum Developed)**
 - Optum Behavioral Clinical Policies: Criteria that stem from evaluation of new services or treatments or new applications of existing services or treatments and are used to make clinical determinations regarding proven or unproven services and treatments.

Licensed practitioners conduct all reviews with a focus on measurable outcome goals and objectives for treatment. A senior UBH Medical Director is responsible for directing and implementing behavioral health utilization management programs. A referral is sent to UBH when a member is identified as potentially benefiting from behavioral health services during a “medical event”.

The UBH UM Program is staffed by clinical, non-clinical and administrative personnel. All clinical denials or adverse decisions are made by board certified psychiatrists, or, if the health plans choose, by a panel of other appropriate health care service reviewers. If the health plan chooses to use a panel to make adverse decisions, the panel contains at least one physician who is board certified in psychiatry. When the health care service under review is a mental health or substance abuse service, the adverse decision is made by a licensed physician who is board certified in psychiatry. All potential clinical denials are referred to a physician who is board certified in psychiatry for final determination. An evaluation of the overall effectiveness of the Behavioral Health UM Program is conducted annually to determine how well resources have been deployed to improve UM activities and the clinical care and service provided to members.”

The Plan’s terms require services to be medically necessary for coverage.

Step 2 – Factors Used in the Design and Application of the NQTL

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

When Surest (Bind) plans first launched in 2016, the Plans were designed to offer a simpler and more transparent way for people to access the system. The Plan included coverage for services with the option to buy-up specific benefits based on member need.

In 2022, UnitedHealthcare acquired Surest (Bind) and agreed to adopt the existing list of services that had been identified to be subject to Concurrent Review. Clinical Appropriateness is presently the factor that is determinative in imposing the Concurrent Review limitation. At this time, the Plan is assessing the value of managing the services, the consistency of adherence to evidence-based guidelines, and volume of services utilized to further refine which OON outpatient services are subject to Concurrent Review.

The Plan relies on the following factor to determine which OON outpatient services are added to the list of services subject to

Concurrent Review – Out-of-Network Outpatient Non-Quantitative Treatment Limitation (NQTL) Analysis

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Concurrent Review. This factor applies to M/S and MH/SUD for the following:

- I. M/S: OON outpatient services
 - II. MH/SUD: OON outpatient services
- Clinical Appropriateness (Qualitative)

Applies to M/S and MH/SUD services..

Meeting Clinical Appropriateness is determinative in imposing the limitation.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below is the evidentiary standard and source used to define, trigger, and/or implicate the factor used to add services to the list of services subject to outpatient Concurrent Review This evidentiary standard and source applies to benefits for the following:

- I. M/S: OON outpatient services
- II. MH/SUD: OON outpatient services

Factor – Clinical Appropriateness

Meeting Clinical Appropriateness is determinative in imposing the limitation.

The factor and evidentiary standard used as the basis for subjecting MH/SUD OON outpatient benefits to Concurrent Review are comparable to, and applied no more stringently than, the factor and evidentiary standard used as the basis for subjecting M/S OON outpatient benefits to Concurrent Review "as written" and "in operation."

Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

As Written

In Operation

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan's or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The findings of the Plan's comparative analyses confirmed the strategies, processes, factor, evidentiary standard, and source information used to determine the MH/SUD OON outpatient services subject to Concurrent Review were comparable to, and applied no more stringently than, the strategies, processes, factor, evidentiary standard, and source information used to determine the M/S OON outpatient services subject to Concurrent Review "as written."

The Plan found the factor used to add outpatient services on the list of services subject to Concurrent Review was comparable to, and applied no more stringently than, the factor used to add M/S OON outpatient services on the list of services subject to Concurrent Review. OON M/S and MH/SUD outpatient services that met the applicable factor(s) were subject to Concurrent Review "in operation."

Conclusions

The Plan reviewed the M/S and MH/SUD Concurrent Review operational policies and procedures and concluded the methodology used to determine which MH/SUD OON outpatient services are subject to Concurrent Review "as written" were comparable to, and applied no more stringently than, the methodology used to determine which M/S OON outpatient services are subject to Concurrent Review "as written." Additionally, the Plan concluded that how Concurrent Review is applied to MH/SUD OON outpatient services was comparable to, and applied no more stringently than, how Concurrent Review is applied to M/S OON outpatient services "as written."

The Plan reviewed the M/S and MH/SUD processes, including responsibility for submission, timeframes for submission and review, notification to members and providers, clinical standards for review, staff qualifications, and IRR assessment results and concluded how the Plan conducts Concurrent Review for MH/SUD OON outpatient services "in operation" was comparable to, and applied no more stringently than, how the Plan conducts Concurrent Review for M/S OON outpatient services "in operation."

Overview

Pursuant to a federal law called the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical and surgical (M/S) benefits. This generally means that financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements, such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage.

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors considered in the design and application of the NQTL (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4). Findings and conclusions both “as written” and “in operation” are presented (Step 5).

Specific NQTL

Credentialing is performed to determine if a provider or facility meets standards to join (credential) or maintain (recredential) its status in the Plan’s network of participating providers. The Plan uses its credentialing and recredentialing processes to validate that its network of contracted providers and facilities providing inpatient, outpatient, and emergency services meet the baseline criteria, as applicable, to the state and practicing specialty. The Plan requires all providers/facilities to be credentialed.

The credentialing process is triggered by a provider or facility seeking to join or continue participation in the Plan’s network. Its purpose is to determine whether the provider or facility has the appropriate level of education/licensure/certification and satisfies additional qualifications (as applicable) to provide covered care to Plan members. The Plan uses credentialing processes and plans based on National Committee for Quality Assurance (NCQA) standards and applicable state or federal regulatory requirements when determining whether to credential M/S and MH/SUD providers or facilities.

This document includes the following information:

- Process for credentialing both M/S and MH/SUD providers and facilities
- Description of the NQTL and application (Step 1)
- Factors used to facilitate credentialing for both M/S and MH/SUD (Step 2)
- Evidentiary standards and sources used to define and/or trigger each of the identified factors (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

The analysis refers to the following attachments:

- *Certificate of Coverage – COC23-INS-BIND-2021-LG-GA-UHIC* – Plan document that explains covered services, terms, conditions, and limitations of the member’s policy

The Plan concludes that its methodologies for credentialing for M/S and MH/SUD providers and facilities are comparable and applied no more stringently for MH/SUD providers and facilities than for M/S providers and facilities both “as written” and “in operation.”

Process

For both M/S and MH/SUD, the Plan uses comparable credentialing processes.

For M/S, the *UnitedHealthcare (UHC) Credentialing Plan* defines Credential, Credentialing, or Recredentialing as “the process of assessing and validating the applicable criteria and qualifications of Licensed Independent Practitioners and Facilities to become or continue as Participating Licensed Individual Providers (PLIPs) and Participating Facilities, as set forth in the Credentialing Plan and pursuant to Credentialing Authorities.”

For MH/SUD, the *United Behavioral Health (UBH) Credentialing Plan* defines Credentialing or Recredentialing as “the process of assessing and validating the applicable criteria and qualifications of providers to become or continue as Participating Providers, as set forth in the Credentialing Plan.”

Key steps in the credentialing process for both M/S and MH/SUD include:

- The provider/facility submits a completed application to the Plan to be included in the Plan’s provider network
- The Plan confirms the information in the application
- If the provider/facility passes the credentialing requirements as outlined in the respective credentialing plan, the provider/facility is credentialed

Credentialing Plan

The purpose of the applicable credentialing plan is to explain the policy for credentialing. All providers/facilities included in the M/S and MH/SUD network are subject to the applicable credentialing plan. Providers/facilities that provide health care services to Covered Persons under their out-of-network benefits or on an emergency basis are not subject to the credentialing plans.

Credentialing Plan Approval

For M/S, the National Peer Review and Credentialing Policy Committee (NPRCPC) has the authority to approve the *UHC Credentialing Plan*. M/S has the right to change the *UHC Credentialing Plan* to meet regulatory requirements or other organizational or business needs with the Quality Oversight Committee approval. The *UHC Credentialing Plan* can be referenced on the website <https://www.uhcprovider.com/en/resource-library/Join-Our-Network.html> to access the regulatory and accreditation timeframes.

The NPRCPC is comprised of stakeholders from multiple UHC regions and meets regularly. The primary role of the NPRCPC is to ensure that the Regional Peer Review Committees (RPRCs) do not rely on an improper or discriminatory basis for making their decisions. The NPRCPC has the final decision-making authority on all disciplinary actions the RPRC recommends that affect restriction, suspension, or termination of participation status of physicians or health care professionals. In addition, this committee is responsible for review and approval of the *UHC Credentialing Plan* and interpretation of the *UHC Credentialing Plan* as needed. The NPRCPC, when authorized by applicable state or federal law, endeavors to conduct its activities in a manner that constitutes peer review.

For MH/SUD, the Plan delegates credentialing of behavioral health network providers to its affiliate UBH d/b/a Optum Behavioral Health (OBH). The Quality Improvement Committee (QIC) has oversight of the Credentialing Committee and delegates overall responsibility and authority to its standing Credentialing Committee for credentialing. The QIC also delegates to the Credentialing Committee the authority to administer the *UBH Credentialing Plan*. The Credentialing Committee is responsible for administering the *UBH Credentialing Plan* and reviewing and approving policies related to credentialing activities on behalf of OBH, subject to oversight by the QIC. The *UBH Credentialing Plan* can be referenced on the website <https://www.providerexpress.com/content/dam/ope-provexpr/us/pdfs/clinResourcesMain/guidelines/credPlans/credPlanUBH.pdf>.

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The Credentialing Committee is multidisciplinary and must include at least two OBH Medical Directors. The committee is comprised of at a minimum two external participating clinicians. The committee must have at least seven voting members present to form a quorum. At least one representative of the quorum will be a Medical Director and two must be external clinicians. An OBH Medical Director chairs the Credentialing Committee; other OBH Medical Directors will serve as co-chairs and will chair the meeting in the absence of the chairperson. The Credentialing Committee meets at least monthly.

The OBH Credentialing Committee Chair has responsibility to see that the *UBH Credentialing Plan* and policies are administered fairly to all clinicians and organizational providers, to monitor the ongoing quality of clinician and organizational provider services, and to immediately restrict or terminate a participating clinician's or organizational provider's agreement.

Detailed Process for Credentialing

For M/S and MH/SUD, credentialing is a peer-review process designed to review certain information pertinent to the respective Credentialing Entity's decision whether to contract a provider or facility, either initially or on an ongoing basis. The process described in the credentialing plans will be initiated only after the Credentialing Entity makes a preliminary determination that it wishes to pursue contracting or re-contracting with the applicant.

The credentialing process begins when a provider/facility submits a completed application.

Application Verification

For M/S, staff will collect information to assess whether an applicant meets the minimum credentialing requirements for practice location, specialty, and any other business needs.

A Medical Director may approve initial credentialing or recredentialing applications determined to meet all credentialing criteria. If credentialing criteria are not met, the Medical Director forwards all documentation to the National Credentialing Committee (NCC) for determination. All completed applications are also forwarded to the NCC for determination.

The NCC will make credentialing decisions pursuant to the *UHC Credentialing Plan*. The NCC is comprised of PLIPs from the Credentialing Entities, UHC Medical Directors, and a designated Medical Director Chairperson unless a different committee composition is otherwise required by applicable credentialing authorities. The NCC has discretion to ask for missing information or to deny the application as incomplete. The NCC may request further information not covered by the application if necessary to make a determination. Upon receipt of a complete application, the NCC will render a decision in accordance with the timeframes as specified by the *UHC Credentialing Plan*.

Credentialing decisions are communicated to the applicant and the Plan. If an application is not accepted or participation is terminated, the non-acceptance or termination letter will include the reason(s) for the decision. The Plan permits appeals from adverse credentialing or sanctions monitoring decisions as required by the NCQA, the Center for Medicare and Medicaid Services (CMS), and other applicable state and federal regulatory authorities. Any appeal process related to the termination, suspension, or non-renewal of providers/facilities will be communicated to the affected provider/facility with the notice of termination, suspension, or non-renewal.

For MH/SUD, credentialing decisions and actions of OBH will be guided primarily by (a) consideration of each applicant's potential contribution to the objective of providing effective and efficient health care services to UBH's members, (b) UBH's need for clinicians and organizational providers within its service area, and (c) judging each applicant for credentialing and recredentialing without discrimination due to age, race, gender, color, religion, ethnic/national identity, ancestry, disability, marital status, covered veteran status, sexual orientation, status with respect to public assistance, blindness or partial blindness, handicap, physical or mental impairment, victims of domestic violence, types of patients seen, or any other characteristic protected under state, federal, or local law.

The Credentialing Committee is responsible for making credentialing decisions about inclusion of providers and facilities in the network. Applications that meet all the credentialing criteria and require no further review by the Credentialing Committee are

sent to the Medical Director for approval. Applications that require additional review are presented to the Credentialing Committee. In this instance the Credentialing Committee has the sole discretion to make a credentialing exception to the required criteria, such as network need. Decisions to make exceptions based on appropriate factors are done in compliance with state and federal regulations. The Credentialing Committee may also at its sole discretion and determination, make the decision to deny the application for network participation.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- Credentialing

Benefit Classification(s)

- Applies to all in-network (INN) M/S and MH/SUD providers and facilities providing covered services in the Inpatient, Outpatient, and Emergency Care classifications as described in the credentialing plans

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHIC)

Plan Terms

The Plan's credentialing process confirms public information about the professionals' and facilities' licenses and other credentials but does not assure the quality of their services. These professionals and facilities are independent practitioners and entities that are solely responsible for the care they deliver.

List of M/S and MH/SUD Benefits Subject to NQTL

Applies to all INN M/S and MH/SUD providers and facilities providing covered services in the Inpatient, Outpatient, and Emergency Care classifications as described in the Credentialing Plan.

Step 2 – Factors Used in the Design and Application of the NQTLs

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

The Plan relies on the following factors to determine if a provider or facility meets standards to join (credential) or maintain (recredential) its status in the Plan's network of participating providers, determine credentialing for M/S and MH/SUD INN inpatient and outpatient services. These factors apply to both M/S and MH/SUD benefits in the following classifications:

- I. INN M/S providers and facilities providing covered services in the Inpatient, Outpatient, and Emergency classification
 - II. INN MH/SUD providers and facilities providing covered services in the Inpatient, Outpatient, and Emergency classification
- The provider or facility completes and attests to the accuracy of the content of the application (Qualitative)
 - Applies to both M/S and MH/SUD
 - The Plan verifies certain information (Qualitative)
 - Applies to both M/S and MH/SUD
 - The provider or facility continues to meet the applicable requirements (Qualitative)
 - Applies to both M/S and MH/SUD

The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factors used in credentialing.

These evidentiary standards and sources apply to the following benefit classifications:

- I. INN M/S providers and facilities providing covered services in the Inpatient, Outpatient, and Emergency classification
- II. INN MH/SUD providers and facilities providing covered services in the Inpatient, Outpatient, and Emergency classification

Factor – Completed Application

- The Plan’s evidentiary standard and source that triggers and/or defines the identification of the factor:
 - Submission of application

This evidentiary standard and source applies to both M/S and MH/SUD INN providers and facilities providing covered services in the Inpatient, Outpatient, and Emergency Care classifications as described in the credentialing plans. This evidentiary standard and source is defined in a qualitative manner.

Factor – The Plan verifies certain information

- The Plan’s evidentiary standard and source that triggers and/or defines the identification of the factor:
 - The UHC and UBH Credentialing Plans describe the information, i.e., primary source verification, which is required

This evidentiary standard and source applies to both M/S and MH/SUD INN providers and facilities providing covered services in the Inpatient, Outpatient, and Emergency Care classifications as described in the credentialing plans. This evidentiary standard and source is defined in a qualitative manner.

Factor – The provider or facility continues to meet the applicable requirements

- The Plan’s evidentiary standards and sources that trigger and/or define the identification of the factor:
 - State and federal regulatory requirements
 - National accreditation standards, for example NCQA credentialing standards

These evidentiary standards and sources apply to both M/S and MH/SUD INN providers and facilities providing covered services in the Inpatient, Outpatient, and Emergency Care classifications as described in the credentialing plans. These evidentiary standards and sources are defined in a qualitative manner.

The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL.

Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

The results of the comparison of the average time to complete the initial credentialing process confirms that both M/S and MH/SUD are meeting applicable state/federal requirements.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The above analysis confirmed the strategies, processes, factors, evidentiary standards, and source information used to determine if an MH/SUD provider or facility meets credentialing or recredentialing standards were comparable to, and applied no more stringently than, the strategies, processes, factors, evidentiary standards, and source information used to determine if an M/S provider or facility meets credentialing or recredentialing standards, both “as written” and “in operation.” The Plan identified the factors and evidentiary standards used to determine if a provider or facility meets credentialing standards apply to both M/S and MH/SUD.

The findings of the parity analysis revealed the *UBH Credentialing Plan* for MH/SUD network providers was comparable to, and applied no more stringently than, the *UHC Credentialing Plan* for M/S network providers. The parity analysis also revealed that credentialing application requirements for MH/SUD network providers are comparable to, and applied no more stringently than, the application requirements for M/S network providers.

In addition, the findings revealed there were [no significant disparate credentialing outcomes for MH/SUD providers as compared to M/S providers.]

Lastly, the amount of time it takes to complete initial credentialing for both M/S and MH/SUD providers and facilities was comparable and both M/S and MH/SUD meet applicable state and federal requirements.

Conclusions

In light of the above findings, the Plan concludes that the credentialing requirements for M/S and MH/SUD providers and facilities are comparable and applied no more stringently for MH/SUD than for M/S, both “as written” and “in operation.”

Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical/surgical (M/S) benefits. This generally means that the financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements such as, deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs, which may limit the scope or duration of benefits for treatment under a plan or coverage.

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

The Plan excludes coverage of technologies (e.g., services, interventions, devices, medically administered M/S and MH/SUD drugs, etc.) determined to be experimental, investigational, or unproven (EIU) for specific diagnoses based on medical/behavioral clinical policies and Plan documents. The Plan develops evidence-based medical/behavioral clinical policies for select M/S and MH/SUD technologies. The medical/behavioral clinical policies may identify specific technologies that are categorically considered EIU or that are considered EIU under certain circumstances.

This document includes the following information:

- Process for determining if a technology is EIU for both M/S and MH/SUD technologies
- Description of the NQTL and application (Step 1)
- Factors used to determine which technologies are subject to the NQTL (Step 2)
- Evidentiary standards and sources used to define, trigger and/or implicate a factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

This analysis refers to the following attachments:

- *2023 UnitedHealthcare Provider Administrative Guide* - Informs providers of the EIU limitation. The *UnitedHealthcare Provider Administrative Guide* can be accessed on the website <https://www.uhcprovider.com/en/admin-guides.html>
- September 2023, *Optum National Network Manual* - Informs providers of the EIU limitation. The *Optum National Network Manual* can be accessed on the website <https://public.providerexpress.com/content/open-provexpr/us/en/clinical-resources/guidelines-policies/optum-network-manual.html>
- *Certificates of Coverage* - COC23-INS-BIND-2021-LG-GA-UHIC - Plan document that explains covered services, terms, conditions, and limitations of the member’s policy
- *Schedule of Benefits* - SBN23-Medical-INS-BIND-2021-Choice Plus-LG-GA-UHIC - Plan document that outlines member responsibilities
- M/S medical clinical policies are publicly available: [Medical & Drug Policies and Coverage Determination Guidelines for UnitedHealthcare Commercial Plans | UHCprovider.com](https://www.uhcprovider.com/en/clinical-resources/guidelines-policies/medical-drug-policies-and-coverage-determination-guidelines-for-unitedhealthcare-commercial-plans)

- MH/SUD behavioral clinical policies are publicly available: [Guidelines/Policies/Manuals \(providerexpress.com\)](#)
- *UnitedHealthcare (UHC) Hierarchy of Clinical Evidence* – M/S policy that defines the order of clinical evidence to ensure a transparent and consistent approach within UnitedHealthcare
- *Behavioral Health Hierarchy of Clinical Evidence* – MH/SUD policy that defines the order of clinical evidence to ensure a transparent and consistent approach to the review and development of Optum's Clinical Technology Assessments and Behavioral Clinical Policies
- *Clinical Technology Assessment Committee (CTAC) Charter* – document that outlines the purpose, structure, responsibility and membership of the committee that develops internal medical criteria and reviews and approves externally developed criteria for MH/SUD
- *Clinical Quality and Operations Committee (CQOC) Charter* – document that outlines the purpose, structure, responsibility, and membership of the committee that oversees CTAC
- *Utilization Management Program Committee Charter* – document that outlines the purpose, responsibility, functions, and composition of the committee that oversees the M/S utilization management program
- *Applying Benefit Plan and Review Criteria* Standard Operating Procedure - outlines the hierarchy of authorities to be reviewed (i.e., state/federal laws and regulations followed by Benefit Plan criteria) when making coverage determinations
- *Utilization Management Program Description (UMPD) of United HealthCare Services, Inc. and UnitedHealthcare Insurance Company* – M/S summarizes the philosophy, structure and standards that govern UHC's medical management, utilization management (UM) and utilization review responsibilities and functions
- *Clinical Review Criteria Operational Policy* - The purpose of this operational policy is to document that UHC will use evidence-based clinical review criteria to support clinical review decisions for UM programs, and to ensure that the clinical review process is applied consistently
- *Clinical Criteria Development Selection and Application Policy* - addresses Optum's selection, development, and use of clinical criteria in making benefit determinations
- *UnitedHealthcare Commercial Omnibus Codes* – M/S policy that outlines technologies that are considered EIU

The Plan concludes that the methodologies used to determine whether a M/S or MH/SUD technology is EIU are comparable and applied no more stringently to MH/SUD technologies for all benefit classifications, both “as written” and “in operation.”

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- EIU: The Plan excludes coverage of technologies determined to be EIU for specific diagnoses based on medical/behavioral clinical policies and Plan documents. The Plan develops evidence-based medical/behavioral clinical policies for select M/S and MH/SUD technologies (e.g., services, interventions, devices, medically administered M/S and MH/SUD drugs, etc.). The medical/behavioral clinical policies may identify specific technologies that are categorically considered EIU or that are considered unproven under certain circumstances

Benefit Classification(s)

- In-network (INN) inpatient, out-of-network (OON) inpatient, INN outpatient, and OON outpatient

Plan(s) at Issue

- UnitedHealthcare Insurance Company

Plan Terms/Source Document(s)

The Plan's *Certificate of Coverage*, defines EIU as:

- “Experimental or Investigational Service(s) – medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications, or devices that, at the time we make a determination regarding coverage in a particular case, are determined to be any of the following:
 - Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified as appropriate for proposed use in any of the following:
 - *AHFS Drug Information (AHFS DI)* under therapeutic uses section;
 - *Elsevier Gold Standard's Clinical Pharmacology* under the indications section;
 - *DRUGDEX System by Micromedex* under the therapeutic uses section and has a strength recommendation rating of class I, class IIa, or class IIb; or
 - *National Comprehensive Cancer Network (NCCN)* drugs and biologics compendium category of evidence 1, 2A, or 2B.
 - Subject to review and approval by any institutional review board for the proposed use. (Devices which are FDA approved under the Humanitarian Use Device exemption are not Experimental or Investigational.)
 - The subject of an ongoing clinical trial that meets the definition of a Phase I, II or III clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.
 - Only obtainable, with regard to outcomes for the given indication, within research settings.

Exceptions:

- Clinical trials for which Benefits are available as described under Clinical Trials in Section 1: Covered Health Care Services.
- We may, as we determine, consider an otherwise Experimental or Investigational Service to be a Covered Health Care Service for that Sickness or condition if:
 - You are not a participant in a qualifying clinical trial, as described under Clinical Trials in Section 1: Covered Health Care Services and
 - You have a Sickness or condition that is likely to cause death within one year of the request for treatment.

Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that Sickness or condition.”

- “Unproven Service(s) - services, including medications and devices, regardless of U.S. Food and Drug Administration (FDA) approval, that are not determined to be effective for treatment of the medical condition or not determined to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.
 - Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
 - Well-conducted cohort studies from more than one institution. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

We have a process by which we compile and review clinical evidence with respect to certain health care services. From time to time, we issue medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. [\[You can view these policies at *\[benefits.surest.com\]*.\]](#)

Please note:

- If you have a Life-Threatening Illness or condition (one that is likely to cause death within one year of the request for treatment) we may, as we determine, consider an otherwise Unproven Service to be a Covered Health Care Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that Sickness or condition.”

Step 2 – Factors Used to Determine if a Technology is Experimental, Investigational or Unproven

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

The Plan relies on the following factor to determine whether technologies are EIU for M/S and MH/SUD. This factor applies to M/S and MH/SUD benefits for the following:

- I. All M/S INN inpatient, OON inpatient, INN outpatient, and OON outpatient technologies subject to UM
 - II. All MH/SUD INN inpatient, OON inpatient, INN outpatient, and OON outpatient technologies subject to UM
- M/S and MH/SUD Committee Considerations (Qualitative)

The factor applies to M/S and MH/SUD technologies.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factor used in determining whether a MH/SUD or M/S technology is EIU. These evidentiary standards apply to the following:

- I. All M/S INN inpatient, OON inpatient, INN outpatient, and OON outpatient technologies subject to UM
- II. All MH/SUD INN inpatient, OON inpatient, INN outpatient, and OON outpatient technologies subject to UM

Factor – M/S and MH/SUD Committee Considerations

These evidentiary standards and sources apply to M/S and MH/SUD technologies and are defined in a qualitative manner.

The factor and evidentiary standards used as the basis for determining which MH/SUD technologies are EIU are comparable to, and applied no more stringently than, the factor and evidentiary standards used as the basis for determining which M/S technologies are EIU both “as written” and “in operation.”

Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

As Written

The Plan conducted an “as written” comparative analysis of the strategies, processes, factors, evidentiary standards, and source information used by M/S and MH/SUD to assess whether a technology is EIU and to develop objective evidence-based medical/behavioral clinical policies.

The Plan uses the following standard process to assess the safety and efficacy of technologies:

The Plan uses committees to assess technologies and conduct a thorough review of the scientifically based clinical evidence and peer-reviewed literature in accordance with the *Hierarchies of Clinical Evidence* to develop medical/behavioral clinical policies that apply to the technologies. The subject matter experts in the committees follow a consistent and comparable process to assess and review technologies and apply comparable *UHC* and *Behavioral Health Hierarchies of Clinical Evidence* (discussed in greater detail below). National internal committees evaluate the applicable factor and standards described in Steps 2 and 3 when determining EIU.

Review of Factor and Evidentiary Standards. M/S and MH/SUD committees both consider clinical efficacy, safety, and appropriateness of the proposed technology, and whether the technology is an unproven treatment for a specific diagnosis when assessing whether a technology is EIU. In doing so, both M/S and MH/SUD consider the respective *UHC* and *Behavioral Health Hierarchies of Clinical Evidence* to assess the clinical efficacy, safety, and appropriateness of the proposed technologies. The *UHC* and *Behavioral Health Hierarchies of Clinical Evidence* are comparable. Both use the following categories of sources (with source-specific differences if the source is specific to M/S or MH/SUD):

- Well-designed evidence-based studies
- Observational studies
- Case studies
- Consensus statements
- Clinical and professional opinion papers

Review of Operational Policies and Procedures. The Plan reviewed M/S and MH/SUD operational policies and procedures to confirm comparability and found MH/SUD policies, procedures, and processes to be comparable and no more stringent than M/S policies, procedures, and processes.

The MTAC assesses the safety and efficacy of technologies used to treat M/S conditions. MTAC uses scientifically based clinical evidence and *UHC Hierarchy of Clinical Evidence* in its development, assessment, and approval processes. MTAC conducts its processes in a timely manner to ensure transparency and consistency, and to identify safe and effective M/S technologies for members.

As of April 1, 2023, UMPC began reviewing and validating the medical clinical policies endorsed by MTAC.

The CTAC assesses the safety and efficacy of technologies used to treat MH/SUD conditions. CTAC uses scientifically based

clinical evidence and *UHC Hierarchy of Clinical Evidence* in its development, assessment, and approval processes. CTAC conducts its processes in a timely manner to ensure transparency and consistency, and to identify safe and effective MH/SUD technologies for members.

The CQOC reviews and validates behavioral clinical policies endorsed by CTAC.

The Plan reviewed and compared the stated purpose of the *UHC* and *Behavioral Health Hierarchies of Clinical Evidence*. The *UHC Hierarchy of Clinical Evidence* states that its purpose is to define the order of clinical evidence to ensure a transparent and consistent approach within the Plan. The *UHC Hierarchy of Clinical Evidence* further states that the Plan uses scientifically based clinical evidence to identify safe and effective technologies for members. The *Behavioral Health Hierarchy of Clinical Evidence* policy statement reflects that scientifically based clinical evidence is used to evaluate behavioral health treatments, technologies for members, and that the hierarchy is used to determine which technologies are safe and effective and potentially eligible for benefit coverage. CTAC's technology assessment process for MH/SUD technologies, including CTAC's application of the *Behavioral Health Hierarchy of Clinical Evidence*, is comparable to, and applied no more stringently than, MTAC's technology assessment process for M/S technologies, including MTAC's application of the *UHC Hierarchy of Clinical Evidence*.

When assessing the safety and efficacy of technologies used to treat M/S and MH/SUD conditions, both MTAC and CTAC first look for any strong and compelling scientific evidence such as statistically robust, well-designed, randomized, controlled trials, and cohort studies. In addition, MTAC will look for multi-site observational studies and single site observational studies. CTAC will also look for systematic reviews and meta-analyses, large prospective trials, cross-sectional studies, retrospective studies, surveillance studies, case reviews/case series, anecdotal/editorial statements, and professional opinions.

In the absence of any strong and compelling scientific evidence, MTAC and CTAC assess technologies by looking at any national consensus statements and/or publications by recognized authorities such as clinical position papers published by professional specialty societies and CMS NCDs.

Neither MTAC nor CTAC will deem a technology unproven solely based on a lack of randomized controlled trials, particularly for new and emerging technologies.

M/S and MH/SUD committees use comparable evidentiary standards and sources to evaluate clinical efficacy, safety, appropriateness of the proposed technologies, and whether the technology is unproven treatment for a specified diagnosis to develop or approve medical/behavioral clinical policies.

M/S and MH/SUD technologies assessed by the MTAC and CTAC committees as not being safe, clinically effective, and/or appropriate are determined to be EIU. Once a technology has been assessed, a medical/behavioral clinical policy is developed which outlines the applicable committee's findings. This includes a summary of the clinical evidence and the identification of specific technologies or uses of technologies considered to be EIU. For both M/S and MH/SUD, all medical/behavioral clinical policies are reviewed and/or updated at least once annually.

As part of the Plan's comparative analysis, the Plan reviewed and compared the MTAC and CTAC charters. The Plan first reviewed the mission/role/scope of the committees, as set forth in their charters. MTAC's mission is to review the scientifically based clinical evidence used in the development of medical policies and clinical programs in an effort to ensure transparency and consistency and to identify safe and effective technologies for members. The purpose of CTAC is to provide a framework by which the organization evaluates and addresses new developments in technology and new applications of existing technology. The CTAC charter also states that it reviews the scientifically based clinical evidence utilized in the development of policies and clinical programs in an effort to ensure transparency, consistency and to identify safe and effective technologies for members.

The Plan also reviewed and compared the composition of the MTAC and CTAC committees. Both committees include both voting members and non-voting members. The Plan reviewed each committee's membership requirements for voting members and non-voting members.

The Plan also reviewed the responsibilities/goals of the committees. The responsibilities/goals of MTAC include the development of evidence-based position statements on selected medical technologies; assessments of the evidence supporting new and emerging technologies; and review and approval of clinical criteria within new or existing medical policies. Similarly, the responsibilities/goals of CTAC include evaluating new behavioral health technologies and new applications of existing behavioral health technologies.

In Operation

The Plan compared the strategies, processes, factors, evidentiary standards, and source information MH/SUD uses to assess whether a technology is EIU and develop evidence-based behavioral clinical policies to the strategies, processes, factors, evidentiary standards, and source information M/S uses to assess whether a technology is EIU and develop evidence-based medical clinical policies "in operation."

M/S MTAC assessment of EIU technologies and development of medical clinical policies is reviewed and validated by UMPC. Similarly, CTAC assessment of EIU technologies and development of behavioral clinical policies is reviewed and validated by the CQOC.

M/S and MH/SUD committees both consider the *UHC* and *Behavioral Health Hierarchies of Clinical Evidence* to assess the clinical efficacy, safety, and appropriateness of the proposed technologies.

The Plan also reviewed and compared how the *UHC* and *Behavioral Health Hierarchies of Clinical Evidence* addressed technology assessments where strong and compelling scientific evidence is lacking. In that scenario, both M/S and MH/SUD *UHC* and *Behavioral Health Hierarchies of Clinical Evidence* assess technologies by looking at any national consensus statements and/or publications by recognized authorities, such as clinical position papers published by professional specialty societies and CMS NCD.

Both M/S and MH/SUD UM processes are guided by their respective *Utilization Management Program Descriptions*. Clinical reviewers utilize medical/behavioral clinical policies when making clinical coverage benefit determinations regarding EIU technologies.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The findings of the Plan's analyses confirmed the strategies, processes, factors, evidentiary standards, and source information used to assess EIU technologies and develop MH/SUD behavioral clinical policies were comparable to, and applied no more stringently than, the strategies, processes, factors, evidentiary standards, and source information used to assess EIU technologies and develop the M/S medical clinical policies "as written" and "in operation."

The MH/SUD policies, procedures, and processes were found to be comparable and no more stringent than M/S policies,

procedures, and processes.

As discussed above, both M/S and MH/SUD committees follow comparable technology assessment processes, including consideration of comparable hierarchies of clinical evidence.

Conclusions

The Plan concluded the methodologies MH/SUD used to assess whether a technology is EIU and develop evidence-based behavioral clinical policies were comparable to, and applied no more stringently than, the methodologies M/S used to assess whether a technology is EIU and develop evidence-based medical clinical policies, both “as written” and “in operation.”

Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical and surgical (M/S) benefits. This generally means that financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements, such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

The out-of-network (OON), out-of-area, geographic service limitation (geographic restrictions requirement) is intended to encourage members to utilize in-network (INN) providers. The geographic restrictions requirement does not limit coverage for OON benefits within the member’s state of residence, nor does it limit INN services nationally. The goal is to promote access to evidence-based care and improved treatment outcomes.

This document includes the following information:

- Geographic restrictions process for both M/S and MH/SUD services
- The description of the NQTL and application (Step 1)
- Factors used to determine which services are subject to the NQTL (Step 2)
- Evidentiary standards and sources used to define, trigger and/or implicate a factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

This analysis refers to the following attachments:

- *Certificates of Coverage - COC23-INS-BIND-2021-LG-GA-UHIC* - Plan document that explains covered services, terms, conditions, and limitations of the member’s policy

The Plan concludes that the geographic restrictions requirements for M/S and MH/SUD are comparable and applied no more stringently for OON benefits both “as written” and “in operation.”

Process

The OON, out-of-area, geographic service limitation (geographic restrictions requirement) is intended to encourage members to utilize INN providers, with the goal being to promote access to evidence-based care and improve treatment outcomes. Health care services from an OON provider for non-emergent, sub-acute inpatient, or outpatient services at any of the following non-hospital facilities: alternate facility, freestanding facility, inpatient rehabilitation facility, or skilled nursing facility received outside of the member’s State of Residence are not covered. This applies to facility based services that could be Inpatient or Outpatient.

A member's request for care is assessed to determine whether the servicing provider is an INN or OON provider and within a level of care subject to the restriction. Service requests within these levels of care, rendered by an OON provider at certain non-hospital, sub-acute, non-emergent facilities, and programs that are out of the member's state of residence, as defined in Plan documents, are denied administratively as a non-covered benefit.

The limitation does not apply in the case of an emergency.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- Geographic Restrictions

Benefit Classification(s)

- OON, inpatient and outpatient services as described in the Plan benefit documents
- Under the Plan benefit documents, services received at the following facilities are subject to the OON geographic restriction:
 - Health care services from an OON provider for non-emergent, sub-acute inpatient, or outpatient services at any of the following non-hospital facilities: alternate facility, freestanding facility, residential treatment facility, inpatient rehabilitation facility, or skilled nursing facility received outside of the member's State of Residence

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHIC)

Plan Terms

The Plan's *Certificate of Coverage* states: "Health care services from an Out-of-Network provider for non-emergent, sub-acute inpatient, or outpatient services at any of the following non-hospital facilities: alternate facility, freestanding facility, residential treatment facility, inpatient rehabilitation facility and skilled nursing facility received outside of the covered person's State of Residence. For the purpose of this exclusion, the 'State of Residence' is the state where the covered person is a legal resident, plus any geographically bordering adjacent state or, for a covered person who is a student, the state where they attend school during the school year. This exclusion does not apply in the case of an Emergency or if authorization through network exception has been obtained in advance."

Step 2 – Factor Used to Determine Geographic Restriction Applies

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

The Plan relies on the following factor to determine whether OON services are subject to geographic restrictions for both M/S and MH/SUD:

- Whether the OON facility is providing non-emergent, sub-acute inpatient and/or outpatient services located outside of the member's state of residence (Qualitative)

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factor used to determine whether OON services are subject to geographic restrictions for both M/S and MH/SUD services:

Factor – Whether the OON facility is providing non-emergent, sub-acute inpatient, and/or outpatient services located outside of the member's state of residence

- The Plan's evidentiary standards that trigger and/or define the factor:
 - Facility is OON; AND
 - Facility provides non-emergent, sub-acute inpatient and/or outpatient services; AND
 - Facility is located outside of the member's state of residence
 - "State of Residence" is defined as:
 - "The state where the member is a legal resident; plus, any geographically bordering adjacent state;" or
 - "For a member who is a student, the state where the student is attending school, during the school year"

The Plan's sources used to define the factor:

- Provider Directory
- Treatment type requested and/or billed, e.g., revenue codes, Healthcare Common Procedure Coding System (HCPCS), etc.
- Facility service location/address
- Member address
- Plan benefit documents

These evidentiary standards and sources apply to both M/S and MH/SUD services. These standards are defined in a qualitative manner.

Step 4 – NQTL "As Written" and "In Operation" Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The findings of the analysis confirmed the strategies, processes, factor, evidentiary standards, and source information used to subject certain MH/SUD OON services to geographic restrictions were comparable to, and applied no more stringently than, the strategies, processes, factor, evidentiary standards, and source information used to subject certain M/S OON services to geographic restrictions “as written.”

Additionally, the same triggering events for the geographic restrictions were applied to both M/S and MH/SUD services and state of residence was defined similarly for all services. The same sources of information were used to define the factor used to determine whether the geographic restriction applies.

Conclusions

The Plan reviewed the M/S and MH/SUD OON triggering events and state of residence definitions and concluded the methodology used to determine which MH/SUD OON services are subject to geographic restrictions “as written” were comparable to, and applied no more stringently than, the methodology used to determine which M/S OON services are subject to geographic restrictions “as written.” Additionally, the Plan concluded the way in which geographic restrictions were applied to MH/SUD OON services were comparable to, and applied no more stringently than, the way in which geographic restrictions were applied to M/S OON services “as written.”

The Plan concluded that MH/SUD processes, triggering events, definitions, and how the Plan applies geographic restrictions for MH/SUD OON services were comparable to, and applied no more stringently than how the Plan applies geographic restrictions for M/S OON services “in operation.”

Overview

Pursuant to a federal law called the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical and surgical (M/S) benefits. This generally means that financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements, such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

In-network (INN) facility reimbursement is the process by which the Plan establishes reimbursement for INN facility-based services.

This document includes the following information:

- Description of process for negotiating reimbursement rates for INN facility-based services for both M/S and MH/SUD facilities
- Description of the NQTL and application (Step 1)
- Factors used to negotiate reimbursement rates for INN facility-based services for both M/S and MH/SUD facilities (Step 2)
- Evidentiary standards and sources used to define and/or trigger each of the identified factors (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

The analysis refers to the following attachments:

- *Certificate of Coverage*- COC23-INS-BIND-2021-LG-GA-UHIC – Plan document that explains covered services, terms, conditions, and limitations of the member’s policy

The Plan concludes that the INN facility reimbursement requirements for M/S and MH/SUD are comparable and applied no more stringently both “as written” and “in operation.”

In-Network Facility Reimbursement Non-Quantitative Treatment Limitation (NQTL) Analysis

GA Surest - UnitedHealthcare Insurance Company

12/29/23

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- INN Facility Reimbursement

Benefit Classification(s)

- INN, facility-based

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHIC)

Plan Terms/Source Document(s)

In each of the plans *Certificate of Coverage*, the following is referenced:

“What Is Our Relationship with Providers and Groups?

We have agreements in place that govern the relationship between us, our Groups and Network providers, some of which are affiliated providers. Network providers enter into agreements with us to provide Covered Health Care Services to Covered Persons.”

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

In-Network Facility Reimbursement Non-Quantitative Treatment Limitation (NQTL) Analysis

GA Surest - UnitedHealthcare Insurance Company

12/29/23

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the plan's or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the plan or coverage is or is not in compliance with MHPAEA.

Findings

Conclusions

Based upon these findings, the Plan concluded the INN facility reimbursement strategy for MH/SUD was comparable to, and applied no more stringently than, the INN facility reimbursement strategy for M/S “as written.”

Additionally, the Plan concluded the factors, evidentiary standards, and source information used to negotiate and establish MH/SUD INN facility reimbursement rates were comparable to, and applied no more stringently than, the factors, evidentiary standards and source information used to negotiate and establish M/S INN facility reimbursement rates “in operation.”

Overview

Pursuant to a federal law called the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical and surgical (M/S) benefits. This generally means that financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

In-network (INN) provider reimbursement is the process by which the Plan establishes reimbursement for INN professional services.

This document includes the following information:

- Process for negotiating and establishing reimbursement rates for INN professional services for both M/S and MH/SUD providers
- Description of the NQTL and application (Step 1)
- Factors used to negotiate reimbursement rates for INN professional services for both M/S and MH/SUD providers (Step 2)
- Evidentiary standards and sources used to define and/or trigger each of the identified factors (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

The analysis refers to the following attachments:

- *Certificates of Coverage* – COC23-INS-BIND-2021-LG-GA-UHIC – Plan document that explains covered services, terms, conditions, and limitations of the member’s policy

The Plan concludes that its methodologies for negotiating and establishing INN reimbursement rates for M/S and MH/SUD professional services are comparable and applied no more stringently for MH/SUD providers than for M/S providers both “as written” and “in operation.”

Process

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- INN Professional Provider Reimbursement

Benefit Classification(s)

- INN, professional services

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHIC)

Plan Terms/Source Document(s)

In each of the Plan's *Certificate of Coverage*, the following is referenced:

“What Is Our Relationship with Providers and Groups?

We have agreements in place that govern the relationship between us, our Groups and Network providers, some of which are affiliated providers. Network providers enter into agreements with us to provide Covered Health Care Services to Covered Persons.”

Step 2 – Factors Used in the Design and Application of the NQTL

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Conclusions

Based upon these findings, the Plan concluded that the methodologies to negotiate and establish INN provider reimbursement for MH/SUD INN professional services was comparable to, and applied no more stringently than, the methodologies to negotiate and establish the INN provider reimbursement for M/S INN professional services “as written.”

Because the reimbursement for MH/SUD physicians and non-physicians compared to M/S physicians and non-physicians was no more stringent, the Plan’s methodologies to negotiate and establish reimbursement for MH/SUD INN professional services is comparable to, and applied no more stringently than, its methodologies to negotiate and establish reimbursement for M/S INN professional services “in operation.”

Medical Necessity Non-Quantitative Treatment Limitation (NQTL) Analysis

GA Surest - UnitedHealthcare Insurance Company
12/29/2023

Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical/surgical (M/S) benefits. This generally means that the financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements such as, deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs, which may limit the scope or duration of benefits for treatment under a plan or coverage.

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

The Plan covers M/S and MH/SUD services/technologies (e.g., services, interventions, devices, medically administered M/S and MH/SUD drugs, etc.) that are medically necessary. Medical necessity refers to the principle that healthcare services, technologies and treatments should be in accordance with generally accepted standards of medical practice, appropriate for the member’s disorder, disease, or symptoms, cost-effective, and essential for diagnosing, preventing, or treating a medical condition. The concept of medical necessity takes into account the best interests of the patient and the evidence-based standards of medical practice. It helps ensure that healthcare resources are allocated efficiently and that patients receive appropriate care based on their medical needs. The Plan makes medical necessity clinical coverage determinations using externally developed, evidence-based clinical criteria (also known as medical necessity criteria) such as InterQual®, MCG®, American Society of Addiction Medicine (ASAM) Criteria¹, Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System-Child and Adolescent Service Intensity Instrument (CALOCUS-CASII), and Early Childhood Service Intensity Instrument (ECSII) guidelines as well as internally developed objective, evidence-based, medical/behavioral clinical policies.

Application of medical necessity criteria is integral to the utilization management (UM) processes of a medical necessity clinical coverage benefit determination.

The Plan publishes its medical necessity criteria, which are available through www.uhcprovider.com (M/S) and www.providerexpress.com (MH/SUD), and upon request.

This document includes the following information:

- Process for developing and approving medical necessity criteria for both M/S and MH/SUD services and technologies
- Description of the NQTL and application (Step 1)
- Factors used to determine which services and technologies are subject to the NQTL (Step 2)
- Evidentiary standards and sources used to define, trigger and/or implicate a factor (Step 3)

¹ Only ASAM Criteria are used to make substance use disorder (SUD) medical necessity coverage determinations, unless otherwise mandated by state law or contract.

Medical Necessity Non-Quantitative Treatment Limitation (NQTL) Analysis

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- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

This analysis refers to the following attachments:

- *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions* - M/S policy that defines Medical Necessity
- *Optum National Policy Definitions List* - MH/SUD policy that defines Medical Necessity
- *UnitedHealthcare (UHC) Hierarchy of Clinical Evidence* – M/S policy that defines the hierarchy of clinical evidence to ensure a transparent and consistent approach within UnitedHealthcare
- *Behavioral Health Hierarchy of Clinical Evidence* – MH/SUD policy that defines the hierarchy of clinical evidence to ensure a transparent and consistent approach to the review and development of Optum’s Clinical Technology Assessments and Behavioral Clinical Policies
- *2023 UnitedHealthcare Provider Administrative Guide* - Informs providers of the Prior Authorization process. The *UnitedHealthcare Provider Administrative Guide* can be accessed on the website <https://www.uhcprovider.com/en/admin-guides.html>
- *September 2023 Optum National Network Manual* - Informs providers of the Prior Authorization process. The *Optum National Network Manual* can be accessed on the website <https://public.providerexpress.com/content/optum-network-manual.html>
- *Utilization Management Program Description (UMPD) of United HealthCare Services, Inc. and UnitedHealthcare Insurance Company* - summarizes the philosophy, structure and standards that govern UHC’s medical management, UM and utilization review responsibilities and functions
- *Certificates of Coverage - COC23-INS-BIND-2021-LG-GA-UHIC* - Plan document that explains covered services, terms, conditions, and limitations of the member’s policy
- *Schedule of Benefits - SBN23-Medical-INS-BIND-2021-Choice Plus-LG-GA-UHIC* - Plan document that outlines member responsibilities
- *Utilization Management Program Committee Charter* – document that outlines the purpose, responsibility, functions, and composition of the committee that oversees the M/S utilization management program
- *Clinical Technology Assessment Committee (CTAC) Charter* – document that outlines the purpose, structure, responsibility and membership of the committee that develops internal medical criteria and reviews and approves externally developed criteria for MH/SUD
- *Clinical Quality and Operations Committee (CQOC) Charter* – document that outlines the purpose, structure, responsibility, and membership of the committee that oversees CTAC
- *Applying Benefit Plan and Review Criteria Standard Operating Procedure* - outlines the hierarchy of authorities to be reviewed (i.e., state/federal laws and regulations followed by Benefit Plan criteria) when making coverage determinations
- *Clinical Review Criteria Operational Policy* - The purpose of this operational policy is to document that UHC will use evidence-based clinical review criteria to support clinical review decisions for UM programs, and to ensure that the clinical review process is applied consistently
- *Clinical Criteria Development Selection and Application Policy* - addresses Optum’s selection, development, and use of clinical criteria in making benefit determinations

The Plan concludes that the methodologies used to develop and approve medical necessity criteria and medical/behavioral clinical policies for M/S and MH/SUD services and technologies are comparable and applied no more stringently for MH/SUD both “as written” and “in operation.”

Medical Necessity Non-Quantitative Treatment Limitation (NQL) Analysis

GA Surest - UnitedHealthcare Insurance Company
12/29/2023

Process

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Medical Necessity is defined as: “Health care services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms, that are all of the following.

- In accordance with Generally Accepted Standards of Medical Practice.
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.”

The *September 2023, Optum National Network Manual* defines Medical Necessity as “Generally, the evaluation of health care services to determine whether the services meet plan criteria for coverage; are medically appropriate and necessary to meet basic health needs; are consistent with the diagnosis or condition; are rendered in a cost-effective manner; and are consistent with national medical practice guidelines regarding type, frequency and duration of treatment. This definition may vary according to member benefit plans or state laws (also referred to as clinical necessity).”

The Plan delegates UM of MH/SUD services to United Behavioral Health d/b/a Optum Behavioral Health (OBH), its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor.

Both M/S and MH/SUD have UM program descriptions that are the foundation for the objectives and guidelines of the Plan’s UM strategy. Medical necessity criteria or medical/behavioral clinical policies are not included in the UM program descriptions.

The Plan develops internal, objective, evidence-based, clinical policies and approves third-party, externally developed medical necessity criteria. Where available, both M/S and MH/SUD use externally developed evidence-based medical necessity criteria (e.g., InterQual, MCG, ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII) when making clinical coverage determinations. When M/S or MH/SUD technologies (e.g., services, interventions, devices, medically administered drugs, etc.) fall outside the scope of externally developed medical necessity criteria, internally developed, evidence-based, medical/behavioral clinical policies are used when making medical necessity clinical coverage determinations. All M/S and MH/SUD internally developed medical and behavioral clinical policies are reviewed at least annually. The *M/S Clinical Review Criteria Operational Policy* and *MH/SUD Clinical Criteria Development/Selection and Application Policy* outline the processes to ensure medical necessity criteria are developed consistently.

The Plan uses the following standard process to apply medical necessity criteria:

M/S and MH/SUD clinical reviewers follow an established process of reviewing state/federal laws and regulations, followed by Plan documents when making medical necessity coverage benefit determinations. The criteria chosen for review are based on the treatment type, diagnosis, and services requested. Where available, both M/S and MH/SUD use externally developed evidence-based medical necessity criteria (e.g., InterQual, MCG, ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII) when making medical necessity coverage benefit determinations. When M/S or MH/SUD technologies (e.g., services, interventions, devices, medically administered drugs, etc.) fall outside the scope of externally developed medical necessity criteria, internally developed, evidence-based, medical/behavioral clinical policies are used when making medical necessity clinical coverage determinations. There is no duplication between internally and externally developed medical necessity criteria. This means that there are either externally developed medical necessity criteria available or there are internally developed medical/behavioral clinical policies available. M/S and MH/SUD clinical reviewers do not have to make a choice between using internal or external medical necessity criteria.

Medical Necessity Non-Quantitative Treatment Limitation (NQTL) Analysis

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Second level, or peer review, medical necessity coverage benefit determinations include clinical judgment. The M/S *Peer Clinical Review Operational Policy* and the MH/SUD *Management of Behavioral Health Benefits Policy* outline the processes. Clinicians use their clinical judgment when they apply evidence-based medical necessity criteria to each member's specific clinical condition. Clinicians use their independent clinical judgment when they evaluate whether the member's clinical condition meets the medical necessity criteria per the applicable externally developed medical necessity criteria or internal medical/behavioral clinical policies.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- Medical Necessity

Benefit Classification(s)

- In-Network (INN) Inpatient, Out-of-Network (OON) Inpatient, INN Outpatient, and OON Outpatient

Please note that the Prior Authorization, Concurrent Review, and Retrospective Review NQTLs describe the services in scope for UM. These NQTLs also describe the factors and evidentiary standards used to determine whether a covered service is subject to a medical necessity review.

The Plan notes that not all covered services are subject to a medical necessity review.

Plan(s) at Issue

- UnitedHealthcare Insurance Company

Plan Terms/Source Document(s)

In each of the Plan products, Medically Necessary is the Plan term used to guide UM decision-making for both M/S and MH/SUD services and technologies. Medically Necessary is generally defined as follows:

“Medically Necessary – health care services are all of the following as determined by us or our designee.

- In accordance with *Generally Accepted Standards of Care*.
- Clinically appropriate, in terms of type, frequency, extent, service site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s), service site or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.
- Or, are subject to Bind Coverage with Evidence Development Policy (CED Policy).

Generally Accepted Standards of Care are evidence based independent standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties. Valid, evidence based sources reflecting generally accepted standards of care include credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

Medical Necessity Non-Quantitative Treatment Limitation (NQTL) Analysis

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If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or nationally recognized clinical practice guidelines may be considered. We have the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be determined by us.

We develop and maintain clinical policies that describe the Generally Accepted Standards of Care scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. [[These clinical policies (as developed by us and revised from time to time), are available to Covered Persons through [MyBind.com] or by calling the telephone number on your ID card.] [They are [also] available to Physicians and other health care professionals on [MyBind.com].]]”

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Medical Necessity is defined as follows:

“Health care services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms, that are all of the following.

- In accordance with Generally Accepted Standards of Medical Practice.
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.”

The *2023 United Healthcare Provider Administrative Guide* Chapter 7 describes Plan medical necessity processes as follows

“We base coverage decisions, including medical necessity decisions, on:

- Member’s benefits.
- State and federal requirements.
- The contract between us and the plan sponsor.
- Medicare guidelines including NCDs and local coverage determination (LCD) guidelines.
- Medicare Benefit Policy Manual (MA members).
- UnitedHealthcare medical policies, medical benefit drug policies, coverage determination guidelines, utilization review guidelines and MA coverage summaries.

Our employees, contractors and delegates do not receive financial incentives for issuing non-coverage decisions or denials. We and our delegates do not offer incentives for underutilization of care/services or for barriers to care/service. We do not hire, promote or terminate employees or contractors based on whether they deny benefits.

We use tools such as UnitedHealthcare medical policies and third-party resources (such as InterQual® criteria and other guidelines), to assist us in administering health benefits and determining coverage.

These tools and resources are not equivalent to the practice of medicine or medical advice, and you should use them in addition to independent, qualified medical judgment.”

The *Optum National Policy Definitions List* defers to the definition of Medical Necessity as set forth in member Plan documents: “This term is variable and defined in the member’s applicable Plan or Coverage document.”

The *September 2023, Optum National Network Manual* defines Medical Necessity as:

“Generally, the evaluation of health care services to determine whether the services meet plan criteria for coverage; are medically appropriate and necessary to meet basic health needs; are consistent with the diagnosis or condition; are rendered in a cost-effective manner; and are consistent with national medical practice guidelines regarding type, frequency and duration of treatment. This definition may vary according to Member Benefit Plans or state laws (also

Medical Necessity Non-Quantitative Treatment Limitation (NQTL) Analysis

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referred to as Clinical Necessity).”

List of M/S and MH/SUD Services and Technologies Subject to NQTL

All M/S and MH/SUD INN inpatient, OON inpatient, INN outpatient, and OON outpatient services and technologies subject to UM.

Step 2 – Factor Used to Develop and Approve Medical and Behavioral Clinical Policies

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/ SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

The Plan relies on the following factor to develop and approve medical necessity criteria. This factor applies to both M/S and MH/SUD benefits for the following:

- I. All M/S INN inpatient, OON inpatient, INN outpatient, and OON outpatient services and technologies subject to UM
 - II. All MH/SUD INN inpatient, OON inpatient, INN outpatient, and OON outpatient services and technologies subject to UM
- M/S and MH/ SUD Committee Considerations (Qualitative)

This factor applies to M/S and MH/SUD services and technologies.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factor used in developing or approving medical necessity criteria. These evidentiary standards and sources apply for the following:

- I. All M/S INN inpatient, OON inpatient, INN outpatient, and OON outpatient services and technologies subject to UM
- II. All MH/SUD INN inpatient, OON inpatient, INN outpatient, and OON outpatient services and technologies subject to UM

Factor – M/S and MH/SUD Committee Considerations

The factor and evidentiary standards used as the basis for developing and approving MH/SUD medical necessity criteria are comparable to, and applied no more stringently than, the factor and evidentiary standards used as the basis for developing and approving M/S medical necessity criteria “as written” and “in operation.”

Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan's or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The findings of the Plan's analyses confirmed the strategies, processes, factor, evidentiary standards, and source information used to develop MH/SUD medical necessity criteria and behavioral clinical policies and review externally developed criteria were comparable to, and applied no more stringently than, the strategies, processes, factor, evidentiary standards, and source information used to develop the M/S medical necessity criteria and medical clinical policies and review externally developed criteria “as written” and “in operation.”

The MH/SUD policies, procedures, and processes were found to be comparable and no more stringent than M/S policies, procedures, and processes.

The Plan used comparable processes and methodologies to assess and develop internal medical/behavioral clinical policies and externally developed medical necessity criteria.

The Plan's Medical Necessity definitions for M/S and MH/SUD are the same, as published in the Plan documents. Additionally, both M/S and MH/SUD clinical reviewers follow the established process of reviewing state/federal laws and regulations, followed by Plan documents and then medical/behavioral clinical policies when making clinical coverage benefit determinations.

Conclusions

The Plan concluded the methodologies used to develop MH/SUD internal evidence-based behavioral clinical policies and approve MH/SUD externally developed medical necessity criteria for use in medical necessity clinical coverage benefit determinations were comparable to, and applied no more stringently than, the methodologies used to develop M/S internal evidence-based medical clinical policies and approve M/S externally developed medical necessity criteria for use in medical necessity clinical coverage benefit determinations both “as written” and “in operation.”

Overview

Pursuant to a federal law called the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical and surgical (M/S) benefits. This generally means that financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA protections include:

- Financial requirements such as, deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs, which may limit the scope or duration of benefits for treatment under a plan or coverage.

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors considered in the design and application of the NQTL (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTLs

The Plan assesses the adequacy of its network based on regulatory requirements.

This document includes the following information:

- Process for both M/S and MH/SUD network management – network adequacy
- Description of the NQTL and application (Step 1)
- Factors used to facilitate network management – network adequacy for both M/S and MH/SUD (Step 2)
- Evidentiary standards and sources used to define and/or trigger each of the identified factors (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

The Plan concludes M/S and MH/SUD network management – network adequacy processes are comparable and applied to MH/SUD no more stringently both “as written” and “in operation.”

Process

The Plan assesses network adequacy based on access standards that are in accordance with the Centers for Medicare & Medicaid Services (CMS) and/or applicable state laws. When determining whether to recruit providers in a given geographic market (such as a county or metropolitan area), the Plan considers network adequacy and access reports.

Key steps in the network management process for both M/S and MH/SUD services include:

- The Plan determines Time, Distance, and Provider Threshold requirements based on state/federal requirements
- The Plan conducts M/S and MH/SUD network adequacy reporting (by state/county) to determine if Time, Distance, and Provider Threshold requirements are met
- If network adequacy requirements are not met, the Plan actively seeks to add providers to the network in that specialty or provider type

For M/S and MH/SUD, the Plan conducts M/S and MH/SUD network adequacy reporting (by state/county) on a regular basis (no less than quarterly) to determine if Time, Distance, and Provider Threshold requirements are met. The network adequacy report incorporates both M/S and MH/SUD provider specialties. M/S and MH/SUD utilize the network adequacy report and ensure that the Network Variation Tracker (NVT) and Analytics tools are used when inconsistencies are identified.

For M/S, the results of the network adequacy report are sent to the UnitedHealthcare Network (UHN) Regional Director of Network Deficiencies through an NVT. If network gaps are identified, a network recruitment plan is developed by the M/S Provider Relations and Contracting teams.

For MH/SUD, the results of the network adequacy report are sent to the National Quality Improvement Committees (NQIC) as well as the respective Health Plan Oversight Committee through the NVT. The Health Plan Oversight Committee assesses and reviews the results and recommends interventions, as needed. If a network gap is identified, a network recruitment plan is developed by the MH/SUD Provider Relations and Contracting teams.

For M/S and MH/SUD, if there is a validated/confirmed supply gap, the Plan language for both M/S and MH/SUD allows members to seek an exception and receive services from an out-of-network (OON) provider at the in-network (INN) benefit level.

The Plan notes that MH/SUD network adequacy standards are reviewed during the product filing and/or annual reporting process by the regulator as applicable.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- Network Management – Network Adequacy

Benefit Classification(s)

- Applies to all INN, inpatient and outpatient services

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHIC)

Plan Terms/Source Document(s)

Per the Plan's member portal, "UnitedHealthcare networks consist of a variety of primary care and behavioral professionals, specialists, hospitals and other facilities. To help provide members with reasonable access to providers who meet their needs, we look at the number of providers and the types of services offered within a geographic area. Additionally, we conduct an assessment of how well the network meets members' cultural needs and preferences, as well as any special healthcare needs. We make outreach to providers, as needed, in order to recruit them to our network. We also accept requests from employers, members, and providers to accommodate needs and preferences." (<https://www.uhc.com/legal/provider/commercial-plans>)

List of M/S and MH/SUD Benefits Subject to NQTL

Applies to all INN M/S and MH/SUD services

Step 2 – Factors Used in the Design and Application of the NQTLs

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

The Plan relies on the following factors to determine network adequacy. These factors apply to both M/S and MH/SUD benefits in the following classifications:

- I. M/S INN inpatient/outpatient services
- II. MH/SUD INN inpatient/outpatient services

- State-specific standards (Quantitative)

Applies to both M/S and MH/SUD services.

- Centers for Medicare & Medicaid Services (CMS)/Health Services Delivery (HSD) table (Quantitative)

Applies to both M/S and MH/SUD services.

The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factors used in determining network adequacy. These evidentiary standards and sources apply to the following benefit classifications:

- I. M/S INN inpatient/outpatient services
- II. MH/SUD INN inpatient/outpatient services

Factor – State-specific standards

These evidentiary standards and sources apply to both M/S and MH/SUD INN inpatient/outpatient services. This evidentiary standard and source is defined in a quantitative manner.

Factor – Centers for Medicare & Medicaid Services (CMS)/Health Services Delivery (HSD) table

These evidentiary standards and sources apply to both M/S and MH/SUD INN inpatient/outpatient services. This evidentiary standard and source is defined in a quantitative manner.

These evidentiary standards and sources are applicable to both M/S and MH/SUD services. In addition, all of these standards/sources are considered and used to define the factors.

Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The above analysis confirmed the strategies, processes, factors, evidentiary standards, and source information used to determine MH/SUD network adequacy were comparable to, and applied no more stringently than, the strategies, processes, factors, evidentiary standards, and source information used to determine M/S network adequacy “as written.”

Both MH/SUD and M/S run network adequacy reports at least quarterly which are in accordance with CMS and/or state established time and distance thresholds to assess the continued adequacy of the network. Additionally, both M/S and MH/SUD have processes in place to authorize benefit coverage at the INN benefit level for services provided by an OON provider if a network gap is identified. When a network gap is identified, the Plan will collaborate with the member's network provider to coordinate care through an OON provider.

In addition, the above analysis revealed the process and methodology MH/SUD used to assess network adequacy “in operation” was comparable to, and applied no more stringently than, the process and methodology M/S used to assess network adequacy.

Conclusions

In light of the above findings, the Plan concluded the M/S and MH/SUD network management – network adequacy processes are applied to M/S and MH/SUD networks comparably and are applied no more stringently to MH/SUD both “as written” and “in operation.”

Limitations Analysis

GA Surest - UnitedHealthcare Insurance Company

12/29/2023

Overview

Pursuant to a federal law called the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical and surgical (M/S) benefits. This generally means that financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA protections include:

- Financial requirements, such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

Out-of-network (OON) emergency care reimbursement is the process by which the Plan establishes reimbursement for OON emergency claims as defined in the member’s plan documents. The methodologies applicable to emergency services reimbursement may also be applicable to reimbursement for out of network services provided in network facilities.

This document includes the following information:

- Process for establishing OON emergency care reimbursement rates for both M/S and MH/SUD services
- The description of the NQTL and application (Step 1)
- Factors used to determine which services are subject to the NQTL (Step 2)
- Evidentiary standards and sources used to define, trigger and/or implicate a factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

The analysis refers to the following attachments:

- *Certificates of Coverage* – COC23-INS-BIND-2021-LG-GA-UHIC – Plan document that explains covered services, terms, conditions, and limitations of the member’s policy
- *Schedule of Benefits* – SBN23-Medical-INS-BIND-2021-Choice Plus-LG-GA-UHIC – Plan document that outlines member responsibilities

The Plan concludes that its methodology for establishing M/S and MH/SUD OON emergency care services reimbursement rates is comparable and applied no more stringently for MH/SUD than for M/S both “as written” and “in operation.”

Process

Out-of-Network Reimbursement: Out-of-Network Emergency Care Non-Quantitative Treatment

Limitations Analysis

GA Surest - UnitedHealthcare Insurance Company
12/29/2023

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- OON Emergency Care Reimbursement

Benefit Classification(s)

- OON, emergency care

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHC)

Plan Terms/Source Documents

The Plan's *Certificate of Coverage* defines emergency health care services.

"Emergency Health Care Services - with respect to an Emergency:

- An appropriate medical screening exam (as required under section 1867 of the *Social Security Act* or as would be required under such section if such section applied to an Independent Freestanding Emergency Department) that is within the capability of the emergency department of a Hospital, or an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency, and
- Such further medical exam and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital or an Independent Freestanding Emergency Department, as applicable, as are required under section 1867 of the *Social Security Act*, or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient. regardless of the department of the Hospital in which such further exam or treatment is provided). For the purpose of this definition, "to stabilize" has the meaning as given such term in section 1867(e)(3) of the *Social Security Act* (42 U.S.C. 1395dd(e)(3)).
- Emergency Health Care Services include items and services otherwise covered under the Policy when provided by an out-of-Network provider or facility (regardless of the department of the Hospital in which the items and services are provided) after the patient is stabilized and as part of outpatient observation, or an Inpatient Stay or outpatient stay that is connected to the original Emergency, unless each of the following conditions are met:
 - a) The attending Emergency Physician or treating provider determines the patient is able to travel using nonmedical transportation or non-Emergency medical transportation to an available Network provider or facility located within a reasonable distance taking into consideration the patient's medical condition.
 - b) The provider furnishing the additional items and services satisfies notice and consent criteria in accordance with applicable law.
 - c) The patient is in such a condition to receive information as stated in b) above and to provide informed consent in accordance with applicable law.
 - d) The provider or facility satisfies any additional requirements or prohibitions as may be imposed by state law.
 - e) Any other conditions as specified by the Secretary.

The above conditions do not apply to unforeseen or urgent medical needs that arise at the time the service is provided regardless of whether notice and consent criteria has been satisfied."

The Plan's *Schedule of Benefits* informs Members of how OON Emergency Health Care Services are reimbursed.

"Emergency Health Care Services provided by an out-of-Network provider will be reimbursed as set forth under *Allowed Amounts* as described at the end of this *Schedule of Benefits*."

Out-of-Network Reimbursement: Out-of-Network Emergency Care Non-Quantitative Treatment

Limitations Analysis

GA Surest - UnitedHealthcare Insurance Company

12/29/2023

For Emergency Health Care Services provided by an out-of-Network provider, the Allowed Amount is based on one of the following in the order listed below as applicable:

The reimbursement rate as determined by a state *All Payer Model Agreement*.

The reimbursement rate as determined by state law.

The initial payment made by us or the amount subsequently agreed to by the out-of-Network provider and us.

The amount determined by Independent Dispute Resolution (IDR)."

Step 2 – Factors Used in the Design and Application of the NQTLs

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The findings of the comparative analysis revealed the process and methodology used for OON emergency care reimbursement for MH/SUD conditions “as written” and “in operation” was comparable to, and applied no more stringently than, the process and methodology used for OON emergency care reimbursement for M/S conditions.

Conclusions

Based upon these findings, the Plan concluded the methodology and processes that the Plan uses for OON emergency care reimbursement for MH/SUD conditions was comparable to the methodology and processes that is used for OON emergency care reimbursement for M/S conditions “as written” and “in operation.”

Overview

Pursuant to a federal law called the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical and surgical (M/S) benefits. This generally means that financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA protections include:

- Financial requirements such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage.

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

Out-of-network (OON) inpatient and outpatient reimbursement is the process by which the Plan establishes reimbursement for OON inpatient and outpatient claims as defined in the member’s plan documents.

This document includes the following information:

- OON inpatient and outpatient services reimbursement process for both M/S and MH/SUD services
- The description of the NQTL and application (Step 1)
- Factors used to determine which services are subject to the NQTL (Step 2)
- Evidentiary standards and sources used to define, trigger and/or implicate a factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

The analysis refers to the following attachments:

- *Certificates of Coverage* – COC23-INS-BIND-2021-LG-GA-UHIC – Plan document that explains covered services, terms, conditions, and limitations of the member’s policy
- *Schedule of Benefits* – SBN23-Medical-INS-BIND-2021-Choice Plus-LG-GA-UHIC – Plan document that outlines member responsibilities

The Plan concludes that the OON inpatient and outpatient reimbursement process for M/S and MH/SUD services are comparable and applied no more stringently both “as written” and “in operation.”

Process

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- OON reimbursement: Inpatient and outpatient services

Benefit Classification(s)

- OON, inpatient and outpatient

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHC)

Plan Terms / Source Document(s)

The Plan's *Schedule of Benefits* notifies members of OON reimbursement processes.

"Out-of-Network Benefits apply to Covered Health Care Services that are provided by an out-of-Network Physician or other out-of-Network provider, or Covered Health Care Services that are provided at an out-of-Network facility.

Covered Health Care Services provided at certain Network facilities by an out-of-Network Physician, when not Emergency Health Care Services, will be reimbursed as set forth under *Allowed Amounts* as described at the end of this *Schedule of Benefits*. For these Covered Health Care Services, "certain Network facility" is limited to a hospital (as defined in 1861(e) of the Social Security Act), a hospital outpatient department, a critical access hospital (as defined in 1861(mm)(1) of the Social Security Act), an ambulatory surgical center as described in section 1833(i)(1)(A) of the Social Security Act, and any other facility specified by the Secretary."

Step 2 – Factors Used in the Design and Application of the NQTL

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The findings of the comparative analysis revealed the process and methodology MH/SUD used to determine OON inpatient and outpatient reimbursement “as written” and “in operation” was comparable to, and applied no more stringently than, the process and methodology M/S used to determine OON inpatient and outpatient reimbursement.

Conclusions

Based upon these findings, the Plan concluded the methodology and processes that M/S and MH/SUD use to determine OON reimbursement was comparable “as written” and “in operation.”

Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical and surgical (M/S) benefits. This generally means that financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits must be comparable to and cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA protections include:

- Financial requirements such as, deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs, which may limit the scope or duration of benefits for treatment under a plan or coverage

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

Prescription Drug List (PDL) a/k/a formulary design is a component of the Plan’s utilization management (UM) program. The goal of PDL/formulary design is to assess the prescription drug’s place in therapy.

This document includes the following information:

- PDL process for both M/S and MH/SUD prescription drugs
- The description of the NQTL and application (Step 1)
- Factors used to determine prescription drugs tier placement and/or benefit coverage (Step 2)
- Evidentiary standards and sources used to define, trigger and/or implicate a factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

This analysis does not refer to any attachments.

The Plan concludes that the PDL/formulary design requirements for M/S and MH/SUD are comparable and applied no more stringently for prescription drug benefits both “as written” and “in operation.”

Process

The Pharmacy & Therapeutics (P&T) Committee assesses a prescription drug’s place in therapy and its relative safety and efficacy in order to provide a clinical recommendation/designation used in determining coverage and tier assignment. The P&T Committee is comprised of individuals from diverse clinical disciplines, including, behavioral health. Additional physician specialists with specific expertise are consulted as part of the clinical evaluation of new and existing drugs.

To approve clinical drug policies, the established committee follows a standard process. The P&T Committee evaluates the FDA approved product labeling, peer-reviewed medical literature, published clinical practice guidelines, including randomized clinical trials, drug comparison studies, outcomes research data, pharmacoeconomic studies, comparisons of efficacy, side effects, potential for off-label use and claims data analysis, as relevant, as part of the review and approval process of clinical policies. The P&T Committee assesses external clinical evidence and nationally recognized evidence-based guidelines and

benchmarks, as well as a prescription drug's place in therapy, and its relative safety and efficacy to approve clinical drug policies for select M/S and MH/SUD prescription drugs.

The UnitedHealthcare (UHC) Prescription Drug List Management Committee (PDL MC) makes tiering decisions by considering clinical, economic/financial and pharmacoeconomic evidence for populations with an incentive based PDL. The PDL MC makes benefit exclusion decisions using the same types of evidence. This information is provided by UHC Evidence Based Decision Support Committees, including but not limited to, the UHC P&T Committee as outlined above.

PDL a/k/a formulary design is based on the Plan's policy to assign tiers for prescription drugs. Newly launched generic prescription drugs are also reviewed to determine initial tier placement on the PDL and/or benefit coverage. A generic prescription drug includes a prescription drug that is chemically equivalent to a brand drug or that the Plan identifies as a generic based on available data resources including, but not limited to, the daily Medi-Span file load memo that classifies drugs as either brand or generic based on several factors. Generics will be considered for initial tier placement and/or benefit coverage equal to that of the current placement of the brand prescription drug.

The Plan reviews the number of M/S and MH/SUD prescription drugs by tier on a tri-annual basis. The results are reviewed with the UM Committee to determine if any changes should be made in the PDL/formulary design.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- PDL a/k/a Formulary Design

Benefit Classification(s)

- Prescription Drugs

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHC)

Plan Terms

- Prescription Drug List - a list that places into tiers medications or products that have been approved by the U.S. Food and Drug Administration (FDA). This list is subject to our review and change from time to time. You may find out to which tier a particular Prescription Drug Product has been placed by [visiting [benefits.surest.com]] [or] [calling the telephone number on your ID card] for the most up-to-date tier placement.

List of M/S and MH/SUD Services Subject to NQTL

- All prescription drugs are part of the Plan's PDL a/k/a formulary design
- The PDLs generally contain brand and generics that provide the highest overall value on Tiers 1 and 2, with brand and generics that provide the lowest overall value on Tier 3

Step 2 – Factors Used to Determine Formulary Design Applies

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

The Plan relies on the following factors to determine the PDL for both M/S and MH/SUD prescription drugs:

- Assessment of the prescription drug's place in therapy (Qualitative)

Applies to M/S and MH/SUD prescription drugs

- Relative safety and efficacy (Qualitative)

Applies to M/S and MH/SUD prescription drugs

- Available therapeutic equivalent prescription drugs (Quantitative)

Applies to M/S and MH/SUD prescription drugs

The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL. The factors apply to both M/S and MH/SUD prescription drugs.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factors used in determining the PDL. These evidentiary standards and sources apply to both M/S and MH/SUD prescription drugs.

Factor – Assessment of the prescription drug’s place in therapy

This evidentiary standard and source applies to both M/S and MH/SUD prescription drugs and is defined in a qualitative manner.

Factor – Relative safety and efficacy

This evidentiary standard and source applies to both M/S and MH/SUD prescription drugs and is defined in a qualitative manner.

Factor – Available therapeutic equivalent prescription drugs

This evidentiary standard and source applies to both M/S and MH/SUD prescription drugs and is defined in a quantitative manner.

The factors and evidentiary standards used as the basis for determining the PDL for MH/SUD prescription drugs are comparable to, and applied no more stringently than, the factors used as the basis for determining the PDL for M/S prescription drugs “as written” and “in operation.” The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL.

Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer’s analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert’s qualifications and the extent to which the Plan or issuer

As Written

Review of Operational Policies and Procedures

In Operation

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The findings of the analysis revealed the strategies, processes, factors, evidentiary standards, and source information the Plan used to administer the PDL a/k/a formulary design for MH/SUD prescription drugs were comparable to, and applied no more stringently than, the strategies, processes, factors, evidentiary standards, and source information used to administer the PDL a/k/a formulary design for M/S prescription drugs “as written.”

Conclusions

Based upon these findings, the Plan concluded that the methodologies to administer the PDL a/k/a formulary design for MH/SUD prescription drugs were comparable to, and applied no more stringently than, the methodologies to administer the PDL a/k/a formulary design for M/S prescription drugs “as written.”

Based on the above review and data, the Plan concluded the methodologies to administer the PDL a/k/a formulary design for MH/SUD prescription drugs were comparable to, and applied no more stringently than, the methodologies to administer the PDL a/k/a formulary design for M/S prescription drugs “in operation.”

Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical and surgical (M/S) benefits. This generally means that financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits are comparable to and no more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA protections include:

- Financial requirements such as, deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs, which may limit the scope or duration of benefits for treatment under a plan or coverage

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

Per the Outpatient Prescription Drug *Schedule of Benefits*, “Before certain Prescription Drug Products are dispensed to you, your Physician, your pharmacist or you are required to obtain prior authorization from us or our designee. The reason for obtaining prior authorization from us is to determine whether the Prescription Drug Product, in accordance with our approved guidelines, is each of the following:

- It meets the definition of a Covered Health Care Service.
- It is not an Experimental or Investigational or Unproven Service.”

The *Certificate of Coverage* defines Covered Health Care Service as “health care services, including supplies or Pharmaceutical Products, which we determine to be all of the following:

- Provided for the purpose of preventing, evaluating, diagnosing or treating a sickness, injury, mental illness, substance-related and addictive disorders, condition, disease or its symptoms.
- Medically Necessary
- Described as a Covered Health Care Service in the Certificate under Section 1: Covered Health Care Services and in the Schedule of Benefits
- Not excluded in the Certificate under Section 2: Exclusions and Limitations”

Prior Authorization is a component of the Plan’s utilization management (UM) program that helps members receive appropriate coverage based on their specific clinical status and health care needs. The process is designed to achieve optimal clinical outcomes by applying objective, evidence-based clinical criteria and nationally recognized guidelines and best practices.

Prior Authorization for prescription drugs commences prior to a drug being covered. Prior Authorization is a UM process that involves applying clinical criteria to member clinical information in order to render a clinical coverage benefit determination.

The goal of Prior Authorization, Step Therapy, and Quantity Limits is to ensure cost-effective and clinically effective prescription drugs are covered to achieve a positive clinical outcome. Prior Authorization, Step Therapy, and Quantity Limits apply to prescription drugs provided to a member at the point-of-sale. Drug products are selected for Quantity Limits to encourage Food and Drug Administration (FDA) labeling, prevent abuse, address safety concerns, prevent pharmacy billing errors and encourage dose optimization.

Prior Authorization, Step Therapy, and Quantity Limits for prescription drugs begin after a provider or member requests

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coverage for a prescription drug and receipt of clinical information. The provider or member's submission of a request (notification) triggers the Prior Authorization, Step Therapy, and Quantity Limits process. Quantity Limits trigger a Prior Authorization if the member is seeking more than the quantity limit set.

Note: The comparative analysis "as written" and "in operation" are the same for Prior Authorization, Step Therapy and Quantity Limits; therefore, the analysis has been combined.

This document includes the following information:

- Prior Authorization, Step Therapy, and Quantity Limits process for both M/S and MH/SUD prescription drugs
- The description of the NQTL and application (Step 1)
- Factors used to determine which prescription drugs are subject to the NQTL (Step 2)
- Evidentiary standards and sources used to define, trigger, and/or implicate a factor (Step 3)
- NQTL "as written" and "in operation" comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

This analysis refers to the following attachments:

- *UnitedHealthcare Provider Administrative Guide* - [2023 UnitedHealthcare Care Provider Administrative Guide \(uhcprovider.com\)](https://uhcprovider.com) - Informs providers of the Prior Authorization process
- *Certificates of Coverage - COC23-INS-BIND-2021-LG-GA-UHIC* - Plan document that explains covered services, terms, conditions, and limitations of the member's policy
- *Schedule of Benefits - SBN23-Pharmacy-INS-BIND-2021-Pharmacy Network-LG-GA-UHIC* - Plan document that outlines member responsibilities
- Drugs with Clinical Programs dated 12/01/2023

The Plan concludes that the Prior Authorization, Step Therapy, and Quantity Limit requirements for M/S and MH/SUD are comparable and applied no more stringently for M/S or MH/SUD prescription drug benefits both "as written" and "in operation."

Process

For all prescription drugs covered under the pharmacy benefit, the Plan uses the same policies and procedures to create clinical criteria and develop clinical drug policies through a single Pharmacy & Therapeutics (P&T) Committee.

The P&T Committee is comprised of individuals from diverse clinical disciplines including, behavioral health. Additional physician specialists with specific expertise are consulted as part of the clinical evaluation of new and existing drugs.

To approve clinical drug policies, the established committee follows a standard process. The P&T Committee evaluates the FDA approved product labeling, peer-reviewed medical literature, published clinical practice guidelines, including randomized clinical trials, drug comparison studies, outcomes research data, pharmacoeconomic studies, comparisons of efficacy, side effects, potential for off-label use and claims data analysis, as relevant, as part of the review and approval process of clinical policies. The P&T Committee assesses external clinical evidence and nationally recognized evidence-based guidelines and benchmarks, as well as a prescription drug's place in therapy, and its relative safety and efficacy to approve clinical drug policies for select M/S and MH/SUD prescription drugs.

Per the *Outpatient Prescription Drug Schedule of Benefits*, "before certain prescription drugs are covered, the member, their physician, or their pharmacist are required to obtain Prior Authorization from UnitedHealthcare. The reason for obtaining Prior Authorization is to determine whether the prescription drug, in accordance with our approved guidelines, is each of the following:

- It meets the definition of a Covered Health Care Service.
- It is not an Experimental or Investigational or Unproven Service"

The *Certificate of Coverage* defines Covered Health Care Service as “health care services, including supplies or Pharmaceutical Products, which we determine to be all of the following:

- Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms.
- Medically Necessary
- Described as a Covered Health Care Service in the Certificate under Section 1: Covered Health Care Services and in the Schedule of Benefits
- Not excluded in the Certificate under Section 2: Exclusions and Limitations”

The Plan structures prescription drug Prior Authorization processes to be compliant with all applicable federal and state laws, as well as the National Committee for Quality Assurance (NCQA) accreditation standards. NCQA confirms that Plan operations and policies identify appropriate time frames for decisions, requires decision-making by appropriate personnel, and governs communication of adverse benefit determinations. In addition, Prior Authorization is governed at both the state and federal level, which includes consumer protections such as external review for adverse benefit determinations after internal appeals options are exhausted, as applicable.

Prior Authorization, Step Therapy and Quantity Limits review of M/S and MH/SUD prescription drugs consists of the following:

Prior Authorization, Step Therapy, and Quantity Limits for prescription drugs begin after a provider or member requests coverage for a prescription drug and receipt of clinical information. The provider or member’s submission of a request (notification) triggers the Prior Authorization, Step Therapy, and Quantity Limits process. Quantity Limits trigger a Prior Authorization if the member is seeking more than the quantity limit set. A Prior Authorization (including Quantity Limits) or Step Therapy request may be submitted by telephone or electronically. The Plan confirms receipt of the Prior Authorization, Step Therapy or Quantity Limit request. Non-clinical staff confirm member eligibility and benefit plan coverage. The Plan can administratively deny cases for lack of eligibility or benefit coverage.

Determinations. Clinical reviewers (Medical Director or healthcare professional) consult clinical drug policies when making clinical coverage benefit determinations. The clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical drug policies in the case review to assess whether a prescription drug should be covered. The Prior Authorization, Step Therapy, or Quantity Limit request is approved based on whether the member’s clinical condition meets criteria for coverage as determined by the application of clinical drug policies. Only qualified clinical reviewers (e.g., physicians or pharmacists) can issue adverse benefit determinations. If an adverse benefit determination is issued, then the adverse benefit determination and appeal rights are communicated to the member and provider.

Adverse Benefit Determinations. For prescription drugs, an adverse benefit determination is an administrative or clinical review decision resulting in a reduction or termination, non-coverage or non-certification of a prescription drug. Adverse benefit determinations are recorded as administrative denials when member eligibility and benefit coverage cannot be confirmed, or benefits are exhausted. Adverse benefit determinations are recorded as clinical denials when they are based on clinical drug policies and member clinical information

Clinical Criteria. Clinical reviewers base Prior Authorization clinical coverage benefit determinations on objective, evidence-based clinical drug policies.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- Prescription Drug Prior Authorization, Step Therapy, and/or Quantity Limits

Benefit Classification(s)

- Prescription Drugs

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHC)

Plan Terms/Source Document(s)

The Plan's *Certificates of Coverage* notify members of the Prior Authorization requirements. Members or providers are required to comply with UM protocols established by the Plan.

Per the *Outpatient Prescription Drug Schedule of Benefits*, "before certain prescription drugs are covered, the member, their physician, or their pharmacist are required to obtain Prior Authorization from UnitedHealthcare. The reason for obtaining Prior Authorization is to determine whether the prescription drug, in accordance with our approved guidelines, is each of the following:

- It meets the definition of a Covered Health Care Service.
- It is not an Experimental or Investigational or Unproven Service"

The *Certificate of Coverage* defines Covered Health Care Service as "health care services, including supplies or Pharmaceutical Products, which we determine to be all of the following:

- Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms.
- Medically Necessary
- Described as a Covered Health Care Service in the Certificate under Section 1: Covered Health Care Services and in the Schedule of Benefits
- Not excluded in the Certificate under Section 2: Exclusions and Limitations"

The *2023 UnitedHealthcare Care Provider Administrative Guide* notifies providers of the Prior Authorization requirements. In-network providers are required to comply with UM protocols established by the Plan.

"We develop medical policies, medical benefit drug policies, coverage determination guidelines, and utilization review guidelines to support the administration of medical benefits. You may request a copy of our medical policies and guidelines by calling our care management team at 1-877-842-3210 or 1-888-478-4760 (Individual Exchange Plans). They are only for informational purposes; they are not medical advice. You are responsible for deciding what care to give our members. Members should talk to their health care providers before making medical decisions. Drug policies for commercial members covered under the pharmacy benefit are on uhcprovider.com/pharmacy.

Benefit coverage is determined by the following:

- Laws that may require coverage
- The member's benefit plan document
 - Summary Plan Description
 - Schedule of Benefits
 - Certificate of Coverage

The member's benefit plan document identifies which services are covered, which are excluded, and which are subject to limitations. If there is a conflict, the member's benefit plan document supersedes our policies and guidelines.

We develop our policies and guidelines as needed. We regularly review and update them. They are subject to change. We believe the information in these policies and guidelines is accurate and current as of the publication date. We also use tools developed by third parties, such as InterQual criteria, to help us manage health benefits. If you believe we should consider new or additional clinical evidence pertaining to a specific medical policy, complete this form for

UnitedHealthcare medical policy review. Do not submit protected health information using this form. If you have questions or concerns about a specific service for a member, refer to the appropriate benefits, claims or prior authorization/notification process.”

List of M/S and MH/SUD Services Subject to NQTL

See list of Drugs with Clinical Programs dated 12/01/2023

Step 2 – Factors Used to in the Design and Application of the NQTL

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

The Plan relies on the following factors to determine whether prescription drugs are subject to Prior Authorization, Step Therapy, or Quantity Limits for both M/S and MH/SUD:

- Assessment of the prescription drug’s place in therapy (Qualitative)

Applies to M/S and MH/SUD prescription drugs.

- Availability of clinically similar lower cost medications to treat the condition (Quantitative)

Applies to M/S and MH/SUD prescription drugs.

- Value to implement Prior Authorization/ Step Therapy (Qualitative)

Applies to M/S and MH/SUD prescription drugs.

- Relative safety and efficacy (Qualitative)

Applies to M/S and MH/SUD prescription drugs.

Prevention of off-label use or unproven uses (Qualitative)

Applies to M/S and MH/SUD prescription drugs.

The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL. The factors apply to both M/S and MH/SUD prescription drugs.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below are the sources and evidentiary standards used to define, trigger, and/or implicate the factor used in designing or applying the Plan’s Prior Authorization, Step Therapy, or Quantity Limits requirement to prescription drugs.

Factor – Assessment of the prescription drug’s place in therapy -

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Factor – Availability of clinically similar lower cost medications to treat the condition -

These evidentiary standards and sources apply to both M/S and MH/SUD prescription drugs. These evidentiary standards and sources are defined in a quantitative manner.

Factor – Value to implement Prior Authorization/Step Therapy -

These evidentiary standards and sources apply to both M/S and MH/SUD prescription drugs. These evidentiary standards and sources are defined in a qualitative manner.

Factor – Relative safety and efficacy -

These evidentiary standards and sources apply to both M/S and MH/SUD prescription drugs. These evidentiary standards and sources are defined in a qualitative manner.

Factor – Prevention of off-label use or unproven uses -

These are the factors and evidentiary standards used in designing or applying the Plan's Prior Authorization, Step Therapy, or Quantity Limits requirement to prescription drugs. The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL.

Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

As Written

Review of Factors and Evidentiary Standards

Review of Operational Policies and Procedures

In Operation

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

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The findings of the analyses confirmed the strategies, processes, factors, evidentiary standards, and source information used to subject certain MH/SUD prescription drugs to Prior Authorization, Step Therapy, or Quantity Limits were comparable to, and applied no more stringently than, the strategies, processes, factors, evidentiary standards, and source information used to subject certain M/S prescription drugs to Prior Authorization, Step Therapy, or Quantity Limits “as written.”

Conclusions

The Plan reviewed the M/S and MH/SUD processes and noted the Plan uses a single P&T committee which follows a standard process to create clinical criteria and develop clinical drug policies for M/S and MH/SUD prescription drugs. From review of the Prior Authorization Step Therapy, or Quantity Limit policies and procedures, the Plan concluded the methodology used to determine which MH/SUD prescription drugs are subject to Prior Authorization Step Therapy, or Quantity Limits “as written” were comparable to, and applied no more stringently than, the methodology used to determine which M/S prescription drugs are subject to Prior Authorization, Step Therapy, or Quantity Limits “as written.” Additionally, the Plan concluded how Prior Authorization, Step Therapy, or Quantity Limits is applied to MH/SUD prescription drugs was comparable to, and applied no more stringently than, how Prior Authorization, Step Therapy, or Quantity Limits was applied to M/S prescription drugs “as written.”

The Plan notes that the percentage of MH/SUD drugs subject to Prior Authorization, Step Therapy, and/or Quantity Limits is higher than the percentage of M/S drugs subject to Prior Authorization, Step Therapy, and/or Quantity Limits. The Plan concluded this was due to the following contributing factors: a smaller pool of MH/SUD products to evaluate, a broader range of strengths for MH/SUD products, and an increased risk of abuse and diversion of MH/SUD products explain the variance. The Plan concluded this does not indicate a parity concern, but rather is an indicator of patient safety in disbursing MH/SUD drugs.

The Plan reviewed the M/S and MH/SUD processes and noted the Plan uses the same policies and procedures to create clinical criteria and develop clinical drug policies for both M/S and MH/SUD prescription drugs. The Plan also reviewed the percentage of M/S and MH/SUD prescription drugs which are subject to Prior Authorization, Step Therapy, or Quantity Limits and concluded the methodology used to determine which MH/SUD prescription drugs are subject to Prior Authorization, Step Therapy, or Quantity Limits and how Prior Authorization, Step Therapy, or Quantity Limits were applied were comparable to, and applied no more stringent than, the methodology used to determine which M/S prescription drugs were subject to Prior Authorization, Step Therapy, or Quantity Limits “in operation.”

Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical/surgical (M/S) benefits. This generally means that financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements, such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage.

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Prior Authorization is defined as: “A required or mandatory clinical assessment for proposed service(s) based on clinical information provided and the terms of the health plan benefits before the service(s) are performed or delivered. Clinical and medical necessity requirements, level of care appropriateness, and the terms of the health plan benefits must be met in order for services to be covered by the member’s plan.” The *Optum National Policy Definitions List* defines pre-authorization (aka Prior Authorization) as “a form of prospective utilization review of health care services proposed to be provided to a member.”

Prior Authorization is a component of the Plan’s Utilization Management (UM) program that helps ensure members receive appropriate coverage based on their specific clinical status and health care needs. The process is designed to achieve optimal clinical outcomes by applying objective, evidence-based clinical criteria, and nationally recognized guidelines and best practices.

Prior Authorization for inpatient services commences prior to a service being delivered. Prior Authorization is a UM process that involves applying the benefit plan language and/or clinical criteria to make the most appropriate clinical coverage benefit determination.

This document includes the following information:

- Prior Authorization process for M/S and MH/SUD inpatient services
- Description of the NQTL and application (Step 1)
- Factors used to determine which services are subject to the NQTL (Step 2)
- Evidentiary standards and sources used to define, trigger and/or implicate a factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

This analysis refers to the following attachments:

- *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions* - M/S policy that defines Prior Authorization
- *Optum National Policy Definitions List* - MH/SUD policy that defines Prior Authorization

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- *Utilization Management Program Description (UMPD) of United HealthCare Services, Inc. and UnitedHealthcare Insurance Company* - Summarizes the philosophy, structure and standards that govern UHC's medical management, UM and utilization review responsibilities and functions
- *Management of Behavioral Health Benefits Policy* - Describes the mechanisms and processes designed to promote consistency in the management of behavioral health benefits and to ensure that members receive appropriate, high quality behavioral health services in a timely manner
- *Core Principles and Practices* - MH/SUD policy that outlines the core principles and practices that should be used by personnel in their interactions with members, authorized member representatives, practitioners and facilities, related to the management of behavioral health benefits, coverage determinations and appeals/grievances of non-coverage determinations.
- *Performance Assessment and Incentives* - M/S policy confirming that clinical reviewers are not incented to make denials for financial reasons
- *2023 UnitedHealthcare Provider Administrative Guide* – Informs M/S providers of the Prior Authorization process. The *UnitedHealthcare Provider Administrative Guide* can be accessed on the website <https://www.uhcprovider.com/en/admin-guides.html>
- *September 2023 Optum National Network Manual* - Informs MH/SUD providers of the Prior Authorization process. The *Optum National Network Manual* can be accessed on the website <https://public.providerexpress.com/content/optum-provexpr/us/en/clinical-resources/guidelines-policies/optum-network-manual.html>
- *Schedule of Benefits - SBN23-Medical-INS-BIND-2021-Choice Plus-LG-GA-UHIC* - Plan document that outlines member responsibilities

The Plan concludes that the Prior Authorization requirements for M/S and MH/SUD are comparable and applied no more stringently for MH/SUD in-network (INN) inpatient benefits, both “as written” and “in operation.”

Process

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Prior Authorization is defined as: “A required or mandatory clinical assessment for proposed service(s) based on clinical information provided and the terms of the health plan benefits before the service(s) are performed or delivered. Clinical and medical necessity requirements, level of care appropriateness, and the terms of the health plan benefits must be met in order for services to be covered by the member's plan.” The *Optum National Policy Definitions List* defines pre-authorization (aka Prior Authorization) as “a form of prospective utilization review of health care services proposed to be provided to a member.”

The Plan structures inpatient Prior Authorization processes to be compliant with all applicable federal and state requirements. Prior Authorization is governed at both the state and federal level, which includes consumer protections such as external review for adverse benefit determinations after internal appeal options are exhausted.

The Plan delegates management of MH/SUD inpatient services, including Prior Authorization, to United Behavioral Health d/b/a Optum Behavioral Health (OBH), its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor.

The Plan has national committees that approve M/S and MH/SUD services to be subject to Prior Authorization. The Plan publishes the services subject to Prior Authorization on the provider portal(s) ([Advance Notification and Clinical Submission Requirements | UHCprovider.com](#) for M/S and [Optum - Provider Express Home](#) for MH/SUD). Members can learn what services are subject to Prior Authorization in their benefit plan document, through myuhc.com, or by contacting customer service.

Prior Authorization – In-Network Inpatient Non-Quantitative Treatment Limitation (NQTL) Analysis

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Prior Authorization Review of M/S inpatient admissions consists of the following:

The Plan requires INN facilities and providers to submit a Prior Authorization request for services on the Prior Authorization list prior to rendering the service. There may be some INN benefits for which the member is responsible for obtaining Prior Authorization. These are identified in the member's benefit plan document (i.e., *Schedule of Benefits*). The INN provider's submission of a request (notification) triggers the Prior Authorization process.

INN providers can submit Prior Authorization requests through the secure provider portal (www.uhcprovider.com), their connected electronic medical record, by telephone, or by fax (where required). Members may submit Prior Authorization requests by telephone, fax, or mail, in accordance with Plan requirements. Providers and members communicate basic information to create a case. As outlined in the *UnitedHealthcare Care Provider Administrative Guide*, providers must submit advance notification with supporting documentation as soon as possible, but at least two weeks before the planned service, unless otherwise stated.

The Plan confirms receipt of the Prior Authorization request. Non-clinical staff confirm member eligibility and benefit coverage upon receipt of the notification. Non-clinical staff review cases to ensure availability of accurate and thorough case information. Non-clinical staff may approve coverage requests in scenarios where the member's plan documents allow and if a clinical review is not required. Non-clinical staff will also approve a coverage request if the facility's contract does not allow for clinical reviews. Requests that are submitted through the secure provider portal may also be approved based on the benefit plan coverage criteria, member diagnosis, and the clinical information submitted. Non-clinical staff may administratively deny coverage when a member's benefits are exhausted. Non-clinical staff refer coverage requests that they cannot approve or administratively deny to initial clinical reviewers.

First Level Clinical Review/Initial Review. Clinical reviewers (nurses or physicians) consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether the inpatient admission is medically necessary by reviewing the member's clinical information, the applicable clinical criteria or guidelines, and the Plan benefit terms. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs to determine whether the applicable clinical criteria are met or may access clinical information in the provider's electronic medical record (EMR) if the provider has given the Plan access. The clinical reviewer may approve cases that meet applicable clinical criteria.

Second Level Clinical Review/Peer Review. The initial clinical reviewer refers cases to a second level/peer clinical reviewer if the case cannot be approved. Peer clinical reviewers (physician or mid-level practitioner) consult clinical criteria when making clinical coverage benefit determinations. Peer clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. The peer clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. If a peer clinical reviewer issues an adverse benefit determination, then the Plan communicates the adverse benefit determination and appeal rights and offers a peer-to-peer conversation consistent with state and federal requirements.

Adverse Benefit Determination. For M/S, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction, or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when member benefits are exhausted. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials. Modified coverage requests that are approved are recorded as partial denials.

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Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based medical clinical policies and use clinical criteria from third-party sources such as InterQual® or MCG® guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that inpatient Prior Authorization determinations are appropriate.

M/S monitors clinical reviewer and peer clinical reviewer application of clinical criteria through an annual inter-rater reliability (IRR) assessment that is provided by InterQual. Clinical reviewers and peer clinical reviewers are required to pass the IRR assessment with a score of 90% or better through three attempts. After a second failed IRR assessment, staff enter a remediation period and are required to review all cases with a supervisor for 30 days, or until 90% is achieved on the assessment. If the clinical reviewer achieves a passing score within the 30-day period, supervisors review a minimum of one case per week for the remainder of the 30-day period.

The Plan also conducts end-to-end case audits that are designed and approved by clinical leadership each year. The end-to-end audits include all stages of a case review, from intake through appeal. These audits are conducted monthly and approximately 1500 cases are reviewed per month. Results are reported to an oversight team. All deficiencies are remediated. Remediation may include corrective actions and/or additional education, as indicated.

The Plan routinely monitors Prior Authorization performance through its clinical performance oversight functions. Outcomes are monitored against timeliness compliance, performance guarantees, and for potential trends, including overall utilization.

As of April 1, 2023, the Utilization Management Program Committee (UMPC) began overseeing the M/S UM program. The UMPC is responsible for the development and maintenance of the M/S Prior Authorization processes. The UMPC ensures that the UM program considers the factors and evidentiary standards for applying UM. The UMPC is comprised of:

- Chief Medical Officer, Medical Management (Co-Chair)
- Senior Vice President, Clinical Advancement (Co-Chair)
- Chief Medical Officer, UnitedHealthcare
- Senior Vice President, Clinical Appeals & Grievances
- Chief Medical Officer, Clinical Policy
- Chief Medical Officer, UnitedHealthcare Employer & Individual
- Chief Medical Officer, UnitedHealthcare Medicare & Retirement
- Chief Medical Officer, Community & State
- Chief Medical Officer, UnitedHealthcare Individual & Family Plans
- Vice President, Clinical Transformation & Affordability
- Senior Director, Mental Health Parity
- Vice President, Utilization Management Strategy & Implementation

One of the chairs must be an executive leader and a licensed physician. UMPC meets at least six times per year but may meet more frequently if needed.

Per the M/S policy entitled *Performance Assessment and Incentives*, at no time are initial clinical reviewers or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons.

M/S generally structures UM processes to comply with federal Employee Retirement Income Security Act of 1974 (ERISA) requirements, and state law where applicable.

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Prior Authorization review of MH/SUD inpatient admissions consists of the following:

The Plan delegates management of MH/SUD inpatient services, including Prior Authorization, to United Behavioral Health d/b/a OBH, its delegated MH/SUD MBHO vendor.

The Plan requires INN providers and facilities to submit a Prior Authorization request for services on the Prior Authorization list prior to rendering the service. There may be some INN benefits for which the member is responsible for obtaining Prior Authorization. These are identified in the member's benefit plan document (i.e., *Schedule of Benefits*). The INN provider's submission of a request (notification) triggers the inpatient Prior Authorization process.

INN providers may submit Prior Authorization requests through the secure provider portal (www.providerexpress.com), by telephone, or by fax (where required). Providers communicate basic information to create a case. As outlined in the *Optum National Network Manual*, inpatient behavioral health services require an initial Prior Authorization or notification in advance of the service.

As described in the *Management of Behavioral Health Benefits Policy*, the Plan confirms receipt of the Prior Authorization request. Non-clinical staff confirm member eligibility and benefit coverage. Non-clinical staff may approve coverage requests that do not require clinical evaluation or interpretation based on the member's diagnosis and the clinical information submitted by providers. Non-clinical staff may administratively deny coverage when member benefits are exhausted. Non-clinical staff refer cases that they cannot approve or administratively deny to initial clinical reviewers.

First Level Clinical Review/Initial Review. Clinical decisions are made by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse benefit determinations are made by Medical Directors. Clinical reviewers consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether an inpatient admission is medically necessary by reviewing the member's clinical information, the applicable clinical criteria or guidelines, and the Plan benefit terms. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for certification, related diagnostic results, and history of related treatment and services to determine whether the applicable clinical criteria are met. The clinical reviewer may approve the admission based on their review.

Second Level Clinical Review/Peer Review. The initial clinical reviewer refers cases to a peer clinical reviewer for a peer-to-peer discussion if the case cannot be approved. The requesting provider is offered the opportunity to discuss the case with the peer clinical reviewer, consistent with state and federal requirements before an adverse benefit determination is issued. Only qualified peer clinical reviewers (e.g., Medical Directors) can issue adverse benefit determinations. Peer clinical reviewers apply clinical criteria to member clinical information to determine coverage for an inpatient admission. If the requesting provider fails to complete the peer-to-peer discussion, the peer clinical reviewer makes a determination based on the information available. If a peer clinical reviewer issues an adverse benefit determination (e.g., the admission is not medically necessary and is not approved), then the Plan timely communicates the adverse benefit determination, including appeal rights, to the member and provider consistent with applicable state and federal requirements.

Adverse Benefit Determination. For MH/SUD, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction, or termination of a benefit. Adverse benefit determinations are recorded as a clinical denial when it is based on clinical criteria and member clinical information and is recorded as an administrative denial when member benefits are excluded.

Platinum Designation. The Plan offers a Platinum Designation program to MH/SUD facilities based on facilities' quantitative practice patterns (effectiveness and efficiency benchmarks). The Platinum Designation program's effectiveness and efficiency benchmarks include targeted 30- and 90-day readmission rates, 7- and 30-day follow up after hospitalization, outlier length of stay, and outlier behavioral health episode spend. INN MH/SUD facilities that meet the Platinum Designation are required to

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notify the Plan of admissions and provide member information. The Plan covers the first 8 to 21 days of a stay depending on the specific level of care without review. The Plan evaluates INN MH/SUD facilities performance annually as described in the *Optum National Network Manual*.

Clinical Criteria. Initial clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based behavioral clinical policies or use clinical criteria from third-party sources such as American Society of Addiction Medicine (ASAM) Criteria®, Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System-Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) and Early Childhood Service Intensity Instrument (ECSII) guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that inpatient Prior Authorization determinations are appropriate.

Per the MH/SUD policy entitled, *Core Principles and Practices*, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons.

MH/SUD generally structures UM processes to comply with federal ERISA requirements and state law where applicable.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- Prior Authorization

Benefit Classification(s)

- INN, inpatient

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHIC)

Plan Terms/Source Document(s)

In each of the Plan products, “Medically Necessary” is the Plan term used to guide Prior Authorization decision-making for both M/S and MH/SUD services. “Medically Necessary” is generally defined as follows:

“Medically Necessary – health care services are all of the following as determined by us or our designee.

- In accordance with *Generally Accepted Standards of Care*.
- Clinically appropriate, in terms of type, frequency, extent, service site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s), service site or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.
- Or, are subject to Bind Coverage with Evidence Development Policy (CED Policy).

Generally Accepted Standards of Care are evidence based independent standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties. Valid, evidence based sources reflecting generally accepted standards of care include credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

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If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or nationally recognized clinical practice guidelines may be considered. We have the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be determined by us.

We develop and maintain clinical policies that describe the Generally Accepted Standards of Care scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. [[These clinical policies (as developed by us and revised from time to time), are available to Covered Persons through [MyBind.com] or by calling the telephone number on your ID card.] [They are [also] available to Physicians and other health care professionals on [MyBind.com].]]”

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Prior Authorization is defined as:

“A required or mandatory clinical assessment for proposed service(s) based on clinical information provided and the terms of the health plan benefits before the service(s) are performed or delivered. Clinical and medical necessity requirements, level of care appropriateness, and the terms of the health plan benefits must be met in order for services to be covered by the member's plan.”

The *Optum National Policy Definitions List* defines pre-authorization (aka Prior Authorization) as “a form of prospective utilization review of health care services proposed to be provided to a member.”

The Plan's *Schedule of Benefits* notify members of the Prior Authorization requirements:

“We require prior authorization for certain Covered Health Care Services. Network providers are responsible for obtaining prior authorization before they provide these services to you. [\[Benefits for conditional coverage do not require Network provider prior authorization, with the exception of a pre-admission notification for Covered Health Care Services for Inpatient Stays.\]](#)

We recommend that you confirm with us that all Covered Health Care Services have been prior authorized as required. Before receiving these services from a Network provider, you may want to call us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they do not prior authorize as required. You can call us at the telephone number on your ID card.

When you choose to receive certain Covered Health Care Services from out-of-Network providers, you are responsible for obtaining prior authorization before you receive these services. Note that your obligation to obtain prior authorization is also applicable when an out-of-Network provider intends to admit you to a Network facility or to an out-of-Network facility or refers you to other Network or out-of-Network providers. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization. Services for which you are required to obtain prior authorization are shown in the Schedule of Benefits table within each Covered Health Care Service category.

To obtain prior authorization, call the telephone number on your ID card. This call starts the utilization review process.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the Schedule of

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Benefits table to find out how far in advance you must obtain prior authorization.

For Covered Health Care Services that do not require you to obtain prior authorization, when you choose to receive services from out-of-Network providers, we urge you to confirm with us that the services you plan to receive are Covered Health Care Services. That's because in some instances, certain procedures may not be Medically Necessary or may not otherwise meet the definition of a Covered Health Care Service, and therefore are excluded. In other instances, the same procedure may meet the definition of Covered Health Care Services. By calling before you receive treatment, you can check to see if the service is subject to limitations or exclusions.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those received, our final coverage determination will be changed to account for those differences, and we will only pay Benefits based on the services delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Care Service, you will be responsible for paying all charges and no Benefits will be paid.”

The *2023 UnitedHealthcare Care Provider Administrative Guide* notifies providers of the Prior Authorization requirements. INN providers are required to comply with UM protocols established by the Plan:

“We require prior authorization for all MA benefit plans and some commercial benefit plans. Prior authorization requests allow us to verify if services are medically necessary and covered. After you notify us of a planned service listed on the Advance Notification/Prior Authorization List, we tell you if a clinical coverage review is required, as part of our prior authorization process, and what additional information we need to proceed. We notify you of our coverage decision within the time required by law. Just because we require notification for a service, does not mean it is covered. We determine coverage by the member’s benefit plan.

If there is a conflict or inconsistency between applicable regulations and the notification requirements in this guide, the applicable regulations govern.

Physicians, health care professionals and ancillary care providers are responsible for:

- Providing advance notification or requesting prior authorization for services on the Advance Notification/Prior Authorization List, including for non-emergent air transport services.
- Directing members to use care providers within their network. Members may be required to obtain prior authorization for out-of-network services.

Facilities are responsible for:

- Obtaining prior authorization for non-emergent, fixed-wing transportation services and using in-network, fixed-wing air ambulance providers.
- Obtaining prior authorization for inpatient admission to skilled nursing facility, acute inpatient rehabilitation and/or long-term acute care.
- Confirming coverage approval is on file (for services requiring advance notification/prior authorization) prior to the date of service.
- Providing admission and discharge notification for inpatient services, even if coverage approval is on file

If you perform multiple procedures for a member in one day, and at least one service requires prior authorization, you must obtain Prior authorization for any of the services to be paid.

If you do not follow these requirements, we may deny claims. In that case, you cannot bill the member. Advance notification or prior authorization is valid only for the date of service or date range listed on it. If services have not been rendered and the

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specified date of service or date range has passed, you must contact us to update the date of service or date range. When you contact us, we will advise if we will require a new submission.

- Giving us advance notification, or receiving prior authorization from us, is not a guarantee of payment, unless required by law or Medicare guidelines. This includes regulations about health care providers on a sanction or excluded list, the Medicare preclusion list and/or health care providers not included in the Medicare Provider Enrollment Chain and Ownership System (PECOS)* list. Payment of covered services is based on:
 - The member's benefit plan,
 - If you are eligible for payment,
 - Claim processing requirements,
 - Your Agreement.

Information required for advance notification/prior authorization requests Your request must have the following information:

- Member name and member health plan ID number
- Ordering health care provider name and TIN or NPI
- Rendering health care provider name and TIN or NPI
- ICD-10-CM diagnosis code
- All applicable procedure codes
- Anticipated date(s) of service
- Type of service (primary and secondary) procedure code(s) and, if relevant, the volume of service
- Place of service
- Facility name and TIN or NPI where service will be performed (when applicable)
- Original start date of dialysis (End Stage Renal Disease [ESRD] only)

If the member's benefit plan requires a clinical coverage review, we may request additional information, as described in more detail in the Clinical coverage review section.

The list of services that require advance notification and prior authorization is the same. The process for providing notification and submitting a prior authorization request is the same. Services that require Prior authorization require a clinical coverage review based on medical necessity.

View the most current and complete advance notification requirements, including procedure codes and associated services, at uhcprovider.com/priorauth > Advance Notification and Plan Requirement Resources.

Advance notification/prior authorization lists are subject to change. We will inform you of changes on uhcprovider.com/news. Sign up to receive email updates at uhcprovider.com/subscribe. If you need a paper copy of the requirements, contact your UnitedHealthcare Network Management representative or provider advocate at uhcprovider.com > Contact us.

We recommend that you submit advance notification with supporting documentation as soon as possible, but at least 2 weeks before the planned service (unless the Advance Notification Requirements states otherwise). Following a facility discharge, advance notification for home health services and durable medical equipment is required within 48 hours after the start of service."

The *Optum National Network Manual*, September 2023 notifies providers of the Prior Authorization requirements. INN providers are required to comply with UM protocols established by the Plan:

"In most cases, inpatient admissions will be directed only to participating hospitals and attending psychiatrists.

All inpatient and sub-acute level of care admissions require notification or pre-authorization by the network provider or facility. Optum requires notification within one business day after an admission for a facility to request a pre-authorization

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unless a longer period is required by contract or state specific requirements. This includes, but is not limited to, mental health or substance abuse disorder services delivered as inpatient treatment, partial/day hospitalization or residential treatment.

Network providers are solely responsible for completing prior notification or obtaining preauthorization prior to providing inpatient or sub-acute level of care services. This includes timely provision of information necessary for concurrent review of continued stay or ongoing care requests prior to the delivery of services.

Should a provider fail to obtain or otherwise follow the required administrative procedures for notification or pre-authorization, Optum may, in accordance with applicable law, apply a reduction of payment to the network provider up to 100% of provider's reimbursement rate. Network provider payment reductions for failure to complete notification or obtain pre-authorization are solely the network provider's liability (i.e., the member cannot be billed for these reductions in payment)."

The role of the Plan's delegate, United Behavioral Health d/b/a OBH, is discussed in the *UMPD*:

"United Behavioral Health (UBH) performs the review of requests for coverage of behavioral health services (i.e., substance abuse, and mental health requests for services). UBH provides comprehensive behavioral health care delivery for members through a network of behavioral health practitioners, ancillary care providers, hospitals, and other facilities.

For mental health, substance-related disorder services, and wraparound services, UBH uses its Clinical Criteria (see below), behavioral clinical policies, and best practice guidelines to make coverage determinations. UBH adopts externally-developed clinical criteria, and creates internally-developed Clinical Criteria, where appropriate, based on its assessment of relevant guidance. UBH develops clinical criteria that supersedes its standard set or adopts externally-developed clinical criteria when required to do so by contract or regulation.

- Clinical Criteria (Level of Care Utilization System-LOCUS) – Standardized level of care assessment tool developed by the American Association of Community Psychiatrists used to make clinical determinations and placement decisions for mental health disorder benefits for adults ages 19 and older when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (Child and Adolescent Level of Care/Service Intensity Utilization System-CALOCUS-CASII) - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry (AACAP) and the American Association for Community Psychiatry (AAPC) used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children and adolescents ages 6-18 when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (Early Childhood Service Intensity Instrument-ECSII) - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children ages 0-5 when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (State or Contract Specific Level of Care Guidelines) – Criteria used to make medical necessity determinations for mental health disorder benefits when there are explicit mandates or contractual requirements.
- Clinical Criteria (American Society of Addiction Medicine [ASAM]) - Criteria developed by the American Society of Addiction Medicine used to make clinical determinations for substance-related disorder benefits.
- Clinical Criteria (Optum Developed)
 - Optum Behavioral Clinical Policies: Criteria that stem from evaluation of new services or treatments or new applications of existing services or treatments and are used to make clinical determinations regarding proven or unproven services and treatments.

Licensed practitioners conduct all reviews with a focus on measurable outcome goals and objectives for treatment. A senior UBH Medical Director is responsible for directing and implementing behavioral health utilization management programs. A referral is sent to UBH when a member is identified as potentially benefiting from behavioral health services during a "medical event."

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The UBH UM Program is staffed by clinical, non-clinical and administrative personnel. All clinical denials or adverse decisions are made by board certified psychiatrists, or, if the health plans choose, by a panel of other appropriate health care service reviewers. If the health plan chooses to use a panel to make adverse decisions, the panel contains at least one physician who is board certified in psychiatry. When the health care service under review is a mental health or substance abuse service, the adverse decision is made by a licensed physician who is board certified in psychiatry. All potential clinical denials are referred to a physician who is board certified in psychiatry for final determination. An evaluation of the overall effectiveness of the Behavioral Health UM Program is conducted annually to determine how well resources have been deployed to improve UM activities and the clinical care and service provided to members.”

The Plan’s terms require services to be medically necessary for coverage. INN providers are required to comply with the Plan’s UM protocols including complying with Prior Authorization requirements.

Step 2 – Factors Used to Determine Prior Authorization

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

When Surest (Bind) plans first launched in 2016, the Plans were designed to offer a simpler and more transparent way for people to access the system. The Plan included coverage for services with the option to buy-up specific benefits based on member need.

In 2022, UnitedHealthcare acquired Surest (Bind) and agreed to adopt the existing list of services Bind had identified to be subject to Prior Authorization. The Plan has determined that Clinical Appropriateness is one of the factors that is determinative in imposing the Prior Authorization limitation. At this time, the Plan is assessing the value of managing the services, the consistency of adherence to evidence-based guidelines, and volume of services utilized to further refine which INN Inpatient services are subject to Prior Authorization. As a result, the Plan is evaluating the factors to be utilized to determine which INN Inpatient services are subject to Prior Authorization.

The Plan relies on the following factor to determine which INN inpatient benefits will be subject to Prior Authorization. This factor applies to M/S and MH/SUD benefits for the following:

- I. M/S: INN inpatient services
 - II. MH/SUD: INN inpatient services
- Clinical Appropriateness (Qualitative)

Applies to M/S and MH/SUD services.

Meeting Clinical Appropriateness is determinative in imposing the limitation. All Prior Authorization reviews are subject to Clinical Appropriateness and must have medical necessity criteria.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below is the evidentiary standard and source used to define, trigger, and/or implicate the factor used to add services to the Plan's Prior Authorization requirement for INN inpatient services. This evidentiary standard and source applies to benefits for the following:

- I. M/S: INN inpatient services
- II. MH/SUD: INN inpatient services

Factor – Clinical Appropriateness

Meeting Clinical Appropriateness is determinative in imposing the limitation.

The factor and evidentiary standard used as the basis for subjecting MH/SUD INN inpatient benefits to Prior Authorization are comparable to, and applied no more stringently than, the factor and evidentiary standard used as the basis for subjecting M/S INN inpatient benefits to Prior Authorization “as written” and “in operation.”

Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

As Written

The Plan conducted a comparative analysis of the strategies, processes, factor, evidentiary standard, and source information used to determine which M/S and MH/SUD INN inpatient services are subject to Prior Authorization and how Prior Authorization is applied to M/S and MH/SUD INN inpatient services “as written.” The Plan identified the factor and evidentiary standard used as the basis for subjecting M/S and MH/SUD benefits to Prior Authorization.

National internal committees apply the factor and standard described in Steps 2 and 3 to M/S and MH/SUD services when determining whether the services should be included on the Prior Authorization list.

Review of Factors and Evidentiary Standards

The Plan reviewed the factor that triggers an INN inpatient service to be subject to Prior Authorization. The factor and evidentiary standard were applied to M/S and MH/SUD services comparably and not more stringently to MH/SUD services than to M/S services.

Review of Operational Policies and Procedures

The Plan reviewed M/S and MH/SUD operational policies and procedures, IRR assessment processes, and UM annual oversight to confirm comparability and found MH/SUD policies, procedures, and processes to be comparable and no more stringent than M/S policies, procedures, and processes.

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- Medical management operational policies and procedures establish the standards for how the Plan conducts inpatient Prior Authorization. The policies and procedures are consistent with state and federal law governing Prior Authorization. Timeframes for decisions, content of adverse benefit determinations, appeal rights, and external review are all governed by state and federal law.
- The IRR assessment measures the consistency with which clinical reviewers and peer clinical reviewers apply the Plan's clinical criteria. IRR assessment processes apply to M/S and MH/SUD inpatient services.
- UM oversight monitors and evaluates UM processes by reviewing program outcomes, clinical appeals, IRR assessments, and under- and over-utilization.

Review of Inpatient Prior Authorization Processes

The strategy for applying Prior Authorization to INN inpatient services is comparable for M/S and MH/SUD services and is applied no more stringently to MH/SUD INN inpatient services. The Plan conducted a review of the M/S and MH/SUD Prior Authorization processes to confirm comparability. The review focused on the following aspects of the process for both M/S and MH/SUD:

- **Prior Authorization Request.** INN M/S and MH/SUD facilities and providers are contractually responsible for submitting Prior Authorization requests. The provider can submit the Prior Authorization request through the secure provider portal, by telephone, or by fax (where required). The member is responsible for obtaining Prior Authorization for certain services that are identified in the member Plan document.
- **Timeframe to Submit.** *The UnitedHealthcare Administrative Guide* (for M/S) and *Optum National Network Manual* (for MH/SUD) were reviewed for notification timeframes. The timeframes for the provider or member to notify of an inpatient admission were reviewed and determined that MH/SUD was comparable and no more stringent.
 - M/S – As outlined in the *UnitedHealthcare Administrative Guide*, providers must submit advance notification with supporting documentation as soon as possible, but at least two weeks before the planned service, unless otherwise stated.
 - Unplanned or emergency admissions are not subject to Prior Authorization.
 - MH/SUD – As outlined in *Optum National Network Manual*, MH/SUD requires notification within one business day after an inpatient admission to a facility unless a longer period is required by contract or state-specific requirements.
 - Unplanned or emergency services are not subject to Prior Authorization.
- **Clinical Reviews.** For M/S and MH/SUD inpatient Prior Authorization requests, clinical reviewers may gather more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for certification, related diagnostic results, history of related treatment and services, and photographs. The clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. The clinical reviewer may approve cases that meet applicable clinical criteria.
- **Review Timeframes.** M/S and MH/SUD inpatient Prior Authorization determination timeframes are defined by state and federal requirements. The same determination timeframes apply to M/S and MH/SUD determinations.
- **Determinations and Non-Clinical Reviews, First Level Clinical Reviews, and Second Level Peer Clinical Reviews.**
 - Non-clinical staff refer coverage requests that they cannot approve or administratively deny to clinical reviewers. Clinical reviewers consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether an inpatient admission is medically necessary. The clinical reviewer may approve the admission based on their review. The clinical reviewer refers cases to a peer clinical reviewer for a peer-to-peer discussion if the case cannot be approved. Only qualified peer clinical reviewers (e.g., Medical Directors) may issue adverse benefit determinations. Peer-to-peer discussions are offered as required.
 - Platinum Designation. Providers that meet the Platinum Designation are required to notify the Plan of admissions and provide member information. The Plan covers the first 13 days of a mental health inpatient admission and 8 days of a substance use disorder inpatient admission without review.
- **Adverse Benefit Determinations and Peer-to-Peer Conversations.** The Plan offers INN inpatient facilities and providers the opportunity to discuss a potential adverse benefit determination before the Plan issues such

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determination. This process allows INN inpatient facilities and providers the opportunity to provide additional information and/or modify their request prior to an adverse benefit determination being issued. Only M/S and MH/SUD peer clinical reviewers (e.g., Medical Directors) may issue adverse benefit determinations for coverage of M/S and MH/SUD inpatient services.

- Notification of Decisions to Providers and Members. The Plan notifies M/S and MH/SUD INN facilities, providers, and members of approvals and adverse benefit determinations, including applicable appeal rights, consistent with state and federal requirements.
 - INN inpatient M/S and MH/SUD services:
 - An adverse benefit determination is recorded as a clinical denial when it is based on clinical criteria and member clinical information and is recorded as an administrative denial when member benefits are exhausted.
- Review of Staff Qualifications. For M/S and MH/SUD, clinical staff qualifications align with the type of clinical review and state and federal requirements.
 - M/S is staffed by clinical, non-clinical, and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., nurses, physicians, etc.) and all adverse benefit determinations are made by Medical Directors.
 - MH/SUD is staffed by clinical, non-clinical, and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse determinations are made by Medical Directors.
- Clinical Criteria. For M/S and MH/SUD, clinical reviewers and peer clinical reviewers base determinations on the objective, evidence-based, medical/behavioral clinical policies and use clinical criteria from third party sources such as InterQual, MCG®, ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines.

In Operation

The Plan compared the strategies, processes, factor, evidentiary standard, and source information used to determine which M/S and MH/SUD INN inpatient services are subject to Prior Authorization and how Prior Authorization is applied “in operation.”

The Plan required INN M/S and MH/SUD providers to submit requests for approval of inpatient services for which the Plan requires Prior Authorization. The Plan publishes the services subject to Prior Authorization on the provider portal(s) (www.uhcprovider.com for M/S and www.providerexpress.com for MH/SUD). Members can learn what services are subject to Prior Authorization in their benefit plan document (i.e., *Schedule of Benefits*), through myuhc.com, or by contacting customer service. Notification triggered the Prior Authorization process for INN M/S and MH/SUD inpatient admissions.

M/S and MH/SUD inpatient Prior Authorization reviews included confirmation of member eligibility and benefit availability for the requested services. For M/S and MH/SUD INN inpatient services, non-clinical staff approved coverage for inpatient admissions that did not require clinical review or interpretation and where member's plan documents allowed. Non-clinical staff also approved coverage requests if the facility's contract did not allow for clinical reviews.

M/S and MH/SUD inpatient cases that were not administratively approved in initial administrative review were referred to a clinical reviewer for further research and evaluation. The M/S and MH/SUD clinical reviewers applied benefit plan documents and medical necessity criteria to member clinical information. M/S and MH/SUD clinical reviewers requested additional clinical information if they were unable to approve cases based on the available member clinical information. The clinical reviewers approved the admission based on their review when clinical criteria were met.

If the requested clinical information was not received or if the case could not be approved, M/S and MH/SUD clinical reviewers referred cases to a peer clinical reviewer. The Plan offered peer-to-peer conversations so the INN provider could provide additional clinical information prior to issuance of an adverse benefit determination. Only qualified peer clinical reviewers issued M/S and MH/SUD adverse benefit determinations.

The Plan communicated all adverse benefit determinations for M/S and MH/SUD inpatient cases that did not meet applicable clinical criteria consistent with state and federal requirements, including appeal rights, as applicable.

The Plan monitored M/S and MH/SUD clinical and peer clinical reviewers' application of clinical criteria through annual IRR assessments. The Plan also conducted quality audits of cases. The Plan routinely monitors Prior Authorization performance through its clinical performance oversight functions. In addition to comparing these "in operation" processes, the Plan reviewed medical necessity approval and denial rates, internal appeals outcomes, and external appeals outcomes related to Prior Authorization determinations for M/S and MH/SUD INN inpatient services. The results of these analyses are discussed in greater detail in Step 5.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The findings of the Plan's comparative analyses confirmed the strategies, processes, factor, evidentiary standard, and source information used to determine the MH/SUD INN inpatient services subject to Prior Authorization were comparable to, and applied no more stringently than, the strategies, processes, factors, evidentiary standards, and source information used to determine the M/S INN inpatient services subject to Prior Authorization "as written."

Conclusions

The Plan reviewed the M/S and MH/SUD Prior Authorization operational policies and procedures and concluded the methodology used to determine which MH/SUD INN inpatient services are subject to Prior Authorization "as written" were comparable to, and applied no more stringently than, the methodology used to determine which M/S INN inpatient services are subject to Prior Authorization "as written." Additionally, the Plan concluded that how Prior Authorization is applied to MH/SUD INN inpatient services was comparable to, and applied no more stringently than, how Prior Authorization is applied to M/S INN inpatient services "as written."

The Plan reviewed the M/S and MH/SUD processes including responsibility for submission, timeframes for submission and review, notification to members and providers, clinical standards for review, and staff qualifications and concluded how the Plan conducts Prior Authorization for MH/SUD INN inpatient services "in operation" was comparable to, and applied no more stringently than, how the Plan conducts Prior Authorization for M/S INN inpatient services "in operation."

Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical/surgical (M/S) benefits. This generally means that financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements, such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage.

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth the findings and conclusions both “as written” and “in operation” (Step 5).

Specific NQTL

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Prior Authorization is defined as: “A required or mandatory clinical assessment for proposed service(s) based on clinical information provided and the terms of the health plan benefits before the service(s) are performed or delivered. Clinical and medical necessity requirements, level of care appropriateness, and the terms of the health plan benefits must be met in order for services to be covered by the member’s plan.” The *Optum National Policy Definitions List* defines pre-authorization (aka Prior Authorization) as “a form of prospective utilization review of health care services proposed to be provided to a member.”

Prior Authorization is a component of the Plan’s Utilization Management (UM) program that helps ensure members receive appropriate coverage based on their specific clinical status and health care needs. The process is designed to achieve optimal clinical outcomes by applying objective, evidence-based clinical criteria and nationally recognized guidelines and best practices.

Prior Authorization for outpatient services commences prior to a service being delivered. Prior Authorization is a UM process that involves applying the benefit plan language and/or clinical criteria to make the most appropriate clinical coverage benefit determination.

This document includes the following information:

- Prior Authorization process for M/S and MH/SUD outpatient services
- Description of the NQTL and application (Step 1)
- Factors used to determine which services are subject to the NQTL (Step 2)
- Evidentiary standards and sources used to define, trigger and/or implicate a factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

This analysis refers to the following attachments:

- *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions* - M/S policy that defines Prior Authorization
- *Optum National Policy Definitions List* - MH/SUD policy that defines Prior Authorization

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- *Utilization Management Program Description (UMPD) of United HealthCare Services, Inc. and UnitedHealthcare Insurance Company* - Summarizes the philosophy, structure and standards that govern UHC's medical management, UM and utilization review responsibilities and functions
- *Management of Behavioral Health Benefits Policy* - Describes the mechanisms and processes designed to promote consistency in the management of behavioral health benefits and to ensure that members receive appropriate, high quality behavioral health services in a timely manner
- *Core Principles and Practices* - MH/SUD policy that outlines the core principles and practices that should be used by personnel in their interactions with members, authorized member representatives, practitioners and facilities, related to the management of behavioral health benefits, coverage determinations and appeals/grievances of non-coverage determinations.
- *Performance Assessment and Incentives* - M/S policy confirming that clinical reviewers are not incented to make denials for financial reasons
- *2023 UnitedHealthcare Provider Administrative Guide* – Informs M/S providers of the Prior Authorization process. The *UnitedHealthcare Provider Administrative Guide* can be accessed on the website <https://www.uhcprovider.com/en/admin-guides.html>
- *September 2023 Optum National Network Manual* - Informs MH/SUD providers of the Prior Authorization process. The *Optum National Network Manual* can be accessed on the website <https://public.providerexpress.com/content/optum-provexpr/us/en/clinical-resources/guidelines-policies/optum-network-manual.html>
- *Schedule of Benefits - SBN23-Medical-INS-BIND-2021-Choice Plus-LG-GA-UHIC* - Plan document that outlines member responsibilities

The Plan concludes that the Prior Authorization requirements for M/S and MH/SUD are comparable and applied no more stringently for MH/SUD in-network (INN) outpatient benefits both "as written" and "in operation."

Process

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Prior Authorization is defined as: "A required or mandatory clinical assessment for proposed service(s) based on clinical information provided and the terms of the health plan benefits before the service(s) are performed or delivered. Clinical and medical necessity requirements, level of care appropriateness, and the terms of the health plan benefits must be met in order for services to be covered by the member's plan." The *Optum National Policy Definitions List* defines pre-authorization (aka Prior Authorization) as "a form of prospective utilization review of health care services proposed to be provided to a member."

The Plan structures outpatient Prior Authorization processes to be compliant with all applicable federal and state requirements. Prior Authorization is governed at both the state and federal level, which includes consumer protections such as external review for adverse benefit determinations after internal appeals options are exhausted.

The Plan delegates management of MH/SUD outpatient services, including Prior Authorization, to United Behavioral Health d/b/a Optum Behavioral Health (OBH), its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor.

The Plan has national committees that approve M/S and MH/SUD outpatient services to be subject to Prior Authorization. Additionally, the Plan has a standard process for assessing the services that are subjected to Prior Authorization and whether they should be retained or removed from the Prior Authorization list. The Plan publishes the services subject to Prior Authorization on the provider portal(s) ([Advance Notification and Clinical Submission Requirements | UHCprovider.com](#) for M/S and [Optum - Provider Express Home](#) for MH/SUD). Members can learn what services are subject to Prior Authorization in their benefit plan document, through <https://member.uhc.com/myuhc>, myuhc.com, or by contacting customer service.

Prior Authorization review of M/S outpatient services consists of the following:

The Plan requires INN providers to submit a Prior Authorization request for services on the Prior Authorization list prior to rendering the service. There may be some INN benefits for which the member is responsible for obtaining Prior Authorization. These are identified in the member's benefit plan document (i.e., *Schedule of Benefits*). The INN provider's submission of a request (notification) triggers the Prior Authorization process.

INN providers may submit Prior Authorization requests through the secure provider portal (www.uhcprovider.com), their connected electronic medical record, by telephone, or by fax (where required). Members may submit Prior Authorization requests by phone, fax, or mail, in accordance with Plan requirements. Providers and members communicate basic information to create a case. As outlined in the *UnitedHealthcare Care Provider Administrative Guide*, providers must submit advance notification with supporting documentation as soon as possible, but at least two weeks before the planned service, unless otherwise stated.

The Plan confirms receipt of the Prior Authorization request. Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. Non-clinical staff review cases to ensure availability of accurate and thorough case information. Non-clinical staff may approve coverage requests in scenarios where the member's plan documents allow and if a clinical review is not required. Requests that are submitted through the secure provider portal may also be approved based on the benefit plan coverage criteria, member diagnosis, and the clinical information submitted. Non-clinical staff may administratively deny coverage when a member's benefits are exhausted. Non-clinical staff refer cases that they cannot approve or administratively deny to the initial clinical reviewers for medical necessity review.

First Level Clinical Review/Initial Review. Clinical reviewers (nurses) consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs to determine whether the applicable clinical criteria are met. The clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. The clinical reviewer can approve cases that meet applicable clinical criteria.

Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Peer clinical reviewers (physician or mid-level practitioner) consult clinical criteria when making clinical coverage benefit determinations. Peer clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs. The peer clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If a peer clinical reviewer issues an adverse benefit determination, then the Plan communicates the adverse benefit determination, including appeal rights, and offers a peer-to-peer conversation consistent with state and federal requirements.

Adverse Benefit Determination. For M/S an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction, or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when member benefits are exhausted. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials. Modified coverage requests that are approved are recorded as partial denials.

Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based, medical clinical policies or use clinical criteria from third-party sources such as InterQual® or MCG® guidelines.

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Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that outpatient Prior Authorization determinations are appropriate.

Per the M/S policy entitled, *Performance Assessment and Incentives*, at no time are initial or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons.

M/S generally structures UM processes to comply with federal Employee Retirement Income Security Act of 1974 (ERISA) requirements, and state law where applicable.

Prior Authorization review of MH/SUD outpatient services consists of the following:

The Plan delegates management of MH/SUD outpatient services, including Prior Authorization, to United Behavioral Health d/b/a OBH, its delegated MH/SUD MBHO vendor.

The Plan requires INN providers to submit a Prior Authorization request for services on the Prior Authorization list prior to rendering the service. There may be some INN benefits for which the member is responsible for obtaining Prior Authorization. These are identified in the member's benefit plan document (i.e., *Schedule of Benefits*).

INN providers may submit Prior Authorization requests through the secure provider portal (www.providerexpress.com), by telephone, or by fax (where required). Providers and members communicate basic information to create a case. As outlined in the *Optum National Network Manual*, most routine outpatient behavioral health services do not require an initial pre-authorization or notification in advance of the service. The INN provider's submission of a request (notification) triggers the Prior Authorization process.

As described in the *Management of Behavioral Health Benefits Policy*, the Plan confirms receipt of the Prior Authorization request. Non-clinical staff confirm member eligibility and benefit plan coverage. Non-clinical staff may approve cases that do not require clinical evaluation or interpretation based on the member's diagnosis and the clinical information submitted by providers. Non-clinical staff may administratively deny coverage when member benefits are exhausted. Non-clinical staff refer cases that they cannot approve or administratively deny to the initial clinical reviewers.

First Level Clinical Review/Initial Review. Clinical decisions are made by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse benefit determinations are made by Medical Directors or psychologists. Clinical reviewers consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether a service is medically necessary by reviewing the member's clinical information, the applicable clinical criteria or guidelines, and the Plan benefit terms. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for certification, related diagnostic results, and history of related treatment and services. The clinical reviewer may approve cases that meet applicable clinical criteria.

Second Level Clinical Review/Peer Review. The initial clinical reviewer refers cases to a peer clinical reviewer for a peer-to-peer discussion if the case cannot be approved. The requesting provider is offered the opportunity to discuss the case with the peer clinical reviewer, consistent with state and federal requirements, before an adverse benefit determination is issued. Only qualified peer clinical reviewers (e.g., Medical Directors or psychologists) can issue adverse benefit determinations. Peer clinical reviewers apply clinical criteria to member clinical information to determine coverage. If the requesting provider fails to complete the peer-to-peer discussion, the peer clinical reviewer makes a determination based on the information available. If a peer clinical reviewer issues an adverse benefit determination (e.g., the number of treatments are not authorized), then the Plan timely communicates the adverse benefit determination including appeal rights, to the member and provider consistent with applicable state and federal requirements.

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Adverse Benefit Determination. For MH/SUD, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction, or termination of a benefit. Adverse benefit determinations are recorded as a clinical denial when it is based on clinical criteria and member clinical information and is recorded as an administrative denial when member benefits are excluded.

Platinum Designation. The Plan offers a Platinum Designation program to MH/SUD providers based on facilities' quantitative practice patterns (effectiveness and efficiency benchmarks). The Platinum Designation program's effectiveness and efficiency benchmarks include targeted 30- and 90-day readmission rates, 7- and 30-day follow up after hospitalization, outlier length of stay, and outlier behavioral health episode spend. INN MH/SUD facilities that meet the Platinum Designation are required to notify the Plan of admissions to Partial Hospitalization Program (PHP) and provide member information. The Plan covers the first 17 days of admission to PHP without review. Facilities notify the Plan if additional days are needed. The Plan evaluates INN MH/SUD facilities' performance annually as described in the *Optum National Network Manual*.

Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity clinical coverage determinations on objective, evidence-based behavioral clinical policies or use clinical criteria from third-party sources such as American Society of Addiction Medicine (ASAM) Criteria®, Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System-Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) and Early Childhood Service Intensity Instrument (ECSII) guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that outpatient Prior Authorization determinations are appropriate.

Per the MH/SUD policy entitled, *Core Principles and Practices*, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse clinical coverage benefit determinations (clinical denials) for financial reasons.

MH/SUD generally structures UM processes to comply with federal ERISA requirements and state law where applicable.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- Prior Authorization

Benefit Classification(s)

- INN, outpatient

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHIC)

Plan Terms/Source Document(s)

In each of the Plan products, "Medically Necessary" is the Plan term used to guide Prior Authorization decision-making for both M/S and MH/SUD services. "Medically Necessary" is generally defined as follows:

"Medically Necessary – health care services are all of the following as determined by us or our designee.

- In accordance with *Generally Accepted Standards of Care*.
- Clinically appropriate, in terms of type, frequency, extent, service site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.

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- Not more costly than an alternative drug, service(s), service site or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.
- Or, are subject to Bind Coverage with Evidence Development Policy (CED Policy).

Generally Accepted Standards of Care are evidence based independent standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties. Valid, evidence based sources reflecting generally accepted standards of care include credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or nationally recognized clinical practice guidelines may be considered. We have the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be determined by us.

We develop and maintain clinical policies that describe the Generally Accepted Standards of Care scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. [[These clinical policies (as developed by us and revised from time to time), are available to Covered Persons through [MyBind.com] or by calling the telephone number on your ID card.] [They are [also] available to Physicians and other health care professionals on [MyBind.com].]]”

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Prior Authorization is defined as:

“A required or mandatory clinical assessment for proposed service(s) based on clinical information provided and the terms of the health plan benefits before the service(s) are performed or delivered. Clinical and medical necessity requirements, level of care appropriateness, and the terms of the health plan benefits must be met in order for services to be covered by the member's plan.”

The *Optum National Policy Definitions List* defines pre-authorization (aka Prior Authorization) as “a form of prospective utilization review of health care services proposed to be provided to a member.”

The Plan's *Schedule of Benefits* notify members of the Prior Authorization requirements:

“We require prior authorization for certain Covered Health Care Services. Network providers are responsible for obtaining prior authorization before they provide these services to you. [\[Benefits for conditional coverage do not require Network provider prior authorization, with the exception of a pre-admission notification for Covered Health Care Services for Inpatient Stays.\]](#)”

We recommend that you confirm with us that all Covered Health Care Services have been prior authorized as required. Before receiving these services from a Network provider, you may want to call us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they do not prior authorize as required. You can call us at the telephone number on your ID card.

When you choose to receive certain Covered Health Care Services from out-of-Network providers, you are responsible for obtaining prior authorization before you receive these services. Note that your obligation to obtain prior authorization is also applicable when an out-of-Network provider intends to admit you to a Network facility or to an out-of-Network facility or refers you to other Network or out-of-Network providers. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization. Services for which you are required to obtain prior authorization

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are shown in the Schedule of Benefits table within each Covered Health Care Service category.

To obtain prior authorization, call the telephone number on your ID card. This call starts the utilization review process.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the Schedule of Benefits table to find out how far in advance you must obtain prior authorization.

For Covered Health Care Services that do not require you to obtain prior authorization, when you choose to receive services from out-of-Network providers, we urge you to confirm with us that the services you plan to receive are Covered Health Care Services. That's because in some instances, certain procedures may not be Medically Necessary or may not otherwise meet the definition of a Covered Health Care Service, and therefore are excluded. In other instances, the same procedure may meet the definition of Covered Health Care Services. By calling before you receive treatment, you can check to see if the service is subject to limitations or exclusions.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those received, our final coverage determination will be changed to account for those differences, and we will only pay Benefits based on the services delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Care Service, you will be responsible for paying all charges and no Benefits will be paid.”

The *2023 UnitedHealthcare Care Provider Administrative Guide* notifies providers of the Prior Authorization requirements. INN providers are required to comply with UM protocols established by the Plan:

“We require prior authorization for all MA benefit plans and some commercial benefit plans. Prior authorization requests allow us to verify if services are medically necessary and covered. After you notify us of a planned service listed on the Advance Notification/Prior Authorization List, we tell you if a clinical coverage review is required, as part of our prior authorization process, and what additional information we need to proceed. We notify you of our coverage decision within the time required by law. Just because we require notification for a service, does not mean it is covered. We determine coverage by the member’s benefit plan.

If there is a conflict or inconsistency between applicable regulations and the notification requirements in this guide, the applicable regulations govern.

Physicians, health care professionals and ancillary care providers are responsible for:

- Providing advance notification or requesting prior authorization for services on the Advance Notification/Prior Authorization List, including
- for non-emergent air transport services.
- Directing members to use care providers within their network. Members may be required to obtain prior authorization for out-of-network services.

Facilities are responsible for:

- Obtaining prior authorization for non-emergent, fixed-wing transportation services and using in-network, fixed-wing air ambulance providers.

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- Obtaining prior authorization for inpatient admission to skilled nursing facility, acute inpatient rehabilitation and/or long-term acute care.
- Confirming coverage approval is on file (for services requiring advance notification/prior authorization) prior to the date of service.
- Providing admission and discharge notification for inpatient services, even if coverage approval is on file

If you perform multiple procedures for a member in one day, and at least one service requires prior authorization, you must obtain Prior authorization for any of the services to be paid.

If you do not follow these requirements, we may deny claims. In that case, you cannot bill the member. Advance notification or prior authorization is valid only for the date of service or date range listed on it. If services have not been rendered and the specified date of service or date range has passed, you must contact us to update the date of service or date range. When you contact us, we will advise if we will require a new submission.

- Giving us advance notification, or receiving prior authorization from us, is not a guarantee of payment, unless required by law or Medicare guidelines. This includes regulations about health care providers on a sanctions or excluded list, the Medicare preclusion list and/or health care providers not included in the Medicare Provider Enrollment Chain and Ownership System (PECOS)* list. Payment of covered services is based on:
 - The member's benefit plan,
 - If you are eligible for payment,
 - Claim processing requirements, and
 - Your Agreement.

Information required for advance notification/prior authorization requests Your request must have the following information:

- Member name and member health plan ID number
- Ordering health care provider name and TIN or NPI
- Rendering health care provider name and TIN or NPI
- ICD-10-CM diagnosis code
- All applicable procedure codes
- Anticipated date(s) of service
- Type of service (primary and secondary) procedure code(s) and, if relevant, the volume of service
- Place of service
- Facility name and TIN or NPI where service will be performed (when applicable)
- Original start date of dialysis (End Stage Renal Disease [ESRD] only)

If the member's benefit plan requires a clinical coverage review, we may request additional information, as described in more detail in the Clinical coverage review section.

The list of services that require advance notification and prior authorization is the same. The process for providing notification and submitting a prior authorization request is the same. Services that require Prior authorization require a clinical coverage review based on medical necessity.

View the most current and complete advance notification requirements, including procedure codes and associated services, at uhcprovider.com/priorauth > Advance Notification and Plan Requirement Resources.

Advance notification/prior authorization lists are subject to change. We will inform you of changes on uhcprovider.com/news. Sign up to receive email updates at uhcprovider.com/subscribe. If you need a paper copy of the requirements, contact your UnitedHealthcare Network Management representative or provider advocate at uhcprovider.com > Contact us.

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We recommend that you submit advance notification with supporting documentation as soon as possible, but at least 2 weeks before the planned service (unless the Advance Notification Requirements states otherwise). Following a facility discharge, advance notification for home health services and durable medical equipment is required within 48 hours after the start of service.”

The *Optum National Network Manual*, September 2023 Edition notifies providers of the Prior Authorization requirements. INN providers are required to comply with UM protocols established by the Plan:

“In accordance with the Participation Agreement and many benefit plans, most routine outpatient behavioral health services do not require an initial pre-authorization or notification.

Some non-routine outpatient services require ongoing authorization prior to providing services. These include:

- Applied Behavioral Analysis for the treatment of Autism

Authorization for some non-routine services may be requested through either the Provider Express website, the Provider Express secure portal:

- [ABA services: Autism Corner](#): Autism/ABA Information
 - [ABA Assessment Portal](#) (electronic authorization request submissions)
 - ABA Treatment Request Documents (please review webpage for specific forms)

The role of the Plan’s delegate, United Behavioral Health d/b/a OBH, is discussed in the UMPD:

“United Behavioral Health (UBH) performs the review of requests for coverage of behavioral health services (i.e., substance abuse, and mental health requests for services). UBH provides comprehensive behavioral health care delivery for members through a network of behavioral health practitioners, ancillary care providers, hospitals and other facilities.

For mental health, substance-related disorder services, and wraparound services, UBH uses its Clinical Criteria (see below), behavioral clinical policies, and best practice guidelines to make coverage determinations. UBH adopts externally-developed clinical criteria, and creates internally-developed Clinical Criteria, where appropriate, based on its assessment of relevant guidance. UBH develops clinical criteria that supersedes its standard set or adopts externally-developed clinical criteria when required to do so by contract or regulation.

- Clinical Criteria (Level of Care Utilization System-LOCUS) – Standardized level of care assessment tool developed by the American Association of Community Psychiatrists used to make clinical determinations and placement decisions for mental health disorder benefits for adults ages 19 and older when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (Child and Adolescent Level of Care/Service Intensity Utilization System-CALOCUS-CASII) - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry (AACAP) and the American Association for Community Psychiatry (AACP) used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children and adolescents ages 6-18 when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (Early Childhood Service Intensity Instrument-ECSII) - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children ages 0-5 when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (State or Contract Specific Level of Care Guidelines) – Criteria used to make medical necessity determinations for mental health disorder benefits when there are explicit mandates or contractual requirements.
- Clinical Criteria (American Society of Addiction Medicine [ASAM]) - Criteria developed by the American Society of Addiction Medicine used to make clinical determinations for substance-related disorder benefits.
- Clinical Criteria (Optum Developed)
 - Optum Behavioral Clinical Policies: Criteria that stem from evaluation of new services or treatments or new applications of existing services or treatments and are used to make clinical determinations regarding proven or unproven services and treatments.

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Licensed practitioners conduct all reviews with a focus on measurable outcome goals and objectives for treatment. A senior UBH Medical Director is responsible for directing and implementing behavioral health utilization management programs. A referral is sent to UBH when a member is identified as potentially benefiting from behavioral health services during a “medical event.”

The UBH UM Program is staffed by clinical, non-clinical and administrative personnel. All clinical denials or adverse decisions are made by board certified psychiatrists, or, if the health plans choose, by a panel of other appropriate health care service reviewers. If the health plan chooses to use a panel to make adverse decisions, the panel contains at least one physician who is board certified in psychiatry. When the health care service under review is a mental health or substance abuse service, the adverse decision is made by a licensed physician who is board certified in psychiatry. All potential clinical denials are referred to a physician who is board certified in psychiatry for final determination. An evaluation of the overall effectiveness of the Behavioral Health UM Program is conducted annually to determine how well resources have been deployed to improve UM activities and the clinical care and service provided to members.”

The Plan’s terms require services to be medically necessary for coverage.

Step 2 – Factors Used in the Design and Application of the NQTL

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

When Surest (Bind) plans first launched in 2016, the Plans were designed to offer a simpler and more transparent way for people to access the system. The Plan included coverage for services with the option to buy-up specific benefits based on member need.

In 2022, UnitedHealthcare acquired Surest (Bind) and agreed to adopt the existing list of services that had been identified to be subject to Prior Authorization. The Plan has determined that Clinical Appropriateness is one of the factors that is determinative in imposing the Prior Authorization limitation. At this time, the Plan is assessing the value of managing the services, the consistency of adherence to evidence-based guidelines, and volume of services utilized to further refine which INN Inpatient services are subject to Prior Authorization. As a result, the Plan is evaluating additional factors to be utilized to determine which INN Inpatient services are subject to Prior Authorization.

The Plan relies on the following factor to determine which INN outpatient services are added to the Prior Authorization list. This factor applies to M/S and MH/SUD benefits for the following:

- I. M/S INN outpatient services
 - II. MH/SUD INN outpatient services
- Clinical Appropriateness (Qualitative)
Applies to M/S and MH/SUD services.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below is the evidentiary standard and source used to define, trigger, and/or implicate the factor used to add services to the Plan's Prior Authorization list for INN outpatient services. This evidentiary standard and source applies to benefits for the following:

- I. M/S INN outpatient services
- II. MH/SUD INN outpatient services

Factor – Clinical Appropriateness

The factor and evidentiary standard used as the basis for subjecting MH/SUD INN outpatient benefits to Prior Authorization are comparable to, and applied no more stringently than, the factor and evidentiary standard used as the basis for subjecting M/S INN outpatient benefits to Prior Authorization “as written” and “in operation.”

Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan's or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The findings of the Plan's comparative analyses confirmed the strategies, processes, factor, evidentiary standard, and source information used to determine the MH/SUD INN outpatient services subject to Prior Authorization were comparable to, and applied no more stringently than, the strategies, processes, factors, evidentiary standards, and source information used to determine the M/S INN outpatient services subject to Prior Authorization “as written.”

Conclusions

The Plan reviewed the M/S and MH/SUD Prior Authorization policies and procedures and concluded the methodology used to determine which MH/SUD INN outpatient services are subject to Prior Authorization “as written” were comparable to, and applied no more stringently than, the methodology used to determine which M/S INN outpatient services are subject to Prior Authorization “as written.” Additionally, the Plan concluded that how Prior Authorization is applied to MH/SUD INN outpatient services was comparable to, and applied no more stringently than, how Prior Authorization is applied to M/S INN outpatient services “as written.”

The Plan reviewed the M/S and MH/SUD processes including responsibility for submission, timeframes for submission and review, notification to members and providers, clinical standards for review, and staff qualifications and concluded how the Plan conducts Prior Authorization for MH/SUD INN outpatient services “in operation” was comparable to, and applied no more stringently than, how the Plan conducts Prior Authorization for M/S INN outpatient services “in operation.”

Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical/surgical (M/S) benefits. This generally means that the financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements, such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage.

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Prior Authorization is defined as: “A required or mandatory clinical assessment for proposed service(s) based on clinical information provided and the terms of the health plan benefits before the service(s) are performed or delivered. Clinical and medical necessity requirements, level of care appropriateness, and the terms of the health plan benefits must be met in order for services to be covered by the member’s plan.” The *Optum National Policy Definitions List* defines pre-authorization (aka Prior Authorization) as “a form of prospective utilization review of health care services proposed to be provided to a member.”

Prior Authorization is a component of the Plan’s Utilization Management (UM) program that helps ensure members receive appropriate coverage based on their specific clinical status and health care needs. The process is designed to achieve optimal clinical outcomes by applying objective, evidence-based clinical criteria, and nationally recognized guidelines and best practices.

Prior Authorization for inpatient services commences prior to a service being delivered. Prior Authorization is a UM process that involves applying the benefit plan language and/or clinical criteria to make the most appropriate clinical coverage benefit determination.

This document includes the following information:

- Prior Authorization process for M/S and MH/SUD inpatient services
- Description of the NQTL and application (Step 1)
- Factors used to determine which services are subject to the NQTL (Step 2)
- Evidentiary standards and sources used to define, trigger and/or implicate a factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

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This analysis refers to the following attachments:

- *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions* - M/S policy that defines Prior Authorization
- *Optum National Policy Definitions List* - MH/SUD policy that defines Prior Authorization
- *Utilization Management Program Description (UMPD) of United HealthCare Services, Inc. and UnitedHealthcare Insurance Company* - Summarizes the philosophy, structure and standards that govern UHC's medical management, UM and utilization review responsibilities and functions
- *Management of Behavioral Health Benefits Policy* - Describes the mechanisms and processes designed to promote consistency in the management of behavioral health benefits and to ensure that members receive appropriate, high quality behavioral health services in a timely manner
- *Core Principles and Practices* - MH/SUD policy that outlines the core principles and practices that should be used by personnel in their interactions with members, authorized member representatives, practitioners and facilities, related to the management of behavioral health benefits, coverage determinations and appeals/grievances of non-coverage determinations.
- *Performance Assessment and Incentives* - M/S policy confirming that clinical reviewers are not incented to make denials for financial reasons
- *Schedule of Benefits - SBN23-Medical-INS-BIND-2021-Choice Plus-LG-GA-UHIC* - Plan document that outlines member responsibilities

The Plan concludes that the Prior Authorization requirements for M/S and MH/SUD are comparable and applied no more stringently for MH/SUD for out-of-network (OON) inpatient benefits, both “as written” and “in operation.”

Process

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Prior Authorization is defined as: “A required or mandatory clinical assessment for proposed service(s) based on clinical information provided and the terms of the health plan benefits before the service(s) are performed or delivered. Clinical and medical necessity requirements, level of care appropriateness, and the terms of the health plan benefits must be met in order for services to be covered by the member's plan.” The *Optum National Policy Definitions List* defines pre-authorization (aka Prior Authorization) as “a form of prospective utilization review of health care services proposed to be provided to a member.”

The Plan structures inpatient Prior Authorization processes to be compliant with all applicable federal and state requirements. Prior Authorization is governed at both the state and federal level, which includes consumer protections such as external review for adverse benefit determinations after internal appeals options are exhausted.

The Plan delegates management of MH/SUD inpatient services, including Prior Authorization, to United Behavioral Health d/b/a Optum Behavioral Health (OBH), its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor.

The Plan has national committees that approve M/S and MH/SUD services to be subject to Prior Authorization. Members can learn what services are subject to Prior Authorization in their benefit plan document, through myuhc.com, or by contacting customer service.

Prior Authorization review of M/S inpatient admissions consists of the following:

Members are responsible for obtaining Prior Authorization for services rendered by OON facilities and providers. The member's benefit plan document (i.e., *Schedule of Benefits*) identify the services for which the member is responsible for

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obtaining Prior Authorization and the required timeframe(s). The member or OON provider's submission of a request (notification) triggers the Prior Authorization process.

Members may submit Prior Authorization requests by phone, fax, or mail, in accordance with Plan requirements. OON providers may submit Prior Authorization requests on behalf of the member by phone or by fax (where required). Members or providers communicate basic information to create a case.

The Plan confirms receipt of the Prior Authorization request. Non-clinical staff confirm member eligibility and benefit coverage upon receipt of the notification. Non-clinical staff review cases to ensure availability of accurate and thorough case information. Non-clinical staff may approve coverage requests in scenarios where the member's plan documents allow and if a clinical review is not required. Non-clinical staff may administratively deny coverage when a member's benefits are exhausted. Non-clinical staff refer coverage requests that they cannot approve or administratively deny to the initial clinical reviewers.

First Level Clinical Review/Initial Review. Clinical reviewers (nurses or physicians) consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether the inpatient admission is medically necessary by reviewing the member's clinical information, the applicable clinical criteria or guidelines, and the Plan benefit terms. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs to determine whether the applicable clinical criteria are met. The clinical reviewer may approve cases that meet applicable clinical criteria.

Second Level Clinical Review/Peer Review. The initial clinical reviewer refers cases to a second level/peer clinical reviewer if the case cannot be approved. Peer clinical reviewers (physician or mid-level practitioner) consult clinical criteria when making clinical coverage benefit determinations. Peer clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. The peer clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. If a peer clinical reviewer issues an adverse benefit determination, then the Plan communicates the adverse benefit determination, including appeal rights, and offers a peer-to-peer conversation consistent with state and federal requirements.

Adverse Benefit Determination. For M/S, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when member benefits are exhausted. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials. Modified coverage requests that are approved are recorded as partial denials.

Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based medical clinical policies and use clinical criteria from third-party sources such as InterQual® or MCG® guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that inpatient Prior Authorization determinations are appropriate.

Per the M/S policy entitled, *Performance Assessment and Incentives*, at no time are initial or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons.

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M/S generally structures UM processes to comply with federal Employee Retirement Income Security Act of 1974 (ERISA) requirements, and state law where applicable.

Prior Authorization review of MH/SUD inpatient admissions consists of the following:

The Plan delegates management of MH/SUD inpatient services, including Prior Authorization, to United Behavioral Health d/b/a OBH, its delegated MH/SUD MBHO vendor.

Members are responsible for ensuring Prior Authorization is obtained by the OON provider administering the service. The OON provider must provide clinical information on the member's behalf. The member's benefit plan document (i.e., *Schedule of Benefits*) identifies the services for which the member is responsible for ensuring Prior Authorization is obtained. As outlined in the Plan document, OON providers must submit the Prior Authorization request before inpatient MH/SUD services are received. OON provider's submission of a request (notification) triggers the Prior Authorization process. OON providers may submit Prior Authorization requests on behalf of the member by telephone, or by fax (where required). Providers communicate basic information to create a case.

As described in the *Management of Behavioral Health Benefits Policy*, the Plan confirms receipt of the Prior Authorization request. Non-clinical staff confirm member eligibility and benefit coverage. Non-clinical staff may approve coverage requests that do not require clinical evaluation or interpretation based on the member's diagnosis and the clinical information submitted by providers. Non-clinical staff may administratively deny coverage when member benefits are exhausted. Non-clinical staff refer cases that they cannot approve or administratively deny to the initial clinical reviewers.

First Level Clinical Review/ Initial Review. Clinical decisions are made by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse benefit determinations are made by Medical Directors. Clinical reviewers consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether an inpatient admission is medically necessary by reviewing the member's clinical information, the applicable clinical criteria or guidelines, and the Plan benefit terms. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for certification, related diagnostic results, and history of related treatment and services to determine whether the applicable clinical criteria are met. The clinical reviewer may approve the admission based on their review.

Second Level Clinical Review/ Peer Review. The initial clinical reviewer refers cases to a peer clinical reviewer for a peer-to-peer discussion if the case cannot be approved. The requesting provider is offered the opportunity to discuss the case with the peer clinical reviewer, consistent with state and federal requirements before an adverse benefit determination is issued. Only qualified peer clinical reviewers (e.g., Medical Directors) can issue adverse benefit determinations. Peer clinical reviewers apply clinical criteria to member clinical information to determine coverage for an inpatient admission. If the requesting provider fails to complete the peer-to-peer discussion, the peer clinical reviewer makes a determination based on the information available. If a peer clinical reviewer issues an adverse benefit determination (e.g., the admission is not medically necessary and is not approved), then the Plan timely communicates the adverse benefit determination, including appeal rights, to the member and provider consistent with applicable state and federal requirements.

Adverse Benefit Determination. For MH/SUD, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as a clinical denial when it is based on clinical criteria and member clinical information and is recorded as an administrative denial when member benefits are excluded.

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Clinical Criteria. Initial clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based behavioral clinical policies or use clinical criteria from third-party sources such as American Society of Addiction Medicine (ASAM) Criteria®, Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System-Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) and Early Childhood Service Intensity Instrument (ECSII) guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that inpatient Prior Authorization determinations are appropriate.

MH/SUD generally structures UM processes to comply with federal ERISA requirements and state law where applicable.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- Prior Authorization

Benefit Classification(s)

- OON, inpatient

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHIC)

Plan Terms/Source Document(s)

In each of the Plan products, “Medically Necessary” is the Plan term used to guide Prior Authorization decision-making for both M/S and MH/SUD services. “Medically Necessary” is generally defined as follows:

“Medically Necessary – health care services are all of the following as determined by us or our designee.

- In accordance with *Generally Accepted Standards of Care*.
- Clinically appropriate, in terms of type, frequency, extent, service site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s), service site or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.
- Or, are subject to Bind Coverage with Evidence Development Policy (CED Policy).

Generally Accepted Standards of Care are evidence based independent standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties. Valid, evidence based sources reflecting generally accepted standards of care include credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or nationally recognized clinical practice guidelines may be considered. We have the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician

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specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be determined by us.

We develop and maintain clinical policies that describe the Generally Accepted Standards of Care scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. [[These clinical policies (as developed by us and revised from time to time), are available to Covered Persons through [MyBind.com] or by calling the telephone number on your ID card.] [They are [also] available to Physicians and other health care professionals on [MyBind.com].]]”

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Prior Authorization is defined as:

“A required or mandatory clinical assessment for proposed service(s) based on clinical information provided and the terms of the health plan benefits before the service(s) are performed or delivered. Clinical and medical necessity requirements, level of care appropriateness, and the terms of the health plan benefits must be met in order for services to be covered by the member's plan.”

The *Optum National Policy Definitions List* defines pre-authorization (aka Prior Authorization) as “a form of prospective utilization review of health care services proposed to be provided to a member.”

The Plan's *Schedule of Benefits* notify members of the Prior Authorization requirements:

“We require prior authorization for certain Covered Health Care Services. Network providers are responsible for obtaining prior authorization before they provide these services to you. [\[Benefits for conditional coverage do not require Network provider prior authorization, with the exception of a pre-admission notification for Covered Health Care Services for Inpatient Stays.\]](#)

We recommend that you confirm with us that all Covered Health Care Services have been prior authorized as required. Before receiving these services from a Network provider, you may want to call us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they do not prior authorize as required. You can call us at the telephone number on your ID card.

When you choose to receive certain Covered Health Care Services from out-of-Network providers, you are responsible for obtaining prior authorization before you receive these services. Note that your obligation to obtain prior authorization is also applicable when an out-of-Network provider intends to admit you to a Network facility or to an out-of-Network facility or refers you to other Network or out-of-Network providers. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization. Services for which you are required to obtain prior authorization are shown in the Schedule of Benefits table within each Covered Health Care Service category.

To obtain prior authorization, call the telephone number on your ID card. This call starts the utilization review process.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the Schedule of Benefits table to find out how far in advance you must obtain prior authorization.

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For Covered Health Care Services that do not require you to obtain prior authorization, when you choose to receive services from out-of-Network providers, we urge you to confirm with us that the services you plan to receive are Covered Health Care Services. That's because in some instances, certain procedures may not be Medically Necessary or may not otherwise meet the definition of a Covered Health Care Service, and therefore are excluded. In other instances, the same procedure may meet the definition of Covered Health Care Services. By calling before you receive treatment, you can check to see if the service is subject to limitations or exclusions.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those received, our final coverage determination will be changed to account for those differences, and we will only pay Benefits based on the services delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Care Service, you will be responsible for paying all charges and no Benefits will be paid.”

The role of the Plan’s delegate, United Behavioral Health d/b/a OBH, is discussed in the *UMPD*:

“United Behavioral Health (UBH) performs the review of requests for coverage of behavioral health services (i.e., substance abuse, and mental health requests for services). UBH provides comprehensive behavioral health care delivery for members through a network of behavioral health practitioners, ancillary care providers, hospitals and other facilities.

For mental health, substance-related disorder services, and wraparound services, UBH uses its Clinical Criteria (see below), behavioral clinical policies, and best practice guidelines to make coverage determinations. UBH adopts externally-developed clinical criteria, and creates internally-developed Clinical Criteria, where appropriate, based on its assessment of relevant guidance. UBH develops clinical criteria that supersedes its standard set or adopts externally-developed clinical criteria when required to do so by contract or regulation.

- Clinical Criteria (Level of Care Utilization System-LOCUS) – Standardized level of care assessment tool developed by the American Association of Community Psychiatrists used to make clinical determinations and placement decisions for mental health disorder benefits for adults ages 19 and older when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (Child and Adolescent Level of Care/Service Intensity Utilization System-CALOCUS-CASII) - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry (AACAP) and the American Association for Community Psychiatry (AACP) used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children and adolescents ages 6-18 when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (Early Childhood Service Intensity Instrument-ECSII) - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children ages 0-5 when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (State or Contract Specific Level of Care Guidelines) – Criteria used to make medical necessity determinations for mental health disorder benefits when there are explicit mandates or contractual requirements.
- Clinical Criteria (American Society of Addiction Medicine [ASAM]) - Criteria developed by the American Society of Addiction Medicine used to make clinical determinations for substance-related disorder benefits.
- Clinical Criteria (Optum Developed)
 - Optum Behavioral Clinical Policies: Criteria that stem from evaluation of new services or treatments or new applications of existing services or treatments and are used to make clinical determinations regarding proven or unproven services and treatments.

Prior Authorization –Out-of-Network Inpatient Non-Quantitative Treatment Limitation (NQTL) Analysis

GA Surest - UnitedHealthcare Insurance Company

12/29/2023

Licensed practitioners conduct all reviews with a focus on measurable outcome goals and objectives for treatment. A senior UBH Medical Director is responsible for directing and implementing behavioral health utilization management programs. A referral is sent to UBH when a member is identified as potentially benefiting from behavioral health services during a “medical event”.

The UBH UM Program is staffed by clinical, non-clinical and administrative personnel. All clinical denials or adverse decisions are made by board certified psychiatrists, or, if the health plans choose, by a panel of other appropriate health care service reviewers. If the health plan chooses to use a panel to make adverse decisions, the panel contains at least one physician who is board certified in psychiatry. When the health care service under review is a mental health or substance abuse service, the adverse decision is made by a licensed physician who is board certified in psychiatry. All potential clinical denials are referred to a physician who is board certified in psychiatry for final determination. An evaluation of the overall effectiveness of the Behavioral Health UM Program is conducted annually to determine how well resources have been deployed to improve UM activities and the clinical care and service provided to members.”

The Plan’s terms require services to be medically necessary for coverage.

Step 2 – Factors Used to Determine the Listed Services are Subject to Prior Authorization

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

When Surest (Bind) plans first launched in 2016, the Plans were designed to offer a simpler and more transparent way for people to access the system. The Plan included coverage for services with the option to buy-up specific benefits based on member need.

In 2022, UnitedHealthcare acquired Surest (Bind) and agreed to adopt the existing list of services that had been identified to be subject to Prior Authorization. The Plan has determined that Clinical Appropriateness is one of the factors that is determinative in imposing the Prior Authorization limitation. At this time, the Plan is assessing the value of managing the services, the consistency of adherence to evidence-based guidelines, and volume of services utilized to further refine which INN Inpatient services are subject to Prior Authorization. As a result, the Plan is evaluating the factors to be utilized to determine which INN Inpatient services are subject to Prior Authorization.

The Plan relies on the following factor to determine which OON inpatient benefits will be subject to Prior Authorization. This factor applies to M/S and MH/SUD benefits for the following:

- I. M/S: OON inpatient services
 - II. MH/SUD: OON inpatient services
- Clinical Appropriateness (Qualitative)

Applies to M/S and MH/SUD services.

Meeting Clinical Appropriateness is determinative in imposing the limitation. All Prior Authorization reviews are subject to Clinical Appropriateness and must have medical necessity criteria.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below are the evidentiary standard and source used to define, trigger, and/or implicate the factor used to add services to the Plan's Prior Authorization requirement for OON inpatient services. This evidentiary standard and source applies to benefits for the following:

- I. M/S: OON inpatient services
- II. MH/SUD: OON inpatient services

Factor – Clinical Appropriateness

These evidentiary standards and sources apply to M/S and MH/SUD services and are defined in a qualitative manner.

Meeting Clinical Appropriateness is determinative in imposing the limitation.

The factor and evidentiary standard used as the basis for subjecting MH/SUD OON inpatient benefits to Prior Authorization are comparable to, and applied no more stringently than, the factor and evidentiary standard used as the basis for subjecting M/S OON inpatient benefits to Prior Authorization “as written” and “in operation.”

Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The findings of the Plan's comparative analysis confirmed the strategies, processes, factor, evidentiary standard, and source information used to determine the MH/SUD OON inpatient services subject to Prior Authorization were comparable to, and applied no more stringently than, the strategies, processes, factor, evidentiary standard, and source information used to determine the M/S OON inpatient services subject to Prior Authorization “as written.”

Prior Authorization –Out-of-Network Inpatient Non-Quantitative Treatment Limitation (NQTL) Analysis

GA Surest - UnitedHealthcare Insurance Company

12/29/2023

Conclusions

The Plan reviewed the M/S and MH/SUD Prior Authorization operational policies and procedures and concluded the methodology used to determine which MH/SUD OON inpatient services are subject to Prior Authorization “as written” were comparable to, and applied no more stringently than, the methodology used to determine which M/S OON inpatient services are subject to Prior Authorization “as written.” Additionally, the Plan concluded that how Prior Authorization is applied to MH/SUD OON inpatient services was comparable to, and applied no more stringently than, how Prior Authorization is applied to M/S OON inpatient services “as written.”

The Plan reviewed the M/S and MH/SUD processes including responsibility for submission, timeframes for submission and review, notification to members and providers, clinical standards for review, and staff qualifications and concluded how the Plan conducts Prior Authorization for MH/SUD OON inpatient services “in operation” was comparable to, and applied no more stringently than, how the Plan conducts Prior Authorization for M/S OON inpatient services “in operation.”

Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical/surgical (M/S) benefits. This generally means that the financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements, such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage.

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth the findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Prior Authorization is defined as: “A required or mandatory clinical assessment for proposed service(s) based on clinical information provided and the terms of the health plan benefits before the service(s) are performed or delivered. Clinical and medical necessity requirements, level of care appropriateness, and the terms of the health plan benefits must be met in order for services to be covered by the member’s plan.” The *Optum National Policy Definitions List* defines pre-authorization (aka Prior Authorization) as “a form of prospective utilization review of health care services proposed to be provided to a member.”

Prior Authorization is a component of the Plan’s Utilization Management (UM) program that helps ensure members receive appropriate coverage based on their specific clinical status and health care needs. The process is designed to achieve optimal clinical outcomes by applying objective, evidence-based clinical criteria and nationally recognized guidelines and best practices.

Prior Authorization for outpatient services commences prior to a service being delivered. Prior Authorization is a UM process that involves applying the benefit plan language and/or clinical criteria to make the most appropriate clinical coverage benefit determination.

This document includes the following information:

- Prior Authorization process for M/S and MH/SUD outpatient services
- Description of the NQTL and application (Step 1)
- Factors used to determine which services are subject to the NQTL (Step 2)
- Evidentiary standards and sources used to define, trigger and/or implicate a factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

This analysis refers to the following attachments:

- *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions* - M/S policy that defines Prior Authorization
- *Optum National Policy Definitions List* - MH/SUD policy that defines Prior Authorization

- *Utilization Management Program Description (UMPD) of United HealthCare Services, Inc. and UnitedHealthcare Insurance Company* - Summarizes the philosophy, structure and standards that govern UHC's medical management, UM and utilization review responsibilities and functions
- *Management of Behavioral Health Benefits Policy* - Describes the mechanisms and processes designed to promote consistency in the management of behavioral health benefits and to ensure that members receive appropriate, high quality behavioral health services in a timely manner
- *Core Principles and Practices* - MH/SUD policy that outlines the core principles and practices that should be used by personnel in their interactions with members, authorized member representatives, practitioners and facilities, related to the management of behavioral health benefits, coverage determinations and appeals/grievances of non-coverage determinations.
- *Performance Assessment and Incentives* - M/S policy confirming that clinical reviewers are not incented to make denials for financial reasons
- *2023 UnitedHealthcare Provider Administrative Guide* – Informs M/S providers of the Prior Authorization process. The *UnitedHealthcare Provider Administrative Guide* can be accessed on the website <https://www.uhcprovider.com/en/admin-guides.html>
- *September 2023 Optum National Network Manual* - Informs MH/SUD providers of the Prior Authorization process. The *Optum National Network Manual* can be accessed on the website <https://public.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/optum-network-manual.html>
- *Schedule of Benefits - SBN23-Medical-INS-BIND-2021-Choice Plus-LG-GA-UHIC* - Plan document that outlines member responsibilities

The Plan concludes that the Prior Authorization requirements for M/S and MH/SUD are comparable and applied no more stringently for MH/SUD out-of-network (OON) outpatient benefits both "as written" and "in operation."

Process

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Prior Authorization is defined as: "A required or mandatory clinical assessment for proposed service(s) based on clinical information provided and the terms of the health plan benefits before the service(s) are performed or delivered. Clinical and medical necessity requirements, level of care appropriateness, and the terms of the health plan benefits must be met in order for services to be covered by the member's plan." The *Optum National Policy Definitions List* defines pre-authorization (aka Prior Authorization) as "a form of prospective utilization review of health care services proposed to be provided to a member."

The Plan structures outpatient Prior Authorization processes to be compliant with all applicable federal and state requirements. Prior Authorization is governed at both the state and federal level, which includes consumer protections such as external review for adverse benefit determinations after internal appeals options are exhausted.

The Plan delegates management of MH/SUD outpatient services, including Prior Authorization, to United Behavioral Health d/b/a Optum Behavioral Health (OBH), its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor.

The Plan has national committees that approve M/S and MH/SUD outpatient services to be subject to Prior Authorization. Additionally, the Plan has a standard process for assessing the services that are subjected to Prior Authorization and whether they should be retained or removed from the Prior Authorization list. The Plan publishes the services subject to Prior Authorization on the provider portal(s) ([Advance Notification and Clinical Submission Requirements | UHCprovider.com](#) for M/S and [Optum - Provider Express Home](#) for MH/SUD). Members can learn what services are subject to Prior Authorization in their benefit plan document, through <https://member.uhc.com/myuhc>, myuhc.com, or by contacting customer service.

Prior Authorization review of M/S outpatient services consists of the following:

Members are responsible for obtaining Prior Authorization for services rendered by OON providers. The member's benefit plan document (i.e., *Schedule of Benefits*) identifies the services for which the member is responsible for obtaining Prior Authorization and the required timeframe(s). The member or OON provider's submission of a request (notification) triggers the Prior Authorization process.

Members may submit Prior Authorization requests by phone, fax, or mail, in accordance with Plan requirements. OON providers may submit Prior Authorization requests on behalf of the member by phone, online or by fax (where required). Members or providers communicate basic information to create a case.

The Plan confirms receipt of the Prior Authorization request. Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. Non-clinical staff review cases to ensure availability of accurate and thorough case information. Non-clinical staff may approve coverage requests in scenarios where the member's plan documents allow and if a clinical review is not required. Non-clinical staff may administratively deny coverage when a member's benefits are exhausted. Non-clinical staff refer cases that they cannot approve or administratively deny to clinical reviewers.

First Level Clinical Review/Initial Review. Clinical reviewers (nurses) consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs. The clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. The clinical reviewer can approve cases that meet applicable clinical criteria.

Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Peer clinical reviewers (physician or mid-level practitioner) consult clinical criteria when making clinical coverage benefit determinations. Peer clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs. The peer clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If a peer clinical reviewer issues an adverse benefit determination, then the Plan communicates the adverse benefit determination, including appeal rights, and offers a peer-to-peer conversation consistent with state and federal requirements.

Adverse Benefit Determination. For M/S an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction, or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when member benefits are exhausted. Modified coverage requests that are approved are recorded as partial denials.

Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based medical clinical policies and use clinical criteria from third-party sources such as InterQual® or MCG® guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that outpatient Prior Authorization determinations are appropriate.

Per the M/S policy entitled, *Performance Assessment and Incentives*, at no time are initial or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons.

M/S generally structures UM processes to comply with federal Employee Retirement Income Security Act of 1974 (ERISA) requirements, and state law where applicable.

Prior Authorization review of MH/SUD outpatient services consists of the following:

The Plan delegates management of MH/SUD outpatient services, including Prior Authorization, to United Behavioral Health d/b/a OBH, its delegated MH/SUD MBHO vendor.

Members are responsible for ensuring Prior Authorization is obtained by the OON provider administering the service. The OON provider must provide clinical information on the member's behalf. The member's benefit plan document (i.e., *Schedule of Benefits*) identifies the services for which the member is responsible for ensuring Prior Authorization is obtained. As outlined in the Plan document, OON providers must submit the Prior Authorization request before outpatient MH/SUD services are received.

OON providers may submit Prior Authorization requests on behalf of the member by telephone, online (for certain services) or by fax (where required). Providers communicate basic information to create a case. OON provider's submission of a request (notification) triggers the Prior Authorization process.

As described in the *Management of Behavioral Health Benefits Policy*, the Plan confirms receipt of the Prior Authorization request. Non-clinical staff confirm member eligibility and benefit coverage. Non-clinical staff may administratively deny coverage when member benefits are exhausted. Non-clinical staff may approve coverage requests that do not require clinical evaluation or interpretation based on the member's diagnosis and the clinical information submitted by providers. Non-clinical staff refer cases that they cannot approve or administratively deny to the initial clinical reviewers.

First Level Clinical Review/Initial Review. Clinical decisions are made by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse benefit determinations are made by Medical Directors or psychologists. Clinical reviewers consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether a service is medically necessary by reviewing the member's clinical information, the applicable clinical criteria or guidelines, and the Plan benefit terms. Clinical reviewers may request additional clinical information including, but not limited to, office or facility medical records, consultations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for certification, related diagnostic results, and history of related treatment and services. The clinical reviewer may approve cases that meet applicable clinical criteria.

Second Level Clinical Review/Peer Review. The initial clinical reviewer refers cases to a peer clinical reviewer for a peer-to-peer discussion if the case cannot be approved. The requesting provider is offered the opportunity to discuss the case with the peer clinical reviewer, consistent with state and federal requirements before an adverse benefit determination is issued. Only qualified peer clinical reviewers (e.g., Medical Directors or psychologists) can issue adverse benefit determinations. Peer clinical reviewers apply clinical criteria to member clinical information to determine coverage. If the requesting provider fails to complete the peer-to-peer discussion, the peer clinical reviewer makes a determination based on the information available. If a peer clinical reviewer issues an adverse benefit determination (e.g., number of treatments are not authorized), then the Plan timely communicates the adverse benefit determination, including appeal rights, to the member and provider consistent with applicable state and federal requirements.

Adverse Benefit Determination. For MH/SUD, an adverse benefit determination is recorded as a clinical denial when it is based on clinical criteria and member clinical information and is recorded as an administrative denial when member benefits are exhausted.

Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity clinical coverage determinations on objective, evidence-based behavioral clinical policies or use clinical criteria from third-party sources such as American Society of Addiction Medicine (ASAM) Criteria®, Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care

Utilization System-Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) and Early Childhood Service Intensity Instrument (ECSII) guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that outpatient Prior Authorization determinations are appropriate.

Per the MH/SUD policy entitled, *Core Principles and Practices*, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse clinical coverage benefit determinations (clinical denials) for financial reasons.

MH/SUD generally structures UM processes to comply with federal ERISA requirements and state law where applicable.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- Prior Authorization

Benefit Classification(s)

- OON, outpatient

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHIC)

Plan Terms/Source Document(s)

In each of the Plan products, “Medically Necessary” is the Plan term used to guide Prior Authorization decision-making for both M/S and MH/SUD services. “Medically Necessary” is generally defined as follows:

“Medically Necessary – health care services are all of the following as determined by us or our designee.

- In accordance with *Generally Accepted Standards of Care*.
- Clinically appropriate, in terms of type, frequency, extent, service site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s), service site or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.
- Or, are subject to Bind Coverage with Evidence Development Policy (CED Policy).

Generally Accepted Standards of Care are evidence based independent standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties. Valid, evidence based sources reflecting generally accepted standards of care include credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or nationally recognized clinical practice guidelines may be considered. We have the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be determined by us.

We develop and maintain clinical policies that describe the Generally Accepted Standards of Care scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. [[These

clinical policies (as developed by us and revised from time to time), are available to Covered Persons through [MyBind.com] or by calling the telephone number on your ID card.] [They are [also] available to Physicians and other health care professionals on [MyBind.com].]]”

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Prior Authorization is defined as:

“A required or mandatory clinical assessment for proposed service(s) based on clinical information provided and the terms of the health plan benefits before the service(s) are performed or delivered. Clinical and medical necessity requirements, level of care appropriateness, and the terms of the health plan benefits must be met in order for services to be covered by the member's plan.”

The *Optum National Policy Definitions List* defines pre-authorization (aka Prior Authorization) as “a form of prospective utilization review of health care services proposed to be provided to a member.”

The Plan's *Schedule of Benefits* notify members of the Prior Authorization requirements:

“We require prior authorization for certain Covered Health Care Services. Network providers are responsible for obtaining prior authorization before they provide these services to you. [\[Benefits for conditional coverage do not require Network provider prior authorization, with the exception of a pre-admission notification for Covered Health Care Services for Inpatient Stays.\]](#)

We recommend that you confirm with us that all Covered Health Care Services have been prior authorized as required. Before receiving these services from a Network provider, you may want to call us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they do not prior authorize as required. You can call us at the telephone number on your ID card.

When you choose to receive certain Covered Health Care Services from out-of-Network providers, you are responsible for obtaining prior authorization before you receive these services. Note that your obligation to obtain prior authorization is also applicable when an out-of-Network provider intends to admit you to a Network facility or to an out-of-Network facility or refers you to other Network or out-of-Network providers. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization. Services for which you are required to obtain prior authorization are shown in the Schedule of Benefits table within each Covered Health Care Service category.

To obtain prior authorization, call the telephone number on your ID card. This call starts the utilization review process.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the Schedule of Benefits table to find out how far in advance you must obtain prior authorization.

For Covered Health Care Services that do not require you to obtain prior authorization, when you choose to receive services from out-of-Network providers, we urge you to confirm with us that the services you plan to receive are Covered Health Care Services. That's because in some instances, certain procedures may not be Medically Necessary or may not otherwise meet the definition of a Covered Health Care Service, and therefore are excluded. In other instances, the same

procedure may meet the definition of Covered Health Care Services. By calling before you receive treatment, you can check to see if the service is subject to limitations or exclusions.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those received, our final coverage determination will be changed to account for those differences, and we will only pay Benefits based on the services delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Care Service, you will be responsible for paying all charges and no Benefits will be paid.”

The role of the Plan’s delegate, United Behavioral Health d/b/a OBH, is discussed in the UMPD:

“United Behavioral Health (UBH) performs the review of requests for coverage of behavioral health services (i.e., substance abuse, and mental health requests for services). UBH provides comprehensive behavioral health care delivery for members through a network of behavioral health practitioners, ancillary care providers, hospitals and other facilities.

For mental health, substance-related disorder services, and wraparound services, UBH uses its Clinical Criteria (see below), behavioral clinical policies and best practice guidelines to make coverage determinations. UBH adopts externally-developed clinical criteria, and creates internally-developed Clinical Criteria, where appropriate, based on its assessment of relevant guidance. UBH develops clinical criteria that supersedes its standard set or adopts externally-developed clinical criteria when required to do so by contract or regulation.

- Clinical Criteria (Level of Care Utilization System-LOCUS) – Standardized level of care assessment tool developed by the American Association of Community Psychiatrists used to make clinical determinations and placement decisions for mental health disorder benefits for adults ages 19 and older when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (Child and Adolescent Level of Care/Service Intensity Utilization System-CALOCUS-CASII) - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry (AACAP) and the American Association for Community Psychiatry (AACP) used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children and adolescents ages 6-18 when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (Early Childhood Service Intensity Instrument-ECSII) - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children ages 0-5 when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (State or Contract Specific Level of Care Guidelines) – Criteria used to make medical necessity determinations for mental health disorder benefits when there are explicit mandates or contractual requirements.
- Clinical Criteria (American Society of Addiction Medicine [ASAM]) - Criteria developed by the American Society of Addiction Medicine used to make clinical determinations for substance-related disorder benefits.
- Clinical Criteria (Optum Developed)
 - Optum Behavioral Clinical Policies: Criteria that stem from evaluation of new services or treatments or new applications of existing services or treatments and are used to make clinical determinations regarding proven or unproven services and treatments.

Licensed practitioners conduct all reviews with a focus on measurable outcome goals and objectives for treatment. A senior UBH Medical Director is responsible for directing and implementing behavioral health utilization management programs. A referral is sent to UBH when a member is identified as potentially benefiting from behavioral health services during a “medical event”.

The UBH UM Program is staffed by clinical, non-clinical and administrative personnel. All clinical denials or adverse decisions are made by board certified psychiatrists, or, if the health plans choose, by a panel of other appropriate health care service reviewers. If the health plan chooses to use a panel to make adverse decisions, the panel contains at least one physician who is board certified in psychiatry. When the health care service under review is a mental health or substance abuse service, the

adverse decision is made by a licensed physician who is board certified in psychiatry. All potential clinical denials are referred to a physician who is board certified in psychiatry for final determination. An evaluation of the overall effectiveness of the Behavioral Health UM Program is conducted annually to determine how well resources have been deployed to improve UM activities and the clinical care and service provided to members.”

The Plan’s terms require services to be medically necessary for coverage.

Step 2 – Factors Used in the Design and Application of the NQTL

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

When Surest (Bind) plans first launched in 2016, the Plans were designed to offer a simpler and more transparent way for people to access the system. The Plan included coverage for services with the option to buy-up specific benefits based on member need.

In 2022, UnitedHealthcare acquired Surest (Bind) and agreed to adopt the existing list of services that had been identified to be subject to Prior Authorization. The Plan has determined that Clinical Appropriateness is one of the factors that is determinative in imposing the Prior Authorization limitation. At this time, the Plan is assessing the value of managing the services, the consistency of adherence to evidence-based guidelines, and volume of services utilized to further refine which INN Inpatient services are subject to Prior Authorization. As a result, the Plan is evaluating the factors to be utilized to determine which INN Inpatient services are subject to Prior Authorization.

The Plan relies on the following factor to determine which OON outpatient services are added to the Prior Authorization list. This factor applies to M/S and MH/SUD benefits for the following:

- I. M/S OON outpatient services
 - II. MH/SUD OON outpatient services
- Clinical Appropriateness (Qualitative)

Applies to M/S and MH/SUD services

Meeting Clinical Appropriateness is determinative in imposing the limitation.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below is the evidentiary standard and source used to define, trigger, and/or implicate the factor used to add services to the Plan’s Prior Authorization requirement for OON outpatient services. This evidentiary standard and source applies to benefits for the following:

- I. M/S OON outpatient services
- II. MH/SUD OON outpatient services

Factor – Clinical Appropriateness

The factor and evidentiary standard used as the basis for subjecting MH/SUD OON outpatient benefits to Prior Authorization are comparable to, and applied no more stringently than, the factor and evidentiary standard used as the basis for subjecting M/S OON outpatient benefits to Prior Authorization “as written” and “in operation.”

Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan's or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The findings of the Plan's comparative analyses confirmed the strategies, processes, factor, evidentiary standard, and source information used to determine the MH/SUD OON outpatient services subject to Prior Authorization were comparable to, and applied no more stringently than, the strategies, processes, factors, evidentiary standards, and source information used to determine the M/S OON outpatient services subject to Prior Authorization “as written.”

The Plan found the factor used to add MH/SUD OON outpatient services to the Prior Authorization list was comparable to, and applied no more stringently than, the factor used to add M/S OON outpatient services to the Prior Authorization list. OON M/S and MH/SUD outpatient services that met the applicable factor(s) were subject to Prior Authorization review “in operation.”

Conclusions

The Plan reviewed the M/S and MH/SUD Prior Authorization policies and procedures and concluded the methodology used to determine which MH/SUD OON outpatient services are subject to Prior Authorization “as written” were comparable to, and applied no more stringently than, the methodology used to determine which M/S OON outpatient services are subject to Prior Authorization “as written.” Additionally, the Plan concluded that how Prior Authorization is applied to MH/SUD OON outpatient services was comparable to, and applied no more stringently than, how Prior Authorization is applied to M/S OON outpatient services “as written.”

The Plan reviewed the M/S and MH/SUD processes including responsibility for submission, timeframes for submission and review, notification to members and providers, clinical standards for review, and staff qualifications and concluded how the Plan conducts Prior Authorization for MH/SUD OON outpatient services “in operation” was comparable to, and applied no more stringently than, how the Plan conducts Prior Authorization for M/S OON outpatient services “in operation.”

Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical/surgical (M/S) benefits. This generally means that the financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements, such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage.

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

Per the Plan’s *Certificate of Coverage*, the Plan reviews and determines benefits in accordance with reimbursement policies. Reimbursement policies are developed in accordance with:

- The most recent edition of the Current Procedural Terminology® (CPT), a publication of the American Medical Association (AMA), and/or the Centers for Medicare and Medicaid Services (CMS)
- As reported by generally recognized professionals or publications
- As used for Medicare
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that we accept

Reimbursement policies are applied to provider billings concurrent with the Plan’s Fraud, Waste, Abuse, and Error (FWAE) processes.

In-network (INN) providers adhere to *UnitedHealthcare’s (UHC) Provider Administrative Guide* (M/S) and the *Optum National Network Manual* (MH/SUD), while out-of-network (OON) providers are guided by the member’s Plan documents.

This document includes the following information:

- Process for the development and application of reimbursement policies for both M/S and MH/SUD
- Description of the NQTL and application (Step 1)
- Factors used to develop and apply reimbursement policies for both M/S and MH/SUD (Step 2)
- Evidentiary standards and sources used to define, trigger and/or implicate a factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

Process

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, plan terms, and policies at issue. Identification of the specific MH/SUD and medical/surgical benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as medical/surgical.

Specific NQTL

- Development and application of reimbursement policies

Benefit Classification(s)

- Applies to all benefit classifications

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHC)

Step 2 – Factors Used in the Design and Application of the NQTL

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH or SUD benefits and medical or surgical benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and medical/surgical benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the plan's or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the plan or coverage is or is not in compliance with MHPAEA.

Conclusions

The Plan reviewed the M/S and MH/SUD reimbursement policies and procedures and concluded the methodology used to develop the MH/SUD reimbursement policies “as written” was comparable to, and applied no more stringently than, the methodology used to develop the M/S reimbursement policies “as written.” Additionally, the Plan concluded that the MH/SUD reimbursement policies were applied no more stringently than, the M/S reimbursement policies were applied “as written.”

The Plan reviewed the M/S and MH/SUD processes for applying the reimbursement policies and found they were comparable and no more stringently applied for MH/SUD. Additionally, from review of the M/S and MH/SUD processes for applying the

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reimbursement policies, including notification, timeframes for processing, determinations, and determination communications, the Plan concluded the methodology used to apply the MH/SUD reimbursement policies “in operation” was comparable to, and applied no more stringently than, the methodology used to apply the M/S reimbursement policies “in operation.”

Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical/surgical (M/S) benefits. This generally means that the financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements, such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage.

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

Retrospective Review is a component of the Plan’s Utilization Management (UM) program. Medical directors and other clinical staff review services in order to detect and better manage over- and under-utilization and determine whether the services reviewed are consistent with the member’s coverage, medically appropriate, and consistent with evidence-based guidelines. Retrospective Review assesses the appropriateness of services on a case-by-case basis after the service has been provided but prior to payment for services. Retrospective Reviews are based on established review guidelines and may include:

- Review of medical necessity
- Appropriateness of level of care
- Identifying claims issues
- Eligibility determination
- Initiation of appropriate follow-up actions for utilization and quality issues

The Plan conducts medical necessity Retrospective Review of claims/requests for certain inpatient services that have not previously been reviewed as part of the Prior Authorization or Concurrent Review processes. The Plan may conduct Retrospective Review if the service or procedure codes do not match a diagnosis code, if services are experimental, investigational, or unproven (EIU), or if the services are subject to benefit limits/exclusions. The Plan conducts medical necessity Retrospective Review for inpatient services where Prior Authorization was required, but not obtained upon claim submission. INN M/S providers may also request Retrospective Review of inpatient claims that are denied.

This document includes the following information:

- The Retrospective Review process for M/S and MH/SUD inpatient services
- The description of the NQTL and application (Step 1)
- Factor used to determine which services are subject to the NQTL (Step 2)
- Evidentiary standards and sources used to define, trigger and/or implicate the factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

This comparative analysis refers to the following attachments:

- *Utilization Management Program Description (UMPD) of United HealthCare Services, Inc. and UnitedHealthcare Insurance Company* - Summarizes the philosophy, structure and standards that govern UHC's medical management, UM and utilization review responsibilities and functions
- *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions* - M/S policy that defines Retrospective Review
- *Optum National Policy Definitions List* - MH/SUD policy that defines Retrospective Review
- *M/S Retrospective Review Codes* - Excel document that lists M/S codes that may be subject to Retrospective Review
- *Schedule of Benefits - SBN23-Medical-INS-BIND-2021-Choice Plus-LG-GA-UHIC* - Plan document that outlines member responsibilities
- *Core Principles and Practices* - MH/SUD policy that outlines the core principles and practices that should be used by personnel in their interactions with members, authorized member representatives, practitioners, and facilities, related to the management of behavioral health benefits, coverage determinations and appeals/grievances of non-coverage determinations
- *Performance Assessment and Incentives* - M/S policy confirming that clinical reviewers are not incented to make denials for financial reasons
- *2023 UnitedHealthcare Provider Administrative Guide* - Informs M/S providers of the Prior Authorization process. The *UnitedHealthcare Provider Administrative Guide* can be accessed on the website <https://www.uhcprovider.com/en/admin-guides.html>
- *September 2023 Optum National Network Manual* - Informs MH/SUD providers of the Prior Authorization process. The *Optum National Network Manual* can be accessed on the website <https://public.providerexpress.com/content/open-provexpr/us/en/clinical-resources/guidelines-policies/optum-network-manual.html>
- *Medical Necessity NQTL* - Comparative analysis that describes the processes, strategies, evidentiary standards and other factors used to apply medical necessity to M/S and MH/SUD services in accordance with MHPAEA and other regulatory guidance

The Plan concludes that the Retrospective Review requirements for M/S and MH/SUD are comparable and applied no more stringently to MH/SUD in-network (INN) inpatient benefits both "as written" and "in operation."

Process

The Plan structures inpatient Retrospective Review processes to be compliant with all applicable federal and state laws. Retrospective Review is governed at both the state and federal level, which includes consumer protections such as external review for adverse benefit determinations after internal appeals options are exhausted.

The Plan delegates management of MH/SUD inpatient services, including Retrospective Review to United Behavioral Health d/b/a Optum Behavioral Health (OBH), its delegated MH/SUD Managed Behavioral Healthcare Organization (MBHO) vendor.

Retrospective Review of M/S Inpatient Admissions consists of the following:

Retrospective Review for certain inpatient services begins after the Plan receives claims or notification of inpatient admission post discharge from an INN facility. The Plan conducts medical necessity Retrospective Review of claims/requests for certain inpatient services that have not previously been reviewed as part of the Prior Authorization or Concurrent Review processes. The Plan may conduct Retrospective Review if the service or procedure codes do not match a diagnosis code, if services EIU, or if the services are subject to benefit limits/exclusions. The Plan conducts medical necessity Retrospective Review for inpatient services where Prior Authorization was required but not obtained upon claim submission.

Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. If needed, non-clinical staff request medical records for claims containing services that are subject to Retrospective Review. When medical records are received, the case is referred to clinical reviewers to assess medical necessity.

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First Level Clinical Review/Initial Review. The clinical reviewer (physicians or nurses) reviews the claim to determine if the inpatient service billed meets clinical criteria for coverage based on application of objective, evidence-based clinical criteria, nationally recognized guidelines, and the member's benefit plan documents. Clinical reviewers either approve claims for payment or refer claims to peer clinical reviewers (e.g., Medical Directors).

Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If a peer clinical reviewer determines that a service was not medically necessary, then an adverse benefit determination will be issued for the claim. The Plan communicates the adverse benefit determination, including applicable appeal rights, and offers a peer-to-peer conversation consistent with state and federal requirements. Appeal rights are set forth in the member's benefit plan document (*Certificate of Coverage*). The Plan communicates results of Retrospective Review within 30 days of receipt of a claim.

Adverse Benefit Determination. For M/S, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction, or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when benefits are exhausted. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials.

Clinical Criteria: Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based medical clinical policies or use clinical criteria from third party sources such as InterQual® or MCG® guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that Retrospective Review determinations are appropriate.

The Plan conducts end-to-end case audits that are designed and approved by clinical leadership each year. The end-to-end audits include all stages of a case review, from intake through appeal. These audits are conducted monthly and approximately 1500 cases are reviewed per month. Results are reported to an oversight team. All deficiencies are remediated. Remediation may include corrective actions and/or additional education, as indicated.

The Plan routinely monitors Retrospective Review performance through its clinical performance oversight functions. Outcomes are monitored against timeliness requirements, performance guarantees, and for potential trends, including overall utilization.

As of April 1, 2023, the Utilization Management Program Committee (UMPC) began overseeing the M/S UM program. The UMPC is responsible for the development and maintenance of the M/S Prior Authorization processes. The UMPC ensures that the UM program considers the factors and evidentiary standards for applying UM. The UMPC is comprised of:

- Chief Medical Officer, Medical Management (Co-Chair)
- Senior Vice President, Clinical Advancement (Co-Chair)
- Chief Medical Officer, UnitedHealthcare
- Senior Vice President, Clinical Appeals & Grievances
- Chief Medical Officer, Clinical Policy
- Chief Medical Officer, UnitedHealthcare Employer & Individual
- Chief Medical Officer, UnitedHealthcare Medicare & Retirement
- Chief Medical Officer, Community & State
- Chief Medical Officer, UnitedHealthcare Individual & Family Plans
- Vice President, Clinical Transformation & Affordability
- Senior Director, Mental Health Parity
- Vice President, Utilization Management Strategy & Implementation

One of the chairs must be an executive leader and a licensed physician. UMPC meets at least six times per year but may meet more frequently if needed.

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Per the M/S policy entitled, *Performance Assessment and Incentives*, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons.

M/S generally structures UM processes to comply with federal Employee Retirement Income Security Act of 1974 (ERISA) requirements, and state law where applicable.

Retrospective Review of MH/SUD Inpatient Admissions consist of the following:

The Plan delegates management of MH/SUD inpatient services, including Retrospective Review to United Behavioral Health d/b/a OBH, its delegated MH/SUD MBHO vendor.

MH/SUD claims/requests for inpatient services submitted by INN providers may be subject to Retrospective Review if the service or procedure code required Prior Authorization or Concurrent Review, but that review was not conducted and there is a mitigating circumstance. Additionally, claims may be subject to Retrospective Review if the billed services or procedure codes do not match the authorized codes or if services are EIU.

Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. If needed, non-clinical staff request medical records for requests or claims containing services that are subject to Retrospective Review. When medical records are received, the case is referred to clinical reviewers to assess medical necessity.

First Level Clinical Review/Initial Review. The clinical reviewer (e.g., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) review the claim to determine if the inpatient admission billed meets clinical criteria for coverage based on application of objective, evidence-based, clinical criteria, or nationally recognized guidelines. Clinical reviewers either approve requests for payment or refer requests to peer clinical reviewers (Medical Directors).

Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If the peer clinical reviewer determines that an admission was not medically necessary, then an adverse benefit determination will be issued for the claim. The Plan communicates the adverse benefit determination, including applicable appeal rights. Appeal rights are set forth in the member's benefit plan document (*Certificate of Coverage*). The Plan communicates results of Retrospective Review within 30 days of receipt of a request/claim.

Adverse Benefit Determination. For MH/SUD, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction, or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when benefits are exhausted. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials.

Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based behavioral clinical policies or use clinical criteria from third party sources such as American Society of Addiction Medicine (ASAM) Criteria®, Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System-Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) and Early Childhood Service Intensity Instrument (ECSII) guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that inpatient Retrospective Review determinations are appropriate.

Per the MH/SUD policy entitled, *Core Principles and Practices*, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse clinical coverage benefit determinations (clinical denials) for financial reasons.

MH/SUD generally structures UM processes to comply with federal ERISA requirements and state law where applicable.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- Retrospective Review

Benefit Classification(s)

- INN, inpatient

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHIC)

Plan Terms

The Plan's *Schedule of Benefits* notify members of Retrospective Review requirements.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

The *Utilization Management Program Description (UMPD)* discusses Post-Service Reviews and indicates:

Post-service review assesses the appropriateness of medical services on a case-by-case basis after the service has been provided but prior to payment for services. Post-service reviews are based on established review guidelines and includes:

- Review of medical necessity;
- Appropriateness of level of care;
- Identifying claims issues;
- Eligibility determination;
- Initiation of appropriate follow-up actions for utilization and quality issues; and
- Identifying appropriateness and administrative issues such as physician notification, emergency status of admission.

The Plan's delegate, United Behavioral Health d/b/a OBH, is discussed in the *UMPD*:

United Behavioral Health (UBH) performs the review of requests for coverage of behavioral health services (i.e., substance abuse, and mental health requests for services). UBH provides comprehensive behavioral health care delivery for members through a network of behavioral health practitioners, ancillary care providers, hospitals, and other facilities.

For mental health, substance-related disorder services, and wraparound services, UBH uses its Clinical Criteria (see below), behavioral clinical policies, and best practice guidelines to make coverage determinations. UBH adopts externally-developed clinical criteria, and creates internally-developed Clinical Criteria, where appropriate, based on its assessment of relevant guidance. UBH develops clinical criteria that supersedes its standard set or adopts externally-developed clinical criteria when required to do so by contract or regulation.

- Clinical Criteria (Level of Care Utilization System-LOCUS) – Standardized level of care assessment tool developed by the American Association of Community Psychiatrists used to make clinical determinations and placement decisions for mental health disorder benefits for adults ages 19 and older when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (Child and Adolescent Level of Care/Service Intensity Utilization System-CALOCUS-CASII)- Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry (AACAP) and the American Association for Community Psychiatry (AACP) used to make clinical determinations and to provide

level of service intensity recommendations for mental health disorder benefits for children and adolescents ages 6-18 when State or Contract Specific Level of Care Guidelines do not apply.

- Clinical Criteria (Early Childhood Service Intensity Instrument-ECSII) – Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children ages 0-5 when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (State or Contract Specific Level of Care Guidelines) - Criteria used to make medical necessity determinations for mental health disorder benefits when there are explicit mandates or contractual requirements.
- Clinical Criteria (American Society of Addiction Medicine [ASAM]) - Criteria developed by the American Society of Addiction Medicine used to make clinical determinations for substance-related disorder benefits.
- Clinical Criteria (Optum Developed)
 - Optum Behavioral Clinical Policies: Criteria that stem from evaluation of new services or treatments or new applications of existing services or treatments and are used to make clinical determinations regarding proven or unproven services and treatments.

Licensed practitioners conduct all reviews with a focus on measurable outcome goals and objectives for treatment. A senior UBH Medical Director is responsible for directing and implementing behavioral health utilization management programs. A referral is sent to UBH when a member is identified as potentially benefiting from behavioral health services during a “medical event.”

The UBH UM Program is staffed by clinical, non-clinical and administrative personnel. All clinical denials or adverse decisions are made by board certified psychiatrists, or, if the health plans choose, by a panel of other appropriate health care service reviewers. If the health plan chooses to use a panel to make adverse decisions, the panel contains at least one physician who is board certified in psychiatry. When the health care service under review is a mental health or substance abuse service, the adverse decision is made by a licensed physician who is board certified in psychiatry. All potential clinical denials are referred to a physician who is board certified in psychiatry for final determination. An evaluation of the overall effectiveness of the Behavioral Health UM Program is conducted annually to determine how well resources have been deployed to improve UM activities and the clinical care and service provided to members.

The Plan’s terms require services to be medically necessary for coverage. INN providers are required to comply with the Plan’s UM protocols including complying with Retrospective Review requirements.

Step 2 – Factors Used to Determine Retrospective Review Applies

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

The Plan relies on the following factor to determine which INN inpatient admissions are subject to Retrospective Review. This factor applies to M/S and MH/SUD for the following:

- I. M/S INN inpatient admissions
 - II. MH/SUD INN inpatient admissions
- Consistency with Clinical Criteria (Qualitative):

This factor applies to M/S and MH/SUD services. Meeting Consistency with Clinical Criteria is determinative in imposing the limitation.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factor used in designing or applying the Plan's Retrospective Review requirement to INN inpatient services. These evidentiary standards and sources apply to the following:

- I. M/S INN inpatient admissions
- II. MH/SUD INN inpatient admissions

Factor: Consistency with Clinical Criteria

The factor and evidentiary standards used as the basis for subjecting MH/SUD INN inpatient benefits to Retrospective Review are comparable to, and applied no more stringently than, the factor and evidentiary standards used as the basis for subjecting M/S INN inpatient benefits to Retrospective Review "as written" and "in operation."

Step 4 – NQTL "As Written" and "In Operation" Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The findings of the Plan's comparative analyses confirmed the strategies, processes, factor, evidentiary standards, and source information used to subject certain MH/SUD INN inpatient services to Retrospective Review were comparable to, and applied no more stringently than, the strategies, processes, factor, evidentiary standards, and source information used to subject certain M/S INN inpatient services to Retrospective Review "as written."

Conclusions

The Plan concluded that how Retrospective Review is applied to MH/SUD INN inpatient services was comparable to, and applied no more stringently than, how Retrospective Review is applied to M/S INN inpatient services "as written."

The Plan reviewed the M/S and MH/SUD processes including responsibility for submission, timeframes for submission and review, notification to members and providers, clinical standards for review, and staff qualifications and concluded how the Plan conducts Retrospective Review for MH/SUD INN inpatient services "in operation" was comparable to, and applied no more stringently than, how the Plan conducts Retrospective Review for M/S INN inpatient services "in operation."

Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical/surgical (M/S) benefits. This generally means that financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements, such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage.

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

Retrospective Review is a component of the Plan’s Utilization Management (UM) program. Medical directors and other clinical staff review services in order to detect and better manage over- and under-utilization and determine whether the services reviewed are consistent with the member’s coverage, medically appropriate, and consistent with evidence-based guidelines. Retrospective Review assesses the appropriateness of services on a case-by-case basis after the service has been provided, but prior to payment for services. Retrospective Reviews are based on established review guidelines and may include:

- Review of medical necessity
- Appropriateness of level of care
- Identifying claims issues
- Eligibility determination
- Initiation of appropriate follow-up actions for utilization and quality issues

The Plan conducts medical necessity Retrospective Review of claims/requests for certain outpatient services that have not previously been reviewed as part of the Prior Authorization or Concurrent Review processes. The Plan may conduct Retrospective Review if the service or procedure codes do not match a diagnosis code, if services are experimental, investigational, or unproven (EIU), or if the services are subject to benefit limits/exclusion. The Plan conducts medical necessity Retrospective Review for outpatient services where Prior Authorization was required, but not obtained upon claim submission. INN M/S providers may also request Retrospective Review of outpatient claims that are denied.

This document includes the following information:

- The Retrospective Review process for M/S and MH/SUD outpatient services
- The description of the NQTL and application (Step 1)
- Factor used to determine which services are subject to the NQTL (Step 2)
- Evidentiary standards and sources used to define, trigger and/or implicate a factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

This comparative analysis refers to the following attachments:

Retrospective Review – Out-of-Network Inpatient Non-Quantitative Treatment Limitation (NQTL) Analysis

GA Surest - UnitedHealthcare Insurance Company

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- *Utilization Management Program Description (UMPD) of United HealthCare Services, Inc. and UnitedHealthcare Insurance Company* - Summarizes the philosophy, structure and standards that govern UHC's medical management, UM and utilization review responsibilities and functions
- *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions* - M/S policy that defines Retrospective Review
- *Optum National Policy Definitions List* - MH/SUD policy that defines Retrospective Review
- *M/S Retrospective Review Codes* - Excel document that lists M/S codes that may be subject to Retrospective Review
- *Schedule of Benefits - SBN23-Medical-INS-BIND-2021-Choice Plus-LG-GA-UHIC* - Plan document that outlines member responsibilities
- *Core Principles and Practices* - MH/SUD policy that outlines the core principles and practices that should be used by personnel in their interactions with members, authorized member representatives, practitioners, and facilities, related to the management of behavioral health benefits, coverage determinations and appeals/grievances of non-coverage determinations
- *Performance Assessment and Incentives* - M/S policy confirming that clinical reviewers are not incented to make denials for financial reasons
- *2023 UnitedHealthcare Provider Administrative Guide* - Informs M/S providers of the Prior Authorization process. The *UnitedHealthcare Provider Administrative Guide* can be accessed on the website <https://www.uhcprovider.com/en/admin-guides.html>
- *September 2023 Optum National Network Manual* - Informs MH/SUD providers of the Prior Authorization process. The *Optum National Network Manual* can be accessed on the website <https://public.providerexpress.com/content/optum-network-manual.html>
- *Medical Necessity NQTL* - Comparative analysis that describes the processes, strategies, evidentiary standards and other factors used to apply medical necessity to M/S and MH/SUD services in accordance with MHPAEA and other regulatory guidance

The Plan concludes that the Retrospective Review requirements for M/S and MH/SUD are comparable and applied no more stringently to MH/SUD in-network (INN) outpatient benefits both “as written” and “in operation.”

Process

The Plan structures outpatient Retrospective Review processes to be compliant with all applicable federal and state laws. Retrospective Review is governed at both the state and federal level, which includes consumer protections such as external review for adverse benefit determinations after internal appeals options are exhausted.

The Plan delegates management of MH/SUD outpatient services, including Retrospective Review to United Behavioral Health d/b/a Optum Behavioral Health (OBH), its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor.

Retrospective Review of M/S Outpatient Services consists of the following:

Retrospective Review for certain outpatient services begins after the Plan receives claims from INN providers. The Plan conducts medical necessity Retrospective Review of claims/requests for certain outpatient services that have not previously been reviewed as part of the Prior Authorization or Concurrent Review processes. The Plan may conduct Retrospective Review if the service or procedure codes do not match a diagnosis code, if services are EIU, or if the services are subject to benefit limits/exclusion. The Plan also conducts medical necessity Retrospective Review for outpatient services where Prior Authorization was required, but not obtained upon claim submission. INN providers may also request Retrospective Review of outpatient claims that are denied.

Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. If needed, non-clinical staff request medical records for claims containing services that are subject to Retrospective Review. When medical records are received, the case is referred to clinical reviewers to assess medical necessity.

Retrospective Review –Out-of-Network Inpatient Non-Quantitative Treatment Limitation (NQTL) Analysis

GA Surest - UnitedHealthcare Insurance Company

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First Level Clinical Review/Initial Review. The clinical reviewer (physician or nurse) reviews the claim to determine if the outpatient service billed meets clinical criteria for coverage based on application of objective, evidence-based clinical criteria, nationally recognized guidelines, and the member's benefit plan documents. Clinical reviewers either approve claims for payment or refer claims to peer clinical reviewers (Medical Directors).

Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If a peer clinical reviewer determines that a service was not medically necessary, then an adverse benefit determination will be issued for the claim. The Plan communicates the adverse benefit determination, including applicable appeal rights, and offers a peer-to-peer conversation consistent with state and federal requirements. Appeal rights are set forth in the member's benefit plan document (*Certificate of Coverage*). The Plan communicates results of Retrospective Review within 30 days of receipt of a claim.

Adverse Benefit Determination. For M/S, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when benefits are exhausted. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials.

Clinical Criteria: Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based medical clinical policies or use clinical criteria from third party sources such as InterQual® or MCG® guidelines.

Monitoring/Quality Oversight: The Plan conducts a variety of activities that ensure that Retrospective Review determinations are appropriate.

Per the M/S policy entitled, *Performance Assessment and Incentives*, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons.

M/S generally structures UM processes to comply with federal Employee Retirement Income Security Act of 1974 (ERISA) requirements and state law where applicable.

Retrospective Review of MH/SUD Outpatient Services consists of the following:

The Plan delegates management of MH/SUD outpatient services, including Retrospective Review to United Behavioral Health d/b/a OBH, its delegated MH/SUD MBHO vendor.

MH/SUD claims/requests for outpatient services submitted by INN providers may be subject to Retrospective Review if the service or procedure code required Prior Authorization or Concurrent Review, but that review was not conducted and there is a mitigating circumstance. Additionally, claims may be subject to Retrospective Review if the billed services or procedure codes do not match the authorized codes or if services are EIU.

Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. If needed, non-clinical staff request medical records for claims containing services that are subject to Retrospective Review. When medical records are received, the case is referred to clinical reviewers to assess medical necessity.

First Level Clinical Review/Initial Review. The clinical reviewer (e.g., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) reviews the request or claim to determine if the outpatient service meets clinical criteria for coverage based on application of objective, evidence-based clinical criteria, or nationally recognized guidelines. Clinical reviewers either approve claims for payment or refer claims to peer clinical reviewers (Medical Directors or psychologists).

Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit

determinations. If the peer clinical reviewer determines that a service was not medically necessary, then an adverse benefit determination is issued. The Plan communicates the adverse benefit determination, including appeal rights, and offers a peer-to-peer conversation consistent with state and federal requirements. Appeal rights are set forth in the member's benefit plan document (*Certificate of Coverage*). The Plan communicates results of Retrospective Review within 30 days of receipt of a request/claim.

Adverse Benefit Determination. For MH/SUD, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when benefits are excluded. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials.

Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based behavioral clinical policies, or use clinical criteria from third party sources such as American Society of Addiction Medicine (ASAM) Criteria®, Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System-Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) and Early Childhood Service Intensity Instrument (ECSII) guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that outpatient Retrospective Review determinations are appropriate.

Per the MH/SUD policy entitled, *Core Principles and Practices*, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse clinical coverage benefit determinations (clinical denials) for financial reasons.

MH/SUD generally structures UM processes to comply with federal ERISA requirements and state law where applicable.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- Retrospective Review

Benefit Classification(s)

- INN, outpatient

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHC)

Plan Terms

The Plan's *Schedule of Benefits* notify members of Retrospective Review requirements.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

The *Utilization Management Program Description (UMPD)* discusses Post-Service Reviews and indicates:

Post-service review assesses the appropriateness of medical services on a case by-case basis after the service has been provided but prior to payment for services. Post- service reviews are based on established review guidelines and includes:

- Review of medical necessity
- Appropriateness of level of care
- Identifying claims issues

- Eligibility determination
- Initiation of appropriate follow-up actions for utilization and quality issues
- Identifying appropriateness and administrative issues such as physician notification, emergency status of admission

The role of the Plan's delegate, United Behavioral Health d/b/a OBH, is discussed in the *UMPD*:

United Behavioral Health (UBH) performs the review of requests for coverage of behavioral health services (i.e., substance abuse, and mental health requests for services). UBH provides comprehensive behavioral health care delivery for members through a network of behavioral health practitioners, ancillary care providers, hospitals and other facilities.

For mental health, substance-related disorder services, and wraparound services, UBH uses its Clinical Criteria (see below), behavioral clinical policies, and best practice guidelines to make coverage determinations. UBH adopts externally-developed clinical criteria, and creates internally-developed Clinical Criteria, where appropriate, based on its assessment of relevant guidance. UBH develops clinical criteria that supersedes its standard set or adopts externally-developed clinical criteria when required to do so by contract or regulation.

- Clinical Criteria (Level of Care Utilization System-LOCUS) – Standardized level of care assessment tool developed by the American Association of Community Psychiatrists used to make clinical determinations and placement decisions for mental health disorder benefits for adults ages 19 and older when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (Child and Adolescent Level of Care/Service Intensity Utilization System-CALOCUS-CASII) - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry (AACAP) and the American Association for Community Psychiatry (AACP) used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children and adolescents ages 6-18 when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (Early Childhood Service Intensity Instrument-ECSII) – Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children ages 0-5 when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (State or Contract Specific Level of Care Guidelines) - Criteria used to make medical necessity determinations for mental health disorder benefits when there are explicit mandates or contractual requirements.
- Clinical Criteria (American Society of Addiction Medicine [ASAM]) - Criteria developed by the American Society of Addiction Medicine used to make clinical determinations for substance-related disorder benefits.
- Clinical Criteria (Optum Developed)
 - Optum Behavioral Clinical Policies: Criteria that stem from evaluation of new services or treatments or new applications of existing services or treatments and are used to make clinical determinations regarding proven or unproven services and treatments.

Licensed practitioners conduct all reviews with a focus on measurable outcome goals and objectives for treatment. A senior UBH Medical Director is responsible for directing and implementing behavioral health utilization management programs. A referral is sent to UBH when a member is identified as potentially benefiting from behavioral health services during a “medical event.”

The UBH UM Program is staffed by clinical, non-clinical and administrative personnel. All clinical denials or adverse decisions are made by board certified psychiatrists, or, if the health plans choose, by a panel of other appropriate health care service reviewers. If the health plan chooses to use a panel to make adverse decisions, the panel contains at least one physician who is board certified in psychiatry. When the health care service under review is a mental health or substance abuse service, the adverse decision is made by a licensed physician who is board certified in psychiatry. All potential clinical denials are referred to a physician who is board certified in psychiatry for final determination. An evaluation of the overall effectiveness of the Behavioral Health UM Program is conducted annually to determine how well resources have been deployed to improve UM activities and the clinical care and service provided to members.

The Plan's terms require services to be medically necessary for coverage. INN providers are required to comply with UM protocols established by the Plan including complying with Retrospective Review requirements.

Step 2 – Factors Used to Determine Retrospective Review Applies

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

The Plan relies on the following factor to determine which INN outpatient services are subject to Retrospective Review. This factor applies to M/S and MH/SUD for the following:

- I. M/S INN outpatient services
 - II. MH/SUD INN outpatient services
- Consistency with Clinical Criteria (Qualitative):

This factor applies to M/S and MH/SUD services. Meeting Consistency with Clinical Criteria is determinative in imposing the limitation.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factor used in designing or applying the Plan's Retrospective Review requirement to INN outpatient services. These evidentiary standards and sources apply to the following:

- I. M/S INN outpatient services
- II. MH/SUD INN outpatient services

Factor - Consistency with Clinical Criteria

The factor and evidentiary standards used as the basis for subjecting MH/SUD INN outpatient benefits to Retrospective Review are comparable to, and applied no more stringently than, the factor and evidentiary standards used as the basis for subjecting M/S INN outpatient benefits to Retrospective Review "as written" and "in operation."

Step 4 – NQTL "As Written" and "In Operation" Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The findings of the Plan's comparative analyses confirmed the strategies, processes, factor, evidentiary standards, and source information used to subject certain MH/SUD INN outpatient services to Retrospective Review were comparable to, and applied no more stringently than, the strategies, processes, factor, evidentiary standards, and source information used to subject certain M/S INN outpatient services to Retrospective Review "as written."

The Plan found the factor used to subject INN MH/SUD outpatient services to Retrospective Review was comparable to and applied no more stringently than the factor used to subject INN M/S outpatient services to Retrospective Review "in operation."

Conclusions

The Plan concluded that how Retrospective Review is applied to MH/SUD INN outpatient services was comparable to, and applied no more stringently than, how Retrospective Review is applied to M/S INN outpatient services "as written."

The Plan reviewed the M/S and MH/SUD processes including responsibility for submission, timeframes for submission and review, notification to members and providers, clinical standards for review, and staff qualifications and concluded how the Plan conducts Retrospective Review for MH/SUD INN outpatient services "in operation" was comparable to, and applied no more stringently than, how the Plan conducts Retrospective Review for M/S INN outpatient services "in operation."

Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical/surgical (M/S) benefits. This generally means that the financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements, such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage.

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

Retrospective Review is a component of the Plan’s Utilization Management (UM) program. Medical directors and other clinical staff review services in order to detect and better manage over- and under-utilization and determine whether the services reviewed are consistent with the member’s coverage, medically appropriate, and consistent with evidence-based guidelines. Retrospective Review assesses the appropriateness of services on a case-by-case basis after the service has been provided but prior to payment for services. Retrospective Reviews are based on established review guidelines and may include:

- Review of medical necessity
- Appropriateness of level of care
- Identifying claims issues
- Eligibility determination
- Initiation of appropriate follow-up actions for utilization and quality issues

The Plan conducts medical necessity Retrospective Review of claims/requests for certain inpatient services that have not previously been reviewed as part of the Prior Authorization or Concurrent Review processes. The Plan may conduct Retrospective Review if the service or procedure codes do not match a diagnosis code, if services are experimental, investigational, or unproven (EIU), or if the services are subject to benefit limits/exclusions. The Plan conducts medical necessity Retrospective Review for inpatient services where Prior Authorization was required but not obtained upon claim submission.

This document includes the following information:

- The Retrospective Review process for M/S and MH/SUD inpatient services
- The description of the NQTL and application (Step 1)
- Factor used to determine which services are subject to the NQTL (Step 2)
- Evidentiary standards and sources used to define, trigger and/or implicate the factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

This comparative analysis refers to the following attachments:

- *Utilization Management Program Description (UMPD) of United HealthCare Services, Inc. and UnitedHealthcare Insurance Company* - summarizes the philosophy, structure and standards that govern UHC’s medical management, UM and utilization review responsibilities and functions

- *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions* - M/S policy that defines Retrospective Review
- *Optum National Policy Definitions List* - MH/SUD policy that defines Retrospective Review
- *M/S Retrospective Review Codes* – Excel document that lists M/S codes that may be subject to Retrospective Review
- *Schedule of Benefits - SBN23-Medical-INS-BIND-2021-Choice Plus-LG-GA-UHIC* - Plan document that outlines member responsibilities
- *Core Principles and Practices* - MH/SUD policy that outlines the core principles and practices that should be used by personnel in their interactions with members, authorized member representatives, practitioners, and facilities, related to the management of behavioral health benefits, coverage determinations and appeals/grievances of non-coverage determinations
- *Performance Assessment and Incentives* - M/S policy confirming that clinical reviewers are not incented to make denials for financial reasons
- *Medical Necessity NQTL* – Comparative analysis that describes the processes, strategies, evidentiary standards and other factors used to apply medical necessity to M/S and MH/SUD services in accordance with MHPAEA and other regulatory guidance

The Plan concludes that the Retrospective Review requirements for M/S and MH/SUD are comparable and applied no more stringently to MH/SUD out-of-network (OON) inpatient benefits both “as written” and “in operation.”

Process

The Plan structures inpatient Retrospective Review processes to be compliant with all applicable federal and state laws. Retrospective Review is governed at both the state and federal level, which includes consumer protections such as external review for adverse benefit determinations after internal appeals options are exhausted.

The Plan delegates management of MH/SUD Inpatient services, including Retrospective Review to United Behavioral Health d/b/a Optum Behavioral Health (OBH), its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor.

Retrospective Review of M/S Inpatient Admissions consist of the following:

Retrospective Review for certain inpatient services begins after the Plan receives claims or notification of an inpatient admission post discharge from an OON facility. The Plan conducts medical necessity Retrospective Review of claims/requests for certain inpatient services that have not previously been reviewed as part of the Prior Authorization or Concurrent Review processes. The Plan may conduct Retrospective Review if the service or procedure codes do not match a diagnosis code, if services EIU, or if the services are subject to benefit limits/exclusions. The Plan conducts medical necessity Retrospective Review for inpatient services where Prior Authorization was required but not obtained upon claim submission.

Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. If needed, non-clinical staff request medical records for claims containing services that are subject to Retrospective Review. When medical records are received, cases are referred to clinical reviewers to assess medical necessity.

First Level Clinical Review/Initial Review. The clinical reviewer (physicians or nurses) reviews the claim to determine if the inpatient service billed meets clinical criteria for coverage based on application of objective, evidence-based clinical criteria, nationally recognized guidelines, and the member’s benefit plan documents. Clinical reviewers either approve claims for payment or refer claims to peer clinical reviewers (Medical Directors).

Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If a peer clinical reviewer determines that a service was not medically necessary, then an adverse benefit determination will be issued for the claim. The Plan communicates the adverse benefit determination, including applicable

Retrospective Review – Out-of-Network Inpatient Non-Quantitative Treatment Limitation (NQTL) Analysis

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appeal rights, and offers a peer-to-peer conversation consistent with state and federal requirements. Appeal rights are set forth in the member's benefit plan document (*Certificate of Coverage*). The Plan communicates results of Retrospective Review within 30 days of receipt of a claim.

Adverse Benefit Determination. For M/S, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when benefits are exhausted. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials.

Clinical Criteria: Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based medical clinical policies or use clinical criteria from third party sources such as InterQual® or MCG® Guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that Retrospective Review determinations are appropriate.

Per the M/S policy entitled, *Performance Assessment and Incentives*, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons.

M/S generally structures UM processes to comply with federal Employee Retirement Income Security Act of 1974 (ERISA) requirements, and state law where applicable.

Retrospective Review of MH/SUD Inpatient Admissions consist of the following:

The Plan delegates management of MH/SUD inpatient services, including Retrospective Review to United Behavioral Health d/b/a OBH, its delegated MH/SUD MBHO vendor.

MH/SUD claims/requests for inpatient services submitted by OON providers may be subject to Retrospective Review if the service or procedure code required Prior Authorization or Concurrent Review, but that review was not conducted and there is a mitigating circumstance. Additionally, claims may be subject to Retrospective Review if the billed services or procedure codes do not match the authorized codes, or if services are EIU.

Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. If needed, non-clinical staff request medical records for requests or claims containing services that are subject to Retrospective Review. When medical records are received, the case is referred to clinical reviewers to assess medical necessity.

First Level Clinical Review/Initial Review. The clinical reviewer (e.g., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) review the claim to determine if the inpatient admission billed meets clinical criteria for coverage based on application of objective, evidence-based, clinical criteria, or nationally recognized guidelines. Clinical reviewers either approve claims for payment or refer claims to peer clinical reviewers (Medical Directors).

Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If the peer clinical reviewer determines that an admission was not medically necessary, then an adverse benefit determination will be issued for the claim. The Plan communicates the adverse benefit determination, including applicable appeal rights. Appeal rights are set forth in the member's benefit plan document (*Certificate of Coverage*). The Plan communicates results of Retrospective Review within 30 days of receipt of a request/claim.

The OON provider may bill non-reimbursable charges to the member.

Adverse Benefit Determination. For MH/SUD, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when benefits are exhausted. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials

Clinical Criteria: Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based behavioral clinical policies or use clinical criteria from third party sources such as American Society of Addiction Medicine (ASAM) Criteria®, Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System-Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) and Early Childhood Service Intensity Instrument (ECSII) guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that inpatient Retrospective Review determinations are appropriate.

The Plan conducts monthly quality audits of individual non-clinical staff, clinical reviewers, and peer clinical reviewers, including staff performing appeal functions. These audits are designed and approved by clinical leadership each year. A minimum of two audits are completed per staff, per month. The results of these real-time audits are shared with supervisors for staff oversight, and all findings are remediated. Remediation may include corrective actions and/or additional education, as indicated.

The Plan routinely monitors Retrospective Review performance through its clinical performance oversight functions. Outcomes are monitored against timeliness requirements, performance guarantees, and for potential trends, including overall utilization. The Plan's national Clinical Quality & Operations Committee (CQOC) annually reviews overall UM program outcomes, including inpatient Retrospective Review outcomes, to confirm overall utilization is appropriate. The national CQOC is comprised of representatives from sub-committees, and representatives from the clinical quality improvement, UM, care engagement, medical operations, medical policy and standards, clinical operations, appeals, product, legal, compliance, network strategy, provider experience, accreditation, and benefits teams. The Chair of the CQOC must be an executive leader, board certified in psychiatry or psychiatric subspecialty, and a licensed physician.

Per the MH/SUD policy entitled, *Core Principles and Practices*, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse clinical coverage benefit determinations (clinical denials) for financial reasons.

MH/SUD generally structures UM processes to comply with federal ERISA requirements and state law where applicable.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- Retrospective Review

Benefit Classification(s)

- OON, inpatient

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHC)

Plan Terms

The Plan's *Schedule of Benefits* notify members of Retrospective Review requirements.

"The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs."

The *Utilization Management Program Description (UMPD)* discusses Post-Service Reviews and indicates:

"Post-service review assesses the appropriateness of medical services on a case-by-case basis after the service has been provided but prior to payment for services. Post-service reviews are based on established review guidelines and includes:

- Review of medical necessity;
- Appropriateness of level of care;
- Identifying claims issues;
- Eligibility determination;
- Initiation of appropriate follow-up actions for utilization and quality issues; and
- Identifying appropriateness and administrative issues such as physician notification, emergency status of admission."

The Plan's delegate, United Behavioral Health d/b/a OBH, is discussed in the *UMPD*:

"United Behavioral Health (UBH) performs the review of requests for coverage of behavioral health services (i.e., substance abuse, and mental health requests for services). UBH provides comprehensive behavioral health care delivery for members through a network of behavioral health practitioners, ancillary care providers, hospitals and other facilities.

For mental health, substance-related disorder services, and wraparound services, UBH uses its Clinical Criteria (see below), behavioral clinical policies, and best practice guidelines to make coverage determinations. UBH adopts externally-developed clinical criteria, and creates internally-developed Clinical Criteria, where appropriate, based on its assessment of relevant guidance. UBH develops clinical criteria that supersedes its standard set or adopts externally-developed clinical criteria when required to do so by contract or regulation.

- Clinical Criteria (Level of Care Utilization System-LOCUS) – Standardized level of care assessment tool developed by the American Association of Community Psychiatrists used to make clinical determinations and placement decisions for mental health disorder benefits for adults ages 19 and older when State or Contract Specific Level of Care Guidelines do not apply.
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- Clinical Criteria (Optum Developed)
 - Optum Behavioral Clinical Policies: Criteria that stem from evaluation of new services or treatments or new applications of existing services or treatments and are used to make clinical determinations regarding proven or unproven services and treatments.

Licensed practitioners conduct all reviews with a focus on measurable outcome goals and objectives for treatment. A senior UBH Medical Director is responsible for directing and implementing behavioral health utilization management programs. A referral is sent to UBH when a member is identified as potentially benefiting from behavioral health services during a “medical event.”

The UBH UM Program is staffed by clinical, non-clinical and administrative personnel. All clinical denials or adverse decisions are made by board certified psychiatrists, or, if the health plans choose, by a panel of other appropriate health care service reviewers. If the health plan chooses to use a panel to make adverse decisions, the panel contains at least one physician who is board certified in psychiatry. When the health care service under review is a mental health or substance abuse service, the adverse decision is made by a licensed physician who is board certified in psychiatry. All potential clinical denials are referred to a physician who is board certified in psychiatry for final determination. An evaluation of the overall effectiveness of the Behavioral Health UM Program is conducted annually to determine how well resources have been deployed to improve UM activities and the clinical care and service provided to members.”

The Plan’s terms require services to be medically necessary for coverage.

Step 2 – Factors Used to Determine Retrospective Review Applies

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

The Plan relies on the following factor to determine which OON inpatient admissions are subject to Retrospective Review. This factor applies to M/S and MH/SUD for the following:

- I. M/S OON inpatient admissions
 - II. MH/SUD OON inpatient admissions
- Consistency with Clinical Criteria (Qualitative):

This factor applies to M/S and MH/SUD services. Meeting Consistency with Clinical Criteria is determinative in imposing the limitation.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factor used in designing or applying the Plan’s Retrospective Review requirements to OON inpatient services. These evidentiary standards and sources apply to the following:

- I. M/S OON inpatient admissions
- II. MH/SUD OON inpatient admissions

Factor: Consistency with Clinical Criteria

The factor and evidentiary standards used as the basis for subjecting MH/SUD OON inpatient benefits to Retrospective Review are comparable to, and applied no more stringently than, the factor and evidentiary standards used as the basis for subjecting M/S OON inpatient benefits to Retrospective Review “as written” and “in operation.”

Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

As Written

The Plan conducted a comparative analysis of the strategies, processes, factor, evidentiary standards, and source information used to determine which M/S and MH/SUD OON inpatient services are subject to Retrospective Review “as written.” The Plan identified the factors and evidentiary standards used as the basis for subjecting M/S and MH/SUD benefits to Retrospective Review for each benefit classification.

Review of Factor and Evidentiary Standards

The Plan reviewed the factor that triggers an OON inpatient service to be subject to Retrospective Review. The factor and evidentiary standards were applied to M/S and MH/SUD services comparably and not more stringently to MH/SUD services than M/S services.

Review of Operational Policies and Procedures

The Plan reviewed M/S and MH/SUD operational policies and procedures and UM annual oversight to confirm comparability and found MH/SUD policies, procedures, and processes to be comparable and no more stringent than M/S policies, procedures, and processes.

- Medical management operational policies and procedures establish the standards for how the Plan conducts inpatient Retrospective Review. The policies and procedures are consistent with state and federal law governing Retrospective Review. Timeframes for decisions, content of adverse benefit determinations, appeal rights and external review are all governed by state and federal requirements
- UM oversight monitors and evaluates UM processes by reviewing denial rates, clinical appeals, and under- and over-utilization.

Review of Inpatient Retrospective Review Processes

The strategy for applying Retrospective Review to OON inpatient claims/requests is comparable for M/S and MH/SUD services and applied no more stringently to MH/SUD OON inpatient services. The Plan conducted a review of the M/S and MH/SUD Retrospective Review processes to confirm comparability. The review focused on the following aspects of the processes for both M/S and MH/SUD:

- **Responsibility.** The member is responsible for notifying the Plan of an inpatient admission to an OON provider or advising of a change to procedure for both M/S and MH/SUD. OON providers may submit notification on behalf of the member.
- **Timeframe to submit.** The timeframe for the member to submit the Retrospective Review request was reviewed and it was determined that MH/SUD was no more stringent.
 - For M/S, members must notify the Plan within timely filing requirements
 - For MH/SUD, members have 180 days after the service is rendered to request a Retrospective Review
- **Clinical Reviews.** For M/S and MH/SUD claims/requests, the Plan may request clinical information and refers the claim/request to a clinical reviewer for Retrospective Review. The clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. The clinical reviewer either approves cases that meet applicable clinical criteria or refers the case to a peer clinical reviewer.
- **Review Timeframes.** M/S and MH/SUD Retrospective Review determination timeframes are defined by state and federal requirements. The same determination timeframes apply to M/S and MH/SUD determinations.
- **Determinations, First Level Clinical Review, and Second Level/Peer Clinical Reviews.** Clinical reviewers determine whether an inpatient admission is medically necessary. The clinical reviewer may approve the admission based on

their review. The clinical reviewer refers cases they cannot approve to a peer clinical reviewer. If the peer clinical reviewer determines that an admission was not medically necessary and will not be covered, an adverse benefit determination will be issued. Only qualified peer clinical reviewers may issue adverse benefit determinations.

- **Adverse Benefit Determinations.** An adverse benefit determination is recorded as a clinical denial when it is based on clinical criteria and member clinical information and is recorded as an administrative denial when member benefits are exhausted.
- **Notification of Decisions to Providers and Members.** The Plan notifies M/S and MH/SUD OON facilities and members of approvals and adverse benefit determinations, including applicable appeal rights consistent with state and federal requirements.
- **Review of Staff Qualifications.** For M/S and MH/SUD, clinical staff qualifications align with the type of clinical review and state and federal requirements.
 - M/S is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are conducted by clinical staff (nurses, physicians) and all adverse benefit determinations are made by a physician or other appropriate health care professionals.
 - MH/SUD is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse benefit determinations are made by Medical Directors.
- **Clinical Criteria.** For M/S and MH/SUD, clinical reviewers and peer clinical reviewers base determinations on objective, evidence-based medical/behavioral clinical policies or use clinical criteria from third party sources such as InterQual, MCG, ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines.

In Operation

The Plan compared the strategies, processes, factor, evidentiary standards, and source information used to determine which M/S and MH/SUD OON inpatient services are subject to Retrospective Review and how Retrospective Review is applied “in operation.”

The Plan subjected claims/requests for M/S and MH/SUD inpatient admissions to Retrospective Review that were not reviewed via Prior Authorization or Concurrent Review. Additionally, M/S claims/requests for inpatient services submitted by OON providers were subject to Retrospective Review if the services or procedure codes did not match a diagnosis code, if services were EIU, or if the services had benefit limits/exclusions. Claims/requests for inpatient services submitted by OON providers may be subject to Retrospective Review if the service or procedure code required Prior Authorization or Concurrent Review, but that review was not conducted and there is a mitigating circumstance. Additionally, claims may be subject to Retrospective Review if the billed services or procedure codes do not match the authorized codes or if services are EIU.

The Plan may have requested member clinical information for M/S and MH/SUD inpatient claims/requests and referred them to a clinical reviewer. The clinical reviewer reviewed applicable member clinical information, benefit plan documents, and clinical criteria in the case review. The clinical reviewer approved cases that met applicable clinical criteria or referred cases to peer clinical reviewers. If an appropriately qualified peer clinical reviewer determined that a service was not medically necessary and would not be covered, an adverse benefit determination was issued for the claim.

The Plan communicated all adverse benefit determinations for M/S and MH/SUD inpatient claims/requests that did not meet applicable clinical criteria, including appeal rights, consistent with state and federal requirements.

The Plan conducted monthly quality audits of individual non-clinical staff, clinical reviewers, including staff performing appeal functions. The Plan routinely monitored Retrospective Review performance through its clinical performance oversight functions. In addition to comparing these “in operation” processes, the Plan reviewed medical necessity approval and denial rates, internal appeals outcomes, and external appeals outcomes related to Retrospective Review determinations for M/S and MH/SUD INN inpatient services.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The findings of the Plan's comparative analyses confirmed the strategies, processes, factor, evidentiary standards, and source information used to subject certain MH/SUD OON inpatient services to Retrospective Review were comparable to, and applied no more stringently than, the strategies, processes, factor, evidentiary standards, and source information used to subject certain M/S OON inpatient services to Retrospective Review "as written."

The Plan found the factor used to subject OON MH/SUD inpatient services to Retrospective Review was comparable to and applied no more stringently than the factor used to subject ONN M/S inpatient services to Retrospective Review "in operation."

Conclusions

The Plan concluded that how Retrospective Review is applied to MH/SUD OON inpatient services was comparable to, and applied no more stringently than, how Retrospective Review is applied to M/S OON inpatient services "as written."

The Plan reviewed the M/S and MH/SUD processes including responsibility for submission, timeframes for submission and review, notification to members and providers, clinical standards for review, and staff qualifications and concluded how the Plan conducts Retrospective Review for MH/SUD OON inpatient services "in operation" was comparable to, and applied no more stringently than, how the Plan conducts Retrospective Review for M/S OON inpatient services "in operation."

Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical/surgical (M/S) benefits. This generally means that financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements, such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage.

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

Retrospective Review is a component of the Plan’s Utilization Management (UM) program. Medical directors and other clinical staff review services in order to detect and better manage over- and under-utilization and determine whether the services reviewed are consistent with the member’s coverage, medically appropriate, and consistent with evidence-based guidelines. Retrospective Review assesses the appropriateness of services on a case-by-case basis after the service has been provided but prior to payment for services. Retrospective Reviews are based on established review guidelines and may include:

- Review of medical necessity
- Appropriateness of level of care
- Identifying claims issues
- Eligibility determination
- Initiation of appropriate follow-up actions for utilization and quality issues

The Plan conducts medical necessity Retrospective Review of claims/requests for certain outpatient services that have not previously been reviewed as part of the Prior Authorization or Concurrent Review processes. The Plan may conduct Retrospective Review if the service or procedure codes do not match a diagnosis code, if services are experimental, investigational, or unproven (EIU), or if the services are subject to benefit limits/exclusions. The Plan conducts medical necessity Retrospective Review for outpatient services where Prior Authorization was required, but not obtained upon claim submission.

This document includes the following information:

- The Retrospective Review process for M/S and MH/SUD outpatient services
- The description of the NQTL and application (Step 1)
- Factor used to determine which services are subject to the NQTL (Step 2)
- Evidentiary standards and sources used to define, trigger and/or implicate a factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

This comparative analysis refers to the following attachments:

- *Utilization Management Program Description of United HealthCare Services, Inc. and UnitedHealthcare Insurance Company* - Summarizes the philosophy, structure and standards that govern UHC’s medical management, UM and utilization review responsibilities and functions

- *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions* - M/S policy that defines Retrospective Review
- *Optum National Policy Definitions List* – MH/SUD policy that defines Retrospective Review
- *M/S Retrospective Review Codes* - Excel document that lists the M/S codes that may be subject to Retrospective Review
- *Schedule of Benefits - SBN23-Medical-INS-BIND-2021-Choice Plus-LG-GA-UHIC* - Plan document that outlines member responsibilities
- *Core Principles and Practices* - MH/SUD policy that outlines the core principles and practices that should be used by personnel in their interactions with members, authorized member representatives, practitioners and facilities, related to the management of behavioral health benefits, coverage determinations and appeals/grievances of non-coverage determinations
- *Performance Assessment and Incentives* - M/S policy confirming that clinical reviewers are not incented to make denials for financial reasons
- *Medical Necessity NQTL* – Comparative analysis that describes the processes, strategies, evidentiary standards and other factors used to apply medical necessity to M/S and MH/SUD services in accordance with MHPAEA and other regulatory guidance

The Plan concludes that the Retrospective Review requirements for M/S and MH/SUD are comparable and applied no more stringently to MH/SUD out-of-network (OON) outpatient benefits both "as written" and "in operation."

Process

The Plan structures outpatient Retrospective Review processes to be compliant with all applicable federal and state laws. Retrospective Review is governed at both the state and federal level, which includes consumer protections such as external review for adverse benefit determinations after internal appeals options are exhausted.

The Plan delegates management of MH/SUD outpatient services, including Retrospective Review to United Behavioral Health d/b/a Optum Behavioral Health (OBH), its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor.

Retrospective Review of M/S Outpatient Services consists of the following:

Retrospective Review for certain outpatient services begins after the Plan receives claims from OON providers. The Plan conducts medical necessity Retrospective Review of claims/requests for certain outpatient services that have not previously been reviewed as part of the Prior Authorization or Concurrent Review processes. The Plan may conduct Retrospective Review if the service or procedure codes do not match a diagnosis code, if services are EIU, or if the services are subject to benefit limits/exclusion. The Plan also conducts medical necessity Retrospective Review for outpatient services where Prior Authorization was required, but not obtained upon claim submission.

Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. If needed, non-clinical staff request medical records for claims containing services that are subject to Retrospective Review. When medical records are received, the case is referred to clinical reviewers to assess medical necessity.

First Level Clinical Review/ Initial Review. The clinical reviewer (physicians or nurses) reviews the claim to determine if the outpatient service billed meets clinical criteria for coverage based on application of objective, evidence-based clinical criteria, nationally recognized guidelines, and the member's benefit plan documents. Clinical reviewers either approve claims for payment or refer claims to peer clinical reviewers (Medical Directors).

Second Level Clinical Review/ Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If a peer clinical reviewer determines that a service was not medically necessary, then an adverse benefit determination will be issued for the claim. The Plan communicates the adverse benefit determination, including applicable

Retrospective Review – Out-of-Network Outpatient Non-Quantitative Treatment Limitation (NQTL) Analysis

GA Surest - UnitedHealthcare Insurance Company

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appeal rights, and offers a peer-to-peer conversation consistent with state and federal requirements. Appeal rights are set forth in the member's benefit plan document (*Certificate of Coverage*). The Plan communicates results of Retrospective Review within 30 days of receipt of a claim. The OON provider may bill non-reimbursable charges to the member.

Adverse Benefit Determination. For M/S, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when benefits are exhausted. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials.

Clinical Criteria: Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based medical clinical policies or use clinical criteria from third party sources such as InterQual® or MCG® guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that Retrospective Review determinations are appropriate.

Per the M/S policy entitled, *Performance Assessment and Incentives*, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons.

M/S generally structures UM processes to comply with federal Employee Retirement Income Security Act of 1974 (ERISA) requirements and state law where applicable.

Retrospective Review of MH/SUD Outpatient Services consists of the following:

The Plan delegates management of MH/SUD outpatient services, including Retrospective Review to United Behavioral Health d/b/a OBH, its delegated MH/SUD MBHO vendor.

MH/SUD claims/requests for outpatient services submitted by OON providers may be subject to Retrospective Review if the service or procedure code required Prior Authorization or Concurrent Review, but that review was not conducted and there is a mitigating circumstance. Additionally, claims may be subject to Retrospective Review if the billed services or procedure codes do not match the authorized codes or if services are EIU.

Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. If needed, non-clinical staff request medical records for claims containing services that are subject to Retrospective Review. When medical records are received, the case is referred to clinical reviewers to assess medical necessity.

First Level Clinical Review/Initial Review. The clinical reviewer (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) reviews the request or claim to determine if the outpatient service meets clinical criteria for coverage based on application of objective, evidence-based clinical criteria, or nationally recognized guidelines. Clinical reviewers either approve claims for payment or refer claims to peer clinical reviewers (Medical Directors or psychologists).

Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If the peer clinical reviewer determines that a service was not medically necessary, then an adverse benefit determination is issued. The Plan communicates the adverse benefit determination, including appeal rights, and offers a peer-to-peer conversation consistent with state and federal requirements. Appeal rights are set forth in the member's benefit plan document (*Certificate of Coverage*). The Plan communicates results of Retrospective Review within 30 days of receipt of a request/claim.

The OON provider may bill non-reimbursable charges to the member.

Retrospective Review – Out-of-Network Outpatient Non-Quantitative Treatment Limitation (NQTL) Analysis

GA Surest - UnitedHealthcare Insurance Company

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Adverse Benefit Determination. For MH/SUD, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when benefits are excluded. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials.

Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based behavioral clinical policies, or use clinical criteria from third party sources such as American Society of Addiction Medicine (ASAM) Criteria®, Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System-Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) and Early Childhood Service Intensity Instrument (ECSII) guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that outpatient Retrospective Review determinations are appropriate.

Per the MH/SUD policy entitled, *Core Principles and Practices*, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse clinical coverage benefit determinations (clinical denials) for financial reasons.

MH/SUD generally structures UM processes to comply with federal ERISA requirements and state law where applicable.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- Retrospective Review

Benefit Classification(s)

- OON, outpatient

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHC)

Plan Terms

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The Plan's terms require services to be medically necessary for coverage.

Step 2 – Factors Used to Determine Retrospective Review Applies

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The Plan relies on the following factor to determine which OON outpatient services are subject to Retrospective Review. This factor applies to M/S and MH/SUD for the following:

- I. M/S OON outpatient services
 - II. MH/SUD OON outpatient services
- Consistency with Clinical Criteria (Qualitative):

This factor applies to M/S and MH/SUD services. Meeting Consistency with Clinical Criteria is determinative in imposing the limitation.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factor used in designing or applying the Plan's Retrospective Review requirement to OON outpatient services. These evidentiary standards and sources apply to the following:

- I. M/S OON outpatient services
- II. MH/SUD OON outpatient services

Factor - Consistency with Clinical Criteria

The factor and evidentiary standards used as the basis for subjecting MH/SUD OON outpatient benefits to Retrospective Review are comparable to, and applied no more stringently than, the factor and evidentiary standards used as the basis for subjecting M/S OON outpatient benefits to Retrospective Review "as written" and "in operation."

Step 4 – NQTL "As Written" and "In Operation" Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan's or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The findings of the Plan's comparative analyses confirmed the strategies, processes, factor, evidentiary standards, and source information used to subject certain MH/SUD OON outpatient services to Retrospective Review were comparable to, and applied no more stringently than, the strategies, processes, factor, evidentiary standards, and source information used to subject certain M/S OON outpatient services to Retrospective Review "as written."

The Plan found the factor used to subject OON MH/SUD outpatient services to Retrospective Review was comparable to and applied no more stringently than the factor used to subject OON M/S outpatient services to Retrospective Review "in operation."

Conclusions

The Plan concluded that how Retrospective Review is applied to MH/SUD OON outpatient services was comparable to, and applied no more stringently than, how Retrospective Review is applied to M/S OON outpatient services "as written."

The Plan reviewed the M/S and MH/SUD processes including responsibility for submission, timeframes for submission and review, notification to members and providers, clinical standards for review, and staff qualifications review and concluded how the Plan conducts Retrospective Review for MH/SUD OON outpatient services "in operation" was comparable to, and applied no more stringently than, how the Plan conducts Retrospective Review for M/S OON outpatient services "in operation."

Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical/surgical (M/S) benefits. This generally means that financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements, such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage.

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Concurrent Review is defined as “a clinical review of an extension of previously approved, ongoing course of treatment over a period of time or number of treatments conducted during an inpatient stay or ongoing ambulatory care. It is sometimes called a “continued stay review.”” The *Optum National Policy Definitions List* defines a Concurrent (Review) Request as “a request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care.” Concurrent Review does not involve onsite reviews.

Concurrent Review is a component of the Plan’s Utilization Management (UM) program that helps ensure members receive appropriate coverage based on their specific clinical status and health care needs. The process is designed to achieve optimal clinical outcomes by applying objective, evidence-based clinical criteria, and nationally recognized guidelines and best practices. Concurrent Review is a UM process that involves applying the benefit plan language and/or clinical criteria to make the most appropriate clinical coverage benefit determination.

This document includes the following information:

- The Concurrent Review process for M/S and MH/SUD inpatient services
- The description of the NQTL and application (Step 1)
- Factors used to determine which services are subject to the NQTL (Step 2)
- Evidentiary standards and sources used to define, trigger, and/or implicate a factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

This analysis refers to the following attachments:

- *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions* - M/S policy that defines Concurrent Review
- *Optum National Policy Definitions List* - MH/SUD policy that defines Concurrent Review

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- *Utilization Management Program Description (UMPD) of United HealthCare Services, Inc. and UnitedHealthcare Insurance Company* - Summarizes the philosophy, structure and standards that govern UHC's medical management, UM and utilization review responsibilities and functions
- *Management of Behavioral Health Benefits Policy* - Describes the mechanisms and processes designed to promote consistency in the management of behavioral health benefits and to ensure that members receive appropriate, high quality behavioral health services in a timely manner
- *Schedule of Benefits - SBN23-Medical-INS-BIND-2021-Choice Plus-LG-GA-UHIC* - Plan document that outlines member responsibilities
- *Core Principles and Practices* - MH/SUD policy that outlines the Core Principles and Practices that should be used by personnel in their interactions with members, authorized member representatives, practitioners and facilities, related to the management of behavioral health benefits, coverage determinations and appeals/grievances of non-coverage determinations
- *Performance Assessment and Incentives* - M/S policy confirming that clinical reviewers are not incented to make denials for financial reasons
- *2023 UnitedHealthcare Provider Administrative Guide* – Informs M/S providers of the Concurrent Review process. The *UnitedHealthcare Provider Administrative Guide* can be accessed on the website <https://www.uhcprovider.com/en/admin-guides.html>
- *September 2023 Optum National Network Manual* - Informs MH/SUD providers of the Concurrent Review process. The *Optum National Network Manual* can be accessed on the website <https://public.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/optum-network-manual.html>

The Plan concludes that the Concurrent Review requirements for M/S and MH/SUD are comparable and applied no more stringently for MH/SUD in-network (INN) inpatient benefits both “as written” and “in operation.”

Process

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Concurrent Review is defined as “a clinical review of an extension of previously approved, ongoing course of treatment over a period of time or number of treatments conducted during an inpatient stay or ongoing ambulatory care. It is sometimes called “continued stay review.”” The *Optum National Policy Definitions List* defines a Concurrent (Review) Request as “a request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care.”

The Plan structures inpatient Concurrent Review processes to be compliant with all applicable federal and state laws. Concurrent Review is governed at both the state and federal level, which includes consumer protections such as external review for adverse benefit determinations after internal appeals options are exhausted.

The Plan delegates management of MH/SUD inpatient services, including Concurrent Review for MH/SUD inpatient services, to United Behavioral Health d/b/a Optum Behavioral Health (OBH), its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor.

Concurrent Review of M/S inpatient admissions consists of the following:

Initial Concurrent Review. The Plan requires INN facilities and providers to timely notify the Plan (e.g., within 24 hours) of an unplanned (e.g., urgent/emergent) inpatient admission. Provider notification triggers the inpatient Concurrent Review process. Providers can notify the Plan through the secure provider portal (www.uhcprovider.com), their connected electronic medical record, by telephone, or by fax (where required).

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The Plan confirms receipt of the Concurrent Review request. Non-clinical staff confirm member eligibility and benefit coverage upon receipt of the notification. Non-clinical staff may approve coverage requests in scenarios where the member's plan documents allow and if a clinical review is not required. Non-clinical staff will also approve a coverage request if the facility's contract does not allow for clinical reviews. Non-clinical staff refer coverage requests that they cannot approve to initial clinical reviewers.

First Level Clinical Review/Initial Review. Clinical reviewers (nurses or physicians) consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether the inpatient admission is medically necessary by reviewing the member's clinical information, the applicable clinical criteria or guidelines, and the Plan benefit terms. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs to determine whether the applicable clinical criteria are met or may access clinical information in the provider's electronic medical record (EMR) if the provider has given the Plan access. The clinical reviewer may approve the admission based on their review.

Second Level Clinical Review/Peer Review. The initial clinical reviewer refers cases to a second level/peer clinical reviewer if the case cannot be approved. Peer clinical reviewers (physician or mid-level practitioner) consult clinical criteria when making clinical coverage benefit determinations. Peer clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs. Only qualified peer clinical reviewers (e.g., Medical Director) can issue adverse benefit determinations. The peer clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. If a peer clinical reviewer issues an adverse benefit determination, then the Plan timely communicates the adverse benefit determination, including appeal rights, and offers a peer-to-peer conversation consistent with state and federal requirements.

Adverse Benefit Determination. For M/S, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction, or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when benefits are exhausted. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials. Modified coverage requests that are approved are recorded as partial denials.

Ongoing Concurrent Review. INN M/S facilities may request coverage of additional days prior to the expiration of the last day of an approved inpatient admission. The Plan conducts ongoing Concurrent Reviews for additional days for approved inpatient M/S admissions as follows:

- General acute care facilities reimbursed on a per diem basis: every two days
- General acute care facilities reimbursed on a diagnosis related group (DRG) basis: when the inpatient admission meets the number of days stated in the provider participation agreement
- Skilled Nursing Facility (SNF) admissions: initial Concurrent Review at day three and then weekly. Subsequent reviews may be sooner if clinically appropriate
- Acute Inpatient Rehab (AIR) admissions: initial Concurrent Review at day five and then weekly. Subsequent reviews may be sooner if clinically appropriate
- Long Term Acute Care Hospital (LTACH) admissions: initial Concurrent Review at day 14 and then weekly

The Plan follows the initial Concurrent Review clinical review process when conducting ongoing Concurrent Reviews.

Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based medical clinical policies and clinical criteria from third party sources such as InterQual® or MCG® guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that inpatient Concurrent Review determinations are appropriate.

M/S monitors clinical reviewer and peer clinical reviewer application of clinical criteria through an annual inter-rater reliability (IRR) assessment that is provided by InterQual. Clinical reviewers and peer clinical reviewers are required to pass the IRR assessment with a score of 90% or better through three attempts. After a second failed IRR assessment, staff enter a remediation period and are required to review all cases with a supervisor for 30 days, or until 90% is achieved on the assessment. If the clinical reviewer achieves a passing score within the 30-day period, supervisors review a minimum of one case per week for the remainder of the 30-day period.

The Plan also conducts end-to-end case audits that are designed and approved by clinical leadership each year. The end-to-end audits include all stages of a case review, from intake through appeal. These audits are conducted monthly and approximately 1500 cases are reviewed per month. Results are reported to an oversight team. All deficiencies are remediated. Remediation may include corrective actions and/or additional education, as indicated.

The Plan routinely monitors Concurrent Review performance through its clinical performance oversight functions. Outcomes are monitored against timeliness requirements, performance guarantees, and for potential trends, including overall utilization.

As of April 1, 2023, the Utilization Management Program Committee (UMPC) began overseeing the M/S UM program. The UMPC is responsible for the development and maintenance of the M/S Prior Authorization processes. The UMPC ensures that the UM program considers the factors and evidentiary standards for applying UM. The UMPC is comprised of:

- Chief Medical Officer, Medical Management (Co-Chair)
- Senior Vice President, Clinical Advancement (Co-Chair)
- Chief Medical Officer, UnitedHealthcare
- Senior Vice President, Clinical Appeals & Grievances
- Chief Medical Officer, Clinical Policy
- Chief Medical Officer, UnitedHealthcare Employer & Individual
- Chief Medical Officer, UnitedHealthcare Medicare & Retirement
- Chief Medical Officer, Community & State
- Chief Medical Officer, UnitedHealthcare Individual & Family Plans
- Vice President, Clinical Transformation & Affordability
- Senior Director, Mental Health Parity
- Vice President, Utilization Management Strategy & Implementation

One of the chairs must be an executive leader and a licensed physician. UMPC meets at least six times per year but may meet more frequently if needed.

Per the M/S policy entitled, *Performance Assessment and Incentives*, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons.

M/S generally structures UM processes to comply with federal Employee Retirement Income Security Act of 1974 (ERISA) requirements, NCQA UM standards, and state law where applicable.

Concurrent Review of MH/SUD Inpatient Admissions consists of the following:

The Plan delegates management of MH/SUD inpatient services, including Concurrent Review, to United Behavioral Health d/b/a OBH, its delegated MH/SUD MBHO vendor.

Initial Concurrent Review. All INN inpatient admissions are subject to the Concurrent Review process. The Plan requires INN providers and facilities to timely notify the Plan of MH/SUD inpatient admissions. INN facilities must notify the Plan within one business day after an admission unless a longer period is required by contract or state-specific requirements. Provider notification triggers the inpatient Concurrent Review process. Providers notify the Plan of the need for additional days/services by telephone.

As described in the *Management of Behavioral Health Benefits Policy*, upon receipt of admission notification, non-clinical staff confirm member eligibility and benefit coverage. Non-clinical staff may approve cases that do not require clinical evaluation or interpretation based on the member's diagnosis and the clinical information submitted by providers. Non-clinical staff refer cases that they cannot approve to initial clinical reviewers.

First Level Clinical Review/Initial Review. Clinical decisions are made by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse benefit determinations are made by Medical Directors. Clinical reviewers consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether an inpatient admission is medically necessary by reviewing the member's clinical information, the applicable clinical criteria or guidelines, and the Plan benefit terms. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for certification, related diagnostic results, and history of related treatment and services to determine whether the applicable clinical criteria are met. The clinical reviewer may approve the admission based on their review.

Second Level Clinical Review/Peer Review. The initial clinical reviewer refers cases to a peer clinical reviewer for a peer-to-peer discussion if the case cannot be approved. The requesting provider is offered the opportunity to discuss the case with the peer clinical reviewer, consistent with state and federal requirements before an adverse benefit determination is issued. Only qualified peer clinical reviewers (e.g., Medical Directors) can issue adverse benefit determinations. Peer clinical reviewers apply clinical criteria to member clinical information to determine coverage for an inpatient admission. If the requesting provider fails to complete the peer-to-peer discussion, the peer clinical reviewer makes a determination based on the information available. If a peer clinical reviewer issues an adverse benefit determination, (e.g., the admission is not medically necessary and is not approved), then the Plan timely communicates the adverse benefit determination, including appeal rights, to the member and provider consistent with applicable state, federal, and accreditation requirements.

Adverse Benefit Determination. For MH/SUD, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination, or failure to provide or make payment (in whole or in part), of a benefit. Adverse benefit determinations are recorded as a clinical denial when it is based on clinical criteria and member clinical information.

Ongoing Concurrent Review. INN providers may request coverage for additional days by contacting the Plan prior to the expiration of the last covered day of an approved MH/SUD inpatient admission. The Plan's INN MH/SUD general acute care facilities are reimbursed on a per diem basis. The Plan conducts ongoing Concurrent Review for INN MH/SUD admissions depending on the applicable clinical criteria and the member's clinical presentation. Upon receipt of a request for coverage of additional days, the Plan reviews the medical necessity of inpatient admissions. Clinical reviewers and peer clinical reviewers follow the initial Concurrent Review process.

Clinical Criteria. Initial clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based behavioral clinical policies or use clinical criteria from third party sources such as American Society of

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Addiction Medicine (ASAM) Criteria®, Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System-Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) and Early Childhood Service Intensity Instrument (ECSII) guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure inpatient Concurrent Review determinations are appropriate.

MH/SUD monitors clinical reviewer and peer clinical reviewer application of clinical criteria through an annual IRR assessment. Clinical reviewers and peer clinical reviewers are required to pass the IRR assessment with a score of 90% or better through three attempts. After a second failed IRR assessment, the reviewer enters a remediation period and is required to review all cases with a supervisor for 30 days, or until 90% is achieved on the assessment. If the clinical reviewer achieves a passing score within the 30-day period, supervisors review a minimum of one case per week for the remainder of the 30-day period.

The Plan also conducts monthly quality audits of individual non-clinical staff, clinical reviewers, and peer clinical reviewers, including staff performing appeal functions. These audits are designed and approved by clinical leadership. A minimum of two audits are completed per staff, per month. The results of these real-time audits are shared with supervisors for staff oversight, and all findings are remediated. Remediation may include corrective actions and/or additional education, as warranted.

The Plan routinely monitors Concurrent Review program performance through its clinical performance oversight functions. Outcomes are monitored against timeliness requirements, performance guarantees, and for potential trends, including overall utilization.

The Plan's national Clinical Quality & Operations Committee (CQOC) annually reviews UM program outcomes, including inpatient Concurrent Review outcomes, to confirm overall utilization is appropriate. The CQOC is comprised of representatives from sub-committees, and representatives from the clinical quality improvement, UM, care engagement, medical operations, medical policy and standards, clinical operations, appeals, product, legal, compliance, network strategy, provider experience, accreditation, and benefits teams. The Chair of the Clinical Quality & Operations Committee must be an executive leader, board certified in psychiatry or psychiatric subspecialty and a licensed physician.

Per the MH/SUD policy entitled, *Core Principles and Practices*, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons.

MH/SUD generally structures UM processes to comply with federal ERISA requirements and state law, where applicable.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- Concurrent Review

Benefit Classification(s)

- INN, inpatient

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHIC)

Plan Terms/Source Document(s)

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Concurrent Review is defined as “a clinical review of an extension of previously approved, ongoing course of treatment over a period of time or number of treatments conducted during an inpatient stay or ongoing ambulatory care. It is sometimes called a “continued stay review.”” Concurrent Review does not involve onsite reviews.

The *Optum National Policy Definitions List* defines a Concurrent (Review) Request as “a request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care.”

The Plan’s *Schedule of Benefits* notify members of Concurrent Review requirements.

“The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.”

The *2023 UnitedHealthcare Care Provider Administrative Guide* notifies providers of the Concurrent Review requirements. INN providers are required to comply with UM protocols established by the Plan:

We determine the medical necessity of inpatient admissions through either concurrent or retrospective review. We require you to comply with our requests:

- For information, documents or discussions related to our reviews and discharge planning. This includes primary and secondary diagnosis, clinical information, treatment plan, admission order, patient status, discharge planning needs, barriers to discharge and discharge date. When available, provide access to electronic medical records (EMR).
- From our interdisciplinary care coordination team and/or Medical Director. This includes our requests that you help us engage our members directly face-to-face or by phone.
 - If you receive the request before 1 p.m. local time:
 - › Supply all requested information within 4 hours
 - If you receive our request after 1 p.m. local time:
 - › Provide the information within the same business day, but no later than 12 p.m. local time the next business day

The *Optum National Network Manual*, September 1, 2023 Edition notifies providers of the Concurrent Review requirements. INN providers are required to comply with UM protocols established by the Plan:

In most cases, inpatient admissions will be directed only to participating hospitals and attending psychiatrists.

All inpatient and sub-acute level of care admissions require notification or pre-authorization by the network provider or facility. Optum requires notification within one business day after an admission for a facility to request a pre-authorization unless a longer period is required by contract or state specific requirements. This includes, but is not limited to, mental health or substance abuse disorder services delivered as inpatient treatment, partial/day hospitalization or residential treatment.

Network providers are solely responsible for completing prior notification or obtaining preauthorization prior to providing inpatient or sub-acute level of care services. This includes timely provision of information necessary for concurrent review of continued stay or ongoing care requests prior to the delivery of services.

Should a provider fail to obtain or otherwise follow the required administrative procedures for notification or pre-authorization, Optum may, in accordance with applicable law, apply a reduction of payment to the network provider up to 100% of provider's reimbursement rate. Network provider payment reductions for failure to complete notification or obtain pre-authorization are solely the network provider's liability (i.e., the member cannot be billed for these reductions in payment).

The role of the Plan's delegate, United Behavioral Health d/b/a OBH, is discussed in the *UMPD*:

"United Behavioral Health (UBH) performs the review of requests for coverage of behavioral health services (i.e., substance abuse, and mental health requests for services). UBH provides comprehensive behavioral health care delivery for members through a network of behavioral health practitioners, ancillary care providers, hospitals and other facilities.

For mental health, substance-related disorder services, and wraparound services, UBH uses its Clinical Criteria (see below), behavioral clinical policies, and best practice guidelines to make coverage determinations. UBH adopts externally-developed clinical criteria, and creates internally-developed Clinical Criteria, where appropriate, based on its assessment of relevant guidance. UBH develops clinical criteria that supersedes its standard set or adopts externally-developed clinical criteria when required to do so by contract or regulation.

- Clinical Criteria (Level of Care Utilization System-LOCUS) – Standardized level of care assessment tool developed by the American Association of Community Psychiatrists used to make clinical determinations and placement decisions for mental health disorder benefits for adults ages 19 and older when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (Child and Adolescent Level of Care/Service Intensity Utilization System-CALOCUS-CASII) - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry (AACAP) and the American Association for Community Psychiatry (AACP) used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children and adolescents ages 6-18 when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (Early Childhood Service Intensity Instrument-ECSII) - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children ages 0-5 when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (State or Contract Specific Level of Care Guidelines) - Criteria used to make medical necessity determinations for mental health disorder benefits when there are explicit mandates or contractual requirements.
- Clinical Criteria (American Society of Addiction Medicine [ASAM]) - Criteria developed by the American Society of Addiction Medicine used to make clinical determinations for substance-related disorder benefits.
- Clinical Criteria (Optum Developed)
 - Optum Behavioral Clinical Policies: Criteria that stem from evaluation of new services or treatments or new applications of existing services or treatments and are used to make clinical determinations regarding proven or unproven services and treatments.

Licensed practitioners conduct all reviews with a focus on measurable outcome goals and objectives for treatment. A senior UBH Medical Director is responsible for directing and implementing behavioral health utilization management programs. A referral is sent to UBH when a member is identified as potentially benefiting from behavioral health services during a "medical event".

The UBH UM Program is staffed by clinical, non-clinical and administrative personnel. All clinical denials or adverse decisions are made by board certified psychiatrists, or, if the health plans choose, by a panel of other appropriate health care service reviewers. If the health plan chooses to use a panel to make adverse decisions, the panel contains at least one physician who is board certified in psychiatry. When the health care service under review is a mental health or substance abuse service, the

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adverse decision is made by a licensed physician who is board certified in psychiatry. All potential clinical denials are referred to a physician who is board certified in psychiatry for final determination. An evaluation of the overall effectiveness of the Behavioral Health UM Program is conducted annually to determine how well resources have been deployed to improve UM activities and the clinical care and service provided to members.”

The Plan’s terms require services to be medically necessary for coverage. INN providers are required to comply with the Plan’s UM protocols including complying with Concurrent Review requirements.

List of M/S and MH/SUD Services Subject to NQTL

The M/S and MH/SUD INN inpatient services subject to concurrent review are below:

M/S:

- Inpatient Acute Care Hospitalizations
- Inpatient Long Term Acute Care (LTAC)
- Inpatient Post-Acute Inpatient Rehabilitation (AIR)
- Inpatient Skilled Nursing Facility (SNF)
- Critical Access Hospitals

MH/SUD:

- MH Non-Emergent Acute Inpatient
- MH Subacute Residential Treatment
- SUD Acute Inpatient Detoxification
- SUD Acute Inpatient Rehab
- SUD Subacute Residential Treatment

Step 2 – Factors Used in the Design and Application of the NQTL

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

The Plan relies on the following factor to determine which INN inpatient services are subject to initial Concurrent Review (design). This factor applies to M/S and MH/SUD for the following:

- I. M/S: General Hospital, SNF, AIR, LTACH
- II. MH/SUD: Inpatient and residential facilities

- All M/S and MH/SUD Inpatient Admissions – Initial Concurrent Review (Qualitative)
 - All unplanned M/S and MH/SUD inpatient admissions are subject to initial Concurrent Review

The Plan relies on the following factor to determine which INN inpatient services are subject to ongoing Concurrent Review (design). This factor applies to M/S and MH/SUD for the following:

- I. M/S: General Hospital, Specialty Hospital, SNF, AIR, LTACH
- II. MH/SUD: Inpatient and residential facilities

- All M/S and MH/SUD Inpatient Admission Requests for Additional Days – Ongoing Concurrent Review (Qualitative)
 - All M/S and MH/SUD inpatient admissions are subject to ongoing Concurrent Review if coverage of additional days is requested after initial Concurrent Review approved days expire

The factors apply to M/S and MH/SUD services. The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL. All Concurrent Reviews are subject to Clinical Appropriateness and must have medical necessity criteria.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below is the evidentiary standard and source used to define, trigger, and/or implicate the factor used in designing and applying the Plan's initial Concurrent Review requirement to INN inpatient services. This evidentiary standard and source apply to the following:

- I. M/S: General Hospital, Specialty Hospital, SNF, AIR, LTACH
- II. MH/SUD: Inpatient and residential facilities

Factor – All M/S and MH/SUD Inpatient Admissions – Initial Concurrent Review includes all inpatient admissions.

- The Plan's evidentiary standard and source that define and/or trigger the factor is provider notification of an inpatient admission

The Plan's evidentiary standard and source apply to M/S and MH/SUD services and are defined in a qualitative manner.

Below is the evidentiary standard and source used to define, trigger, and/or implicate the factor used in designing and applying the Plan's ongoing Concurrent Review requirement to INN inpatient services. This evidentiary standard and source apply to the following:

- I. M/S: General Hospital, Specialty Hospital, SNF, AIR, LTACH
- II. MH/SUD: Inpatient and residential facilities

Factor – All M/S and MH/SUD Inpatient Admission Requests for Additional Days – Ongoing Concurrent Review includes all inpatient admissions for which a provider requests coverage of additional days.

- The Plan's evidentiary standard and source that define and/or trigger the factor is an inpatient admission for which a provider requests coverage of additional days

The Plan's evidentiary standard and source apply to M/S and MH/SUD services and are defined in a qualitative manner.

The factors and evidentiary standards used as the basis for subjecting MH/SUD INN inpatient services to Concurrent Review are comparable to, and applied no more stringently than, the factors used as the basis for subjecting M/S INN inpatient benefits to Concurrent Review "as written" and "in operation." The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL.

Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

As Written

The Plan conducted a comparative analysis of the strategies, processes, factors, evidentiary standards, and source information used to determine which M/S and MH/SUD INN inpatient services are subject to Concurrent Review and how Concurrent Review is applied to M/S and MH/SUD INN inpatient services “as written.” The Plan identified the factors and evidentiary standards used as the basis for subjecting M/S and MH/SUD benefits to Concurrent Review.

National internal committees apply the applicable factors and standards described in Steps 2 and 3 to M/S and MH/SUD services when determining which services to subject to Concurrent Review.

Review of Factors and Evidentiary Standards

The Plan reviewed the factors that trigger an INN inpatient service to be subject to Concurrent Review. The factors and evidentiary standards were applied to M/S and MH/SUD services comparably and not more stringently to MH/SUD services than to M/S services.

Review of Operational Policies and Procedures

The Plan reviewed M/S and MH/SUD operational policies and procedures, IRR assessment processes, and UM annual oversight to confirm comparability and found MH/SUD policies, procedures, and processes to be comparable and no more stringent than M/S policies, procedures, and processes.

- Medical management operational policies and procedures establish the standards for how the Plan conducts inpatient Concurrent Review. The policies and procedures are consistent with state and federal law governing Concurrent Review. Timeframes for decisions, content of adverse benefit determinations, appeal rights and external review are all governed by state and federal law and accreditation requirements.
- The IRR assessment measures the consistency with which clinical reviewers and peer clinical reviewers apply the Plan's clinical criteria. IRR assessment processes apply to M/S and MH/SUD inpatient services.
- UM oversight monitors and evaluates UM processes by reviewing program outcomes, clinical appeals, IRR assessments, and under- and over-utilization.

Review of Inpatient Concurrent Review Processes

The strategy for applying both initial and ongoing Concurrent Review to INN inpatient services is comparable for M/S and MH/SUD services and is applied no more stringently to MH/SUD INN inpatient services. The Plan conducted a review of the M/S and MH/SUD Concurrent Review processes to confirm comparability. The review focused on the following aspects of the process for both M/S and MH/SUD:

- Notification. INN M/S and MH/SUD facilities and providers are contractually responsible for notifying the Plan of M/S and MH/SUD inpatient admissions.
- Timeframe to Submit. The *UnitedHealthcare Administrative Guide* (for M/S) and *Optum National Network Manual* (for MH/SUD) were reviewed for notification timeframes. The timeframe for the provider or member to notify of an admission was reviewed and determined that MH/SUD was comparable and no more stringent.
 - INN M/S facilities must notify the Plan within 24-hours for week-day admissions, unless otherwise indicated.
 - INN MH/SUD facilities must notify the Plan within one business day after an admission unless a longer period is required by contract or state-specific requirements.

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- **Clinical Reviews.** For M/S and MH/SUD inpatient Concurrent Reviews, clinical reviewers may gather more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for certification, related diagnostic results, and history of related treatment and services, and photographs. The clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. The clinical reviewer may approve cases that meet applicable clinical criteria.
- **Review Timeframes.** M/S and MH/SUD inpatient Concurrent Review determination timeframes are defined by state and federal requirements. The same determination timeframes apply to M/S and MH/SUD determinations.
- **Determinations and Non-clinical Reviews, First Level Clinical Reviews, and Second Level Peer Clinical Reviews.**
 - For M/S, non-clinical staff may approve requests for coverage of cases in scenarios where the Plan identified applicable clinical criteria always indicate that an inpatient level of care is medically necessary. Non-clinical staff refer coverage requests that they cannot approve to clinical reviewers. Clinical reviewers determine whether the inpatient admission is medically necessary. The clinical reviewer may approve the admission based on their review. If the case cannot be approved by the clinical reviewer, it is referred to a peer (physician) clinical reviewer. Only qualified peer clinical reviewers (e.g., Medical Directors) may issue adverse benefit determinations. Peer-to-peer discussions are offered as required.
 - For MH/SUD, non-clinical staff refer coverage requests that they cannot approve to clinical reviewers. Clinical reviewers (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether an inpatient admission is medically necessary. The clinical reviewer may approve the admission based on their review. The clinical reviewer refers cases to a peer clinical reviewer for a peer-to-peer discussion if the case cannot be approved. Only qualified peer clinical reviewers (e.g., Medical Directors) may issue adverse benefit determinations. Peer-to-peer discussions are offered as required.
- **Adverse Benefit Determinations and Peer-to-Peer Conversations.**
 - INN inpatient M/S services
 - The Plan offers INN M/S facilities and providers the opportunity to discuss adverse benefit determinations after the adverse benefit determination is issued. Only M/S peer clinical reviewers (e.g., Medical Directors) may issue adverse benefit determinations for coverage of M/S inpatient services.
 - For M/S, adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information. Modified coverage requests that are approved are recorded as partial denials.
 - INN inpatient MH/SUD services
 - The Plan offers INN inpatient MH/SUD facilities and providers the opportunity to discuss a potential adverse benefit determination before the Plan issues such determination. This process allows INN inpatient MH/SUD facilities and providers the opportunity to provide additional information and/or modify their request prior to an adverse benefit determination being issued.
 - For MH/SUD, an adverse benefit determination is recorded as a clinical denial when it is based on clinical criteria and member clinical information. If during the course of the peer-to-peer conversation the provider withdraws their original request and submits a new request, the case is approved.
- **Notification of Decisions to Providers and Members.** The Plan notifies M/S and MH/SUD INN facilities, providers, and members of approvals and adverse benefit determinations, including applicable appeal rights consistent with state, federal, and accreditation requirements.
- **Review of Staff Qualifications.** For M/S and MH/SUD, clinical staff qualifications align with the type of clinical review and state and federal requirements.
 - M/S is staffed by clinical, non-clinical, and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., nurses, physicians, etc.) and all adverse benefit determinations are made by Medical Directors.
 - MH/SUD is staffed by clinical, non-clinical, and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse benefit determinations are made by Medical Directors.

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- **Clinical Criteria.** For M/S and MH/SUD, clinical reviewers and peer clinical reviewers base determinations on objective, evidence-based medical/behavioral clinical policies and use clinical criteria from third party sources such as InterQual, MCG, ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines.
- **Ongoing Concurrent Review.** All M/S and MH/SUD requests for coverage of additional days trigger ongoing Concurrent Review.

In Operation

The Plan compared the strategies, processes, factors, evidentiary standards, and source information used to determine which M/S and MH/SUD INN inpatient services are subject to Concurrent Review and how Concurrent Review is applied “in operation.”

Initial Concurrent Review

All INN M/S and MH/SUD inpatient services are subject to the Concurrent Review process. The Plan required INN M/S and MH/SUD facilities and providers to notify the Plan timely of inpatient admissions. Notification triggered the initial Concurrent Review process for INN M/S and MH/SUD inpatient admissions.

M/S and MH/SUD initial Concurrent Reviews included confirmation of member eligibility and benefit availability for the requested services. During the initial reviews for M/S and MH/SUD INN inpatient services, non-clinical staff approved coverage for inpatient admissions that did not require clinical review or interpretation and where member’s plan documents allowed. Non-clinical staff also approved coverage requests if the facility’s contract did not allow for clinical reviews. All INN M/S inpatient admissions and MH/SUD inpatient admissions were subject to initial Concurrent Review.

M/S and MH/SUD inpatient cases that were not administratively approved in initial administrative review were referred to a clinical reviewer for further research and evaluation. The M/S and MH/SUD clinical reviewers applied benefit plan documents and medical necessity criteria to member clinical information. M/S and MH/SUD clinical reviewers requested additional clinical information if they were unable to approve cases based on the available member clinical information. The clinical reviewers approved the admission based on their review when clinical criteria were met.

If the requested clinical information was not received or if the case could not be approved, M/S and MH/SUD clinical reviewers referred cases to a peer clinical reviewer. For INN MH/SUD inpatient cases, the Plan offered peer-to-peer conversations so the INN MH/SUD provider could provide additional clinical information prior to the issuance of an adverse benefit determination. For INN M/S inpatient admissions, the Plan offered peer-to-peer conversations at the time of issuing an adverse benefit determination. Only qualified peer clinical reviewers issued M/S and MH/SUD adverse benefit determinations.

The Plan communicated all adverse benefit determinations for M/S and MH/SUD inpatient cases that did not meet applicable clinical criteria consistent with state, federal, and accreditation requirements, including appeal rights, as applicable.

Ongoing Concurrent Review

All INN M/S and MH/SUD inpatient admissions were subject to ongoing Concurrent Review if an INN M/S or MH/SUD facility sought coverage of additional days for an approved admission. INN M/S and MH/SUD facilities were required to request coverage of additional days prior to expiration of the last day of an approved admission.

For all INN M/S and MH/SUD inpatient admissions, the Plan followed the initial Concurrent Review clinical review process when conducting ongoing Concurrent Reviews.

The Plan offered INN MH/SUD facilities the opportunity to discuss a potential adverse benefit determination with a peer clinical reviewer prior to issuing the adverse benefit determination. The Plan offered INN M/S facilities the opportunity to discuss an adverse benefit determination with a peer clinical reviewer when it issued the adverse benefit determination.

The Plan communicated all adverse benefit determinations issued for M/S and MH/SUD inpatient cases that did not meet clinical criteria consistent with state and federal requirements, including appeal rights, as applicable. Only qualified peer clinical reviewers issued adverse benefit determinations for M/S and MH/SUD inpatient admissions.

The Plan monitors M/S and MH/SUD clinical and peer clinical reviewers' application of clinical criteria through annual IRR assessments. The Plan also conducts quality audits of cases. The Plan routinely monitors Concurrent Review performance through its clinical performance oversight functions. In addition to comparing these "in operation" processes, the Plan reviewed medical necessity approval and denial rates, internal appeals outcomes, and external appeals outcomes related to Concurrent Review determinations for M/S and MH/SUD INN inpatient services. The results of these analyses are discussed in greater detail in Step 5.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The findings of the Plan's comparative analyses confirmed the strategies, processes, factors, evidentiary standards, and source information used to determine the MH/SUD INN inpatient services subject to initial and ongoing Concurrent Review were comparable to, and applied no more stringently than, the strategies, processes, factors, evidentiary standards, and source information used to determine the M/S INN inpatient services subject to initial and ongoing Concurrent Review "as written."

The Plan found the factors used to subject INN MH/SUD inpatient services to initial and ongoing Concurrent Review were comparable to and applied no more stringently than the factors used to subject INN M/S inpatient services to initial and ongoing Concurrent Review "in operation." All M/S and MH/SUD inpatient admissions were subject to initial Concurrent Review. All M/S and MH/SUD inpatient admissions were subject to ongoing Concurrent Review if coverage of additional days was requested after initial Concurrent Review approved days expired.

The Plan used comparable processes to conduct initial and ongoing Concurrent Review of INN M/S and MH/SUD inpatient admissions. The Plan required INN M/S and MH/SUD facilities to timely notify the Plan of inpatient admissions. The Plan used qualified staff to confirm member eligibility and benefit availability, and to request additional clinical information if necessary. The Plan issued approvals for M/S and MH/SUD inpatient admissions that met applicable clinical criteria or guidelines. Only qualified M/S and MH/SUD peer clinical reviewers issued adverse benefit determinations. The Plan gave INN MH/SUD facilities the opportunity to discuss potential adverse benefit determinations with qualified peer clinical reviewers prior to issuing adverse benefit determinations. This afforded INN MH/SUD facilities the opportunity to convert potential denials to approvals and avoid adverse benefit determinations. The Plan did not offer the opportunity to avoid potential adverse benefit determinations to INN M/S facilities and only offered the peer-to-peer review at the time the adverse benefit determination was issued.

The Plan operated monitoring and oversight programs to ensure that clinical reviewers and peer clinical reviewers rendered appropriate determinations. Both M/S and MH/SUD required clinical reviewers, including peer clinical reviewers, to successfully complete the annual IRR assessment. Clinical reviewers were required to pass the IRR assessment with a score of 90% or better to render UM decisions independently. 2023 IRR M/S and MH/SUD results are not available. The M/S and MH/SUD clinical reviewers' application of medical necessity criteria when making utilization review determinations will be assessed for comparability when the results are available.

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INN inpatient medical necessity approval and denial rates and appeals outcomes data from 01/01/2022 – 12/31/2022 were evaluated where a minimum threshold of 100 cases were available to ensure a valid data set for analysis. The Plan has established that a minimum of at least 100 M/S and MH/SUD cases are required within each classification for a comparative analysis. Meaningful conclusions cannot be reached when there are fewer than 100 cases within each classification because the data is subject to variability.

Because Georgia Surest Plan became effective on 7/2023 there is minimal membership and as a result an insufficient number of cases from 01/01/2022 – 12/31/2022 to support an in-operation analysis. While the Plan notes that the U.S. Department of Labor has indicated generally that outcomes data are not dispositive of parity compliance, the Plan will conduct a comparative analysis of outcomes data, including medical necessity approval and denial rates and appeals outcomes, when there is a minimum of 100 cases available to ensure a valid data set for analysis.

Conclusions

The Plan reviewed the M/S and MH/SUD Concurrent Review operational policies and procedures and concluded the methodology used to determine which MH/SUD INN inpatient services are subject to Concurrent Review “as written” were comparable to, and applied no more stringently than, the methodology used to determine which M/S INN inpatient services are subject to Concurrent Review “as written.” Additionally, the Plan concluded that how Concurrent Review is applied to MH/SUD INN inpatient services was comparable to, and applied no more stringently than, how Concurrent Review is applied to M/S INN inpatient services “as written.”

The Plan reviewed the M/S and MH/SUD processes, including responsibility for submission, timeframes for submission and review, notification to members and providers, clinical standards for review, and staff qualifications and concluded how the Plan conducts Concurrent Review for MH/SUD INN inpatient services “in operation” was comparable to, and applied no more stringently than, how the Plan conducts Concurrent Review for M/S INN inpatient services “in operation.”

Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical/surgical (M/S) benefits. This generally means that the financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements, such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage.

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Concurrent Review is defined as “a clinical review of an extension of previously approved, ongoing course of treatment over a period of time or number of treatments conducted during an inpatient stay or ongoing ambulatory care. It is sometimes called a “continued stay review.”” The *Optum National Policy Definitions List* defines a Concurrent (Review) Request as “a request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care.” Concurrent Review does not involve onsite reviews.

Concurrent Review is a component of the Plan’s Utilization Management (UM) program that helps ensure members receive appropriate coverage based on their specific clinical status and health care needs. The process is designed to achieve optimal clinical outcomes by applying objective, evidence-based clinical criteria and nationally recognized guidelines and best practices. Concurrent Review is a UM process that involves applying the benefit plan language and/or clinical criteria to make the most appropriate clinical coverage benefit determination.

This document includes the following information:

- The Concurrent Review process for M/S and MH/SUD outpatient services
- The description of the NQTL and application (Step 1)
- Factors used to determine which services are subject to the NQTL (Step 2)
- Evidentiary standards and sources used to define, trigger, and or implicate a factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

This analysis refers to the following attachments:

- *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions* - M/S policy that defines Concurrent Review
- *Optum National Policy Definitions List* - MH/SUD policy that defines Concurrent Review
- *Utilization Management Program Description (UMPD) of United HealthCare Services, Inc. and UnitedHealthcare Insurance Company* - Summarizes the philosophy, structure and standards that govern UHC’s medical management, UM and utilization review responsibilities and functions
- *Management of Behavioral Health Benefits Policy* - Describes the mechanisms and processes designed to promote

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consistency in the management of behavioral health benefits and to ensure that members receive appropriate, high quality behavioral health services in a timely manner

- *Certificates of Coverage (COC23-INS-BIND-2021-LG-GA-UHIC)* - Plan document that explains covered services, terms, conditions, and limitations of the member's policy
- *Schedule of Benefits - SBN23-Medical-INS-BIND-2021-Choice Plus-LG-GA-UHIC* - Plan document that outlines member responsibilities
- *Core Principles and Practices* - MH/SUD policy that outlines the core principles and practices that should be used by personnel in their interactions with members, authorized member representatives, practitioners and facilities, related to the management of behavioral health benefits, coverage determinations and appeals/grievances of non-coverage determinations
- *Performance Assessment and Incentives* - M/S policy confirming that clinical reviewers are not incented to make denials for financial reasons
- *2023 UnitedHealthcare Provider Administrative Guide* – Informs M/S providers of the Prior Authorization process. The *UnitedHealthcare Provider Administrative Guide* can be accessed on the website <https://www.uhcprovider.com/en/admin-guides.html>
- *September 2023 Optum National Network Manual* - Informs MH/SUD providers of the Prior Authorization process. The *Optum National Network Manual* can be accessed on the website <https://public.providerexpress.com/content/open-provexpr/us/en/clinical-resources/guidelines-policies/optum-network-manual.html>

The Plan concludes that the Concurrent Review requirements for M/S and MH/SUD are comparable and applied no more stringently for MH/SUD in-network (INN) outpatient benefits both “as written” and “in operation.”

Process

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Concurrent Review is defined as: “a clinical review of an extension of previously approved, ongoing course of treatment over a period of time or number of treatments conducted during an inpatient stay or ongoing ambulatory care. It is sometimes called “continued stay review.”” The *Optum National Policy Definitions List* defines a Concurrent (Review) Request as: “a request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care.”

The Plan structures outpatient Concurrent Review processes to be compliant with all applicable federal and state requirements, Concurrent Review is governed at both the state and federal level, which includes consumer protections such as external review for adverse benefit determinations after internal appeals options are exhausted.

The Plan delegates management of MH/SUD outpatient services, including Concurrent Review to United Behavioral Health d/b/a Optum Behavioral Health (OBH), its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor.

The Plan has national committees that approve M/S and MH/SUD outpatient services to be subject to Concurrent Review. Additionally, the Plan has a standard process for assessing the services that are subjected to Concurrent Review and whether they should be retained or removed from the list of services that are subject to Concurrent Review.

Concurrent Review of M/S outpatient services consists of the following:

The Plan requires INN M/S providers to submit a Concurrent Review request for outpatient services that are described in Step 1 of this NQTL. The INN provider's submission of a request (notification) triggers the Concurrent Review process.

The Plan requires INN M/S providers to timely request coverage of additional units of service or extensions of time for services previously approved in Prior Authorization. The Plan reclassifies M/S outpatient Concurrent Review coverage requests as preservice/Prior Authorization requests. The Plan follows the outpatient Prior Authorization process for these requests and

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uses the outpatient Prior Authorization process to review requests for coverage of additional units of service or extensions of time for previously approved services.

INN providers may submit Prior Authorization requests through the secure provider portal (www.uhcprovider.com), their connected electronic medical record, by telephone, or by fax (where required). Members may submit Prior Authorization requests by phone, fax, or mail, in accordance with Plan requirements. Providers and members communicate basic information to create a case. As outlined in the *UnitedHealthcare Care Provider Administrative Guide*, providers must submit advance notification with supporting documentation as soon as possible, but at least two weeks before the planned service, unless otherwise stated. The provider's submission of a request (notification) triggers the Prior Authorization process.

The Plan confirms receipt of the Prior Authorization request. Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. Non-clinical staff may administratively deny coverage if member benefits are exhausted. Non-clinical staff review cases to ensure availability of accurate and thorough case information. Non-clinical staff may approve coverage requests in scenarios where the member's plan documents allow and if a clinical review is not required. Requests that are submitted through the secure provider portal may also be approved based on the benefit plan coverage criteria, member diagnosis, and the clinical information submitted. Non-clinical staff refer cases that they cannot approve or administratively deny to initial clinical reviewers for medical necessity review.

First Level Clinical Review/Initial Review. Clinical reviewers (nurses) consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs to determine whether the applicable clinical criteria are met. The clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. The clinical reviewer can approve cases that meet applicable clinical criteria.

Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Peer clinical reviewers (physician or mid-level practitioner) consult clinical criteria when making clinical coverage benefit determinations. Peer clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs. The peer clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If a peer clinical reviewer issues an adverse benefit determination, then the Plan communicates the adverse benefit determination, including appeal rights, and offers a peer-to-peer conversation consistent with state and federal requirements.

Adverse Benefit Determination. For M/S, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction, or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when member benefits are exhausted. Modified coverage requests that are approved are recorded as partial denials.

Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based medical clinical policies or use clinical criteria from third party sources such as InterQual® or MCG® guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that outpatient Concurrent Review determinations are appropriate.

M/S monitors clinical reviewer and peer clinical reviewer application of clinical criteria through an annual inter-rater reliability (IRR) assessment that is provided by InterQual. Clinical reviewers and peer clinical reviewers are required to pass the IRR

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assessment with a score of 90% or better through three attempts. After a second failed IRR assessment, staff enter a remediation period and are required to review all cases with a supervisor for 30 days, or until 90% is achieved on the assessment. If the clinical reviewer achieves a passing score within the 30-day period, supervisors review a minimum of one case per week for the remainder of the 30-day period.

The Plan also conducts end-to-end case audits that are designed and approved by clinical leadership each year. The end-to-end audits include all stages of a case review, from intake through appeal. These audits are conducted monthly and approximately 1500 cases are reviewed per month. Results are reported to an oversight team. All deficiencies are remediated. Remediation may include corrective actions and/or additional education, as indicated.

The Plan routinely monitors Concurrent Review performance through its clinical performance oversight functions. Outcomes are monitored against timeliness requirements, performance guarantees, and for potential trends, including overall utilization.

The Plan's National Medical Care Management Committee (NMCMC) annually reviews overall UM program outcomes, including outpatient Concurrent Review outcomes, to confirm overall utilization is appropriate. The NMCMC is comprised of the Chief Medical Officer, and representatives from clinical policy, clinical advocacy and grievances, business standardization and advancement, regional chief medical officers, inpatient care management, lines of business, medical policy, clinical operations, and OBH. The Chair of the NMCMC must be an executive leader and licensed physician.

As of April 1, 2023, the Utilization Management Program Committee (UMPC) began overseeing the M/S UM program. The UMPC is responsible for the development and maintenance of the M/S Prior Authorization processes. The UMPC ensures that the UM program considers the factors and evidentiary standards for applying UM. The UMPC is comprised of:

- Chief Medical Officer, Medical Management (Co-Chair)
- Senior Vice President, Clinical Advancement (Co-Chair)
- Chief Medical Officer, UnitedHealthcare
- Senior Vice President, Clinical Appeals & Grievances
- Chief Medical Officer, Clinical Policy
- Chief Medical Officer, UnitedHealthcare Employer & Individual
- Chief Medical Officer, UnitedHealthcare Medicare & Retirement
- Chief Medical Officer, Community & State
- Chief Medical Officer, UnitedHealthcare Individual & Family Plans
- Vice President, Clinical Transformation & Affordability
- Senior Director, Mental Health Parity
- Vice President, Utilization Management Strategy & Implementation

One of the chairs must be an executive leader and a licensed physician. UMPC meets at least six times per year but may meet more frequently if needed.

Per the M/S policy entitled, *Performance Assessment and Incentives*, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons.

M/S generally structures UM processes to comply with federal Employee Retirement Income Security Act of 1974 (ERISA) requirements, and state law, where applicable.

Concurrent Review of MH/SUD outpatient services consists of the following:

The Plan delegates management of MH/SUD outpatient services, including Concurrent Review, to United Behavioral Health d/b/a OBH, its delegated MH/SUD MBHO vendor.

The Plan requires INN MH/SUD providers to submit a Concurrent Review request for outpatient services. Provider notification

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triggers the outpatient Concurrent Review process. Outpatient Concurrent Review begins when INN provider requests coverage for additional units of service and/or periods of time beyond those initially authorized by the Plan.

INN providers may submit authorization requests through the secure provider portal (www.providerexpress.com), by telephone, or by fax (where required). Members may submit authorization requests by telephone, fax, or mail, in accordance with Plan requirements. Intensive Outpatient Program (IOP) providers notify the Plan of the need for additional days/services by telephone and Partial Hospitalization Program (PHP) providers notify the Plan of the need for additional days/services by telephone or the secure provider portal.

As described in the *Management of Behavioral Health Benefits Policy*, the Plan confirms receipt of the Concurrent Review request. Non-clinical staff confirm member eligibility and benefit coverage. Non-clinical staff may approve cases that do not require clinical evaluation or interpretation based on the member's diagnosis and the clinical information submitted by providers. Non-clinical staff refer cases that they cannot approve to the initial clinical reviewers.

First Level Clinical Review/Initial Review. Clinical decisions are made by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse benefit determinations are made by Medical Directors or psychologists. Clinical reviewers consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether a service is medically necessary by reviewing the member's clinical information, the applicable clinical criteria or guidelines, and the Plan benefit terms. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for certification, related diagnostic results, and history of related treatment and services. The clinical reviewer may approve cases that meet applicable clinical criteria.

Second Level Clinical Review/Peer Review. The initial clinical reviewer refers cases to a peer clinical reviewer for a peer-to-peer discussion if the case cannot be approved. The requesting provider is offered the opportunity to discuss the case with the peer clinical reviewer, consistent with state and federal requirements before an adverse benefit determination is issued. Only qualified peer clinical reviewers (e.g., Medical Directors or psychologists) can issue adverse benefit determinations. Peer clinical reviewers apply clinical criteria to member clinical information to determine coverage for additional units of service during an extended period of time. If the requesting provider fails to complete the peer-to-peer discussion, the peer clinical reviewer makes a determination based on the information available. If a peer clinical reviewer issues an adverse benefit determination, (e.g., that numbers of treatments or extensions of time are not authorized), then the Plan timely communicates the adverse benefit determination, including appeal rights, to the member and provider consistent with applicable state and federal requirements.

Adverse Benefit Determination. For MH/SUD, an adverse benefit determination is recorded as a clinical denial when it is based on clinical criteria and member clinical information.

IOP Practice Management. The Plan identifies INN MH/SUD IOP facilities and clinics that demonstrate effective performance based on readmission rates, lengths of stay, and post-discharge outcomes for inclusion in Practice Management. INN MH/SUD facilities or clinics that meet these performance criteria do not have to obtain Prior Authorization for IOP services. Instead, the facilities submit claims post-service, which the Plan pays.

Platinum Designation. The Plan offers a Platinum Designation program to INN MH/SUD PHP providers based on facilities' quantitative practice patterns (effectiveness and efficiency benchmarks). The Platinum Designation program's effectiveness and efficiency benchmarks include targeted 30- and 90-day readmission rates, 7- and 30-day follow up after hospitalization, outlier length of stay, and outlier behavioral health episode spend. INN MH/SUD providers that meet the Platinum Designation are required to notify the Plan of admissions to PHP and provide member information. The Plan covers the first 17 days of admission to PHP without review. Facilities notify the Plan if additional days are needed. The Plan evaluates INN MH/SUD facilities' performance annually as described in the *Optum National Network Manual*.

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Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity clinical coverage determinations on objective, evidence-based behavioral clinical policies or use clinical criteria from third-party sources such as, American Society of Addiction Medicine (ASAM) Criteria®, Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System-Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) and Early Childhood Service Intensity Instrument (ECSII) guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that outpatient Concurrent Review determinations are appropriate.

MH/SUD monitors clinical reviewer and peer clinical reviewer application of clinical criteria through an annual IRR assessment. Clinical reviewers and peer clinical reviewers are required to pass the IRR assessment with a score of 90% or better through three attempts. After a second failed IRR assessment, the reviewer enters a remediation period and is required to review all cases with a supervisor for 30 days, or until 90% is achieved on the assessment. If the clinical reviewer achieves a passing score within the 30-day period, supervisors review a minimum of one case per week for the remainder of the 30-day period.

The Plan also conducts monthly quality audits of individual non-clinical staff, clinical reviewers, and peer clinical reviewers, including staff performing appeal functions. These audits are designed and approved by clinical leadership each year. A minimum of two audits are completed per staff, per month. The results of these real-time audits are shared with supervisors for staff oversight, and all findings are remediated. Remediation may include corrective actions and/or additional education, as indicated.

The Plan routinely monitors Concurrent Review performance through its clinical performance oversight functions. Outcomes are monitored for timeliness compliance, performance guarantee compliance, and potential trends, including overall utilization.

The Plan's national Clinical Quality & Operations Committee (CQOC) annually reviews overall UM program outcomes, including outpatient Concurrent Review outcomes, to confirm overall utilization is appropriate. The CQOC is comprised of representatives from sub-committees, and representatives from the clinical quality improvement, UM, care engagement, medical operations, medical policy and standards, clinical operations, appeals, product, legal, compliance, network strategy, provider experience, accreditation, and benefits teams. The Chair of the Clinical Quality & Operations Committee must be an executive leader, board certified in psychiatry or psychiatric subspecialty and a licensed physician.

Per the MH/SUD policy entitled, *Core Principles and Practices*, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse clinical coverage benefit determinations (clinical denials) for financial reasons.

MH/SUD generally structures UM processes to comply with federal ERISA requirements and state law, where applicable.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- Concurrent Review

Benefit Classification(s)

- INN, outpatient

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHIC)

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Plan Terms/Source Document(s)

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Concurrent Review is defined as “A clinical review of an extension of previously approved, ongoing course of treatment over a period of time or number of treatments conducted during an inpatient stay or ongoing ambulatory care. It is sometimes called a “continued stay review.””

The *Optum National Policy Definitions List* defines a Concurrent (Review) Request as “a request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care.”

The Plan’s *Schedule of Benefits* notify members of Concurrent Review requirements.

“The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.”

The *2023 UnitedHealthcare Care Provider Administrative Guide* notifies providers of the Concurrent Review requirements. INN providers are required to comply with UM protocols established by the Plan:

“We determine the medical necessity of inpatient admissions through either concurrent or retrospective review. We require you to comply with our requests:

- For information, documents or discussions related to our reviews and discharge planning. This includes primary and secondary diagnosis, clinical information, treatment plan, admission order, patient status, discharge planning needs, barriers to discharge and discharge date. When available, provide access to electronic medical records (EMR).
- From our interdisciplinary care coordination team and/or Medical Director. This includes our requests that you help us engage our members directly face-to-face or by phone.
 - If you receive the request before 1 p.m. local time:
 - › Supply all requested information within 4 hours
 - If you receive our request after 1 p.m. local time:
 - › Provide the information within the same business day, but no later than 12 p.m. local time the next business day”

The *Optum National Network Manual*, September 1, 2023 Edition notifies providers of the Concurrent Review requirements. INN providers are required to comply with UM protocols established by the Plan:

“In most cases, inpatient admissions will be directed only to participating hospitals and attending psychiatrists.

All inpatient and sub-acute level of care admissions require notification or pre-authorization by the network provider or facility. Optum requires notification within one business day after an admission for a facility to request a pre-authorization unless a longer period is required by contract or state specific requirements. This includes, but is not limited to, mental health or substance abuse disorder services delivered as inpatient treatment, partial/day hospitalization or residential treatment.

Network providers are solely responsible for completing prior notification or obtaining preauthorization prior to providing inpatient or sub-acute level of care services. This includes timely provision of information necessary for concurrent review of continued stay or ongoing care requests prior to the delivery of services.

Should a provider fail to obtain or otherwise follow the required administrative procedures for notification or pre-authorization, Optum may, in accordance with applicable law, apply a reduction of payment to the network provider up to 100% of provider's reimbursement rate. Network provider payment reductions for failure to complete notification or obtain

pre-authorization are solely the network provider's liability (i.e., the member cannot be billed for these reductions in payment)."

The role of the Plan's delegate, United Behavioral Health d/b/a OBH, is discussed in the *UMPD*:

"United Behavioral Health (UBH) performs the review of requests for coverage of behavioral health services (i.e., substance abuse, and mental health requests for services). UBH provides comprehensive behavioral health care delivery for members through a network of behavioral health practitioners, ancillary care providers, hospitals and other facilities.

For mental health, substance-related disorder services, and wraparound services, UBH uses its Clinical Criteria (see below), behavioral clinical policies, and best practice guidelines to make coverage determinations. UBH adopts externally-developed clinical criteria, and creates internally-developed Clinical Criteria, where appropriate, based on its assessment of relevant guidance. UBH develops clinical criteria that supersedes its standard set or adopts externally-developed clinical criteria when required to do so by contract or regulation.

- Clinical Criteria (Level of Care Utilization System-LOCUS) – Standardized level of care assessment tool developed by the American Association of Community Psychiatrists used to make clinical determinations and placement decisions for mental health disorder benefits for adults ages 19 and older when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (Child and Adolescent Level of Care/Service Intensity Utilization System-CALOCUS-CASII) - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry (AACAP) and the American Association for Community Psychiatry (AAP) used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children and adolescents ages 6-18 when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (Early Childhood Service Intensity Instrument-ECSII) - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children ages 0-5 when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (American Psychological Association Psychological and Neuropsychological Billing and Coding Guide) - Comprehensive billing and coding guide developed by the APA used for making medical necessity determinations for behavioral health psychological and neuropsychological testing services.
- Clinical Criteria (State or Contract Specific Level of Care Guidelines) – Criteria used to make medical necessity determinations for mental health disorder benefits when there are explicit mandates or contractual requirements.
- Clinical Criteria (American Society of Addiction Medicine [ASAM]) - Criteria developed by the American Society of Addiction Medicine used to make clinical determinations for substance-related disorder benefits.
- Clinical Criteria (Medicare Required Criteria): Centers for Medicaid and Medicare (CMS) National and Local Coverage Determinations (NCDs/LCDs) - Summary document of Criteria used to make medical necessity determinations for Medicare benefits.
- Clinical Criteria (Optum Developed)
 - Optum Behavioral Clinical Policies: Criteria that stem from evaluation of new services or treatments or new applications of existing services or treatments and are used to make clinical determinations regarding proven or unproven services and treatments.
 - Optum Supplemental Clinical Criteria: Criteria used to make clinical determinations for Applied Behavior Analysis, Electroconvulsive Therapy and Extended Outpatient Sessions.
 - Optum's Supplement to the APA Psychological and Neuropsychological Testing Billing and Coding Guide: Additional criteria used regarding provider qualifications, coverage rationale, limitations, and developmental testing.

Licensed practitioners conduct all reviews with a focus on measurable outcome goals and objectives for treatment. A senior UBH Medical Director is responsible for directing and implementing behavioral health utilization management programs. A referral is sent to UBH when a member is identified as potentially benefiting from behavioral health services during a "medical event".

The UBH UM Program is staffed by clinical, non-clinical and administrative personnel. All clinical denials or adverse decisions

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are made by board certified psychiatrists, or, if the health plans choose, by a panel of other appropriate health care service reviewers. If the health plan chooses to use a panel to make adverse decisions, the panel contains at least one physician who is board certified in psychiatry. When the health care service under review is a mental health or substance abuse service, the adverse decision is made by a licensed physician who is board certified in psychiatry. All potential clinical denials are referred to a physician who is board certified in psychiatry for final determination. An evaluation of the overall effectiveness of the Behavioral Health UM Program is conducted annually to determine how well resources have been deployed to improve UM activities and the clinical care and service provided to members.”

The Plan’s terms require services to be medically necessary for coverage. INN providers are required to comply with the Plan’s UM protocols including complying with Concurrent Review requirements.

List of M/S and MH/SUD Services Subject to NQTL

The M/S and MH/SUD INN outpatient services subject to concurrent review are below:

M/S:

- Cancer supportive care
- Chemotherapy Services
- Continuous Glucose Monitoring
- Durable Medical Equipment (DME) over \$1,000 (for certain codes)
- End-stage renal disease (ESRD) dialysis services
- Home Health Care – Non-nutritional
- Injectable Medications
- Pain Management and Injection
- Radiation Therapy

MH/SUD:

- Applied Behavior Analysis (ABA)
- Partial Hospitalization

Step 2 – Factors Used in the Design and Application of the NQTL

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

When Surest (Bind) plans first launched in 2016, the Plans were designed to offer a simpler and more transparent way for people to access the system. The Plan included coverage for services with the option to buy-up specific benefits based on member need.

In 2022, UnitedHealthcare acquired Surest (Bind) and agreed to adopt the existing list of services that had been identified to be subject to Concurrent Review. Clinical Appropriateness is presently the factor that is determinative in imposing the Concurrent Review limitation. At this time, the Plan is assessing the value of managing the services, the consistency of adherence to evidence-based guidelines, and volume of services utilized to further refine which INN outpatient services are subject to Concurrent Review.

The Plan relies on the following factor to determine which INN outpatient services are added to the list of services subject to Concurrent Review. This factor applies to M/S and MH/SUD for the following:

- I. M/S: INN outpatient Services
- II. MH/SUD: INN outpatient Services
 - Clinical Appropriateness (Qualitative)
 - Whether the application of Concurrent Review promotes optimal clinical outcomes

Applies to M/S and MH/SUD services.

Meeting Clinical Appropriateness is determinative in imposing the limitation.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below is the evidentiary standard and source used to define, trigger, and/or implicate the factor used to add services to the list of services subject to outpatient Concurrent Review. This evidentiary standard and source apply to benefits for the following:

- I. M/S: INN outpatient services
- II. MH/SUD: INN outpatient services

Factor – Clinical Appropriateness is defined as those outpatient services that are determined by internal medical experts to be in accordance with objective, evidence-based clinical criteria, and nationally recognized guidelines.

- The Plan's evidentiary standards and sources that define and/or trigger the identification of the Clinical Appropriateness factor are:
 - Clinical criteria from nationally recognized third-party sources (e.g., InterQual or MCG for M/S services, and ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines for MH/SUD services)
 - Clinical Technology Assessment Committee (CTAC) and Medical Technology and Assessment Committee (MTAC) review
 - Objective, evidence-based medical/behavioral clinical policies, and nationally recognized guidelines approved by professional healthcare associations (e.g., clinical guidance from the American Medical Association, American Psychiatric Association, etc.)

These evidentiary standards and sources apply to M/S and MH/SUD services and are defined in a qualitative manner.

Meeting Clinical Appropriateness is determinative in imposing the limitation.

The factor and evidentiary standard used as the basis for subjecting MH/SUD INN outpatient benefits to Concurrent Review are comparable to, and applied no more stringently than, the factor and evidentiary standard used as the basis for subjecting M/S INN outpatient benefits to Concurrent Review "as written" and "in operation."

Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

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The Plan conducted a comparative analysis of the strategies, processes, factor, evidentiary standard, and source information used to determine which M/S and MH/SUD INN outpatient services are subject to Concurrent Review and how Concurrent Review is applied to M/S and MH/SUD INN outpatient services “as written.” The Plan identified the factor and evidentiary standard used as the basis for subjecting M/S and MH/SUD INN outpatient benefits to Concurrent Review.

National internal committees apply the factor and standard described in Steps 2 and 3 to M/S and MH/SUD services when determining whether the services should be subjected to Concurrent Review

Review of Factors and Evidentiary Standards

The Plan reviewed the factor that triggers an INN outpatient service to be added to the list of services subject to Concurrent Review. The factor and evidentiary standard were applied to M/S and MH/SUD services comparably and not more stringently to MH/SUD services than to M/S services.

Review of Operational Policies and Procedures

The Plan reviewed M/S and MH/SUD operational policies and procedures, IRR assessment processes, and UM annual oversight to confirm comparability and found MH/SUD policies, procedures, and processes to be comparable and no more stringent than M/S policies, procedures, and processes.

- Medical management operational policies and procedures establish the standards for how the Plan conducts outpatient Concurrent Review. The policies and procedures are consistent with state and federal law requirements governing Concurrent Review. Timeframes for decisions, content of adverse benefit determinations, appeal rights and external review are all governed by state and federal law requirements.
- The IRR assessment measures the consistency with which clinical reviewers and peer clinical reviewers apply the Plan’s clinical criteria. IRR assessment processes apply to both M/S and MH/SUD outpatient services.
- UM oversight monitors and evaluates UM processes by reviewing program outcomes, clinical appeals, IRR assessment, and under- and over-utilization.

Review of Outpatient Concurrent Review Processes

The strategy for applying Concurrent Review to INN outpatient services is comparable for M/S and MH/SUD services and is applied no more stringently to MH/SUD INN outpatient services. The Plan conducted a review of the M/S and MH/SUD Concurrent Review processes to confirm comparability. The review focused on the following aspects of the process for both M/S and MH/SUD:

- Notification. INN M/S and MH/SUD providers are contractually responsible for requesting coverage for the continuation of the course of treatment and/or for additional units of outpatient services that exceed the periods of time or units of service previously approved by the Plan, including clinical information for both M/S and MH/SUD. The provider can submit the authorization request through the secure provider portal, by telephone, or by fax (where required).
- Timeframe to Submit. INN M/S and MH/SUD providers should notify the Plan as soon as reasonably possible.
- Clinical Reviews. For M/S and MH/SUD outpatient Concurrent Review requests, clinical reviewers may gather more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs. The clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. The clinical reviewer may approve cases that meet applicable clinical criteria.
- Review Timeframes. M/S and MH/SUD outpatient Concurrent Review determination timeframes are defined by state and federal requirements for both urgent and non-urgent outpatient services. The same determination timeframes apply to M/S and MH/SUD determinations.
- Determinations and Nonclinical Reviews, First Level Clinical Reviews, and Second Level / Peer Clinical Reviews. For M/S outpatient Concurrent Review, non-clinical staff may administratively deny cases when member benefits are exhausted. For M/S and MH/SUD non-clinical staff may approve cases that do not require clinical evaluation or interpretation. M/S INN outpatient cases that are submitted through the provider portal may also be approved based

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on the member diagnosis and the clinical information submitted. Non-clinical staff refer coverage requests that they cannot approve or administratively deny to clinical reviewers. Clinical reviewers consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether an outpatient service is medically necessary. The clinical reviewer may approve the services based on their review. The clinical reviewer refers cases to a peer clinical reviewer for a peer-to-peer discussion if the case cannot be approved. Only qualified peer clinical reviewers may issue adverse benefit determinations. Peer-to-peer discussions are offered as required.

- For MH/SUD INN outpatient Concurrent Review there are programs through which facilities or clinics that would otherwise need to request Concurrent Review are not required to do so.
- Adverse Benefit Determinations and Peer-to-Peer Conversations. The Plan offers INN outpatient providers the opportunity to discuss a potential adverse benefit determination before the Plan issues such determination. This process allows INN outpatient providers the opportunity to provide additional information prior to an adverse benefit determination being issued.
 - INN outpatient M/S and MH/SUD services
 - An adverse benefit determination is recorded as a clinical denial when it is based on clinical criteria and member clinical information and is recorded as an administrative denial when member benefits are exhausted/excluded.
- Notification of Decisions to Providers and Members. The Plan notifies M/S and MH/SUD INN providers and members of approvals and adverse benefit determinations, including applicable appeal rights, consistent with state and federal requirements.
- Review of Staff Qualifications. For M/S and MH/SUD, clinical staff qualifications align with the type of clinical review and state and federal requirements.
 - M/S is staffed by clinical, non-clinical, and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., nurses, physicians, etc.) and all adverse benefit determinations are made by a physician or other appropriate health care professionals.
 - MH/SUD is staffed by clinical, non-clinical, and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse benefit determinations are made by Medical Directors or psychologists.
- Clinical Criteria. For M/S and MH/SUD, clinical reviewers and peer clinical reviewers base determinations on objective, evidence-based medical/behavioral clinical policies and use clinical criteria from third party sources such as InterQual, MCG, ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines.

In Operation

The Plan compared the strategies, processes, factor, evidentiary standard, and source information used to determine which M/S and MH/SUD INN outpatient services are subject to Concurrent Review and how Concurrent Review is applied “in operation.”

The Plan required INN M/S and MH/SUD providers to submit requests for coverage of additional units of outpatient services and/or extended periods of time for previously approved INN outpatient services. M/S and MH/SUD provider requests for INN services triggered the outpatient Concurrent Review process.

M/S and MH/SUD outpatient Concurrent Reviews included confirmation of member eligibility and benefit availability for the requested services. For both M/S and MH/SUD INN outpatient services, non-clinical staff approved coverage for outpatient services that did not require clinical review or interpretation.

M/S and MH/SUD outpatient cases that were not administratively approved in initial review were referred to a clinical reviewer for further research and evaluation. The M/S and MH/SUD clinical reviewers applied benefit plan documents and medical necessity criteria to member clinical information. M/S and MH/SUD clinical reviewers could request additional clinical information if they were unable to approve cases based on the available member clinical information. The clinical reviewers may approve services based on their review.

If the requested clinical information was not received or if the case could not be approved, M/S and MH/SUD clinical reviewers referred cases to a peer clinical reviewer. For INN MH/SUD outpatient cases, the Plan offered peer-to-peer conversations so the INN MH/SUD provider could provide additional clinical information prior to the issuance of an adverse benefit determination. Only qualified peer clinical reviewers issued both M/S and MH/SUD adverse benefit determinations.

The Plan communicated all adverse benefit determinations for M/S and MH/SUD outpatient cases that did not meet applicable clinical criteria consistent with state and federal requirements, including appeal rights, as applicable.

The Plan monitors M/S and MH/SUD clinical and peer clinical reviewers' application of clinical criteria through annual IRR assessments. The Plan also conducts monthly quality audits of individual non-clinical staff, clinical reviewers, and peer clinical reviewers, including staff performing appeal functions. The Plan routinely monitors Concurrent Review performance through its clinical performance oversight functions. In addition to comparing these "in operation" processes, the Plan reviewed medical necessity approval and denial rates, internal appeals outcomes, and external appeals outcomes related to Concurrent Review determinations for M/S and MH/SUD INN outpatient services. The results of these analyses are discussed in greater detail in Step 5.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan's or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The findings of the Plan's comparative analyses confirmed the strategies, processes, factor, evidentiary standard, and source information used to determine the MH/SUD INN outpatient services subject to Concurrent Review were comparable to, and applied no more stringently than, the strategies, processes, factor, evidentiary standard, and source information used to determine the M/S INN outpatient services subject to Concurrent Review "as written."

The Plan found the factor used to add MH/SUD INN outpatient services on the list of services subject to Concurrent Review was comparable to, and applied no more stringently than, the factor used to add M/S INN outpatient services on the list of services subject to Concurrent Review. INN M/S and MH/SUD outpatient services that met the applicable factor(s) were subject to Concurrent Review "in operation."

The Plan used comparable processes to conduct outpatient Concurrent Review of INN M/S and MH/SUD providers' requests for coverage of additional units of service or extended periods of time beyond those previously approved by the Plan. The Plan required M/S and MH/SUD INN providers to timely request coverage. The Plan used qualified staff to confirm member eligibility and benefit availability, and to request additional clinical information if necessary. The Plan issued approvals for M/S and MH/SUD outpatient services that met applicable clinical criteria or guidelines. Only qualified M/S and MH/SUD peer clinical reviewers issued adverse benefit determinations. The Plan gave INN providers the opportunity to discuss potential adverse benefit determinations with qualified peer clinical reviewers prior to issuing adverse benefit determinations. This afforded INN providers the opportunity to provide additional information.

The Plan operated monitoring and oversight programs to ensure that clinical reviewers and peer clinical reviewers rendered appropriate determinations. Both M/S and MH/SUD required clinical reviewers, including peer clinical reviewers, to successfully complete the annual IRR assessment. Clinical reviewers were required to pass the IRR assessment with a score of 90% or better to render UM decisions independently. 2023 IRR M/S and MH/SUD results are not available. The M/S and MH/SUD clinical reviewers' application of medical necessity criteria when making utilization review determinations will be assessed for comparability when the results are available.

INN outpatient medical necessity approval and denial rates and appeals outcomes data from 01/01/2022 – 12/31/2022 were

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evaluated where a minimum threshold of 100 cases were available to ensure a valid data set for analysis. The Plan has established that a minimum of at least 100 M/S and MH/SUD cases are required within each classification for a comparative analysis. Meaningful conclusions cannot be reached when there are fewer than 100 cases within each classification this is because the data is subject to variability.

Because Georgia Surest Plan became effective on 07/2023 there is minimal membership and as a result an insufficient number of cases from 01/01/2022 – 12/31/2022 to support an analysis. While the Plan notes that the U.S. Department of Labor has indicated generally that outcomes data are not dispositive of parity compliance, the Plan will conduct a comparative analysis of outcomes data, including medical necessity approval and denial rates and appeals outcomes, when there is a minimum of 100 cases available to ensure a valid data set for analysis.

Conclusions

The Plan reviewed the M/S and MH/SUD Concurrent Review operational policies and procedures and concluded the methodology used to determine which MH/SUD INN outpatient services are subject to Concurrent Review “as written” were comparable to, and applied no more stringently than, the methodology used to determine which M/S INN outpatient services are subject to Concurrent Review “as written.” Additionally, the Plan concluded that how Concurrent Review is applied to MH/SUD INN outpatient services was comparable to, and applied no more stringently than, how Concurrent Review is applied to M/S INN outpatient services “as written.”

The Plan reviewed the M/S and MH/SUD processes, including responsibility for submission, timeframes for submission and review, notification to members and providers, clinical standards for review, staff qualifications and IRR assessment results and concluded how the Plan conducts Concurrent Review for MH/SUD INN outpatient services “in operation” was comparable to, and applied no more stringently than, how the Plan conducts Concurrent Review for M/S INN outpatient services “in operation.”

Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical/surgical (M/S) benefits. This generally means that the financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements, such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage.

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Concurrent Review is defined as “a clinical review of an extension of previously approved, ongoing course of treatment over a period of time or number of treatments conducted during an inpatient stay or ongoing ambulatory care. It is sometimes called a “continued stay review.”” The *Optum National Policy Definitions List* defines a Concurrent (Review) Request as “a request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care.” Concurrent Review does not involve onsite reviews.

Concurrent Review is a component of the Plan’s Utilization Management (UM) program that helps ensure members receive appropriate coverage based on their specific clinical status and health care needs. The process is designed to achieve optimal clinical outcomes by applying objective, evidence-based clinical criteria and nationally recognized guidelines and best practices. Concurrent Review is a UM process that involves applying the benefit plan language and/or clinical criteria to make the most appropriate clinical coverage benefit determination.

This document includes the following information:

- The Concurrent Review process for M/S and MH/SUD outpatient services
- The description of the NQTL and application (Step 1)
- Factors used to determine which services are subject to the NQTL (Step 2)
- Evidentiary standards and sources used to define, trigger, and or implicate a factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

This analysis refers to the following attachments:

- *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions* - M/S policy that defines Concurrent Review
- *Optum National Policy Definitions List* - MH/SUD policy that defines Concurrent Review
- *Utilization Management Program Description (UMPD) of United HealthCare Services, Inc. and UnitedHealthcare Insurance Company* - Summarizes the philosophy, structure and standards that govern UHC’s medical management, UM and utilization review responsibilities and functions
- *Management of Behavioral Health Benefits Policy* - Describes the mechanisms and processes designed to promote

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consistency in the management of behavioral health benefits and to ensure that members receive appropriate, high quality behavioral health services in a timely manner

- *Certificates of Coverage (COC23-INS-BIND-2021-LG-GA-UHIC)* - Plan document that explains covered services, terms, conditions, and limitations of the member's policy
- *Schedule of Benefits - SBN23-Medical-INS-BIND-2021-Choice Plus-LG-GA-UHIC* - Plan document that outlines member responsibilities
- *Core Principles and Practices* - MH/SUD policy that outlines the core principles and practices that should be used by personnel in their interactions with members, authorized member representatives, practitioners and facilities, related to the management of behavioral health benefits, coverage determinations and appeals/grievances of non-coverage determinations
- *Performance Assessment and Incentives* - M/S policy confirming that clinical reviewers are not incented to make denials for financial reasons
- *2023 UnitedHealthcare Provider Administrative Guide* – Informs M/S providers of the Prior Authorization process. The *UnitedHealthcare Provider Administrative Guide* can be accessed on the website <https://www.uhcprovider.com/en/admin-guides.html>
- *September 2023 Optum National Network Manual* - Informs MH/SUD providers of the Prior Authorization process. The *Optum National Network Manual* can be accessed on the website <https://public.providerexpress.com/content/optum-network-manual.html>

The Plan concludes that the Concurrent Review requirements for M/S and MH/SUD are comparable and applied no more stringently for MH/SUD in-network (INN) outpatient benefits both “as written” and “in operation.”

Process

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Concurrent Review is defined as: “a clinical review of an extension of previously approved, ongoing course of treatment over a period of time or number of treatments conducted during an inpatient stay or ongoing ambulatory care. It is sometimes called “continued stay review.”” The *Optum National Policy Definitions List* defines a Concurrent (Review) Request as: “a request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care.”

The Plan structures outpatient Concurrent Review processes to be compliant with all applicable federal and state requirements, Concurrent Review is governed at both the state and federal level, which includes consumer protections such as external review for adverse benefit determinations after internal appeals options are exhausted.

The Plan delegates management of MH/SUD outpatient services, including Concurrent Review to United Behavioral Health d/b/a Optum Behavioral Health (OBH), its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor.

The Plan has national committees that approve M/S and MH/SUD outpatient services to be subject to Concurrent Review. Additionally, the Plan has a standard process for assessing the services that are subjected to Concurrent Review and whether they should be retained or removed from the list of services that are subject to Concurrent Review.

Concurrent Review of M/S outpatient services consists of the following:

The Plan requires INN M/S providers to submit a Concurrent Review request for outpatient services that are described in Step 1 of this NQTL. The INN provider's submission of a request (notification) triggers the Concurrent Review process.

The Plan requires INN M/S providers to timely request coverage of additional units of service or extensions of time for services previously approved in Prior Authorization. The Plan reclassifies M/S outpatient Concurrent Review coverage requests as preservice/Prior Authorization requests. The Plan follows the outpatient Prior Authorization process for these requests and

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uses the outpatient Prior Authorization process to review requests for coverage of additional units of service or extensions of time for previously approved services.

INN providers may submit Prior Authorization requests through the secure provider portal (www.uhcprovider.com), their connected electronic medical record, by telephone, or by fax (where required). Members may submit Prior Authorization requests by phone, fax, or mail, in accordance with Plan requirements. Providers and members communicate basic information to create a case. As outlined in the *UnitedHealthcare Care Provider Administrative Guide*, providers must submit advance notification with supporting documentation as soon as possible, but at least two weeks before the planned service, unless otherwise stated. The provider's submission of a request (notification) triggers the Prior Authorization process.

The Plan confirms receipt of the Prior Authorization request. Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. Non-clinical staff may administratively deny coverage if member benefits are exhausted. Non-clinical staff review cases to ensure availability of accurate and thorough case information. Non-clinical staff may approve coverage requests in scenarios where the member's plan documents allow and if a clinical review is not required. Requests that are submitted through the secure provider portal may also be approved based on the benefit plan coverage criteria, member diagnosis, and the clinical information submitted. Non-clinical staff refer cases that they cannot approve or administratively deny to initial clinical reviewers for medical necessity review.

First Level Clinical Review/Initial Review. Clinical reviewers (nurses) consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs to determine whether the applicable clinical criteria are met. The clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. The clinical reviewer can approve cases that meet applicable clinical criteria.

Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Peer clinical reviewers (physician or mid-level practitioner) consult clinical criteria when making clinical coverage benefit determinations. Peer clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs. The peer clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If a peer clinical reviewer issues an adverse benefit determination, then the Plan communicates the adverse benefit determination, including appeal rights, and offers a peer-to-peer conversation consistent with state and federal requirements.

Adverse Benefit Determination. For M/S, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction, or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when member benefits are exhausted. Modified coverage requests that are approved are recorded as partial denials.

Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based medical clinical policies or use clinical criteria from third party sources such as InterQual® or MCG® guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that outpatient Concurrent Review determinations are appropriate.

M/S monitors clinical reviewer and peer clinical reviewer application of clinical criteria through an annual inter-rater reliability (IRR) assessment that is provided by InterQual. Clinical reviewers and peer clinical reviewers are required to pass the IRR

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assessment with a score of 90% or better through three attempts. After a second failed IRR assessment, staff enter a remediation period and are required to review all cases with a supervisor for 30 days, or until 90% is achieved on the assessment. If the clinical reviewer achieves a passing score within the 30-day period, supervisors review a minimum of one case per week for the remainder of the 30-day period.

The Plan also conducts end-to-end case audits that are designed and approved by clinical leadership each year. The end-to-end audits include all stages of a case review, from intake through appeal. These audits are conducted monthly and approximately 1500 cases are reviewed per month. Results are reported to an oversight team. All deficiencies are remediated. Remediation may include corrective actions and/or additional education, as indicated.

The Plan routinely monitors Concurrent Review performance through its clinical performance oversight functions. Outcomes are monitored against timeliness requirements, performance guarantees, and for potential trends, including overall utilization.

The Plan's National Medical Care Management Committee (NMCMC) annually reviews overall UM program outcomes, including outpatient Concurrent Review outcomes, to confirm overall utilization is appropriate. The NMCMC is comprised of the Chief Medical Officer, and representatives from clinical policy, clinical advocacy and grievances, business standardization and advancement, regional chief medical officers, inpatient care management, lines of business, medical policy, clinical operations, and OBH. The Chair of the NMCMC must be an executive leader and licensed physician.

As of April 1, 2023, the Utilization Management Program Committee (UMPC) began overseeing the M/S UM program. The UMPC is responsible for the development and maintenance of the M/S Prior Authorization processes. The UMPC ensures that the UM program considers the factors and evidentiary standards for applying UM. The UMPC is comprised of:

- Chief Medical Officer, Medical Management (Co-Chair)
- Senior Vice President, Clinical Advancement (Co-Chair)
- Chief Medical Officer, UnitedHealthcare
- Senior Vice President, Clinical Appeals & Grievances
- Chief Medical Officer, Clinical Policy
- Chief Medical Officer, UnitedHealthcare Employer & Individual
- Chief Medical Officer, UnitedHealthcare Medicare & Retirement
- Chief Medical Officer, Community & State
- Chief Medical Officer, UnitedHealthcare Individual & Family Plans
- Vice President, Clinical Transformation & Affordability
- Senior Director, Mental Health Parity
- Vice President, Utilization Management Strategy & Implementation

One of the chairs must be an executive leader and a licensed physician. UMPC meets at least six times per year but may meet more frequently if needed.

Per the M/S policy entitled, *Performance Assessment and Incentives*, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons.

M/S generally structures UM processes to comply with federal Employee Retirement Income Security Act of 1974 (ERISA) requirements, and state law, where applicable.

Concurrent Review of MH/SUD outpatient services consists of the following:

The Plan delegates management of MH/SUD outpatient services, including Concurrent Review, to United Behavioral Health d/b/a OBH, its delegated MH/SUD MBHO vendor.

The Plan requires INN MH/SUD providers to submit a Concurrent Review request for outpatient services. Provider notification

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triggers the outpatient Concurrent Review process. Outpatient Concurrent Review begins when INN provider requests coverage for additional units of service and/or periods of time beyond those initially authorized by the Plan.

INN providers may submit authorization requests through the secure provider portal (www.providerexpress.com), by telephone, or by fax (where required). Members may submit authorization requests by telephone, fax, or mail, in accordance with Plan requirements. Intensive Outpatient Program (IOP) providers notify the Plan of the need for additional days/services by telephone and Partial Hospitalization Program (PHP) providers notify the Plan of the need for additional days/services by telephone or the secure provider portal.

As described in the *Management of Behavioral Health Benefits Policy*, the Plan confirms receipt of the Concurrent Review request. Non-clinical staff confirm member eligibility and benefit coverage. Non-clinical staff may approve cases that do not require clinical evaluation or interpretation based on the member's diagnosis and the clinical information submitted by providers. Non-clinical staff refer cases that they cannot approve to the initial clinical reviewers.

First Level Clinical Review/Initial Review. Clinical decisions are made by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse benefit determinations are made by Medical Directors or psychologists. Clinical reviewers consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether a service is medically necessary by reviewing the member's clinical information, the applicable clinical criteria or guidelines, and the Plan benefit terms. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for certification, related diagnostic results, and history of related treatment and services. The clinical reviewer may approve cases that meet applicable clinical criteria.

Second Level Clinical Review/Peer Review. The initial clinical reviewer refers cases to a peer clinical reviewer for a peer-to-peer discussion if the case cannot be approved. The requesting provider is offered the opportunity to discuss the case with the peer clinical reviewer, consistent with state and federal requirements before an adverse benefit determination is issued. Only qualified peer clinical reviewers (e.g., Medical Directors or psychologists) can issue adverse benefit determinations. Peer clinical reviewers apply clinical criteria to member clinical information to determine coverage for additional units of service during an extended period of time. If the requesting provider fails to complete the peer-to-peer discussion, the peer clinical reviewer makes a determination based on the information available. If a peer clinical reviewer issues an adverse benefit determination, (e.g., that numbers of treatments or extensions of time are not authorized), then the Plan timely communicates the adverse benefit determination, including appeal rights, to the member and provider consistent with applicable state and federal requirements.

Adverse Benefit Determination. For MH/SUD, an adverse benefit determination is recorded as a clinical denial when it is based on clinical criteria and member clinical information.

IOP Practice Management. The Plan identifies INN MH/SUD IOP facilities and clinics that demonstrate effective performance based on readmission rates, lengths of stay, and post-discharge outcomes for inclusion in Practice Management. INN MH/SUD facilities or clinics that meet these performance criteria do not have to obtain Prior Authorization for IOP services. Instead, the facilities submit claims post-service, which the Plan pays.

Platinum Designation. The Plan offers a Platinum Designation program to INN MH/SUD PHP providers based on facilities' quantitative practice patterns (effectiveness and efficiency benchmarks). The Platinum Designation program's effectiveness and efficiency benchmarks include targeted 30- and 90-day readmission rates, 7- and 30-day follow up after hospitalization, outlier length of stay, and outlier behavioral health episode spend. INN MH/SUD providers that meet the Platinum Designation are required to notify the Plan of admissions to PHP and provide member information. The Plan covers the first 17 days of admission to PHP without review. Facilities notify the Plan if additional days are needed. The Plan evaluates INN MH/SUD facilities' performance annually as described in the *Optum National Network Manual*.

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Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity clinical coverage determinations on objective, evidence-based behavioral clinical policies or use clinical criteria from third-party sources such as, American Society of Addiction Medicine (ASAM) Criteria®, Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System-Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) and Early Childhood Service Intensity Instrument (ECSII) guidelines.

Monitoring/ Quality Oversight. The Plan conducts a variety of activities that ensure that outpatient Concurrent Review determinations are appropriate.

MH/SUD monitors clinical reviewer and peer clinical reviewer application of clinical criteria through an annual IRR assessment. Clinical reviewers and peer clinical reviewers are required to pass the IRR assessment with a score of 90% or better through three attempts. After a second failed IRR assessment, the reviewer enters a remediation period and is required to review all cases with a supervisor for 30 days, or until 90% is achieved on the assessment. If the clinical reviewer achieves a passing score within the 30-day period, supervisors review a minimum of one case per week for the remainder of the 30-day period.

The Plan also conducts monthly quality audits of individual non-clinical staff, clinical reviewers, and peer clinical reviewers, including staff performing appeal functions. These audits are designed and approved by clinical leadership each year. A minimum of two audits are completed per staff, per month. The results of these real-time audits are shared with supervisors for staff oversight, and all findings are remediated. Remediation may include corrective actions and/or additional education, as indicated.

The Plan routinely monitors Concurrent Review performance through its clinical performance oversight functions. Outcomes are monitored for timeliness compliance, performance guarantee compliance, and potential trends, including overall utilization.

The Plan's national Clinical Quality & Operations Committee (CQOC) annually reviews overall UM program outcomes, including outpatient Concurrent Review outcomes, to confirm overall utilization is appropriate. The CQOC is comprised of representatives from sub-committees, and representatives from the clinical quality improvement, UM, care engagement, medical operations, medical policy and standards, clinical operations, appeals, product, legal, compliance, network strategy, provider experience, accreditation, and benefits teams. The Chair of the Clinical Quality & Operations Committee must be an executive leader, board certified in psychiatry or psychiatric subspecialty and a licensed physician.

Per the MH/SUD policy entitled, *Core Principles and Practices*, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse clinical coverage benefit determinations (clinical denials) for financial reasons.

MH/SUD generally structures UM processes to comply with federal ERISA requirements and state law, where applicable.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- Concurrent Review

Benefit Classification(s)

- INN, outpatient

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHIC)

Plan Terms/Source Document(s)

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Concurrent Review is defined as “A clinical review of an extension of previously approved, ongoing course of treatment over a period of time or number of treatments conducted during an inpatient stay or ongoing ambulatory care. It is sometimes called a “continued stay review.””

The *Optum National Policy Definitions List* defines a Concurrent (Review) Request as “a request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care.”

The Plan’s *Schedule of Benefits* notify members of Concurrent Review requirements.

“The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.”

The *2023 UnitedHealthcare Care Provider Administrative Guide* notifies providers of the Concurrent Review requirements. INN providers are required to comply with UM protocols established by the Plan:

“We determine the medical necessity of inpatient admissions through either concurrent or retrospective review. We require you to comply with our requests:

- For information, documents or discussions related to our reviews and discharge planning. This includes primary and secondary diagnosis, clinical information, treatment plan, admission order, patient status, discharge planning needs, barriers to discharge and discharge date. When available, provide access to electronic medical records (EMR).
- From our interdisciplinary care coordination team and/or Medical Director. This includes our requests that you help us engage our members directly face-to-face or by phone.
 - If you receive the request before 1 p.m. local time:
 - › Supply all requested information within 4 hours
 - If you receive our request after 1 p.m. local time:
 - › Provide the information within the same business day, but no later than 12 p.m. local time the next business day”

The *Optum National Network Manual*, September 1, 2023 Edition notifies providers of the Concurrent Review requirements. INN providers are required to comply with UM protocols established by the Plan:

“In most cases, inpatient admissions will be directed only to participating hospitals and attending psychiatrists.

All inpatient and sub-acute level of care admissions require notification or pre-authorization by the network provider or facility. Optum requires notification within one business day after an admission for a facility to request a pre-authorization unless a longer period is required by contract or state specific requirements. This includes, but is not limited to, mental health or substance abuse disorder services delivered as inpatient treatment, partial/day hospitalization or residential treatment.

Network providers are solely responsible for completing prior notification or obtaining preauthorization prior to providing inpatient or sub-acute level of care services. This includes timely provision of information necessary for concurrent review of continued stay or ongoing care requests prior to the delivery of services.

Should a provider fail to obtain or otherwise follow the required administrative procedures for notification or pre-authorization, Optum may, in accordance with applicable law, apply a reduction of payment to the network provider up to 100% of provider's reimbursement rate. Network provider payment reductions for failure to complete notification or obtain

pre-authorization are solely the network provider's liability (i.e., the member cannot be billed for these reductions in payment)."

The role of the Plan's delegate, United Behavioral Health d/b/a OBH, is discussed in the *UMPD*:

"United Behavioral Health (UBH) performs the review of requests for coverage of behavioral health services (i.e., substance abuse, and mental health requests for services). UBH provides comprehensive behavioral health care delivery for members through a network of behavioral health practitioners, ancillary care providers, hospitals and other facilities.

For mental health, substance-related disorder services, and wraparound services, UBH uses its Clinical Criteria (see below), behavioral clinical policies, and best practice guidelines to make coverage determinations. UBH adopts externally-developed clinical criteria, and creates internally-developed Clinical Criteria, where appropriate, based on its assessment of relevant guidance. UBH develops clinical criteria that supersedes its standard set or adopts externally-developed clinical criteria when required to do so by contract or regulation.

- Clinical Criteria (Level of Care Utilization System-LOCUS) – Standardized level of care assessment tool developed by the American Association of Community Psychiatrists used to make clinical determinations and placement decisions for mental health disorder benefits for adults ages 19 and older when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (Child and Adolescent Level of Care/Service Intensity Utilization System-CALOCUS-CASII) - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry (AACAP) and the American Association for Community Psychiatry (AAP) used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children and adolescents ages 6-18 when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (Early Childhood Service Intensity Instrument-ECSII) - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children ages 0-5 when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (American Psychological Association Psychological and Neuropsychological Billing and Coding Guide) - Comprehensive billing and coding guide developed by the APA used for making medical necessity determinations for behavioral health psychological and neuropsychological testing services.
- Clinical Criteria (State or Contract Specific Level of Care Guidelines) – Criteria used to make medical necessity determinations for mental health disorder benefits when there are explicit mandates or contractual requirements.
- Clinical Criteria (American Society of Addiction Medicine [ASAM]) - Criteria developed by the American Society of Addiction Medicine used to make clinical determinations for substance-related disorder benefits.
- Clinical Criteria (Medicare Required Criteria): Centers for Medicaid and Medicare (CMS) National and Local Coverage Determinations (NCDs/LCDs) - Summary document of Criteria used to make medical necessity determinations for Medicare benefits.
- Clinical Criteria (Optum Developed)
 - Optum Behavioral Clinical Policies: Criteria that stem from evaluation of new services or treatments or new applications of existing services or treatments and are used to make clinical determinations regarding proven or unproven services and treatments.
 - Optum Supplemental Clinical Criteria: Criteria used to make clinical determinations for Applied Behavior Analysis, Electroconvulsive Therapy and Extended Outpatient Sessions.
 - Optum's Supplement to the APA Psychological and Neuropsychological Testing Billing and Coding Guide: Additional criteria used regarding provider qualifications, coverage rationale, limitations, and developmental testing.

Licensed practitioners conduct all reviews with a focus on measurable outcome goals and objectives for treatment. A senior UBH Medical Director is responsible for directing and implementing behavioral health utilization management programs. A referral is sent to UBH when a member is identified as potentially benefiting from behavioral health services during a "medical event".

The UBH UM Program is staffed by clinical, non-clinical and administrative personnel. All clinical denials or adverse decisions

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are made by board certified psychiatrists, or, if the health plans choose, by a panel of other appropriate health care service reviewers. If the health plan chooses to use a panel to make adverse decisions, the panel contains at least one physician who is board certified in psychiatry. When the health care service under review is a mental health or substance abuse service, the adverse decision is made by a licensed physician who is board certified in psychiatry. All potential clinical denials are referred to a physician who is board certified in psychiatry for final determination. An evaluation of the overall effectiveness of the Behavioral Health UM Program is conducted annually to determine how well resources have been deployed to improve UM activities and the clinical care and service provided to members.”

The Plan’s terms require services to be medically necessary for coverage. INN providers are required to comply with the Plan’s UM protocols including complying with Concurrent Review requirements.

List of M/S and MH/SUD Services Subject to NQTL

The M/S and MH/SUD INN outpatient services subject to concurrent review are below:

M/S:

- Cancer supportive care
- Chemotherapy Services
- Continuous Glucose Monitoring
- Durable Medical Equipment (DME) over \$1,000 (for certain codes)
- End-stage renal disease (ESRD) dialysis services
- Home Health Care – Non-nutritional
- Injectable Medications
- Pain Management and Injection
- Radiation Therapy

MH/SUD:

- Applied Behavior Analysis (ABA)
- Partial Hospitalization

Step 2 – Factors Used in the Design and Application of the NQTL

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

When Surest (Bind) plans first launched in 2016, the Plans were designed to offer a simpler and more transparent way for people to access the system. The Plan included coverage for services with the option to buy-up specific benefits based on member need.

In 2022, UnitedHealthcare acquired Surest (Bind) and agreed to adopt the existing list of services that had been identified to be subject to Concurrent Review. Clinical Appropriateness is presently the factor that is determinative in imposing the Concurrent Review limitation. At this time, the Plan is assessing the value of managing the services, the consistency of adherence to evidence-based guidelines, and volume of services utilized to further refine which INN outpatient services are subject to Concurrent Review.

The Plan relies on the following factor to determine which INN outpatient services are added to the list of services subject to Concurrent Review. This factor applies to M/S and MH/SUD for the following:

- I. M/S: INN outpatient Services
- II. MH/SUD: INN outpatient Services
 - Clinical Appropriateness (Qualitative)
 - Whether the application of Concurrent Review promotes optimal clinical outcomes

Applies to M/S and MH/SUD services.

Meeting Clinical Appropriateness is determinative in imposing the limitation.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below is the evidentiary standard and source used to define, trigger, and/or implicate the factor used to add services to the list of services subject to outpatient Concurrent Review. This evidentiary standard and source apply to benefits for the following:

- I. M/S: INN outpatient services
- II. MH/SUD: INN outpatient services

Factor – Clinical Appropriateness is defined as those outpatient services that are determined by internal medical experts to be in accordance with objective, evidence-based clinical criteria, and nationally recognized guidelines.

- The Plan's evidentiary standards and sources that define and/or trigger the identification of the Clinical Appropriateness factor are:
 - Clinical criteria from nationally recognized third-party sources (e.g., InterQual or MCG for M/S services, and ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines for MH/SUD services)
 - Clinical Technology Assessment Committee (CTAC) and Medical Technology and Assessment Committee (MTAC) review
 - Objective, evidence-based medical/behavioral clinical policies, and nationally recognized guidelines approved by professional healthcare associations (e.g., clinical guidance from the American Medical Association, American Psychiatric Association, etc.)

These evidentiary standards and sources apply to M/S and MH/SUD services and are defined in a qualitative manner.

Meeting Clinical Appropriateness is determinative in imposing the limitation.

The factor and evidentiary standard used as the basis for subjecting MH/SUD INN outpatient benefits to Concurrent Review are comparable to, and applied no more stringently than, the factor and evidentiary standard used as the basis for subjecting M/S INN outpatient benefits to Concurrent Review "as written" and "in operation."

Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

As Written

The Plan conducted a comparative analysis of the strategies, processes, factor, evidentiary standard, and source information used to determine which M/S and MH/SUD INN outpatient services are subject to Concurrent Review and how Concurrent Review is applied to M/S and MH/SUD INN outpatient services “as written.” The Plan identified the factor and evidentiary standard used as the basis for subjecting M/S and MH/SUD INN outpatient benefits to Concurrent Review.

National internal committees apply the factor and standard described in Steps 2 and 3 to M/S and MH/SUD services when determining whether the services should be subjected to Concurrent Review

Review of Factors and Evidentiary Standards

The Plan reviewed the factor that triggers an INN outpatient service to be added to the list of services subject to Concurrent Review. The factor and evidentiary standard were applied to M/S and MH/SUD services comparably and not more stringently to MH/SUD services than to M/S services.

Review of Operational Policies and Procedures

The Plan reviewed M/S and MH/SUD operational policies and procedures, IRR assessment processes, and UM annual oversight to confirm comparability and found MH/SUD policies, procedures, and processes to be comparable and no more stringent than M/S policies, procedures, and processes.

- Medical management operational policies and procedures establish the standards for how the Plan conducts outpatient Concurrent Review. The policies and procedures are consistent with state and federal law requirements governing Concurrent Review. Timeframes for decisions, content of adverse benefit determinations, appeal rights and external review are all governed by state and federal law requirements.
- The IRR assessment measures the consistency with which clinical reviewers and peer clinical reviewers apply the Plan’s clinical criteria. IRR assessment processes apply to both M/S and MH/SUD outpatient services.
- UM oversight monitors and evaluates UM processes by reviewing program outcomes, clinical appeals, IRR assessment, and under- and over-utilization.

Review of Outpatient Concurrent Review Processes

The strategy for applying Concurrent Review to INN outpatient services is comparable for M/S and MH/SUD services and is applied no more stringently to MH/SUD INN outpatient services. The Plan conducted a review of the M/S and MH/SUD Concurrent Review processes to confirm comparability. The review focused on the following aspects of the process for both M/S and MH/SUD:

- **Notification.** INN M/S and MH/SUD providers are contractually responsible for requesting coverage for the continuation of the course of treatment and/or for additional units of outpatient services that exceed the periods of time or units of service previously approved by the Plan, including clinical information for both M/S and MH/SUD. The provider can submit the authorization request through the secure provider portal, by telephone, or by fax (where required).
- **Timeframe to Submit.** INN M/S and MH/SUD providers should notify the Plan as soon as reasonably possible.
- **Clinical Reviews.** For M/S and MH/SUD outpatient Concurrent Review requests, clinical reviewers may gather more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs. The clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. The clinical reviewer may approve cases that meet applicable clinical criteria.
- **Review Timeframes.** M/S and MH/SUD outpatient Concurrent Review determination timeframes are defined by state and federal requirements for both urgent and non-urgent outpatient services. The same determination timeframes apply to M/S and MH/SUD determinations.
- **Determinations and Nonclinical Reviews, First Level Clinical Reviews, and Second Level / Peer Clinical Reviews.** For M/S outpatient Concurrent Review, non-clinical staff may administratively deny cases when member benefits are exhausted. For M/S and MH/SUD non-clinical staff may approve cases that do not require clinical evaluation or interpretation. M/S INN outpatient cases that are submitted through the provider portal may also be approved based

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on the member diagnosis and the clinical information submitted. Non-clinical staff refer coverage requests that they cannot approve or administratively deny to clinical reviewers. Clinical reviewers consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether an outpatient service is medically necessary. The clinical reviewer may approve the services based on their review. The clinical reviewer refers cases to a peer clinical reviewer for a peer-to-peer discussion if the case cannot be approved. Only qualified peer clinical reviewers may issue adverse benefit determinations. Peer-to-peer discussions are offered as required.

- For MH/SUD INN outpatient Concurrent Review there are programs through which facilities or clinics that would otherwise need to request Concurrent Review are not required to do so.
- Adverse Benefit Determinations and Peer-to-Peer Conversations. The Plan offers INN outpatient providers the opportunity to discuss a potential adverse benefit determination before the Plan issues such determination. This process allows INN outpatient providers the opportunity to provide additional information prior to an adverse benefit determination being issued.
 - INN outpatient M/S and MH/SUD services
 - An adverse benefit determination is recorded as a clinical denial when it is based on clinical criteria and member clinical information and is recorded as an administrative denial when member benefits are exhausted/excluded.
- Notification of Decisions to Providers and Members. The Plan notifies M/S and MH/SUD INN providers and members of approvals and adverse benefit determinations, including applicable appeal rights, consistent with state and federal requirements.
- Review of Staff Qualifications. For M/S and MH/SUD, clinical staff qualifications align with the type of clinical review and state and federal requirements.
 - M/S is staffed by clinical, non-clinical, and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., nurses, physicians, etc.) and all adverse benefit determinations are made by a physician or other appropriate health care professionals.
 - MH/SUD is staffed by clinical, non-clinical, and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse benefit determinations are made by Medical Directors or psychologists.
- Clinical Criteria. For M/S and MH/SUD, clinical reviewers and peer clinical reviewers base determinations on objective, evidence-based medical/behavioral clinical policies and use clinical criteria from third party sources such as InterQual, MCG, ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines.

In Operation

The Plan compared the strategies, processes, factor, evidentiary standard, and source information used to determine which M/S and MH/SUD INN outpatient services are subject to Concurrent Review and how Concurrent Review is applied “in operation.”

The Plan required INN M/S and MH/SUD providers to submit requests for coverage of additional units of outpatient services and/or extended periods of time for previously approved INN outpatient services. M/S and MH/SUD provider requests for INN services triggered the outpatient Concurrent Review process.

M/S and MH/SUD outpatient Concurrent Reviews included confirmation of member eligibility and benefit availability for the requested services. For both M/S and MH/SUD INN outpatient services, non-clinical staff approved coverage for outpatient services that did not require clinical review or interpretation.

M/S and MH/SUD outpatient cases that were not administratively approved in initial review were referred to a clinical reviewer for further research and evaluation. The M/S and MH/SUD clinical reviewers applied benefit plan documents and medical necessity criteria to member clinical information. M/S and MH/SUD clinical reviewers could request additional clinical information if they were unable to approve cases based on the available member clinical information. The clinical reviewers may approve services based on their review.

If the requested clinical information was not received or if the case could not be approved, M/S and MH/SUD clinical reviewers referred cases to a peer clinical reviewer. For INN MH/SUD outpatient cases, the Plan offered peer-to-peer conversations so the INN MH/SUD provider could provide additional clinical information prior to the issuance of an adverse benefit determination. Only qualified peer clinical reviewers issued both M/S and MH/SUD adverse benefit determinations.

The Plan communicated all adverse benefit determinations for M/S and MH/SUD outpatient cases that did not meet applicable clinical criteria consistent with state and federal requirements, including appeal rights, as applicable.

The Plan monitors M/S and MH/SUD clinical and peer clinical reviewers' application of clinical criteria through annual IRR assessments. The Plan also conducts monthly quality audits of individual non-clinical staff, clinical reviewers, and peer clinical reviewers, including staff performing appeal functions. The Plan routinely monitors Concurrent Review performance through its clinical performance oversight functions. In addition to comparing these "in operation" processes, the Plan reviewed medical necessity approval and denial rates, internal appeals outcomes, and external appeals outcomes related to Concurrent Review determinations for M/S and MH/SUD INN outpatient services. The results of these analyses are discussed in greater detail in Step 5.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan's or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The findings of the Plan's comparative analyses confirmed the strategies, processes, factor, evidentiary standard, and source information used to determine the MH/SUD INN outpatient services subject to Concurrent Review were comparable to, and applied no more stringently than, the strategies, processes, factor, evidentiary standard, and source information used to determine the M/S INN outpatient services subject to Concurrent Review "as written."

The Plan found the factor used to add MH/SUD INN outpatient services on the list of services subject to Concurrent Review was comparable to, and applied no more stringently than, the factor used to add M/S INN outpatient services on the list of services subject to Concurrent Review. INN M/S and MH/SUD outpatient services that met the applicable factor(s) were subject to Concurrent Review "in operation."

The Plan used comparable processes to conduct outpatient Concurrent Review of INN M/S and MH/SUD providers' requests for coverage of additional units of service or extended periods of time beyond those previously approved by the Plan. The Plan required M/S and MH/SUD INN providers to timely request coverage. The Plan used qualified staff to confirm member eligibility and benefit availability, and to request additional clinical information if necessary. The Plan issued approvals for M/S and MH/SUD outpatient services that met applicable clinical criteria or guidelines. Only qualified M/S and MH/SUD peer clinical reviewers issued adverse benefit determinations. The Plan gave INN providers the opportunity to discuss potential adverse benefit determinations with qualified peer clinical reviewers prior to issuing adverse benefit determinations. This afforded INN providers the opportunity to provide additional information.

The Plan operated monitoring and oversight programs to ensure that clinical reviewers and peer clinical reviewers rendered appropriate determinations. Both M/S and MH/SUD required clinical reviewers, including peer clinical reviewers, to successfully complete the annual IRR assessment. Clinical reviewers were required to pass the IRR assessment with a score of 90% or better to render UM decisions independently. 2023 IRR M/S and MH/SUD results are not available. The M/S and MH/SUD clinical reviewers' application of medical necessity criteria when making utilization review determinations will be assessed for comparability when the results are available.

INN outpatient medical necessity approval and denial rates and appeals outcomes data from 01/01/2022 – 12/31/2022 were

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evaluated where a minimum threshold of 100 cases were available to ensure a valid data set for analysis. The Plan has established that a minimum of at least 100 M/S and MH/SUD cases are required within each classification for a comparative analysis. Meaningful conclusions cannot be reached when there are fewer than 100 cases within each classification this is because the data is subject to variability.

Because Georgia Surest Plan became effective on 07/2023 there is minimal membership and as a result an insufficient number of cases from 01/01/2022 – 12/31/2022 to support an analysis. While the Plan notes that the U.S. Department of Labor has indicated generally that outcomes data are not dispositive of parity compliance, the Plan will conduct a comparative analysis of outcomes data, including medical necessity approval and denial rates and appeals outcomes, when there is a minimum of 100 cases available to ensure a valid data set for analysis.

Conclusions

The Plan reviewed the M/S and MH/SUD Concurrent Review operational policies and procedures and concluded the methodology used to determine which MH/SUD INN outpatient services are subject to Concurrent Review “as written” were comparable to, and applied no more stringently than, the methodology used to determine which M/S INN outpatient services are subject to Concurrent Review “as written.” Additionally, the Plan concluded that how Concurrent Review is applied to MH/SUD INN outpatient services was comparable to, and applied no more stringently than, how Concurrent Review is applied to M/S INN outpatient services “as written.”

The Plan reviewed the M/S and MH/SUD processes, including responsibility for submission, timeframes for submission and review, notification to members and providers, clinical standards for review, staff qualifications and IRR assessment results and concluded how the Plan conducts Concurrent Review for MH/SUD INN outpatient services “in operation” was comparable to, and applied no more stringently than, how the Plan conducts Concurrent Review for M/S INN outpatient services “in operation.”

Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical/surgical (M/S) benefits. This generally means that financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements, such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage.

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Concurrent Review is defined as “a clinical review of an extension of previously approved, ongoing course of treatment over a period of time or number of treatments conducted during an inpatient stay or ongoing ambulatory care. It is sometimes called a “continued stay review.”” The *Optum National Policy Definitions List* defines a Concurrent (Review) Request as “a request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care.” Concurrent Review does not involve onsite reviews.

Concurrent Review is a component of the Plan’s Utilization Management (UM) program that helps ensure members receive appropriate coverage based on their specific clinical status and health care needs. The process is designed to achieve optimal clinical outcomes by applying objective, evidence-based clinical criteria, and nationally recognized guidelines and best practices. Concurrent Review is a UM process that involves applying the benefit plan language and/or clinical criteria to make the most appropriate clinical coverage benefit determination.

This document includes the following information:

- The Concurrent Review process for both M/S and MH/SUD inpatient services
- The description of the NQTL and application (Step 1)
- Factors used to determine which services are subject to the NQTL (Step 2)
- Evidentiary standards and sources used to define, trigger, and or implicate a factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

This analysis refers to the following attachments:

- *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions* - M/S policy that defines Concurrent Review
- *Optum National Policy Definitions List* - MH/SUD policy that defines Concurrent Review

- *Utilization Management Program Description (UMPD) of United HealthCare Services, Inc. and UnitedHealthcare Insurance Company* - summarizes the philosophy, structure and standards that govern UHC's medical management, UM and utilization review responsibilities and functions
- *Management of Behavioral Health Benefits Policy* - Describes the mechanisms and processes designed to promote consistency in the management of behavioral health benefits and to ensure that members receive appropriate, high quality behavioral health services in a timely manner.
- *Schedule of Benefits - SBN23-Medical-INS-BIND-2021-Choice Plus-LG-GA-UHIC* - Plan document that outlines member responsibilities
- *Core Principles and Practices* - MH/SUD policy that outlines the Core Principles and Practices that should be used by personnel in their interactions with members, authorized member representatives, practitioners and facilities, related to the management of behavioral health benefits, coverage determinations and appeals/grievances of non-coverage determinations
- *Performance Assessment and Incentives* - M/S policy confirming that clinical reviewers are not incented to make denials for financial reasons

The Plan concludes that the Concurrent Review requirements for M/S and MH/SUD are comparable and applied no more stringently for MH/SUD out-of-network (OON) inpatient benefits both "as written" and "in operation."

Process

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Concurrent Review is defined as "a clinical review of an extension of previously approved, ongoing course of treatment over a period of time or number of treatments conducted during an inpatient stay or ongoing ambulatory care. It is sometimes called "continued stay review." The *Optum National Policy Definitions List* defines a Concurrent (Review) Request as "a request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care."

The Plan structures inpatient Concurrent Review processes to be compliant with all applicable federal and state laws. Concurrent Review is governed at both the state and federal level, which includes consumer protections such as external review for adverse benefit determinations after internal appeals options are exhausted.

The Plan delegates management of MH/SUD inpatient services, including Concurrent Review for MH/SUD inpatient services, to United Behavioral Health d/b/a Optum Behavioral Health (OBH), its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor.

Concurrent Review of M/S Inpatient Admissions consists of the following:

Initial Concurrent Review. Members are required to ensure that OON facilities and providers timely notify the Plan (e.g., within 24 hours) of an unplanned (e.g., urgent/emergent) inpatient admission. Notification triggers the inpatient Concurrent Review process. OON facilities can notify the Plan by telephone or fax (where required).

The Plan confirms receipt of the Concurrent Review request. Non-clinical staff confirm member eligibility and benefit coverage upon receipt of the notification. Non-clinical staff may approve coverage requests in scenarios where the member's plan documents allow and if a clinical review is not required. Non-clinical staff refer coverage requests that they cannot approve to initial clinical reviewers.

First Level Clinical Review/Initial Review. Clinical reviewers (nurses or physicians) consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether the inpatient admission is medically

necessary by reviewing the member's clinical information, the applicable clinical criteria or guidelines, and the Plan benefit terms. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs to determine whether the applicable clinical criteria are met. The clinical reviewer may approve the admission based on their review.

Second Level Clinical Review/Peer Review. The initial clinical reviewer refers cases to a second level/peer clinical reviewer if the case cannot be approved. Peer clinical reviewers (physician or mid-level practitioner) consult clinical criteria when making clinical coverage benefit determinations. Peer clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs. Only qualified peer clinical reviewers (e.g., Medical Director) can issue adverse benefit determinations. The peer clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. If a peer clinical reviewer issues an adverse benefit determination, then the Plan timely communicates the adverse benefit determination, including appeal rights, and offers a peer-to-peer conversation consistent with state and federal requirements.

Adverse Benefit Determination. For M/S, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction, or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when benefits are exhausted. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials. Modified coverage requests that are approved are recorded as partial denials.

Ongoing Concurrent Review. OON M/S facilities may request coverage of additional days prior to the expiration of the last day of an approved inpatient admission. The Plan conducts ongoing Concurrent Reviews for additional days for approved inpatient M/S admissions as follows:

- General acute care facilities reimbursed on a per diem basis: every two days
- General acute care facilities reimbursed on a diagnosis related group (DRG) basis: when the inpatient admission meets the number of days stated in the provider participation agreement
- Skilled Nursing Facility (SNF) admissions: initial Concurrent Review at day three and then weekly. Subsequent reviews may be sooner if clinically appropriate
- Acute Inpatient Rehab (AIR) admissions: initial Concurrent Review at day five and then weekly. Subsequent reviews may be sooner if clinically appropriate
- Long Term Acute Care Hospital (LTACH) admissions: initial Concurrent Review at day 14 and then weekly

The Plan follows the initial Concurrent Review clinical review process when conducting ongoing Concurrent Reviews.

Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based medical clinical policies and clinical criteria from third party sources such as InterQual® or MCG® guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that inpatient Concurrent Review determinations are appropriate.

M/S monitors clinical reviewer and peer clinical reviewer application of clinical criteria through an annual inter-rater reliability (IRR) assessment that is provided by InterQual. Clinical reviewers and peer clinical reviewers are required to pass the IRR assessment with a score of 90% or better through three attempts. After a second failed IRR assessment, staff enter a remediation period and are required to review all cases with a supervisor for 30 days, or until 90% is achieved on the assessment. If the clinical reviewer achieves a passing score within 30-day period, supervisors review a minimum of one

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case per week for the remainder of the 30-day period.

The Plan also conducts end-to-end case audits that are designed and approved by clinical leadership each year. The end-to-end audits include all stages of a case review, from intake through appeal. These audits are conducted monthly and approximately 1500 cases are reviewed per month. Results are reported to an oversight team. All deficiencies are remediated. Remediation may include corrective actions and/or additional education, as indicated.

The Plan routinely monitors Concurrent Review performance through its clinical performance oversight functions. Outcomes are monitored against timeliness requirements, performance guarantees, and for potential trends, including overall utilization.

As of April 1, 2023, the Utilization Management Program Committee (UMPC) began overseeing the M/S UM program. The UMPC is responsible for the development and maintenance of the M/S Prior Authorization processes. The UMPC ensures that the UM program considers the factors and evidentiary standards for applying UM. The UMPC is comprised of:

- Chief Medical Officer, Medical Management (Co-Chair)
- Senior Vice President, Clinical Advancement (Co-Chair)
- Chief Medical Officer, UnitedHealthcare
- Senior Vice President, Clinical Appeals & Grievances
- Chief Medical Officer, Clinical Policy
- Chief Medical Officer, UnitedHealthcare Employer & Individual
- Chief Medical Officer, UnitedHealthcare Medicare & Retirement
- Chief Medical Officer, Community & State
- Chief Medical Officer, UnitedHealthcare Individual & Family Plans
- Vice President, Clinical Transformation & Affordability
- Senior Director, Mental Health Parity
- Vice President, Utilization Management Strategy & Implementation

One of the chairs must be an executive leader and a licensed physician. UMPC meets at least six times per year but may meet more frequently if needed.

Per the M/S policy entitled, *Performance Assessment and Incentives*, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons.

M/S generally structures UM processes to comply with federal Employee Retirement Income Security Act of 1974 (ERISA) requirements, NCQA UM standards, and state law where applicable.

Concurrent Review of MH/SUD Inpatient Admissions consists of the following:

The Plan delegates management of MH/SUD inpatient services, including Concurrent Review, to United Behavioral Health d/b/a OBH, its delegated MH/SUD MBHO vendor.

Initial Concurrent Review. All OON inpatient admissions are subject to the Concurrent Review process. The Plan requires that members ensure that OON providers and facilities timely notify the Plan of inpatient admissions. Notification triggers the inpatient Concurrent Review process. Providers notify the Plan of the need for additional days/services by telephone.

As described in the *Management of Behavioral Health Benefits Policy*, upon receipt of admission notification, non-clinical staff confirm member eligibility and benefit coverage. Non-clinical staff may approve cases that do not require clinical evaluation or interpretation based on the member's diagnosis and the clinical information submitted by providers. Non-clinical staff refer cases that they cannot approve to initial clinical reviewers.

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First Level Clinical Review/Initial Review. Clinical decisions are made by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse benefit determinations are made by Medical Directors. Clinical reviewers consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether an inpatient admission is medically necessary by reviewing the member's clinical information, the applicable clinical criteria or guidelines, and the Plan benefit terms. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for certification, related diagnostic results, and history of related treatment and services to determine whether the applicable clinical criteria are met. The clinical reviewer may approve the admission based on their review.

Second Level Clinical Review/Peer Review. The initial clinical reviewer refers cases to a peer clinical reviewer for a peer-to-peer discussion if the case cannot be approved. The requesting provider is offered the opportunity to discuss the case with the peer clinical reviewer, consistent with state and federal requirements before an adverse benefit determination is issued. Only qualified peer clinical reviewers (e.g., Medical Directors) can issue adverse benefit determinations. Peer clinical reviewers apply clinical criteria to member clinical information to determine coverage for an inpatient admission. If the requesting provider fails to complete the peer-to-peer discussion, the peer clinical reviewer makes a determination based on the information available. If a peer clinical reviewer issues an adverse benefit determination, (e.g., the admission is not medically necessary and is not approved), then the Plan timely communicates the adverse benefit determination, including appeal rights, to the member and provider consistent with applicable state and federal requirements.

Adverse Benefit Determination. For MH/SUD, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination or failure to provide or make payment (in whole or in part), of a benefit. Adverse benefit determinations are recorded as a clinical denial when it is based on clinical criteria and member clinical information.

Ongoing Concurrent Review. OON providers may request coverage for additional days by contacting the Plan prior to expiration of the last covered day of an approved MH/SUD inpatient admission. The Plan's OON MH/SUD general acute care facilities are reimbursed on a per diem basis. The Plan conducts ongoing Concurrent Review for OON MH/SUD admissions depending on the applicable clinical criteria and the member's clinical presentation. Upon receipt of a request for coverage of additional days, the Plan reviews the medical necessity of inpatient admissions. Clinical reviewers and peer clinical reviewers follow the initial Concurrent Review process.

Clinical Criteria. Initial clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based behavioral clinical policies or use clinical criteria from third party sources such as American Society of Addiction Medicine (ASAM) Criteria®, Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System-Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) and Early Childhood Service Intensity Instrument (ECSII) guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure inpatient Concurrent Review determinations are appropriate.

MH/SUD monitors clinical reviewer and peer clinical reviewer application of clinical criteria through an annual IRR assessment. Clinical reviewers and peer clinical reviewers are required to pass the IRR assessment with a score of 90% or better through three attempts. After a second failed IRR assessment, the reviewer enters a remediation period and is required to review all cases with a supervisor for 30 days, or until 90% is achieved on the assessment. If the clinical reviewer achieves a passing score within 30-day period, supervisors review a minimum of one case per week for the remainder of the 30-day period.

The Plan also conducts monthly quality audits of individual non-clinical staff, clinical reviewers, and peer clinical reviewers, including staff performing appeal functions. These audits are designed and approved by clinical leadership. A minimum of

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two audits are completed per staff, per month. The results of these real-time audits are shared with supervisors for staff oversight, and all findings are remediated. Remediation may include corrective actions and/or additional education, as warranted.

The Plan routinely monitors Concurrent Review program performance through its clinical performance oversight functions. Outcomes are monitored against timeliness requirements, performance guarantees, and for potential trends, including overall utilization.

The Plan's national Clinical Quality & Operations Committee (CQOC) annually reviews UM program outcomes, including inpatient Concurrent Review outcomes, to confirm overall utilization is appropriate. The CQOC is comprised of representatives from sub-committees, and representatives from the clinical quality improvement, UM, care engagement, medical operations, medical policy and standards, clinical operations, appeals, product, legal, compliance, network strategy, provider experience, accreditation, and benefits teams. The Chair of the Clinical Quality & Operations Committee must be an executive leader, board certified in psychiatry or psychiatric subspecialty and a licensed physician.

Per the MH/SUD policy entitled, *Core Principles and Practices*, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons.

MH/SUD generally structures UM processes to comply with federal ERISA requirements and state law, where applicable.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- Concurrent Review

Benefit Classification(s)

- OON, inpatient

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHIC)

Plan Terms/Source Document(s)

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Concurrent Review is defined as “a clinical review of an extension of previously approved, ongoing course of treatment over a period of time or number of treatments conducted during an inpatient stay or ongoing ambulatory care. It is sometimes called a “continued stay review.”” Concurrent Review does not involve onsite reviews.

The *Optum National Policy Definitions List* defines a Concurrent (Review) Request as “a request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care.”

The Plan's *Schedule of Benefits* notify members of Concurrent Review requirements.

“The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.”

The role of the Plan's delegate, United Behavioral Health d/b/a OBH, is discussed in the *UMPD*:

"United Behavioral Health (UBH) performs the review of requests for coverage of behavioral health services (i.e., substance abuse, and mental health requests for services). UBH provides comprehensive behavioral health care delivery for members through a network of behavioral health practitioners, ancillary care providers, hospitals and other facilities.

For mental health, substance-related disorder services, and wraparound services, UBH uses its Clinical Criteria (see below), behavioral clinical policies, and best practice guidelines to make coverage determinations. UBH adopts externally-developed clinical criteria, and creates internally-developed Clinical Criteria, where appropriate, based on its assessment of relevant guidance. UBH develops clinical criteria that supersedes its standard set or adopts externally-developed clinical criteria when required to do so by contract or regulation.

- **Clinical Criteria (Level of Care Utilization System-LOCUS)** - Standardized level of care assessment tool developed by the American Association of Community Psychiatrists used to make clinical determinations and placement decisions for mental health disorder benefits for adults ages 19 and older when State or Contract Specific Level of Care Guidelines do not apply.
- **Clinical Criteria (Child and Adolescent Level of Care/Service Intensity Utilization System-CALOCUS-CASII) -** Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry (AACAP) and the American Association for Community Psychiatry (AACP) used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children and adolescents ages 6-18 when State or Contract Specific Level of Care Guidelines do not apply.
- **Clinical Criteria (Early Childhood Service Intensity Instrument-ECSII)** - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children ages 0-5 when State or Contract Specific Level of Care Guidelines do not apply.
- **Clinical Criteria (State or Contract Specific Level of Care Guidelines)** - Criteria used to make medical necessity determinations for mental health disorder benefits when there are explicit mandates or contractual requirements.
- **Clinical Criteria (American Society of Addiction Medicine [ASAM])** - Criteria developed by the American Society of Addiction Medicine used to make clinical determinations for substance-related disorder benefits.
- **Clinical Criteria (Optum Developed)**
 - Optum Behavioral Clinical Policies: Criteria that stem from evaluation of new services or treatments or new applications of existing services or treatments and are used to make clinical determinations regarding proven or unproven services and treatments.

Licensed practitioners conduct all reviews with a focus on measurable outcome goals and objectives for treatment. A senior UBH Medical Director is responsible for directing and implementing behavioral health utilization management programs. A referral is sent to UBH when a member is identified as potentially benefiting from behavioral health services during a "medical event".

The UBH UM Program is staffed by clinical, non-clinical and administrative personnel. All clinical denials or adverse decisions are made by board certified psychiatrists, or, if the health plans choose, by a panel of other appropriate health care service reviewers. If the health plan chooses to use a panel to make adverse decisions, the panel contains at least one physician who is board certified in psychiatry. When the health care service under review is a mental health or substance abuse service, the adverse decision is made by a licensed physician who is board certified in psychiatry. All potential clinical denials are referred to a physician who is board certified in psychiatry for final determination. An evaluation of the overall effectiveness of the Behavioral Health UM Program is conducted annually to determine how well resources have been deployed to improve UM activities and the clinical care and service provided to members."

The Plan's terms require services to be medically necessary for coverage.

List of M/S and MH/SUD Services Subject to NQTL

The M/S and MH/SUD OON inpatient services subject to concurrent review are below:

M/S:

- Inpatient Acute Care Hospitalizations
- Inpatient Long Term Acute Care (LTAC)
- Inpatient Post-Acute Inpatient Rehabilitation (AIR)
- Inpatient Skilled Nursing Facility (SNF)
- Critical Access Hospitals

MH/SUD:

- MH Non-Emergent Acute Inpatient
- MH Subacute Residential Treatment
- SUD Acute Inpatient Detoxification
- SUD Acute Inpatient Rehabilitation
- SUD Subacute Residential Treatment

Step 2 – Factors Used in the Design and Application of the NQTL

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

The Plan relies on the following factor to determine which OON inpatient services are subject to initial Concurrent Review (design). This factor applies to M/S and MH/SUD for the following:

- I. M/S: General Hospital, Specialty Hospital, SNF, AIR, LTACH
- II. MH/SUD: Inpatient and residential facilities

- **All M/S and MH/SUD Inpatient Admissions – Initial Concurrent Review (Qualitative)**
 - All unplanned M/S and MH/SUD inpatient admissions are subject to initial Concurrent Review

The Plan relies on the following factor to determine which OON inpatient services are subject to ongoing Concurrent Review (design). This factor applies to M/S and MH/SUD for the following:

- I. M/S: General Hospital, Specialty Hospital, SNF, AIR, LTACH
- II. MH/SUD: Inpatient and residential facilities

- **All M/S and MH/SUD Inpatient Admissions Request for Additional Days – Ongoing Concurrent Review (Qualitative)**
 - All M/S and MH/SUD inpatient admissions are subject to ongoing Concurrent Review if coverage of additional days is requested after initial Concurrent Review approved days expire

The factors apply to M/S and MH/SUD services. The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL. All Concurrent Reviews are subject to Clinical Appropriateness and must have medical necessity criteria.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

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Below is the evidentiary standard and source used to define, trigger, and/or implicate the factor used in designing and applying the Plan's initial Concurrent Review requirement to OON inpatient services. This evidentiary standard and source apply to the following:

- I. M/S: General Hospital, Specialty Hospital, SNF, AIR, LTACH
- II. MH/SUD: Inpatient and residential facilities

Factor – All M/S and MH/SUD Inpatient Admissions – Initial Concurrent Review includes all inpatient admissions.

- The Plan's evidentiary standard and source that define and/or trigger the factor are provider notification of an inpatient admission

The Plan's evidentiary standard and source apply to M/S and MH/SUD services and are defined in a qualitative manner.

Below is the evidentiary standard and source used to define, trigger, and/or implicate the factors used in designing and applying the Plan's ongoing Concurrent Review requirement to OON inpatient services. This evidentiary standard and source apply to the following:

- I. M/S: General Hospital, Specialty Hospital, SNF, AIR, LTACH
- II. MH/SUD: Inpatient and residential facilities

Factor – All M/S and MH/SUD Inpatient Admissions Request for Additional Days – Ongoing Concurrent Review includes all inpatient admissions for which a provider requests coverage of additional days.

- The Plan's evidentiary standard and source that define and/or trigger the factor is an inpatient admission for which a provider requests coverage of additional days

The Plan's evidentiary standard and source apply to M/S and MH/SUD services and is defined in a qualitative manner.

The factors and evidentiary standards used as the basis for subjecting MH/SUD OON inpatient services to Concurrent Review are comparable to, and applied no more stringently than, the factors used as the basis for subjecting M/S OON inpatient benefits to Concurrent Review "as written" and "in operation." The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL.

Step 4 – NQTL "As Written" and "In Operation" Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

As Written

The Plan conducted a comparative analysis of the strategies, processes, factors, evidentiary standards, and source information used to determine which M/S and MH/SUD OON inpatient services are subject to Concurrent Review and how Concurrent Review is applied to M/S and MH/SUD OON inpatient services "as written." The Plan identified the factors and evidentiary standards used as the basis for subjecting M/S and MH/SUD benefits to Concurrent Review.

National internal committees apply the applicable factors and standards described in Steps 2 and 3 to M/S and MH/SUD services when determining which services to subject to Concurrent Review.

Review of Factors and Evidentiary Standards

The Plan reviewed the factors that trigger an OON inpatient service to be subject to Concurrent Review. The factors and evidentiary standards were applied to M/S and MH/SUD services comparably and not more stringently to MH/SUD services than to M/S services.

Review of Operational Policies and Procedures

The Plan reviewed M/S and MH/SUD operational policies and procedures, IRR assessment processes, and UM annual oversight to confirm comparability and found MH/SUD policies, procedures, and processes to be comparable and no more stringent than M/S policies, procedures, and processes.

- Medical management operational policies and procedures establish the standards for how the Plan conducts inpatient Concurrent Review. The policies and procedures are consistent with state and federal law requirements governing Concurrent Review. Timeframes for decisions, content of adverse benefit determinations, appeal rights and external review are all governed by state and federal law.
- The IRR assessment measures the consistency with which clinical reviewers and peer clinical reviewers apply the Plan's clinical criteria. IRR assessment processes apply to M/S and MH/SUD inpatient services.
- UM oversight monitors and evaluates UM processes by reviewing program outcomes, clinical appeals, IRR assessments, and under- and over-utilization.

Review of Inpatient Concurrent Review Processes

The strategy for applying both initial and ongoing Concurrent Review to OON inpatient services is comparable for M/S and MH/SUD services and is applied no more stringently to MH/SUD OON inpatient services. The Plan conducted a review of the M/S and MH/SUD Concurrent Review processes to confirm comparability. The review focused on the following aspects of the process for both M/S and MH/SUD:

- **Notification.** The member is responsible for ensuring OON facilities and providers notify the Plan of an inpatient admission for M/S and MH/SUD.
- **Timeframe to Submit.** The timeframe for the provider or member to notify of an admission was reviewed and determined that MH/SUD was comparable and no more stringent. Members or OON facilities should notify the Plan as soon as possible for scheduled and non-scheduled M/S and MH/SUD admissions.
- **Clinical Reviews.** For M/S and MH/SUD inpatient Concurrent Reviews, clinical reviewers may gather more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for certification, related diagnostic results, and history of related treatment and services, and photographs. The clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. The clinical reviewer may approve cases that meet applicable clinical criteria.
- **Review Timeframes.** M/S and MH/SUD inpatient Concurrent Review determination timeframes are defined by state and federal requirements. The same determination timeframes apply to M/S and MH/SUD determinations.
- **Determinations and Nonclinical Reviews, First Level Clinical Reviews, and Second Level Peer Clinical Reviews.**
 - For M/S, non-clinical staff may approve requests for coverage of cases in scenarios where the Plan identified applicable clinical criteria always indicate that an inpatient level of care is medically necessary. Non-clinical staff refer coverage requests that they cannot approve to clinical reviewers. Clinical reviewers (nurses) determine whether the inpatient admission is medically necessary. The clinical reviewer may approve the admission based on their review. If the case cannot be approved by the clinical reviewer, it is referred to a peer (physician) clinical reviewer. Only qualified peer clinical reviewers (e.g., Medical Directors) may issue adverse benefit determinations. Peer-to-peer discussions are offered as required.
 - For MH/SUD, non-clinical staff refer coverage requests that they cannot approve to clinical reviewers. Clinical reviewers (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether an inpatient admission is medically necessary. The clinical reviewer may approve the admission based on their review. The clinical reviewer refers cases to a peer clinical reviewer for a peer-to-peer discussion if the

case cannot be approved. Only qualified peer clinical reviewers (e.g., Medical Directors) may issue adverse benefit determinations. Peer-to-peer discussions are offered as required.

- Adverse Benefit Determinations and Peer-to-Peer Conversations.
 - OON inpatient M/S services
 - The Plan offers OON M/S facilities and providers the opportunity to discuss adverse benefit determinations after the adverse benefit determination is issued. Only M/S peer clinical reviewers (e.g., Medical Directors) may issue adverse benefit determinations for coverage of M/S inpatient services.
 - For M/S, adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded. Modified coverage requests that are approved are recorded as partial denials.
 - OON inpatient MH/SUD services
 - The Plan offers OON inpatient MH/SUD facilities and providers the opportunity to discuss a potential adverse benefit determination before the Plan issues such determination. This process allows OON inpatient MH/SUD facilities and providers the opportunity to provide additional information and/or modify their request prior to an adverse benefit determination being issued.
 - For MH/SUD, an adverse benefit determination is recorded as a clinical denial when it is based on clinical criteria and member clinical information. If during the course of the peer-to-peer conversation the provider withdraws their original request and submits a new request, the case is approved.
- Notification of Decisions to Providers and Members. The Plan notifies M/S and MH/SUD OON facilities, providers, and members of approvals and adverse benefit determinations, including applicable appeal rights consistent with state and federal requirements.
- Review of Staff Qualifications. For M/S and MH/SUD, clinical staff qualifications align with the type of clinical review and state and federal requirements.
 - M/S is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., nurses, physicians, etc.) and all adverse benefit determinations are made by Medical Directors.
 - MH/SUD is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse determinations are made by Medical Directors.
- Clinical Criteria. For M/S and MH/SUD, clinical reviewers and peer clinical reviewers base determinations on objective, evidence-based medical/behavioral clinical policies and use clinical criteria from third party sources such as InterQual, MCG, ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines.
- Ongoing Concurrent Review. All M/S and MH/SUD requests for coverage of additional days trigger ongoing Concurrent Review.

In Operation

The Plan compared the strategies, processes, factors, evidentiary standards, and source information used to determine which M/S and MH/SUD OON inpatient services are subject to Concurrent Review and how Concurrent Review is applied “in operation.”

Initial Concurrent Review

All OON M/S and MH/SUD inpatient services are subject to the Concurrent Review process. The Plan required members to ensure that OON facilities and providers timely notified the Plan of inpatient admissions. Notification triggered the initial Concurrent Review process for OON M/S and MH/SUD inpatient admissions.

M/S and MH/SUD initial Concurrent Reviews included confirmation of member eligibility and benefit availability for the requested services. During the initial reviews for M/S and MH/SUD OON inpatient services, non-clinical staff approved coverage for inpatient admissions that did not require clinical review or interpretation and where member's plan documents allowed. All OON M/S inpatient admissions and MH/SUD inpatient admissions were subject to initial Concurrent Review.

M/S and MH/SUD inpatient cases that were not administratively approved in initial Concurrent Review were referred to a clinical reviewer for further research and evaluation. The M/S and MH/SUD clinical reviewers applied benefit plan documents and medical necessity criteria to member clinical information. M/S and MH/SUD clinical reviewers could request additional clinical information if they were unable to approve cases based on the available member clinical information. The clinical reviewers may approve the admission based on their review when clinical criteria were not met.

If the requested clinical information was not received or if the case could not be approved, M/S and MH/SUD clinical reviewers referred cases to a peer clinical reviewer. For OON MH/SUD inpatient cases, the Plan offered peer-to-peer conversations so the OON MH/SUD provider could provide additional clinical information prior to the issuance of an adverse benefit determination. For OON M/S cases, the Plan offered peer-to-peer conversations at the time of issuing an adverse benefit determination. Only qualified peer clinical reviewers issued M/S and MH/SUD adverse benefit determinations.

The Plan communicated all adverse benefit determinations for M/S and MH/SUD inpatient cases that did not meet applicable clinical criteria consistent with state and federal requirements, including appeal rights, as applicable.

Ongoing Concurrent Review

All OON M/S and MH/SUD inpatient admissions were subject to ongoing Concurrent Review if an OON M/S or MH/SUD facility sought coverage of additional days for an approved admission. OON M/S and MH/SUD facilities were required to request coverage of additional days prior to expiration of the last day of an approved admission.

For all OON M/S and MH/SUD inpatient admissions, the Plan follows the initial Concurrent Review clinical review process when conducting ongoing Concurrent Reviews.

The Plan offered OON MH/SUD facilities the opportunity to discuss a potential adverse benefit determination with a peer clinical reviewer prior to issuing the adverse benefit determination. The Plan offered OON M/S facilities the opportunity to discuss an adverse benefit determination with a peer clinical reviewer when it issued the adverse benefit determination.

The Plan communicated all adverse benefit determinations issued for M/S and MH/SUD inpatient cases that did not meet clinical criteria consistent with state and federal requirements, including appeal rights, as applicable. Only qualified peer clinical reviewers issued adverse benefit determinations for M/S and MH/SUD inpatient admissions.

The Plan monitors M/S and MH/SUD clinical and peer clinical reviewers' application of clinical criteria through annual IRR assessments. The Plan also conducts quality audits of cases. The Plan routinely monitors Concurrent Review performance through its clinical performance oversight functions. In addition to comparing these "in operation" processes, the Plan reviewed medical necessity approval and denial rates, internal appeals outcomes, and external appeals outcomes related to Concurrent Review determinations for M/S and MH/SUD OON inpatient services. The results of these analyses are discussed in greater detail in Step 5.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The findings of the Plan's comparative analyses confirmed the strategies, processes, factors, evidentiary standards, and source information used to determine the MH/SUD OON inpatient services subject to initial and ongoing Concurrent Review were comparable to, and applied no more stringently than, the strategies, processes, factors, evidentiary standards, and

source information used to determine the M/S OON inpatient services subject to initial and ongoing Concurrent Review “as written.”

The Plan found the factors used to subject OON MH/SUD inpatient services to initial and ongoing Concurrent Review were comparable to and applied no more stringently than the factors used to subject OON M/S inpatient services to initial and ongoing Concurrent Review “in operation.” All M/S and MH/SUD inpatient admissions were subject to initial Concurrent Review. All M/S and MH/SUD inpatient admissions were subject to ongoing Concurrent Review if coverage of additional days was requested after initial Concurrent Review approved days expire.

The Plan used comparable processes to conduct initial and ongoing Concurrent Review of OON M/S and MH/SUD inpatient admissions. The Plan required members to ensure that OON M/S and MH/SUD facilities timely notify the Plan of inpatient admissions. The Plan used qualified staff to confirm member eligibility and benefit availability, and to request additional clinical information if necessary. The Plan issued approvals for M/S and MH/SUD inpatient admissions that met applicable clinical criteria or guidelines. Only qualified M/S and MH/SUD peer clinical reviewers issued adverse benefit determinations. The Plan gave OON MH/SUD facilities the opportunity to discuss potential adverse benefit determinations with qualified peer clinical reviewers prior to issuing adverse benefit determinations. This afforded OON MH/SUD facilities the opportunity to convert potential denials to approvals and avoid adverse benefit determinations. The Plan did not offer the opportunity to avoid potential adverse benefit determinations to OON M/S facilities and only offered the peer-to-peer review at the time the adverse benefit determination was issued.

The Plan operated monitoring and oversight programs to ensure that clinical reviewers and peer clinical reviewers rendered appropriate determinations. Both M/S and MH/SUD required clinical reviewers, including peer clinical reviewers, to successfully complete the annual IRR assessment. Clinical reviewers were required to pass the IRR assessment with a score of 90% or better to render UM decisions independently. 2023 IRR M/S and MH/SUD results are not available. The M/S and MH/SUD clinical reviewers’ application of medical necessity criteria when making utilization review determinations will be assessed for comparability when the results are available.

OON inpatient medical necessity approval and denial rates and appeals outcomes data from 01/01/2022 – 12/31/2022 were evaluated where a minimum threshold of 100 cases were available to ensure a valid data set for analysis. The Plan has established that a minimum of at least 100 M/S and MH/SUD cases are required within each classification for a comparative analysis. Meaningful conclusions cannot be reached when there are fewer than 100 cases within each classification because the data is subject to variability.

Because Georgia Surest Plan became effective on 7/2023 there is minimal membership and as a result an insufficient number of cases from 01/01/2022 – 12/31/2022 to support an analysis. While the Plan notes that the U.S. Department of Labor has indicated generally that outcomes data are not dispositive of parity compliance, the Plan will conduct a comparative analysis of outcomes data, including medical necessity approval and denial rates and appeals outcomes, when there is a minimum of 100 cases available to ensure a valid data set for analysis.

Conclusions

The Plan reviewed the M/S and MH/SUD Concurrent Review operational policies and procedures and concluded the methodology used to determine which MH/SUD OON inpatient services are subject to Concurrent Review “as written” were comparable to, and applied no more stringently than, the methodology used to determine which M/S OON inpatient services are subject to Concurrent Review “as written.” Additionally, the Plan concluded that how Concurrent Review is applied to MH/SUD OON inpatient services was comparable to, and applied no more stringently than, how Concurrent Review is applied to M/S OON inpatient services “as written.”

The Plan reviewed the M/S and MH/SUD processes, including responsibility for submission, timeframes for submission and review, notification to members and providers, clinical standards for review, and staff qualifications and concluded how the Plan

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conducts Concurrent Review for MH/SUD OON inpatient services “in operation” was comparable to, and applied no more stringently than, how the Plan conducts Concurrent Review for M/S OON inpatient services “in operation.

Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical/surgical (M/S) benefits. This generally means that the financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements, such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage.

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Concurrent Review is defined as “a clinical review of an extension of previously approved, ongoing course of treatment over a period of time or number of treatments conducted during an inpatient stay or ongoing ambulatory care. It is sometimes called a “continued stay review.”” The *Optum National Policy Definitions List* defines a Concurrent (Review) Request as “a request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care. Concurrent Review does not involve onsite reviews.”

Concurrent Review is a component of the Plan’s Utilization Management (UM) program that helps ensure members receive appropriate coverage based on their specific clinical status and health care needs. The process is designed to achieve optimal clinical outcomes by applying objective, evidence-based clinical criteria and nationally recognized guidelines and best practices. Concurrent Review is a UM process that involves applying the benefit plan language and/or clinical criteria to make the most appropriate clinical coverage benefit determination.

This document includes the following information:

- The Concurrent Review process for M/S and MH/SUD outpatient services
- The description of the NQTL and application (Step 1)
- Factors used to determine which services are subject to the NQTL (Step 2)
- Evidentiary standards and sources used to define, trigger and or implicate a factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

This analysis refers to the following attachments:

- *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions* – M/S policy that defines Concurrent Review
- *Optum National Policy Definitions List* – MH/SUD policy that defines Concurrent Review
- *Utilization Management Program Description (UMPD) of United HealthCare Services, Inc. and UnitedHealthcare Insurance Company* - Summarizes the philosophy, structure and standards that govern UHC’s medical management, UM and utilization review responsibilities and functions
- *Management of Behavioral Health Benefits Policy* - Describes the mechanisms and processes designed to promote

consistency in the management of behavioral health benefits and to ensure that members receive appropriate, high quality behavioral health services in a timely manner

- *Certificates of Coverage - COC23.INS.BIND.2021.LG.GA* - Plan document that explains covered services, terms, conditions, and limitations of the member's policy
- *Schedule of Benefits - SBN23-Medical-INS-BIND-2021-Choice Plus-LG-GA-UHIC* - Plan document that outlines member responsibilities
- *Core Principles and Practices* – MH/SUD policy that outlines the core principles and practices that should be used by personnel in their interactions with members, authorized member representatives, practitioners and facilities, related to the management of behavioral health benefits, coverage determinations and appeals/grievances of non-coverage determinations
- *Performance Assessment and Incentives* – M/S policy confirming that clinical reviewers are not incented to make denials for financial reasons

The Plan concludes that the Concurrent Review requirements for M/S and MH/SUD are comparable and applied no more stringently for MH/SUD out-of-network (OON) outpatient benefits both "as written" and "in operation."

Process

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Concurrent Review is defined as "a clinical review of an extension of previously approved, ongoing course of treatment over a period of time or number of treatments conducted during an inpatient stay or ongoing ambulatory care. It is sometimes called "continued stay review." The *Optum National Policy Definitions List* defines a Concurrent (Review) Request as "a request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care."

The Plan structures outpatient Concurrent Review processes to be compliant with all applicable federal and state requirements. Concurrent Review is governed at both the state and federal level, which includes consumer protections such as external review for adverse benefit determinations after internal appeals options are exhausted.

The Plan delegates management of MH/SUD outpatient services, including Concurrent Review to United Behavioral Health d/b/a Optum Behavioral Health(OBH), its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor.

The Plan has national committees that approve M/S and MH/SUD outpatient services to be subject to Concurrent Review. Additionally, the Plan has a standard process for assessing the services that are subjected to Concurrent Review and whether they should be retained or removed from the list of services that are subject to Concurrent Review. *Addendum A* includes a list of all service categories subject to outpatient Concurrent Review.

Concurrent Review of M/S outpatient services consists of the following:

Members are required to ensure that OON M/S providers submit clinical information for Concurrent Review for outpatient services that are described on *Addendum A*. The member's benefit plan document (e.g., *Schedule of Benefits*) identifies the services for which the member is responsible for obtaining Prior Authorization and by extension Concurrent Review. The OON provider can request Concurrent Review on behalf of the member.

The Plan requires members, or OON M/S providers on the member's behalf, to timely request coverage of additional units of service or extensions of time for services previously approved in Prior Authorization. The Plan reclassifies M/S outpatient Concurrent Review coverage requests as preservice/Prior Authorization requests. The Plan follows the outpatient Prior Authorization process for these requests and uses the outpatient Prior Authorization process to review requests for coverage of additional units of service or extensions of time for previously approved services.

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Members may submit Prior Authorization requests by phone, fax, or mail, in accordance with Plan requirements. OON providers may submit authorization requests on behalf of the member by phone or by fax (where required). Providers and members communicate basic information to create a case. The member or OON provider's submission of a request (notification) triggers the Prior Authorization process.

The Plan confirms receipt of the Prior Authorization request. Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification and non-clinical staff may administratively deny coverage if member benefits are exhausted. Non-clinical staff review cases to ensure availability of accurate and thorough case information. Non-clinical staff may approve coverage requests in scenarios where the member's plan documents allow and if a clinical review is not required. Non-clinical staff refer cases that they cannot approve or administratively deny to the initial clinical reviewers for medical necessity review.

First Level Clinical Review/Initial Review. Clinical reviewers (nurses) consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs to determine whether the applicable clinical criteria are met. The clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. The clinical reviewer can approve cases that meet applicable clinical criteria.

Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Peer clinical reviewers (physician or mid-level practitioner) consult clinical criteria when making clinical coverage benefit determinations. Peer clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs. The peer clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If a peer clinical reviewer issues an adverse benefit determination, then the Plan communicates the adverse benefit determination, including appeal rights, and offers a peer-to-peer conversation consistent with state and federal requirements.

Adverse Benefit Determination. For M/S, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction, or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when member benefits are exhausted. Modified coverage requests that are approved are recorded as partial denials.

Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity benefit determinations on objective, evidence-based medical clinical policies or use clinical criteria from third party sources such as InterQual® or MCG® guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that outpatient Concurrent Review determinations are appropriate.

M/S monitors clinical reviewer and peer clinical reviewer application of clinical criteria through an annual inter-rater reliability (IRR) assessment that is provided by InterQual. Clinical reviewers and peer clinical reviewers are required to pass the IRR assessment with a score of 90% or better through three attempts. After a second failed IRR assessment, staff enter a remediation period and are required to review all cases with a supervisor for 30 days, or until 90% is achieved on the assessment. If the clinical reviewer achieves a passing score within 30-day period, supervisors review a minimum of one case per week for the remainder of the 30-day period.

The Plan also conducts end-to-end case audits that are designed and approved by clinical leadership each year. The end-to-end

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audits include all stages of a case review, from intake through appeal. These audits are conducted monthly and approximately 1500 cases are reviewed per month. Results are reported to an oversight team. All deficiencies are remediated. Remediation may include corrective actions and/or additional education, as indicated.

The Plan routinely monitors Concurrent Review performance through its clinical performance oversight functions. Outcomes are monitored against timeliness requirements, performance guarantees, and for potential trends, including overall utilization.

The Plan's National Medical Care Management Committee (NMCMC) annually reviews overall UM program outcomes, including outpatient Concurrent Review outcomes, to confirm overall utilization is appropriate. The NMCMC is comprised of the Chief Medical Officer, and representatives from clinical policy, clinical advocacy and grievances, business standardization and advancement, regional chief medical officers, inpatient care management, lines of business, medical policy, clinical operations, and OBH. The Chair of the NMCMC must be an executive leader and licensed physician.

As of April 1, 2023, the Utilization Management Program Committee (UMPC) began overseeing the M/S UM program. The UMPC is responsible for the development and maintenance of the M/S Prior Authorization processes. The UMPC ensures that the UM program considers the factors and evidentiary standards for applying UM. The UMPC is comprised of:

- Chief Medical Officer, Medical Management (Co-Chair)
- Senior Vice President, Clinical Advancement (Co-Chair)
- Chief Medical Officer, UnitedHealthcare
- Senior Vice President, Clinical Appeals & Grievances
- Chief Medical Officer, Clinical Policy
- Chief Medical Officer, UnitedHealthcare Employer & Individual
- Chief Medical Officer, UnitedHealthcare Medicare & Retirement
- Chief Medical Officer, Community & State
- Chief Medical Officer, UnitedHealthcare Individual & Family Plans
- Vice President, Clinical Transformation & Affordability
- Senior Director, Mental Health Parity
- Vice President, Utilization Management Strategy & Implementation

One of the chairs must be an executive leader and a licensed physician. UMPC meets at least six times per year but may meet more frequently if needed.

Per the M/S policy entitled, *Performance Assessment and Incentives*, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons.

M/S generally structures UM processes to comply with federal Employee Retirement Income Security Act of 1974 (ERISA) requirements, and state law, where applicable.

Concurrent Review of MH/SUD outpatient services consists of the following:

The Plan delegates management of MH/SUD outpatient services, including Concurrent Review, to United Behavioral Health d/b/a OBH, its delegated MH/SUD MBHO vendor.

Members are required to ensure that the rendering OON provider submits clinical information for Concurrent Review for outpatient services that are described in Step 1 of this NQTL. The OON provider must provide clinical information on the member's behalf. The member's benefit plan document (e.g., *Schedule of Benefits*) identifies the services for which the member is responsible for obtaining Concurrent Review. Provider notification triggers the outpatient Concurrent Review process. Concurrent Review begins when OON providers request coverage for additional units of service and/or periods of time beyond those initially authorized by the Plan.

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Outpatient OON providers notify the Plan of the need for additional days/services by telephone or by fax (where required).

As described in the *Management of Behavioral Health Benefits Policy*, the Plan confirms receipt of the Concurrent Review request. Non-clinical staff confirm member eligibility and benefit coverage. Non-clinical staff may approve cases that do not require clinical evaluation or interpretation based on the member's diagnosis and the clinical information submitted by providers. Non-clinical staff refer cases that they cannot approve to the initial clinical reviewers.

First Level Clinical Review/Initial Review. Clinical decisions are made by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse benefit determinations are made by Medical Directors or psychologists. Clinical reviewers consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether a service is medically necessary by reviewing the member's clinical information, the applicable clinical criteria or guidelines, and the Plan benefit terms. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for certification, related diagnostic results, and history of related treatment and services. The clinical reviewer may approve cases that meet applicable clinical criteria.

Second Level Clinical Review/Peer Review. The initial clinical reviewer refers cases to a peer clinical reviewer for a peer-to-peer discussion if the case cannot be approved. The requesting provider is offered the opportunity to discuss the case with the peer clinical reviewer, consistent with state and federal requirements before an adverse determination is issued. Only qualified peer clinical reviewers (e.g., Medical Directors or psychologists) can issue adverse benefit determinations. Peer clinical reviewers apply clinical criteria to member clinical information to determine coverage for additional units of service during an extended period of time. If the requesting provider fails to complete the peer-to-peer discussion, the peer clinical reviewer makes a determination based on the information available. If a peer clinical reviewer issues an adverse benefit determination, (e.g., that numbers of treatments or extensions of time are not authorized), then the Plan timely communicates the adverse benefit determination, including appeal rights, to the member and provider consistent with applicable state and federal requirements.

Adverse Benefit Determination. For MH/SUD, an adverse benefit determination is recorded as a clinical denial when it is based on clinical criteria and member clinical information.

Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity clinical coverage determinations on objective, evidence-based behavioral clinical policies or use clinical criteria from third-party sources such as, American Society of Addiction Medicine (ASAM) Criteria®, Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System-Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) and Early Childhood Service Intensity Instrument (ECSII) guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that outpatient Concurrent Review determinations are appropriate.

MH/SUD monitors clinical reviewer and peer clinical reviewer application of clinical criteria through an annual IRR. Clinical reviewers and peer clinical reviewers are required to pass the IRR assessment with a score of 90% or better through three attempts. After a second failed IRR assessment, the reviewer enters a remediation period and is required to review all cases with a supervisor for 30 days, or until 90% is achieved on the assessment. If the clinical reviewer achieves a passing score within 30-day period, supervisors review a minimum of one case per week for the remainder of the 30-day period.

The Plan also conducts monthly quality audits of individual non-clinical staff, clinical reviewers, and peer clinical reviewers, including staff performing appeal functions. These audits are designed and approved by clinical leadership each year. A minimum of two audits are completed per staff, per month. The results of these real-time audits are shared with supervisors for staff oversight, and all findings are remediated. Remediation may include corrective actions and/or additional education, as indicated.

The Plan routinely monitors Concurrent Review performance through its clinical performance oversight functions. Outcomes are monitored for timeliness compliance, performance guarantee compliance, and potential trends, including overall utilization.

The Plan's national Clinical Quality & Operations Committee (CQOC) annually reviews overall UM program outcomes, including outpatient Concurrent Review outcomes, to confirm overall utilization is appropriate. The national CQOC is comprised of the Chief Medical Officer, representatives from sub-committees, and representatives from the clinical quality improvement, UM, care engagement, medical operations, medical policy and standards, clinical operations, appeals, product, legal, compliance, network strategy, provider experience, accreditation, and benefits teams. The Chair of the CQOC must be an executive leader and licensed physician.

Per the MH/SUD policy entitled, *Core Principles and Practices*, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse clinical coverage benefit determinations (clinical denials) for financial reasons.

MH/SUD generally structures UM processes to comply with federal ERISA requirements and state law, where applicable.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- Concurrent Review

Benefit Classification(s)

- OON, outpatient

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHIC)

Plan Terms/Source Document(s)

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Concurrent Review is defined as “a clinical review of an extension of previously approved, ongoing course of treatment over a period of time or number of treatments conducted during an inpatient stay or ongoing ambulatory care. It is sometimes called a “continued stay review.””

The *Optum National Policy Definitions List* defines a Concurrent (Review) Request as “a request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care.”

The Plan's *Schedule of Benefits* notify members of Concurrent Review requirements.

“The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.”

The role of the Plan's delegate, United Behavioral Health d/b/a OBH, is discussed in the *UMPD*:

“United Behavioral Health (UBH) performs the review of requests for coverage of behavioral health services (i.e., substance abuse, and mental health requests for services). UBH provides comprehensive behavioral health care delivery for members

through a network of behavioral health practitioners, ancillary care providers, hospitals and other facilities.

For mental health, substance-related disorder services, and wraparound services, UBH uses its Clinical Criteria (see below), behavioral clinical policies, and best practice guidelines to make coverage determinations. UBH adopts externally-developed clinical criteria, and creates internally-developed Clinical Criteria, where appropriate, based on its assessment of relevant guidance. UBH develops clinical criteria that supersedes its standard set or adopts externally-developed clinical criteria when required to do so by contract or regulation.

- **Clinical Criteria (Level of Care Utilization System-LOCUS)** – Standardized level of care assessment tool developed by the American Association of Community Psychiatrists used to make clinical determinations and placement decisions for mental health disorder benefits for adults ages 19 and older when State or Contract Specific Level of Care Guidelines do not apply.
- **Clinical Criteria (Child and Adolescent Level of Care/Service Intensity Utilization System-CALOCUS-CASII)** - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry (AACAP) and the American Association for Community Psychiatry (AACP) used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children and adolescents ages 6-18 when State or Contract Specific Level of Care Guidelines do not apply.
- **Clinical Criteria (Early Childhood Service Intensity Instrument-ECSII)** - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children ages 0-5 when State or Contract Specific Level of Care Guidelines do not apply.
- **Clinical Criteria (State or Contract Specific Level of Care Guidelines)** - Criteria used to make medical necessity determinations for mental health disorder benefits when there are explicit mandates or contractual requirements.
- **Clinical Criteria (American Society of Addiction Medicine [ASAM])** - Criteria developed by the American Society of Addiction Medicine used to make clinical determinations for substance-related disorder benefits.
- **Clinical Criteria (Optum Developed)**
 - Optum Behavioral Clinical Policies: Criteria that stem from evaluation of new services or treatments or new applications of existing services or treatments and are used to make clinical determinations regarding proven or unproven services and treatments.

Licensed practitioners conduct all reviews with a focus on measurable outcome goals and objectives for treatment. A senior UBH Medical Director is responsible for directing and implementing behavioral health utilization management programs. A referral is sent to UBH when a member is identified as potentially benefiting from behavioral health services during a “medical event”.

The UBH UM Program is staffed by clinical, non-clinical and administrative personnel. All clinical denials or adverse decisions are made by board certified psychiatrists, or, if the health plans choose, by a panel of other appropriate health care service reviewers. If the health plan chooses to use a panel to make adverse decisions, the panel contains at least one physician who is board certified in psychiatry. When the health care service under review is a mental health or substance abuse service, the adverse decision is made by a licensed physician who is board certified in psychiatry. All potential clinical denials are referred to a physician who is board certified in psychiatry for final determination. An evaluation of the overall effectiveness of the Behavioral Health UM Program is conducted annually to determine how well resources have been deployed to improve UM activities and the clinical care and service provided to members.”

The Plan’s terms require services to be medically necessary for coverage.

List of M/S and MH/SUD Services Subject to NQTL

The M/S and MH/SUD OON outpatient services subject to concurrent review are below:

M/S:

- Cellular and gene therapy

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- Diabetes Services
- Durable Medical Equipment (DME) - over \$1000 (for certain codes)
- Home Health Care
- Hospice Care
- Therapeutic treatments - Outpatient

MH/SUD:

- Applied Behavior Analysis (ABA)
- Partial Hospitalization

Step 2 – Factors Used in the Design and Application of the NQTL

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

When Surest (Bind) plans first launched in 2016, the Plans were designed to offer a simpler and more transparent way for people to access the system. The Plan included coverage for services with the option to buy-up specific benefits based on member need.

In 2022, UnitedHealthcare acquired Surest (Bind) and agreed to adopt the existing list of services that had been identified to be subject to Concurrent Review. Clinical Appropriateness is presently the factor that is determinative in imposing the Concurrent Review limitation. At this time, the Plan is assessing the value of managing the services, the consistency of adherence to evidence-based guidelines, and volume of services utilized to further refine which OON outpatient services are subject to Concurrent Review.

The Plan relies on the following factor to determine which OON outpatient services are added to the list of services subject to Concurrent Review. This factor applies to M/S and MH/SUD for the following:

- I. M/S: OON outpatient services
- II. MH/SUD: OON outpatient services
 - Clinical Appropriateness (Qualitative)
 - Whether the application of Concurrent Review promotes optimal clinical outcomes

Applies to M/S and MH/SUD services..

Meeting Clinical Appropriateness is determinative in imposing the limitation.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below is the evidentiary standard and source used to define, trigger, and/or implicate the factor used to add services to the list of services subject to outpatient Concurrent Review. This evidentiary standard and source applies to benefits for the following:

- I. M/S: OON outpatient services
- II. MH/SUD: OON outpatient services

Factor – Clinical Appropriateness is defined as those outpatient services that are determined by internal medical experts to

be in accordance with objective, evidence-based clinical criteria, and nationally recognized guidelines.

- The Plan's evidentiary standards and sources that define and/or trigger the identification of the Clinical Appropriateness factor are:
 - Clinical criteria from nationally recognized third-party sources (e.g., InterQual or MCG for M/S services, and ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines for MH/SUD services)
 - Clinical Technology Assessment Committee (CTAC) and Medical Technology and Assessment Committee (MTAC) review
 - Objective, evidence-based medical/behavioral clinical policies, and nationally recognized guidelines approved by professional healthcare associations (e.g., clinical guidance from the American Medical Association, American Psychiatric Association, etc.)

The Plan's evidentiary standards and sources apply to M/S and MH/SUD services and are defined in a qualitative manner.

Meeting Clinical Appropriateness is determinative in imposing the limitation.

The factor and evidentiary standard used as the basis for subjecting MH/SUD OON outpatient benefits to Concurrent Review are comparable to, and applied no more stringently than, the factor and evidentiary standard used as the basis for subjecting M/S OON outpatient benefits to Concurrent Review "as written" and "in operation."

Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

As Written

The Plan conducted a comparative analysis of the strategies, processes, factor, evidentiary standard, and source information used to determine which M/S and MH/SUD OON outpatient services are subject to Concurrent Review and how Concurrent Review is applied to M/S and MH/SUD OON outpatient services “as written.” The Plan identified the factor and evidentiary standard used as the basis for subjecting M/S and MH/SUD OON outpatient benefits to Concurrent Review.

National internal committees apply the factor and standard described in Steps 2 and 3 to M/S and MH/SUD services when determining whether the services should be subjected to Concurrent Review.

Review of Factors and Evidentiary Standards

The Plan reviewed the factor that triggers an OON outpatient service to be added to the list of services subject to Concurrent Review. The factor and evidentiary standard were applied to M/S and MH/SUD services comparably and not more stringently to MH/SUD services than to M/S services.

Review of Operational Policies and Procedures

The Plan reviewed M/S and MH/SUD operational policies and procedures, IRR assessment processes, and UM annual oversight to confirm comparability and found MH/SUD policies, procedures, and processes to be comparable and no more stringent than M/S policies, procedures, and processes.

- Medical management operational policies and procedures establish the standards for how the Plan conducts outpatient Concurrent Review. The policies and procedures are consistent with state and federal law governing Concurrent Review. Timeframes for decisions, content of adverse benefit determinations, appeal rights and external

review are all governed by state and federal law.

- The IRR assessment measures the consistency with which clinical reviewers and peer clinical reviewers apply the Plan's clinical criteria. IRR assessment processes apply for both M/S and MH/SUD outpatient services.
- UM oversight monitors and evaluates UM processes by reviewing program outcomes, clinical appeals, IRR assessment, and under- and over-utilization.

Review of Outpatient Concurrent Review Processes

The strategy for applying Concurrent Review to OON outpatient services is comparable for M/S and MH/SUD services and is applied no more stringently to MH/SUD OON outpatient services. The Plan conducted a review of the M/S and MH/SUD Concurrent Review processes to confirm comparability. The review focused on the following aspects of the process for both M/S and MH/SUD:

- **Notification.** The member is responsible for ensuring the OON provider requests coverage for the continuation of the course of treatment and/or for additional units of outpatient services that exceed the periods of time or units of service previously approved by the Plan. The provider can submit the authorization request by telephone, or by fax (where required).
- **Timeframe to Submit.** Members and OON M/S and MH/SUD providers should notify the Plan as soon as reasonably possible.
- **Clinical Reviews.** For M/S and MH/SUD outpatient Concurrent Review requests, clinical reviewers may gather more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for certification, related diagnostic results, history of related treatment and services, and photographs. The clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. The clinical reviewer may approve cases that meet applicable clinical criteria.
- **Review Timeframes.** M/S and MH/SUD outpatient Concurrent Review determination timeframes are defined by state and federal requirements for both urgent and non-urgent outpatient services. The same determination timeframes apply to M/S and MH/SUD determinations.
- **Determinations and Nonclinical Reviews, First Level Clinical Reviews, and Second Level Clinical Reviews.** For M/S outpatient Concurrent Review, non-clinical staff may administratively deny cases when member benefits are exhausted. For M/S and MH/SUD non-clinical staff may approve cases that do not require clinical evaluation or interpretation. Non-clinical staff refer coverage requests that they cannot approve or administratively deny to clinical reviewers. Clinical reviewers consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether an outpatient service is medically necessary. The clinical reviewer may approve the services based on their review. The clinical reviewer refers cases to a peer clinical reviewer for a peer-to-peer discussion if the case cannot be approved. Only qualified peer clinical reviewers may issue adverse benefit determinations. Peer-to-peer discussions are offered, as required.
- **Adverse Benefit Determinations and Peer-to-Peer Conversations.** The Plan offers OON outpatient providers the opportunity to discuss a potential adverse benefit determination before the Plan issues such determination. This process allows OON outpatient providers the opportunity to provide additional information prior to an adverse benefit determination being issued.
 - **OON outpatient M/S and MH/SUD services**
 - An adverse benefit determination is recorded as a clinical denial when it is based on clinical criteria and member clinical information and is recorded as an administrative denial when member benefits are exhausted.
- **Notification of Decisions to Providers and Members.** The Plan notifies M/S and MH/SUD OON providers and members of approvals and adverse benefit determinations, including applicable appeal rights, consistent with state and federal requirements.
- **Review of Staff Qualifications.** For M/S and MH/SUD, clinical staff qualifications align with the type of clinical review and state and federal requirements.
 - M/S is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., nurses, physicians, etc.) and all adverse benefit determinations are made by a physician or other appropriate

health care professionals.

- MH/SUD is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse benefit determinations are made by Medical Directors or psychologists.
- Clinical Criteria. For M/S and MH/SUD, clinical reviewers and peer clinical reviewers base determinations on objective, evidence-based medical/behavioral clinical policies and use clinical criteria from third party sources such as InterQual, MCG, ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines.

In Operation

The Plan compared the strategies, processes, factor, evidentiary standard, and source information used to determine which M/S and MH/SUD OON outpatient services are subject to Concurrent Review and how Concurrent Review is applied “in operation.”

The Plan required members to ensure OON M/S and MH/SUD providers submit requests for coverage of additional units of outpatient services and/or extended period of time for OON outpatient services previously approved. M/S and MH/SUD provider requests for OON services triggered the outpatient Concurrent Review process.

M/S and MH/SUD outpatient Concurrent Reviews included confirmation of member eligibility and benefit availability for the requested services. For both M/S and MH/SUD OON outpatient services, non-clinical staff approved coverage for outpatient services that did not require clinical review or interpretation.

M/S and MH/SUD outpatient Concurrent Reviews that were not administratively approved in initial review were referred to a clinical reviewer for further research and evaluation. The M/S and MH/SUD clinical reviewers applied benefit plan documents and medical necessity criteria to member clinical information. M/S and MH/SUD clinical reviewers could request additional clinical information if they were unable to approve cases based on the available member clinical information. The clinical reviewers may approve services based on their review.

If the requested clinical information was not received or if the case could not be approved, M/S and MH/SUD clinical reviewers referred cases to a peer clinical reviewer. For OON MH/SUD outpatient cases, the Plan offered peer-to-peer conversations so the OON MH/SUD provider could provide additional clinical information prior to the issuance of an adverse benefit determination. Only qualified peer clinical reviewers issued both M/S and MH/SUD adverse benefit determinations.

The Plan communicated all adverse benefit determinations for M/S and MH/SUD outpatient cases that did not meet applicable clinical criteria consistent with state and federal requirements, including appeal rights, as applicable.

The Plan monitors M/S and MH/SUD clinical and peer clinical reviewers' application of clinical criteria through annual IRR assessments. The Plan also conducts monthly quality audits of individual non-clinical staff, clinical reviewers, and peer clinical reviewers, including staff performing appeal functions. The Plan routinely monitors Concurrent Review performance through its clinical performance oversight functions. In addition to comparing these “in operation” processes, the Plan reviewed medical necessity approval and denial rates, internal appeals outcomes, and external appeals outcomes related to Concurrent Review determinations for M/S and MH/SUD OON outpatient services. The results of these analyses are discussed in greater detail in Step 5.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan's or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

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The findings of the Plan's comparative analyses confirmed the strategies, processes, factor, evidentiary standard, and source information used to determine the MH/SUD OON outpatient services subject to Concurrent Review were comparable to, and applied no more stringently than, the strategies, processes, factor, evidentiary standard, and source information used to determine the M/S OON outpatient services subject to Concurrent Review "as written."

The Plan found the factor used to add outpatient services on the list of services subject to Concurrent Review was comparable to, and applied no more stringently than, the factor used to add M/S OON outpatient services on the list of services subject to Concurrent Review. OON M/S and MH/SUD outpatient services that met the applicable factor(s) were subject to Concurrent Review "in operation."

The Plan used comparable processes to conduct outpatient Concurrent Review of OON M/S and MH/SUD providers' requests for coverage of additional units of service or extended periods of time beyond those previously approved by the Plan. The Plan required M/S and MH/SUD OON providers to timely request coverage. The Plan used qualified staff to confirm member eligibility and benefit availability, and to request additional clinical information if necessary. The Plan issued approvals for M/S and MH/SUD outpatient services that met applicable clinical criteria or guidelines. Only qualified M/S and MH/SUD peer clinical reviewers issued adverse benefit determinations. The Plan gave OON MH/SUD providers the opportunity to discuss potential adverse benefit determinations with qualified peer clinical reviewers prior to issuing adverse benefit determinations. This afforded OON providers the opportunity to provide additional information.

The Plan operated monitoring and oversight programs to ensure that clinical reviewers and peer clinical reviewers rendered appropriate determinations. Both M/S and MH/SUD required clinical reviewers, including peer clinical reviewers, to successfully complete the annual IRR assessment. Clinical reviewers were required to pass the IRR assessment with a score of 90% or better to render UM decisions independently. 2023 IRR M/S and MH/SUD results are not available. The M/S and MH/SUD clinical reviewers' application of medical necessity criteria when making utilization review determinations will be assessed for comparability when the results are available.

OON outpatient medical necessity approval and denial rates and appeals outcomes data from 01/01/2022 – 12/31/2022 were evaluated where a minimum threshold of 100 cases were available to ensure a valid data set for analysis. The Plan has established that a minimum of at least 100 M/S and MH/SUD cases are required within each classification for a comparative analysis. Meaningful conclusions cannot be reached when there are fewer than 100 cases within each classification this is because the data is subject to variability.

Because Georgia Surest Plan became effective on 07/2023 there is minimal membership and as a result an insufficient number of cases from 01/01/2022 – 12/31/2022 to support an analysis. While the Plan notes that the U.S. Department of Labor has indicated generally that outcomes data are not dispositive of parity compliance, the Plan will conduct a comparative analysis of outcomes data, including medical necessity approval and denial rates and appeals outcomes, when there is a minimum of 100 cases available to ensure a valid data set for analysis.

Conclusions

The Plan reviewed the M/S and MH/SUD Concurrent Review operational policies and procedures and concluded the methodology used to determine which MH/SUD OON outpatient services are subject to Concurrent Review "as written" were comparable to, and applied no more stringently than, the methodology used to determine which M/S OON outpatient services are subject to Concurrent Review "as written." Additionally, the Plan concluded that how Concurrent Review is applied to MH/SUD OON outpatient services was comparable to, and applied no more stringently than, how Concurrent Review is applied to M/S OON outpatient services "as written."

The Plan reviewed the M/S and MH/SUD processes, including responsibility for submission, timeframes for submission and

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review, notification to members and providers, clinical standards for review, staff qualifications, and IRR assessment results and concluded how the Plan conducts Concurrent Review for MH/SUD OON outpatient services “in operation” was comparable to, and applied no more stringently than, how the Plan conducts Concurrent Review for M/S OON outpatient services “in operation.”

Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical/surgical (M/S) benefits. This generally means that the financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements, such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage.

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Concurrent Review is defined as “a clinical review of an extension of previously approved, ongoing course of treatment over a period of time or number of treatments conducted during an inpatient stay or ongoing ambulatory care. It is sometimes called a “continued stay review.”” The *Optum National Policy Definitions List* defines a Concurrent (Review) Request as “a request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care. Concurrent Review does not involve onsite reviews.”

Concurrent Review is a component of the Plan’s Utilization Management (UM) program that helps ensure members receive appropriate coverage based on their specific clinical status and health care needs. The process is designed to achieve optimal clinical outcomes by applying objective, evidence-based clinical criteria and nationally recognized guidelines and best practices. Concurrent Review is a UM process that involves applying the benefit plan language and/or clinical criteria to make the most appropriate clinical coverage benefit determination.

This document includes the following information:

- The Concurrent Review process for M/S and MH/SUD outpatient services
- The description of the NQTL and application (Step 1)
- Factors used to determine which services are subject to the NQTL (Step 2)
- Evidentiary standards and sources used to define, trigger and or implicate a factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

This analysis refers to the following attachments:

- *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions* – M/S policy that defines Concurrent Review
- *Optum National Policy Definitions List* – MH/SUD policy that defines Concurrent Review
- *Utilization Management Program Description (UMPD) of United HealthCare Services, Inc. and UnitedHealthcare Insurance Company* - Summarizes the philosophy, structure and standards that govern UHC’s medical management, UM and utilization review responsibilities and functions
- *Management of Behavioral Health Benefits Policy* - Describes the mechanisms and processes designed to promote

consistency in the management of behavioral health benefits and to ensure that members receive appropriate, high quality behavioral health services in a timely manner

- *Certificates of Coverage - COC23.INS.BIND.2021.LG.GA* - Plan document that explains covered services, terms, conditions, and limitations of the member's policy
- *Schedule of Benefits - SBN23-Medical-INS-BIND-2021-Choice Plus-LG-GA-UHIC* - Plan document that outlines member responsibilities
- *Core Principles and Practices* – MH/SUD policy that outlines the core principles and practices that should be used by personnel in their interactions with members, authorized member representatives, practitioners and facilities, related to the management of behavioral health benefits, coverage determinations and appeals/grievances of non-coverage determinations
- *Performance Assessment and Incentives* – M/S policy confirming that clinical reviewers are not incented to make denials for financial reasons

The Plan concludes that the Concurrent Review requirements for M/S and MH/SUD are comparable and applied no more stringently for MH/SUD out-of-network (OON) outpatient benefits both "as written" and "in operation."

Process

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Concurrent Review is defined as "a clinical review of an extension of previously approved, ongoing course of treatment over a period of time or number of treatments conducted during an inpatient stay or ongoing ambulatory care. It is sometimes called "continued stay review." The *Optum National Policy Definitions List* defines a Concurrent (Review) Request as "a request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care."

The Plan structures outpatient Concurrent Review processes to be compliant with all applicable federal and state requirements. Concurrent Review is governed at both the state and federal level, which includes consumer protections such as external review for adverse benefit determinations after internal appeals options are exhausted.

The Plan delegates management of MH/SUD outpatient services, including Concurrent Review to United Behavioral Health d/b/a Optum Behavioral Health(OBH), its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor.

The Plan has national committees that approve M/S and MH/SUD outpatient services to be subject to Concurrent Review. Additionally, the Plan has a standard process for assessing the services that are subjected to Concurrent Review and whether they should be retained or removed from the list of services that are subject to Concurrent Review. *Addendum A* includes a list of all service categories subject to outpatient Concurrent Review.

Concurrent Review of M/S outpatient services consists of the following:

Members are required to ensure that OON M/S providers submit clinical information for Concurrent Review for outpatient services that are described on *Addendum A*. The member's benefit plan document (e.g., *Schedule of Benefits*) identifies the services for which the member is responsible for obtaining Prior Authorization and by extension Concurrent Review. The OON provider can request Concurrent Review on behalf of the member.

The Plan requires members, or OON M/S providers on the member's behalf, to timely request coverage of additional units of service or extensions of time for services previously approved in Prior Authorization. The Plan reclassifies M/S outpatient Concurrent Review coverage requests as preservice/Prior Authorization requests. The Plan follows the outpatient Prior Authorization process for these requests and uses the outpatient Prior Authorization process to review requests for coverage of additional units of service or extensions of time for previously approved services.

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Members may submit Prior Authorization requests by phone, fax, or mail, in accordance with Plan requirements. OON providers may submit authorization requests on behalf of the member by phone or by fax (where required). Providers and members communicate basic information to create a case. The member or OON provider's submission of a request (notification) triggers the Prior Authorization process.

The Plan confirms receipt of the Prior Authorization request. Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification and non-clinical staff may administratively deny coverage if member benefits are exhausted. Non-clinical staff review cases to ensure availability of accurate and thorough case information. Non-clinical staff may approve coverage requests in scenarios where the member's plan documents allow and if a clinical review is not required. Non-clinical staff refer cases that they cannot approve or administratively deny to the initial clinical reviewers for medical necessity review.

First Level Clinical Review/Initial Review. Clinical reviewers (nurses) consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs to determine whether the applicable clinical criteria are met. The clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. The clinical reviewer can approve cases that meet applicable clinical criteria.

Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Peer clinical reviewers (physician or mid-level practitioner) consult clinical criteria when making clinical coverage benefit determinations. Peer clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs. The peer clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If a peer clinical reviewer issues an adverse benefit determination, then the Plan communicates the adverse benefit determination, including appeal rights, and offers a peer-to-peer conversation consistent with state and federal requirements.

Adverse Benefit Determination. For M/S, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction, or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when member benefits are exhausted. Modified coverage requests that are approved are recorded as partial denials.

Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity benefit determinations on objective, evidence-based medical clinical policies or use clinical criteria from third party sources such as InterQual® or MCG® guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that outpatient Concurrent Review determinations are appropriate.

M/S monitors clinical reviewer and peer clinical reviewer application of clinical criteria through an annual inter-rater reliability (IRR) assessment that is provided by InterQual. Clinical reviewers and peer clinical reviewers are required to pass the IRR assessment with a score of 90% or better through three attempts. After a second failed IRR assessment, staff enter a remediation period and are required to review all cases with a supervisor for 30 days, or until 90% is achieved on the assessment. If the clinical reviewer achieves a passing score within 30-day period, supervisors review a minimum of one case per week for the remainder of the 30-day period.

The Plan also conducts end-to-end case audits that are designed and approved by clinical leadership each year. The end-to-end

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audits include all stages of a case review, from intake through appeal. These audits are conducted monthly and approximately 1500 cases are reviewed per month. Results are reported to an oversight team. All deficiencies are remediated. Remediation may include corrective actions and/or additional education, as indicated.

The Plan routinely monitors Concurrent Review performance through its clinical performance oversight functions. Outcomes are monitored against timeliness requirements, performance guarantees, and for potential trends, including overall utilization.

The Plan's National Medical Care Management Committee (NMCMC) annually reviews overall UM program outcomes, including outpatient Concurrent Review outcomes, to confirm overall utilization is appropriate. The NMCMC is comprised of the Chief Medical Officer, and representatives from clinical policy, clinical advocacy and grievances, business standardization and advancement, regional chief medical officers, inpatient care management, lines of business, medical policy, clinical operations, and OBH. The Chair of the NMCMC must be an executive leader and licensed physician.

As of April 1, 2023, the Utilization Management Program Committee (UMPC) began overseeing the M/S UM program. The UMPC is responsible for the development and maintenance of the M/S Prior Authorization processes. The UMPC ensures that the UM program considers the factors and evidentiary standards for applying UM. The UMPC is comprised of:

- Chief Medical Officer, Medical Management (Co-Chair)
- Senior Vice President, Clinical Advancement (Co-Chair)
- Chief Medical Officer, UnitedHealthcare
- Senior Vice President, Clinical Appeals & Grievances
- Chief Medical Officer, Clinical Policy
- Chief Medical Officer, UnitedHealthcare Employer & Individual
- Chief Medical Officer, UnitedHealthcare Medicare & Retirement
- Chief Medical Officer, Community & State
- Chief Medical Officer, UnitedHealthcare Individual & Family Plans
- Vice President, Clinical Transformation & Affordability
- Senior Director, Mental Health Parity
- Vice President, Utilization Management Strategy & Implementation

One of the chairs must be an executive leader and a licensed physician. UMPC meets at least six times per year but may meet more frequently if needed.

Per the M/S policy entitled, *Performance Assessment and Incentives*, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons.

M/S generally structures UM processes to comply with federal Employee Retirement Income Security Act of 1974 (ERISA) requirements, and state law, where applicable.

Concurrent Review of MH/SUD outpatient services consists of the following:

The Plan delegates management of MH/SUD outpatient services, including Concurrent Review, to United Behavioral Health d/b/a OBH, its delegated MH/SUD MBHO vendor.

Members are required to ensure that the rendering OON provider submits clinical information for Concurrent Review for outpatient services that are described in Step 1 of this NQTL. The OON provider must provide clinical information on the member's behalf. The member's benefit plan document (e.g., *Schedule of Benefits*) identifies the services for which the member is responsible for obtaining Concurrent Review. Provider notification triggers the outpatient Concurrent Review process. Concurrent Review begins when OON providers request coverage for additional units of service and/or periods of time beyond those initially authorized by the Plan.

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Outpatient OON providers notify the Plan of the need for additional days/services by telephone or by fax (where required).

As described in the *Management of Behavioral Health Benefits Policy*, the Plan confirms receipt of the Concurrent Review request. Non-clinical staff confirm member eligibility and benefit coverage. Non-clinical staff may approve cases that do not require clinical evaluation or interpretation based on the member's diagnosis and the clinical information submitted by providers. Non-clinical staff refer cases that they cannot approve to the initial clinical reviewers.

First Level Clinical Review/Initial Review. Clinical decisions are made by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse benefit determinations are made by Medical Directors or psychologists. Clinical reviewers consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether a service is medically necessary by reviewing the member's clinical information, the applicable clinical criteria or guidelines, and the Plan benefit terms. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for certification, related diagnostic results, and history of related treatment and services. The clinical reviewer may approve cases that meet applicable clinical criteria.

Second Level Clinical Review/Peer Review. The initial clinical reviewer refers cases to a peer clinical reviewer for a peer-to-peer discussion if the case cannot be approved. The requesting provider is offered the opportunity to discuss the case with the peer clinical reviewer, consistent with state and federal requirements before an adverse determination is issued. Only qualified peer clinical reviewers (e.g., Medical Directors or psychologists) can issue adverse benefit determinations. Peer clinical reviewers apply clinical criteria to member clinical information to determine coverage for additional units of service during an extended period of time. If the requesting provider fails to complete the peer-to-peer discussion, the peer clinical reviewer makes a determination based on the information available. If a peer clinical reviewer issues an adverse benefit determination, (e.g., that numbers of treatments or extensions of time are not authorized), then the Plan timely communicates the adverse benefit determination, including appeal rights, to the member and provider consistent with applicable state and federal requirements.

Adverse Benefit Determination. For MH/SUD, an adverse benefit determination is recorded as a clinical denial when it is based on clinical criteria and member clinical information.

Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity clinical coverage determinations on objective, evidence-based behavioral clinical policies or use clinical criteria from third-party sources such as, American Society of Addiction Medicine (ASAM) Criteria®, Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System-Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) and Early Childhood Service Intensity Instrument (ECSII) guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that outpatient Concurrent Review determinations are appropriate.

MH/SUD monitors clinical reviewer and peer clinical reviewer application of clinical criteria through an annual IRR. Clinical reviewers and peer clinical reviewers are required to pass the IRR assessment with a score of 90% or better through three attempts. After a second failed IRR assessment, the reviewer enters a remediation period and is required to review all cases with a supervisor for 30 days, or until 90% is achieved on the assessment. If the clinical reviewer achieves a passing score within 30-day period, supervisors review a minimum of one case per week for the remainder of the 30-day period.

The Plan also conducts monthly quality audits of individual non-clinical staff, clinical reviewers, and peer clinical reviewers, including staff performing appeal functions. These audits are designed and approved by clinical leadership each year. A minimum of two audits are completed per staff, per month. The results of these real-time audits are shared with supervisors for staff oversight, and all findings are remediated. Remediation may include corrective actions and/or additional education, as indicated.

The Plan routinely monitors Concurrent Review performance through its clinical performance oversight functions. Outcomes are monitored for timeliness compliance, performance guarantee compliance, and potential trends, including overall utilization.

The Plan's national Clinical Quality & Operations Committee (CQOC) annually reviews overall UM program outcomes, including outpatient Concurrent Review outcomes, to confirm overall utilization is appropriate. The national CQOC is comprised of the Chief Medical Officer, representatives from sub-committees, and representatives from the clinical quality improvement, UM, care engagement, medical operations, medical policy and standards, clinical operations, appeals, product, legal, compliance, network strategy, provider experience, accreditation, and benefits teams. The Chair of the CQOC must be an executive leader and licensed physician.

Per the MH/SUD policy entitled, *Core Principles and Practices*, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse clinical coverage benefit determinations (clinical denials) for financial reasons.

MH/SUD generally structures UM processes to comply with federal ERISA requirements and state law, where applicable.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- Concurrent Review

Benefit Classification(s)

- OON, outpatient

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHIC)

Plan Terms/Source Document(s)

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Concurrent Review is defined as “a clinical review of an extension of previously approved, ongoing course of treatment over a period of time or number of treatments conducted during an inpatient stay or ongoing ambulatory care. It is sometimes called a “continued stay review.””

The *Optum National Policy Definitions List* defines a Concurrent (Review) Request as “a request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care.”

The Plan's *Schedule of Benefits* notify members of Concurrent Review requirements.

“The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.”

The role of the Plan's delegate, United Behavioral Health d/b/a OBH, is discussed in the *UMPD*:

“United Behavioral Health (UBH) performs the review of requests for coverage of behavioral health services (i.e., substance abuse, and mental health requests for services). UBH provides comprehensive behavioral health care delivery for members

through a network of behavioral health practitioners, ancillary care providers, hospitals and other facilities.

For mental health, substance-related disorder services, and wraparound services, UBH uses its Clinical Criteria (see below), behavioral clinical policies, and best practice guidelines to make coverage determinations. UBH adopts externally-developed clinical criteria, and creates internally-developed Clinical Criteria, where appropriate, based on its assessment of relevant guidance. UBH develops clinical criteria that supersedes its standard set or adopts externally-developed clinical criteria when required to do so by contract or regulation.

- **Clinical Criteria (Level of Care Utilization System-LOCUS)** – Standardized level of care assessment tool developed by the American Association of Community Psychiatrists used to make clinical determinations and placement decisions for mental health disorder benefits for adults ages 19 and older when State or Contract Specific Level of Care Guidelines do not apply.
- **Clinical Criteria (Child and Adolescent Level of Care/Service Intensity Utilization System-CALOCUS-CASII)** - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry (AACAP) and the American Association for Community Psychiatry (AACP) used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children and adolescents ages 6-18 when State or Contract Specific Level of Care Guidelines do not apply.
- **Clinical Criteria (Early Childhood Service Intensity Instrument-ECSII)** - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children ages 0-5 when State or Contract Specific Level of Care Guidelines do not apply.
- **Clinical Criteria (State or Contract Specific Level of Care Guidelines)** - Criteria used to make medical necessity determinations for mental health disorder benefits when there are explicit mandates or contractual requirements.
- **Clinical Criteria (American Society of Addiction Medicine [ASAM])** - Criteria developed by the American Society of Addiction Medicine used to make clinical determinations for substance-related disorder benefits.
- **Clinical Criteria (Optum Developed)**
 - Optum Behavioral Clinical Policies: Criteria that stem from evaluation of new services or treatments or new applications of existing services or treatments and are used to make clinical determinations regarding proven or unproven services and treatments.

Licensed practitioners conduct all reviews with a focus on measurable outcome goals and objectives for treatment. A senior UBH Medical Director is responsible for directing and implementing behavioral health utilization management programs. A referral is sent to UBH when a member is identified as potentially benefiting from behavioral health services during a “medical event”.

The UBH UM Program is staffed by clinical, non-clinical and administrative personnel. All clinical denials or adverse decisions are made by board certified psychiatrists, or, if the health plans choose, by a panel of other appropriate health care service reviewers. If the health plan chooses to use a panel to make adverse decisions, the panel contains at least one physician who is board certified in psychiatry. When the health care service under review is a mental health or substance abuse service, the adverse decision is made by a licensed physician who is board certified in psychiatry. All potential clinical denials are referred to a physician who is board certified in psychiatry for final determination. An evaluation of the overall effectiveness of the Behavioral Health UM Program is conducted annually to determine how well resources have been deployed to improve UM activities and the clinical care and service provided to members.”

The Plan’s terms require services to be medically necessary for coverage.

List of M/S and MH/SUD Services Subject to NQTL

The M/S and MH/SUD OON outpatient services subject to concurrent review are below:

M/S:

- Cellular and gene therapy

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- Diabetes Services
- Durable Medical Equipment (DME) - over \$1000 (for certain codes)
- Home Health Care
- Hospice Care
- Therapeutic treatments - Outpatient

MH/SUD:

- Applied Behavior Analysis (ABA)
- Partial Hospitalization

Step 2 – Factors Used in the Design and Application of the NQTL

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

When Surest (Bind) plans first launched in 2016, the Plans were designed to offer a simpler and more transparent way for people to access the system. The Plan included coverage for services with the option to buy-up specific benefits based on member need.

In 2022, UnitedHealthcare acquired Surest (Bind) and agreed to adopt the existing list of services that had been identified to be subject to Concurrent Review. Clinical Appropriateness is presently the factor that is determinative in imposing the Concurrent Review limitation. At this time, the Plan is assessing the value of managing the services, the consistency of adherence to evidence-based guidelines, and volume of services utilized to further refine which OON outpatient services are subject to Concurrent Review.

The Plan relies on the following factor to determine which OON outpatient services are added to the list of services subject to Concurrent Review. This factor applies to M/S and MH/SUD for the following:

- I. M/S: OON outpatient services
 - II. MH/SUD: OON outpatient services
- Clinical Appropriateness (Qualitative)
 - Whether the application of Concurrent Review promotes optimal clinical outcomes

Applies to M/S and MH/SUD services..

Meeting Clinical Appropriateness is determinative in imposing the limitation.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below is the evidentiary standard and source used to define, trigger, and/or implicate the factor used to add services to the list of services subject to outpatient Concurrent Review. This evidentiary standard and source applies to benefits for the following:

- I. M/S: OON outpatient services
- II. MH/SUD: OON outpatient services

Factor – Clinical Appropriateness is defined as those outpatient services that are determined by internal medical experts to

be in accordance with objective, evidence-based clinical criteria, and nationally recognized guidelines.

- The Plan's evidentiary standards and sources that define and/or trigger the identification of the Clinical Appropriateness factor are:
 - Clinical criteria from nationally recognized third-party sources (e.g., InterQual or MCG for M/S services, and ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines for MH/SUD services)
 - Clinical Technology Assessment Committee (CTAC) and Medical Technology and Assessment Committee (MTAC) review
 - Objective, evidence-based medical/behavioral clinical policies, and nationally recognized guidelines approved by professional healthcare associations (e.g., clinical guidance from the American Medical Association, American Psychiatric Association, etc.)

The Plan's evidentiary standards and sources apply to M/S and MH/SUD services and are defined in a qualitative manner.

Meeting Clinical Appropriateness is determinative in imposing the limitation.

The factor and evidentiary standard used as the basis for subjecting MH/SUD OON outpatient benefits to Concurrent Review are comparable to, and applied no more stringently than, the factor and evidentiary standard used as the basis for subjecting M/S OON outpatient benefits to Concurrent Review "as written" and "in operation."

Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

As Written

The Plan conducted a comparative analysis of the strategies, processes, factor, evidentiary standard, and source information used to determine which M/S and MH/SUD OON outpatient services are subject to Concurrent Review and how Concurrent Review is applied to M/S and MH/SUD OON outpatient services “as written.” The Plan identified the factor and evidentiary standard used as the basis for subjecting M/S and MH/SUD OON outpatient benefits to Concurrent Review.

National internal committees apply the factor and standard described in Steps 2 and 3 to M/S and MH/SUD services when determining whether the services should be subjected to Concurrent Review.

Review of Factors and Evidentiary Standards

The Plan reviewed the factor that triggers an OON outpatient service to be added to the list of services subject to Concurrent Review. The factor and evidentiary standard were applied to M/S and MH/SUD services comparably and not more stringently to MH/SUD services than to M/S services.

Review of Operational Policies and Procedures

The Plan reviewed M/S and MH/SUD operational policies and procedures, IRR assessment processes, and UM annual oversight to confirm comparability and found MH/SUD policies, procedures, and processes to be comparable and no more stringent than M/S policies, procedures, and processes.

- Medical management operational policies and procedures establish the standards for how the Plan conducts outpatient Concurrent Review. The policies and procedures are consistent with state and federal law governing Concurrent Review. Timeframes for decisions, content of adverse benefit determinations, appeal rights and external

review are all governed by state and federal law.

- The IRR assessment measures the consistency with which clinical reviewers and peer clinical reviewers apply the Plan's clinical criteria. IRR assessment processes apply for both M/S and MH/SUD outpatient services.
- UM oversight monitors and evaluates UM processes by reviewing program outcomes, clinical appeals, IRR assessment, and under- and over-utilization.

Review of Outpatient Concurrent Review Processes

The strategy for applying Concurrent Review to OON outpatient services is comparable for M/S and MH/SUD services and is applied no more stringently to MH/SUD OON outpatient services. The Plan conducted a review of the M/S and MH/SUD Concurrent Review processes to confirm comparability. The review focused on the following aspects of the process for both M/S and MH/SUD:

- **Notification.** The member is responsible for ensuring the OON provider requests coverage for the continuation of the course of treatment and/or for additional units of outpatient services that exceed the periods of time or units of service previously approved by the Plan. The provider can submit the authorization request by telephone, or by fax (where required).
- **Timeframe to Submit.** Members and OON M/S and MH/SUD providers should notify the Plan as soon as reasonably possible.
- **Clinical Reviews.** For M/S and MH/SUD outpatient Concurrent Review requests, clinical reviewers may gather more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for certification, related diagnostic results, history of related treatment and services, and photographs. The clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. The clinical reviewer may approve cases that meet applicable clinical criteria.
- **Review Timeframes.** M/S and MH/SUD outpatient Concurrent Review determination timeframes are defined by state and federal requirements for both urgent and non-urgent outpatient services. The same determination timeframes apply to M/S and MH/SUD determinations.
- **Determinations and Nonclinical Reviews, First Level Clinical Reviews, and Second Level Clinical Reviews.** For M/S outpatient Concurrent Review, non-clinical staff may administratively deny cases when member benefits are exhausted. For M/S and MH/SUD non-clinical staff may approve cases that do not require clinical evaluation or interpretation. Non-clinical staff refer coverage requests that they cannot approve or administratively deny to clinical reviewers. Clinical reviewers consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether an outpatient service is medically necessary. The clinical reviewer may approve the services based on their review. The clinical reviewer refers cases to a peer clinical reviewer for a peer-to-peer discussion if the case cannot be approved. Only qualified peer clinical reviewers may issue adverse benefit determinations. Peer-to-peer discussions are offered, as required.
- **Adverse Benefit Determinations and Peer-to-Peer Conversations.** The Plan offers OON outpatient providers the opportunity to discuss a potential adverse benefit determination before the Plan issues such determination. This process allows OON outpatient providers the opportunity to provide additional information prior to an adverse benefit determination being issued.
 - OON outpatient M/S and MH/SUD services
 - An adverse benefit determination is recorded as a clinical denial when it is based on clinical criteria and member clinical information and is recorded as an administrative denial when member benefits are exhausted.
- **Notification of Decisions to Providers and Members.** The Plan notifies M/S and MH/SUD OON providers and members of approvals and adverse benefit determinations, including applicable appeal rights, consistent with state and federal requirements.
- **Review of Staff Qualifications.** For M/S and MH/SUD, clinical staff qualifications align with the type of clinical review and state and federal requirements.
 - M/S is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., nurses, physicians, etc.) and all adverse benefit determinations are made by a physician or other appropriate

health care professionals.

- MH/SUD is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse benefit determinations are made by Medical Directors or psychologists.
- Clinical Criteria. For M/S and MH/SUD, clinical reviewers and peer clinical reviewers base determinations on objective, evidence-based medical/behavioral clinical policies and use clinical criteria from third party sources such as InterQual, MCG, ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines.

In Operation

The Plan compared the strategies, processes, factor, evidentiary standard, and source information used to determine which M/S and MH/SUD OON outpatient services are subject to Concurrent Review and how Concurrent Review is applied “in operation.”

The Plan required members to ensure OON M/S and MH/SUD providers submit requests for coverage of additional units of outpatient services and/or extended period of time for OON outpatient services previously approved. M/S and MH/SUD provider requests for OON services triggered the outpatient Concurrent Review process.

M/S and MH/SUD outpatient Concurrent Reviews included confirmation of member eligibility and benefit availability for the requested services. For both M/S and MH/SUD OON outpatient services, non-clinical staff approved coverage for outpatient services that did not require clinical review or interpretation.

M/S and MH/SUD outpatient Concurrent Reviews that were not administratively approved in initial review were referred to a clinical reviewer for further research and evaluation. The M/S and MH/SUD clinical reviewers applied benefit plan documents and medical necessity criteria to member clinical information. M/S and MH/SUD clinical reviewers could request additional clinical information if they were unable to approve cases based on the available member clinical information. The clinical reviewers may approve services based on their review.

If the requested clinical information was not received or if the case could not be approved, M/S and MH/SUD clinical reviewers referred cases to a peer clinical reviewer. For OON MH/SUD outpatient cases, the Plan offered peer-to-peer conversations so the OON MH/SUD provider could provide additional clinical information prior to the issuance of an adverse benefit determination. Only qualified peer clinical reviewers issued both M/S and MH/SUD adverse benefit determinations.

The Plan communicated all adverse benefit determinations for M/S and MH/SUD outpatient cases that did not meet applicable clinical criteria consistent with state and federal requirements, including appeal rights, as applicable.

The Plan monitors M/S and MH/SUD clinical and peer clinical reviewers' application of clinical criteria through annual IRR assessments. The Plan also conducts monthly quality audits of individual non-clinical staff, clinical reviewers, and peer clinical reviewers, including staff performing appeal functions. The Plan routinely monitors Concurrent Review performance through its clinical performance oversight functions. In addition to comparing these “in operation” processes, the Plan reviewed medical necessity approval and denial rates, internal appeals outcomes, and external appeals outcomes related to Concurrent Review determinations for M/S and MH/SUD OON outpatient services. The results of these analyses are discussed in greater detail in Step 5.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan's or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

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The findings of the Plan's comparative analyses confirmed the strategies, processes, factor, evidentiary standard, and source information used to determine the MH/SUD OON outpatient services subject to Concurrent Review were comparable to, and applied no more stringently than, the strategies, processes, factor, evidentiary standard, and source information used to determine the M/S OON outpatient services subject to Concurrent Review "as written."

The Plan found the factor used to add outpatient services on the list of services subject to Concurrent Review was comparable to, and applied no more stringently than, the factor used to add M/S OON outpatient services on the list of services subject to Concurrent Review. OON M/S and MH/SUD outpatient services that met the applicable factor(s) were subject to Concurrent Review "in operation."

The Plan used comparable processes to conduct outpatient Concurrent Review of OON M/S and MH/SUD providers' requests for coverage of additional units of service or extended periods of time beyond those previously approved by the Plan. The Plan required M/S and MH/SUD OON providers to timely request coverage. The Plan used qualified staff to confirm member eligibility and benefit availability, and to request additional clinical information if necessary. The Plan issued approvals for M/S and MH/SUD outpatient services that met applicable clinical criteria or guidelines. Only qualified M/S and MH/SUD peer clinical reviewers issued adverse benefit determinations. The Plan gave OON MH/SUD providers the opportunity to discuss potential adverse benefit determinations with qualified peer clinical reviewers prior to issuing adverse benefit determinations. This afforded OON providers the opportunity to provide additional information.

The Plan operated monitoring and oversight programs to ensure that clinical reviewers and peer clinical reviewers rendered appropriate determinations. Both M/S and MH/SUD required clinical reviewers, including peer clinical reviewers, to successfully complete the annual IRR assessment. Clinical reviewers were required to pass the IRR assessment with a score of 90% or better to render UM decisions independently. 2023 IRR M/S and MH/SUD results are not available. The M/S and MH/SUD clinical reviewers' application of medical necessity criteria when making utilization review determinations will be assessed for comparability when the results are available.

OON outpatient medical necessity approval and denial rates and appeals outcomes data from 01/01/2022 – 12/31/2022 were evaluated where a minimum threshold of 100 cases were available to ensure a valid data set for analysis. The Plan has established that a minimum of at least 100 M/S and MH/SUD cases are required within each classification for a comparative analysis. Meaningful conclusions cannot be reached when there are fewer than 100 cases within each classification this is because the data is subject to variability.

Because Georgia Surest Plan became effective on 07/2023 there is minimal membership and as a result an insufficient number of cases from 01/01/2022 – 12/31/2022 to support an analysis. While the Plan notes that the U.S. Department of Labor has indicated generally that outcomes data are not dispositive of parity compliance, the Plan will conduct a comparative analysis of outcomes data, including medical necessity approval and denial rates and appeals outcomes, when there is a minimum of 100 cases available to ensure a valid data set for analysis.

Conclusions

The Plan reviewed the M/S and MH/SUD Concurrent Review operational policies and procedures and concluded the methodology used to determine which MH/SUD OON outpatient services are subject to Concurrent Review "as written" were comparable to, and applied no more stringently than, the methodology used to determine which M/S OON outpatient services are subject to Concurrent Review "as written." Additionally, the Plan concluded that how Concurrent Review is applied to MH/SUD OON outpatient services was comparable to, and applied no more stringently than, how Concurrent Review is applied to M/S OON outpatient services "as written."

The Plan reviewed the M/S and MH/SUD processes, including responsibility for submission, timeframes for submission and

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review, notification to members and providers, clinical standards for review, staff qualifications, and IRR assessment results and concluded how the Plan conducts Concurrent Review for MH/SUD OON outpatient services “in operation” was comparable to, and applied no more stringently than, how the Plan conducts Concurrent Review for M/S OON outpatient services “in operation.”

Overview

Pursuant to a federal law called the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical and surgical (M/S) benefits. This generally means that financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements, such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage.

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors considered in the design and application of the NQTL (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4). Findings and conclusions both “as written” and “in operation” are presented (Step 5).

Specific NQTL

Credentialing is performed to determine if a provider or facility meets standards to join (credential) or maintain (recredential) its status in the Plan’s network of participating providers. The Plan uses its credentialing and recredentialing processes to validate that its network of contracted providers and facilities providing inpatient, outpatient, and emergency services meet the baseline criteria, as applicable, to the state and practicing specialty. The Plan requires all providers/facilities to be credentialed.

The credentialing process is triggered by a provider or facility seeking to join or continue participation in the Plan’s network. Its purpose is to determine whether the provider or facility has the appropriate level of education/licensure/certification and satisfies additional qualifications (as applicable) to provide covered care to Plan members. The Plan uses credentialing processes and plans based on National Committee for Quality Assurance (NCQA) standards and applicable state or federal regulatory requirements when determining whether to credential M/S and MH/SUD providers or facilities.

This document includes the following information:

- Process for credentialing both M/S and MH/SUD providers and facilities
- Description of the NQTL and application (Step 1)
- Factors used to facilitate credentialing for both M/S and MH/SUD (Step 2)
- Evidentiary standards and sources used to define and/or trigger each of the identified factors (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

The analysis refers to the following attachments:

- *Certificate of Coverage – COC23-INS-BIND-2021-LG-GA-UHIC* – Plan document that explains covered services, terms, conditions, and limitations of the member’s policy

The Plan concludes that its methodologies for credentialing for M/S and MH/SUD providers and facilities are comparable and applied no more stringently for MH/SUD providers and facilities than for M/S providers and facilities both “as written” and “in operation.”

Process

For both M/S and MH/SUD, the Plan uses comparable credentialing processes.

For M/S, the *UnitedHealthcare (UHC) Credentialing Plan* defines Credential, Credentialing, or Recredentialing as “the process of assessing and validating the applicable criteria and qualifications of Licensed Independent Practitioners and Facilities to become or continue as Participating Licensed Individual Providers (PLIPs) and Participating Facilities, as set forth in the Credentialing Plan and pursuant to Credentialing Authorities.”

For MH/SUD, the *United Behavioral Health (UBH) Credentialing Plan* defines Credentialing or Recredentialing as “the process of assessing and validating the applicable criteria and qualifications of providers to become or continue as Participating Providers, as set forth in the Credentialing Plan.”

Key steps in the credentialing process for both M/S and MH/SUD include:

- The provider/facility submits a completed application to the Plan to be included in the Plan’s provider network
- The Plan confirms the information in the application
- If the provider/facility passes the credentialing requirements as outlined in the respective credentialing plan, the provider/facility is credentialed

Credentialing Plan

The purpose of the applicable credentialing plan is to explain the policy for credentialing. All providers/facilities included in the M/S and MH/SUD network are subject to the applicable credentialing plan. Providers/facilities that provide health care services to Covered Persons under their out-of-network benefits or on an emergency basis are not subject to the credentialing plans.

Credentialing Plan Approval

For M/S, the National Peer Review and Credentialing Policy Committee (NPRCPC) has the authority to approve the *UHC Credentialing Plan*. M/S has the right to change the *UHC Credentialing Plan* to meet regulatory requirements or other organizational or business needs with the Quality Oversight Committee approval. The *UHC Credentialing Plan* can be referenced on the website <https://www.uhcprovider.com/en/resource-library/Join-Our-Network.html> to access the regulatory and accreditation timeframes.

The NPRCPC is comprised of stakeholders from multiple UHC regions and meets regularly. The primary role of the NPRCPC is to ensure that the Regional Peer Review Committees (RPRCs) do not rely on an improper or discriminatory basis for making their decisions. The NPRCPC has the final decision-making authority on all disciplinary actions the RPRC recommends that affect restriction, suspension, or termination of participation status of physicians or health care professionals. In addition, this committee is responsible for review and approval of the *UHC Credentialing Plan* and interpretation of the *UHC Credentialing Plan* as needed. The NPRCPC, when authorized by applicable state or federal law, endeavors to conduct its activities in a manner that constitutes peer review.

For MH/SUD, the Plan delegates credentialing of behavioral health network providers to its affiliate UBH d/b/a Optum Behavioral Health (OBH). The Quality Improvement Committee (QIC) has oversight of the Credentialing Committee and delegates overall responsibility and authority to its standing Credentialing Committee for credentialing. The QIC also delegates to the Credentialing Committee the authority to administer the *UBH Credentialing Plan*. The Credentialing Committee is responsible for administering the *UBH Credentialing Plan* and reviewing and approving policies related to credentialing activities on behalf of OBH, subject to oversight by the QIC. The *UBH Credentialing Plan* can be referenced on the website <https://www.providerexpress.com/content/dam/ope-provexpr/us/pdfs/clinResourcesMain/guidelines/credPlans/credPlanUBH.pdf>.

The Credentialing Committee is multidisciplinary and must include at least two OBH Medical Directors. The committee is comprised of at a minimum two external participating clinicians. The committee must have at least seven voting members present to form a quorum. At least one representative of the quorum will be a Medical Director and two must be external clinicians. An OBH Medical Director chairs the Credentialing Committee; other OBH Medical Directors will serve as co-chairs and will chair the meeting in the absence of the chairperson. The Credentialing Committee meets at least monthly.

The OBH Credentialing Committee Chair has responsibility to see that the *UBH Credentialing Plan* and policies are administered fairly to all clinicians and organizational providers, to monitor the ongoing quality of clinician and organizational provider services, and to immediately restrict or terminate a participating clinician's or organizational provider's agreement.

Detailed Process for Credentialing

For M/S and MH/SUD, credentialing is a peer-review process designed to review certain information pertinent to the respective Credentialing Entity's decision whether to contract a provider or facility, either initially or on an ongoing basis. The process described in the credentialing plans will be initiated only after the Credentialing Entity makes a preliminary determination that it wishes to pursue contracting or re-contracting with the applicant.

The credentialing process begins when a provider/facility submits a completed application.

Application Verification

For M/S, staff will collect information to assess whether an applicant meets the minimum credentialing requirements for practice location, specialty, and any other business needs.

A Medical Director may approve initial credentialing or recredentialing applications determined to meet all credentialing criteria. If credentialing criteria are not met, the Medical Director forwards all documentation to the National Credentialing Committee (NCC) for determination. All completed applications are also forwarded to the NCC for determination.

The NCC will make credentialing decisions pursuant to the *UHC Credentialing Plan*. The NCC is comprised of PLIPs from the Credentialing Entities, UHC Medical Directors, and a designated Medical Director Chairperson unless a different committee composition is otherwise required by applicable credentialing authorities. The NCC has discretion to ask for missing information or to deny the application as incomplete. The NCC may request further information not covered by the application if necessary to make a determination. Upon receipt of a complete application, the NCC will render a decision in accordance with the timeframes as specified by the *UHC Credentialing Plan*.

Credentialing decisions are communicated to the applicant and the Plan. If an application is not accepted or participation is terminated, the non-acceptance or termination letter will include the reason(s) for the decision. The Plan permits appeals from adverse credentialing or sanctions monitoring decisions as required by the NCQA, the Center for Medicare and Medicaid Services (CMS), and other applicable state and federal regulatory authorities. Any appeal process related to the termination, suspension, or non-renewal of providers/facilities will be communicated to the affected provider/facility with the notice of termination, suspension, or non-renewal.

For MH/SUD, credentialing decisions and actions of OBH will be guided primarily by (a) consideration of each applicant's potential contribution to the objective of providing effective and efficient health care services to UBH's members, (b) UBH's need for clinicians and organizational providers within its service area, and (c) judging each applicant for credentialing and recredentialing without discrimination due to age, race, gender, color, religion, ethnic/national identity, ancestry, disability, marital status, covered veteran status, sexual orientation, status with respect to public assistance, blindness or partial blindness, handicap, physical or mental impairment, victims of domestic violence, types of patients seen, or any other characteristic protected under state, federal, or local law.

The Credentialing Committee is responsible for making credentialing decisions about inclusion of providers and facilities in the network. Applications that meet all the credentialing criteria and require no further review by the Credentialing Committee are

sent to the Medical Director for approval. Applications that require additional review are presented to the Credentialing Committee. In this instance the Credentialing Committee has the sole discretion to make a credentialing exception to the required criteria, such as network need. Decisions to make exceptions based on appropriate factors are done in compliance with state and federal regulations. The Credentialing Committee may also at its sole discretion and determination, make the decision to deny the application for network participation.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- Credentialing

Benefit Classification(s)

- Applies to all in-network (INN) M/S and MH/SUD providers and facilities providing covered services in the Inpatient, Outpatient, and Emergency Care classifications as described in the credentialing plans

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHIC)

Plan Terms

The Plan's credentialing process confirms public information about the professionals' and facilities' licenses and other credentials, but does not assure the quality of their services. These professionals and facilities are independent practitioners and entities that are solely responsible for the care they deliver.

List of M/S and MH/SUD Benefits Subject to NQTL

Applies to all INN M/S and MH/SUD providers and facilities providing covered services in the Inpatient, Outpatient, and Emergency Care classifications as described in the Credentialing Plan.

Step 2 – Factors Used in the Design and Application of the NQTLs

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

The Plan relies on the following factors to determine if a provider or facility meets standards to join (credential) or maintain (recredential) its status in the Plan's network of participating providers, determine credentialing for M/S and MH/SUD INN inpatient and outpatient services. These factors apply to both M/S and MH/SUD benefits in the following classifications:

- I. INN M/S providers and facilities providing covered services in the Inpatient, Outpatient, and Emergency classification
 - II. INN MH/SUD providers and facilities providing covered services in the Inpatient, Outpatient, and Emergency classification
- The provider or facility completes and attests to the accuracy of the content of the application (Qualitative)
 - Applies to both M/S and MH/SUD
 - The Plan verifies certain information (Qualitative)
 - Applies to both M/S and MH/SUD
 - The provider or facility continues to meet the applicable requirements (Qualitative)
 - Applies to both M/S and MH/SUD

The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factors used in credentialing. These evidentiary standards and sources apply to the following benefit classifications:

- I. INN M/S providers and facilities providing covered services in the Inpatient, Outpatient, and Emergency classification
- II. INN MH/SUD providers and facilities providing covered services in the Inpatient, Outpatient, and Emergency classification

Factor – Completed Application is defined as the provider or facility completes and attests to the accuracy of the content of the application.

- The Plan’s evidentiary standard and source that triggers and/or defines the identification of the factor:
 - Submission of application

This evidentiary standard and source applies to both M/S and MH/SUD INN providers and facilities providing covered services in the Inpatient, Outpatient, and Emergency Care classifications as described in the credentialing plans. This evidentiary standard and source is defined in a qualitative manner.

Factor – The Plan verifies certain information is defined as primary source verification in the application.

- The Plan’s evidentiary standard and source that triggers and/or defines the identification of the factor:
 - The UHC and UBH Credentialing Plans describe the information, i.e., primary source verification, which is required

This evidentiary standard and source applies to both M/S and MH/SUD INN providers and facilities providing covered services in the Inpatient, Outpatient, and Emergency Care classifications as described in the credentialing plans. This evidentiary standard and source is defined in a qualitative manner.

Factor – The provider or facility continues to meet the applicable requirements is defined as what is set forth in the credentialing plans while they are contracted with the Plan.

- The Plan’s evidentiary standards and sources that trigger and/or define the identification of the factor:
 - State and federal regulatory requirements
 - National accreditation standards, for example NCQA credentialing standards

These evidentiary standards and sources apply to both M/S and MH/SUD INN providers and facilities providing covered services in the Inpatient, Outpatient, and Emergency Care classifications as described in the credentialing plans. These evidentiary standards and sources are defined in a qualitative manner.

The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL.

Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

As Written

The Plan conducted a comparative analysis of the strategies, processes, factors, evidentiary standards, and source information used to determine if a provider or facility meets standards to join (credential) or maintain (recredential) their status in the Plan's network of participating providers for M/S and MH/SUD “as written.”

For M/S, the NCC is responsible for implementing the *UHC Credentialing Plan*. The NCC is comprised of PLIPs, UHC Medical Directors, and a designated Medical Director Chairperson, unless a different committee composition is otherwise required by applicable credentialing authorities. The NCC makes the credentialing decision and informs providers within applicable state or federally mandated timeframes.

For MH/SUD, the Plan delegates credentialing of behavioral health network providers to its affiliate OBH.

The OBH Credentialing Committee is responsible for implementing its *UBH Credentialing Plan*. The OBH Credentialing Committee is multi-disciplinary and must have at least two Optum Medical Directors as members. At least two of the 12 members must be external participating clinicians from each major discipline (i.e., MD, PhD, and MSW). The OBH Credentialing Committee informs providers of credentialing decisions within applicable state or federally mandated timeframes.

The M/S and MH/SUD credentialing committees have similar composition, in that they both include licensed providers with expertise in the relevant disciplines as well as Medical Directors. They also both follow applicable state or federal regulations for response timeframes. In addition, the *UHC* and *UBH Credentialing Plans* are both accredited by NCQA and are reviewed annually.

At times, UHC and OBH may delegate credentialing to third parties. The Plan performs oversight of delegated credentialing as outlined in the *UHC* and *UBH Credentialing Plans*.

The Plan conducted a comparative analysis of the application criteria and required documentation for both M/S and MH/SUD providers.

Crosswalk of M/S and MH/SUD Credentialing Application and Required Documentation	
Professional	
M/S credentialing application requirements (<i>UHC Credentialing Plan</i> , uhcprovider.com/content/dam/provider/docs/public/resources/join-network/Credentialing-Plan.pdf , page 22, Attachment A, 11)	MH/SUD credentialing application requirements (<i>UBH Credentialing Plan</i> , providerexpress.com/content/dam/opeprovexpr/us/pdfs/clinResourcesMain/guidelines/credPlans/credPIanUBH.pdf , page 5-6, sections 4.1)
Licensed Individual Providers (LIP) application credentialing criteria: A release granting the Credentialing Entity permission to review the records of and to contact any professional society, hospital, insurance company, present or past employer, professional peer, clinical instructor, or other	A current and signed attestation/release by the Clinician granting UBH unlimited permission to review records of and to contact any professional society, hospital, insurance carrier, employer, entity, institution or organization that has or may have records/information concerning the Applicant.

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person, entity, institution, or organization that does or may have records or professional information about the Applicant.	
A listing of degrees or certifications received from appropriate professional schools, residency training programs, or other specialty training programs appropriate for the type of participation sought, if applicable. May not be required at the time of recredentialing unless it has changed and will impact the LIP's specialty.	A complete list of all professional education/training completed.
Hospital admitting privileges, or coverage arrangements.	For physicians: hospital admitting privileges or a process for providing inpatient care for members in need of a higher level of care, (signed attestation form may be used).
Applicant's current professional liability insurance policy, including the name of insurer, policy number, expiration date, and coverage limits; (Note: M/S standard liability is \$1million/\$3million or an amount or type as otherwise specified by applicable state law)	Professional liability malpractice insurance with liability limits of \$1/\$3 million for physicians and \$1/\$1 million for non-physician Clinicians, or in an amount or type as otherwise specified by applicable state law. This can include evidence of participation in state patient compensation or catastrophic loss funds, if applicable.
Limitations on ability to perform functions of the position with or without accommodation;	Reasons for any inability to perform the essential functions of the position, with or without accommodation.
History of loss or limitation of privileges or disciplinary activity;	Disclosure of any and all loss or limitation of professional privileges or disciplinary activity.
Absence of current, illegal drug use;	Presence of illegal drug use.
History of loss of license and felony convictions;	Disclosure of any and all loss of professional license(s). Disclosure of any and all felony convictions.
Completeness and accuracy of the information provided in the Application.	A signed attestation regarding the correctness and completeness of the application.
(Page 9, section 4.2) Affirmative responses to Disclosure Questions on the Credentialing Application. Applicant is required to provide details on all affirmative responses to Disclosure Questions on the Credentialing Application, which may be reviewed by a Medical Director, and at the discretion of the Medical Director, may be reviewed by Credentialing Committee for a determination of LIP's acceptance into Credentialing Entity's Network.	Completed disclosure statements including questions on license disciplinary actions; criminal felony convictions or civil judgments that involved dishonesty, fraud, deceit or misrepresentation; disciplinary actions by any federal programs; any other disciplinary actions or restrictions; and responses to applicable "Yes" answers
M/ S Required Documentation (Pages 7-9, section 4.2 unless noted otherwise)	MH/ SUD Required Documentation (Pages 5-6, sections 4.1)
Insurance or State-approved alternative. The Applicant must maintain errors and omissions (malpractice) insurance through insurers licensed in their State, or show similar financial commitments made through an appropriate State approved alternative, in the minimum amounts required by UnitedHealth Group's Provider Guidelines. The Credentialing Entity may require a copy of the Applicant's current Certificate of Coverage or may allow the Applicant's attestation to current, adequate insurance of State-approved alternative. The pertinent Participation Agreement may require coverage that	Professional liability malpractice insurance with liability limits of \$1/\$3 million for physicians and \$1/\$1 million for non-physician Clinicians, or in an amount or type as otherwise specified by applicable state law. This can include evidence of participation in state patient compensation or catastrophic loss funds, if applicable.

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exceeds the minimum established by this Credentialing Plan.	
Work History. The Credentialing Entity will obtain a five-year work history. Gaps longer than six months must be explained by the LIP and found acceptable by the Credentialing Committee.	List of five-year work history including month and year, on application or copy of resume/CV, complete explanations for gaps in work history of six months or more.
A copy of the Applicant's current Drug Enforcement Agency ("DEA") or Controlled Dangerous Substance ("CDS") Certificate in each state where the Applicant intends to practice, if applicable.	For prescribers: a current copy of the DEA and/or CDS certificate (where required by state), if applicable; in each state where the physician or prescribing Clinician practices.
M/S does not require, MH/SUD only requests "if applicable."	Copy of Educational Commission for Foreign Medical Graduates (ECFMG) certificate, if applicable.
(Page 22, Attachment A) Any other documents or information that the Credentialing Entity determines are necessary for it to effectively and/or efficiently review the Applicants' qualifications.	Any other documents required by state regulations or client requirement.
(Page 8, Section 4.2) Medicare/Medicaid Sanctions Review and Medicare Opt Out Eligibility. Regardless of the contracted line of business, for example, Medicare, Medicaid or Commercial the Applicant must not be ineligible, excluded, debarred or precluded from participation in the Medicare and/or Medicaid and related state and federal programs, or terminated for cause from Medicare or any state's Medicaid or Children's Health Insurance Program (CHIP) program and must be without any sanctions levied by the Office of Inspector General (OIG), the CMS Preclusion List or other disciplinary action by any federal or state entities identified by CMS. Credentialing Entity will, at a minimum, verify reported information from the Office of Inspector General (OIG), the CMS Preclusion list and Medicare Opt Out.	Proof of participation and meeting CMS Medicare and Medicaid requirements.
Crosswalk of M/S and MH/SUD Credentialing Application Facility/ Organizational Providers	
M/ S credentialing application requirements (UHC Credentialing Plan, uhcprovider.com/content/dam/provider/docs/public/resources/join-network/Credentialing-Plan.pdf, page 12, Section 7)	MH/ SUD credentialing application requirements (UBH Credentialing Plan, providerexpress.com/content/dam/opeprovexpr/us/pdfs/clinResourcesMain/guidelines/credPlans/credPlanUBH.pdf, page 12, sections 6.0)
Current required license(s)	Current, applicable and required state license(s) showing the Organizational Provider is in good standing with state and federal regulatory bodies.
Insurance. The Applicant must maintain general/comprehensive liability insurance as well as errors and omissions (malpractice) insurance for at least the "per occurrence" and aggregate limits established by UnitedHealth Group's Provider Guidelines with an insurer licensed to provide medical malpractice insurance in the Applicant's State of practice, or show similar financial commitments made through an appropriate State	Maintains professional and general liability insurance (malpractice) of \$5 million/occurrence and \$5 million/aggregate for inpatient mental health and/or inpatient rehabilitation substance abuse disorder services and \$1 million/occurrence and \$3 million/aggregate for all other levels of mental health and/or substance use disorder services. UBH does accept umbrellas policy amounts to supplement professional and general liability insurance coverage. All limit requirements listed above are waived,

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<p>approved alternative, as determined by the Credentialing Entity. The pertinent Participation Agreement may require coverage that exceeds the minimum established by this Credentialing Plan</p> <p>(Note: M/S standard liability is \$1million/\$3million or an amount or type as otherwise specified by applicable state law)</p>	<p>if an Organizational Provider is covered under a Federal, State, County, or Municipal policy/law.</p>
<p>Medicare/Medicaid Sanctions Review. Regardless of the contracted line of business, for example, Medicare, Medicaid or Commercial, the Applicant must not be ineligible, excluded or debarred from participation in the Medicare and/or Medicaid and related State and Federal programs, or terminated for cause from Medicare or any state's Medicaid or CHIP program and must be without any sanctions levied by the Office of Inspector General (OIG), the General Services Administration (GSA) and the CMS Preclusion list or other disciplinary action by any Federal or State entities identified by CMS. Exceptions to this requirement may only be granted when there are issues of network adequacy and an OIG waiver has been granted.</p>	<p>Medicare/Medicaid Sanctions Review. Regardless of the contracted line of business (Medicare, Medicaid, or Commercial), the Applicant must not be ineligible, excluded, debarred, or precluded from participation in Medicare and/or Medicaid and related state and federal programs, or terminated for cause from Medicare or any state's Medicaid or CHIP program and must be without any sanctions levied by the Office of Inspector General (OIG), the General Services Administration Systems for Awards Management (SAM), and the CMS Preclusion list or other disciplinary action by any federal or state entities identified by CMS.</p>
<p>Appropriate Accreditation or Satisfactory Alternative. The Credentialing Entity must obtain a copy of the accreditation report or evidence from the Accrediting Body.</p> <p>If the Applicant is not accredited or does not hold alternative certification by an agency recognized by the Credentialing Entity in Attachment C, a site visit of the organization is required and results must be found to be satisfactory as defined by the Credentialing Entity in Attachment D.</p> <p>In lieu of a site visit by the Credentialing Entity, a CMS or State quality review may be used if it is not more than three years old. The organization must provide evidence in the form of a final report or letter from CMS or the State, stating that it has been reviewed and passed inspection.</p>	<p>Current, valid accreditation from an agency recognized by UBH in Attachment A. UBH will conduct primary source verification for all accreditations.</p> <p>If an Organizational Provider is not accredited or certified by an agency recognized by UBH, a site review is required, and the Organizational Provider must achieve a site visit score of 80% or higher. If, during the initial credentialing process, the Organizational Provider does not meet the scoring criteria, UBH will notify the Organizational Provider that they do not meet current standards, provide feedback on the deficiencies and inform the Organizational Provider that they may reapply after six (6) months, at which time a re-audit will be required before the initial credentialing process can commence.</p> <p>In lieu of a site visit by UBH, the Organizational Provider must have been reviewed or received certification by CMS or State Licensing Agency within the past three (3) years. UBH has determined that CMS requirements for Organizational Providers fully meet UBH Organizational Provider site requirements. UBH obtains a copy of the CMS or State Licensing Agency's report from the Organizational Provider</p>

The results of the comparative analysis of the credentialing application and documentation requirements confirms that M/S and MH/SUD have comparable requirements for credentialing providers and facilities.

Credentialing Program Non-Quantitative Treatment Limitation (NQTL) Analysis

GA Surest - UnitedHealthcare Insurance Company

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In Operation

Both M/S and MH/SUD use the credentialing and recredentialing process to ensure their network of contracted providers have the appropriate qualifications to provide care to Plan members according to the *UHC* and *UBH Credentialing Plans*.

A comparative analysis of the number of credentialing applications received, denied, credentialed, and cancelled for organizations and clinicians was conducted in 2022 for both M/S and MH/SUD) as shown in the chart below. [The credentialing application approval rates do not reflect any material differences in the credentialing process.]

GA Credentialing Data - CY2022				
Organization Applications	Med/Surg	%	MH/SUD	%
Received	105		18	
Cancelled Applications*	0		2	
Applications Reviewed	105	100%	16	100%
Denied	14	13.33%	0	0.00%
Credentialed	91	86.67%	16	100.00%
Clinician Applications	Med/Surg	%	MH/SUD	%
Received	1,594		773	
Cancelled Applications*	8		12	
Applications Reviewed	1,586	100%	761	100%
Denied	105	6.62%	1	0.13%
Credentialed	1,481	93.38%	760	99.87%

* Cancelled applications include the following:

- Not eligible to apply
- Incomplete
- Nonresponse
- Withdrawn
- Already Par

Additionally, the Plan compared the average time it takes to complete the initial credentialing for both providers and facilities. This time is calculated from date of receipt of a completed credentialing application to date of committee decision for providers/facilities that pass. The 2022 average number of days to complete initial credentialing are provided below:

2022 Measurement	M/S	MH/SUD
Number of Days for initial Provider Credentialing	13.65	11.2
Number of Days for initial Facility Credentialing	5.73	5.9

The results of the comparison of the average time to complete the initial credentialing process confirms that both M/S and MH/SUD are meeting applicable state/federal requirements.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The above analysis confirmed the strategies, processes, factors, evidentiary standards, and source information used to determine if an MH/SUD provider or facility meets credentialing or recredentialing standards were comparable to, and applied

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under public records or other applicable laws.

Credentialing Program Non-Quantitative Treatment Limitation (NQTL) Analysis

GA Surest - UnitedHealthcare Insurance Company

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no more stringently than, the strategies, processes, factors, evidentiary standards, and source information used to determine if an M/S provider or facility meets credentialing or recredentialing standards, both “as written” and “in operation.” The Plan identified the factors and evidentiary standards used to determine if a provider or facility meets credentialing standards apply to both M/S and MH/SUD.

The findings of the parity analysis revealed the *UBH Credentialing Plan* for MH/SUD network providers was comparable to, and applied no more stringently than, the *UHC Credentialing Plan* for M/S network providers. The parity analysis also revealed that credentialing application requirements for MH/SUD network providers are comparable to, and applied no more stringently than, the application requirements for M/S network providers.

In addition, the findings revealed there were [no significant disparate credentialing outcomes for MH/SUD providers as compared to M/S providers.]

Lastly, the amount of time it takes to complete initial credentialing for both M/S and MH/SUD providers and facilities was comparable and both M/S and MH/SUD meet applicable state and federal requirements.

Conclusions

In light of the above findings, the Plan concludes that the credentialing requirements for M/S and MH/SUD providers and facilities are comparable and applied no more stringently for MH/SUD than for M/S, both “as written” and “in operation.”

Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical/surgical (M/S) benefits. This generally means that the financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements such as, deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs, which may limit the scope or duration of benefits for treatment under a plan or coverage.

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

The Plan excludes coverage of technologies (e.g., services, interventions, devices, medically administered M/S and MH/SUD drugs, etc.) determined to be experimental, investigational, or unproven (EIU) for specific diagnoses based on medical/behavioral clinical policies and Plan documents. The Plan develops evidence-based medical/behavioral clinical policies for select M/S and MH/SUD technologies. The medical/behavioral clinical policies may identify specific technologies that are categorically considered EIU or that are considered EIU under certain circumstances.

This document includes the following information:

- Process for determining if a technology is EIU for both M/S and MH/SUD technologies
- Description of the NQTL and application (Step 1)
- Factors used to determine which technologies are subject to the NQTL (Step 2)
- Evidentiary standards and sources used to define, trigger and/or implicate a factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

This analysis refers to the following attachments:

- *2023 UnitedHealthcare Provider Administrative Guide* - Informs providers of the EIU limitation. The *UnitedHealthcare Provider Administrative Guide* can be accessed on the website <https://www.uhcprovider.com/en/admin-guides.html>
- September 2023, *Optum National Network Manual* - Informs providers of the EIU limitation. The *Optum National Network Manual* can be accessed on the website <https://public.providerexpress.com/content/open-provexpr/us/en/clinical-resources/guidelines-policies/optum-network-manual.html>
- *Certificates of Coverage* - COC23-INS-BIND-2021-LG-GA-UHIC - Plan document that explains covered services, terms, conditions, and limitations of the member’s policy
- *Schedule of Benefits* - SBN23-Medical-INS-BIND-2021-Choice Plus-LG-GA-UHIC - Plan document that outlines member responsibilities
- M/S medical clinical policies are publicly available: [Medical & Drug Policies and Coverage Determination Guidelines for UnitedHealthcare Commercial Plans | UHCprovider.com](https://www.uhcprovider.com/en/clinical-resources/guidelines-policies/medical-drug-policies-and-coverage-determination-guidelines-for-unitedhealthcare-commercial-plans)

- MH/SUD behavioral clinical policies are publicly available: [Guidelines/Policies/Manuals \(providerexpress.com\)](#)
- *UnitedHealthcare (UHC) Hierarchy of Clinical Evidence* – M/S policy that defines the order of clinical evidence to ensure a transparent and consistent approach within UnitedHealthcare
- *Behavioral Health Hierarchy of Clinical Evidence* – MH/SUD policy that defines the order of clinical evidence to ensure a transparent and consistent approach to the review and development of Optum's Clinical Technology Assessments and Behavioral Clinical Policies
- *Clinical Technology Assessment Committee (CTAC) Charter* – document that outlines the purpose, structure, responsibility and membership of the committee that develops internal medical criteria and reviews and approves externally developed criteria for MH/SUD
- *Clinical Quality and Operations Committee (CQOC) Charter* – document that outlines the purpose, structure, responsibility, and membership of the committee that oversees CTAC
- *Utilization Management Program Committee Charter* – document that outlines the purpose, responsibility, functions, and composition of the committee that oversees the M/S utilization management program
- *Applying Benefit Plan and Review Criteria* Standard Operating Procedure - outlines the hierarchy of authorities to be reviewed (i.e., state/federal laws and regulations followed by Benefit Plan criteria) when making coverage determinations
- *Utilization Management Program Description (UMPD) of United HealthCare Services, Inc. and UnitedHealthcare Insurance Company* – M/S summarizes the philosophy, structure and standards that govern UHC's medical management, utilization management (UM) and utilization review responsibilities and functions
- *Clinical Review Criteria Operational Policy* - The purpose of this operational policy is to document that UHC will use evidence-based clinical review criteria to support clinical review decisions for UM programs, and to ensure that the clinical review process is applied consistently
- *Clinical Criteria Development Selection and Application Policy* - addresses Optum's selection, development, and use of clinical criteria in making benefit determinations
- *UnitedHealthcare Commercial Omnibus Codes* – M/S policy that outlines technologies that are considered EIU

The Plan concludes that the methodologies used to determine whether a M/S or MH/SUD technology is EIU are comparable and applied no more stringently to MH/SUD technologies for all benefit classifications, both “as written” and “in operation.”

Process

The Plan uses the following standard process to determine whether a technology is EIU:

The Plan uses committees to assess technologies and conduct a thorough review of the scientifically based clinical evidence and peer-reviewed literature in accordance with the *Hierarchies of Clinical Evidence* to develop medical/behavioral clinical policies that apply to the technologies.

For both M/S and MH/SUD, reviews for potential or identified EIU technologies are triggered either by a request from a member or provider pre-service (i.e., Prior Authorization) or by coding edits in the claims system (i.e., Retrospective Review) that are derived from the medical policies.

For M/S, the Medical Technology Assessment Committee (MTAC) is responsible for developing and maintaining evidence-based medical clinical policies. MTAC uses scientifically based clinical evidence and the *UHC Hierarchy of Clinical Evidence* in its development, assessment, and approval processes. MTAC conducts its processes in a timely manner to ensure transparency and consistency, and to identify safe and effective M/S technologies for members.

MTAC members include medical directors with diverse medical and surgical specialties and sub-specialties, representatives from

business segments, legal services, consumer affairs, medical policy development and operations teams, and benefit interpretation team. MTAC voting members include medical directors with the following specialties (note that some doctors have multiple specialties):

- Plastic Surgery
- Internal Medicine (x7)
- Medical Oncology
- Thoracic and Cardiothoracic Vascular Surgery (x2)
- Preventative Medicine
- Pediatrics
- Diagnostic Radiology and Vascular/Interventional Radiology
- Ophthalmology
- Physical Medicine & Rehabilitation Pain Medicine
- Family Practice
- Emergency Medicine

When assessing the safety and efficacy of technologies used to treat M/S conditions, MTAC first looks for any strong and compelling scientific evidence such as statistically robust, well-designed, randomized, controlled trials, and cohort studies. In addition, MTAC will look for multi-site observational studies and single site observational studies.

In the absence of any strong and compelling scientific evidence, MTAC assesses technologies by looking at any national consensus statements and/or publications by recognized authorities such as clinical position papers published by professional specialty societies and Center for Medicare and Medicaid Services (CMS) National Coverage Determinations (NCDs).

MTAC will not deem a technology unproven solely based on a lack of randomized controlled trials, particularly for new and emerging technologies.

As of April 1, 2023, the Utilization Management Program Committee (UMPC) began overseeing the M/S UM program. The UMPC is responsible for the development and maintenance of the M/S Prior Authorization, Concurrent Review, and Retrospective Review processes. The UMPC ensures that the UM program considers the factors and evidentiary standards for applying UM. The UMPC is comprised of:

- Chief Medical Officer, Medical Management (Co-Chair)
- Senior Vice President, Clinical Advancement (Co-Chair)
- Chief Medical Officer, UnitedHealthcare
- Senior Vice President, Clinical Appeals & Grievances
- Chief Medical Officer, Clinical Policy
- Chief Medical Officer, UnitedHealthcare Employer & Individual
- Chief Medical Officer, UnitedHealthcare Medicare & Retirement
- Chief Medical Officer, Community & State
- Chief Medical Officer, UnitedHealthcare Individual & Family Plans
- Vice President, Clinical Transformation & Affordability
- Senior Director, Mental Health Parity
- Vice President, Utilization Management Strategy & Implementation

One of the chairs must be an executive leader and a licensed physician. UMPC meets at least six times per year but may meet more frequently if needed. MTAC reports to the UMPC.

The Plan delegates UM of MH/SUD services to United Behavioral Health d/b/a OBH, its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor.

For MH/SUD, the Clinical Technology Assessment Committee (CTAC) is responsible for reviewing new or evolving technologies and then developing and maintaining evidence-based behavioral clinical policies for behavioral health technologies. CTAC uses scientifically based clinical evidence and the *Behavioral Health Hierarchy of Clinical Evidence* in its development, assessment, and approval processes. CTAC conducts its processes in a timely manner to ensure transparency and consistency, and to identify safe and effective MH/SUD technologies for members.

CTAC members include behavioral health medical directors, senior leaders of clinical operations, research and development, clinical review, legal, compliance, and policy. CTAC voting members include six psychiatrists and one licensed independent social worker (LISW), plus two co-chairs, both of whom are psychiatrists.

When assessing the safety and efficacy of technologies used to treat MH/SUD conditions, CTAC first looks for any strong and compelling scientific evidence such as statistically robust, well-designed, randomized, controlled trials, and cohort studies. CTAC will also look for systematic reviews and meta-analyses, large prospective trials, cross-sectional studies, retrospective studies, surveillance studies, case reviews/case series, anecdotal/editorial statements, or professional opinions.

In the absence of any strong and compelling scientific evidence, CTAC assesses technologies by looking at any national consensus statements and/or publications by recognized authorities such as clinical position papers published by professional specialty societies and CMS NCDs.

CTAC will not deem a technology unproven solely based on a lack of randomized controlled trials, particularly for new and emerging technologies.

CTAC obtains approval from the Clinical Quality and Operations Committee (CQOC). The CQOC is comprised of representatives from sub-committees and representatives from the clinical quality improvement, UM, care engagement, medical operations, medical policy and standards, clinical operations, appeals, product, legal, compliance, network strategy, provider experience, accreditation, and benefits teams. The Chair of the CQOC must be an executive leader board, certified in psychiatry or psychiatric subspecialty, and licensed physician.

M/S and MH/SUD technologies assessed by the MTAC and CTAC committees as not being safe, clinically effective, and/or appropriate are determined to be EIU. Once a technology has been assessed, a medical/behavioral clinical policy is developed which outlines the applicable committee's findings. This includes a summary of the clinical evidence and the identification of specific technologies or uses of technologies considered to be EIU. All medical/behavioral clinical policies are reviewed and/or updated at least once annually.

M/S and MH/SUD medical/behavioral clinical policies are publicly available.

- M/S medical clinical policies: [Medical & Drug Policies and Coverage Determination Guidelines for UnitedHealthcare Commercial Plans | UHCprovider.com](#)
- MH/SUD behavioral clinical policies: [Guidelines/Policies/Manuals \(providerexpress.com\)](#)

For M/S and MH/SUD conditions, the Plan does not cover technologies determined to be EIU. There may be unspecified M/S and MH/SUD diagnoses for which there are no proven treatments. The Plan does not deny emergency services as EIU, including those submitted with an unspecified diagnosis. The M/S *Clinical Review Criteria Operational Policy* and MH/SUD *Clinical Criteria Development/Selection and Application* policy outline the processes that ensure clinical policies are developed consistently.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- EIU: The Plan excludes coverage of technologies determined to be EIU for specific diagnoses based on medical/behavioral clinical policies and Plan documents. The Plan develops evidence-based medical/behavioral clinical policies for select M/S and MH/SUD technologies (e.g., services, interventions, devices, medically administered M/S and MH/SUD drugs, etc.). The medical/behavioral clinical policies may identify specific technologies that are categorically considered EIU or that are considered unproven under certain circumstances

Benefit Classification(s)

- In-network (INN) inpatient, out-of-network (OON) inpatient, INN outpatient, and OON outpatient

Plan(s) at Issue

- UnitedHealthcare Insurance Company

Plan Terms/Source Document(s)

The Plan's *Certificate of Coverage*, defines EIU as:

- “Experimental or Investigational Service(s) – medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications, or devices that, at the time we make a determination regarding coverage in a particular case, are determined to be any of the following:
 - Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified as appropriate for proposed use in any of the following:
 - *AHFS Drug Information (AHFS DI)* under therapeutic uses section;
 - *Elsevier Gold Standard's Clinical Pharmacology* under the indications section;
 - *DRUGDEX System by Micromedex* under the therapeutic uses section and has a strength recommendation rating of class I, class IIa, or class IIb; or
 - *National Comprehensive Cancer Network (NCCN)* drugs and biologics compendium category of evidence 1, 2A, or 2B.
 - Subject to review and approval by any institutional review board for the proposed use. (Devices which are FDA approved under the Humanitarian Use Device exemption are not Experimental or Investigational.)
 - The subject of an ongoing clinical trial that meets the definition of a Phase I, II or III clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.
 - Only obtainable, with regard to outcomes for the given indication, within research settings.

Exceptions:

- Clinical trials for which Benefits are available as described under Clinical Trials in Section 1: Covered Health Care Services.
- We may, as we determine, consider an otherwise Experimental or Investigational Service to be a Covered Health Care Service for that Sickness or condition if:
 - You are not a participant in a qualifying clinical trial, as described under Clinical Trials in Section 1: Covered Health Care Services and
 - You have a Sickness or condition that is likely to cause death within one year of the request for treatment.

Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that Sickness or condition.”

- “Unproven Service(s) - services, including medications and devices, regardless of U.S. Food and Drug Administration (FDA) approval, that are not determined to be effective for treatment of the medical condition or not determined to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.
 - Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
 - Well-conducted cohort studies from more than one institution. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

We have a process by which we compile and review clinical evidence with respect to certain health care services. From time to time, we issue medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. [\[You can view these policies at **benefits.surest.com**.\]](#)

Please note:

- If you have a Life-Threatening Illness or condition (one that is likely to cause death within one year of the request for treatment) we may, as we determine, consider an otherwise Unproven Service to be a Covered Health Care Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that Sickness or condition.”

List of M/S and MH/SUD Technologies Subject to NQTL

For M/S and MH/SUD this NQTL applies to all INN inpatient, OON inpatient, INN outpatient, and OON outpatient technologies determined to be EIU

- Plan documents provide that technologies considered EIU are excluded from coverage
- Additionally, for both M/S and MH/SUD, certain medical policies identify technologies that have been determined to be EIU, while other medical policies exclude coverage of technologies for some, but not all, conditions based on EIU status
- M/S maintains a medical clinical policy which identifies the codes that have been determined to be EIU (see *Omnibus Policy*)
- Additionally, other technologies may be determined to be EIU for certain medical conditions. These are identified in the applicable medical clinical policies. M/S medical clinical policies are publicly available: [Medical & Drug Policies and Coverage Determination Guidelines for UnitedHealthcare Commercial Plans | UHCprovider.com](#)
- MH/SUD behavioral clinical policies are publicly available: [Guidelines/Policies/Manuals \(providerexpress.com\)](#)
- The following MH/SUD behavioral clinical policies address technologies that are fully denied because they have been deemed to be EIU:
 - *Complementary and Alternative Medicine (CAM) Treatments For Behavioral And Substance Use Disorders*
 - *Computer Based Treatment for Cognitive Behavioral Therapy (CBTCBT) for Substance Use Disorders*
 - *Cranial Electrotherapy Stimulation*
 - *Neurofeedback For Behavioral And Substance Use Disorders*
 - *Wilderness Therapy*
- The following MH/SUD policies address technologies that are partially denied as they have been deemed to be EIU in certain scenarios which are outlined in the policies:
 - *Applied Behavior Analysis (ABA)*
 - *Transcranial Magnetic Stimulation*

Step 2 – Factors Used to Determine if a Technology is Experimental, Investigational or Unproven

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

The Plan relies on the following factor to determine whether technologies are EIU for M/S and MH/SUD. This factor applies to M/S and MH/SUD benefits for the following:

- I. All M/S INN inpatient, OON inpatient, INN outpatient, and OON outpatient technologies subject to UM
 - II. All MH/SUD INN inpatient, OON inpatient, INN outpatient, and OON outpatient technologies subject to UM
- M/S and MH/SUD Committee Considerations (Qualitative) including clinical efficacy, safety, appropriateness of the proposed technology, and whether the technology is an unproven treatment for a specific diagnosis

The factor applies to M/S and MH/SUD technologies.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factor used in determining whether a MH/SUD or M/S technology is EIU. These evidentiary standards apply to the following:

- I. All M/S INN inpatient, OON inpatient, INN outpatient, and OON outpatient technologies subject to UM
- II. All MH/SUD INN inpatient, OON inpatient, INN outpatient, and OON outpatient technologies subject to UM

Factor – M/S and MH/SUD Committee Considerations, including clinical efficacy, safety, appropriateness of the proposed technology, and whether the technology is an unproven treatment for a specific diagnosis

- Clinical Effectiveness – A characteristic of care that is in accordance with objective, evidence-based clinical criteria, and nationally recognized guidelines as determined by internal medical experts. Clinically appropriate care is more likely to be effective
- Safety of Technologies - A state in which hazards and conditions leading to physical or psychological harm are minimized to preserve the health and wellbeing of a person receiving health care
- Appropriateness of the Proposed Technology - The technology is suitable for the member's clinical presentation and the expected health benefits from the medical service are clinically significant and exceed the expected natural history of recovery and the expected health risks by a sufficient margin
- Unproven Treatment for Specific Diagnosis – the technology is only proven for certain diagnoses

The Plan's evidentiary standards and sources that trigger and/or define the M/S and MH/SUD Committee Considerations factor:

- The Plan uses scientifically based clinical evidence and the *UHC* and *Behavioral Health Hierarchies of Clinical Evidence* to determine which M/S and MH/SUD technologies are safe and effective and, therefore, eligible for benefit coverage. The *UHC* and *Behavioral Health Hierarchies of Clinical Evidence* detail the order of clinical evidence that is used to determine which health technologies are safe and effective. To be deemed safe and effective, a health technology does not need to have evidence in every category

- M/S assesses the following categories of evidence when determining whether a technology is EIU:
 - Scientifically based clinical evidence
 - Peer-reviewed literature
 - *UHC Hierarchy of Clinical Evidence*
 - In the absence of strong and compelling scientific evidence, medical policies may be based upon:
 - National guidelines and consensus statements
 - CMS NCD
 - Clinical position papers based upon rigorous review of scientific evidence or clinical registry data from professional specialty societies when their statements are based upon referenced clinical evidence, e.g., American College of Physicians (ACP), The Society for Post-Acute and Long-Term Care Medicine (AMDA), American Academy of Family Physicians (AAFP), American College of Obstetricians and Gynecologists (ACOG), American College of Cardiology (ACC), etc.
- MH/SUD assesses the following categories of evidence when determining whether a technology is EIU:
 - Scientifically based clinical evidence
 - Peer-reviewed literature
 - *Behavioral Health Hierarchy of Clinical Evidence*
 - In the absence of strong and compelling scientific evidence, behavioral clinical policies/clinical criteria may be based upon:
 - National consensus statements
 - Publications by recognized authorities such as government sources and/or professional societies

Note: Anecdotal/editorial statements and professional opinions are only used to support adoption of behavioral clinical policies /clinical criteria when no other source is available.

These evidentiary standards and sources apply to M/S and MH/SUD technologies and are defined in a qualitative manner.

The factor and evidentiary standards used as the basis for determining which MH/SUD technologies are EIU are comparable to, and applied no more stringently than, the factor and evidentiary standards used as the basis for determining which M/S technologies are EIU both “as written” and “in operation.”

Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

As Written

The Plan conducted an “as written” comparative analysis of the strategies, processes, factors, evidentiary standards, and source information used by M/S and MH/SUD to assess whether a technology is EIU and to develop objective evidence-based medical/behavioral clinical policies.

The Plan uses the following standard process to assess the safety and efficacy of technologies:

The Plan uses committees to assess technologies and conduct a thorough review of the scientifically based clinical evidence and peer-reviewed literature in accordance with the *Hierarchies of Clinical Evidence* to develop medical/behavioral clinical policies that apply to the technologies. The subject matter experts in the committees follow a consistent and comparable process to assess

and review technologies and apply comparable *UHC* and *Behavioral Health Hierarchies of Clinical Evidence* (discussed in greater detail below). National internal committees evaluate the applicable factor and standards described in Steps 2 and 3 when determining EIU.

Review of Factor and Evidentiary Standards. M/S and MH/SUD committees both consider clinical efficacy, safety, and appropriateness of the proposed technology, and whether the technology is an unproven treatment for a specific diagnosis when assessing whether a technology is EIU. In doing so, both M/S and MH/SUD consider the respective *UHC* and *Behavioral Health Hierarchies of Clinical Evidence* to assess the clinical efficacy, safety, and appropriateness of the proposed technologies. The *UHC* and *Behavioral Health Hierarchies of Clinical Evidence* are comparable. Both use the following categories of sources (with source-specific differences if the source is specific to M/S or MH/SUD):

- Well-designed evidence-based studies
- Observational studies
- Case studies
- Consensus statements
- Clinical and professional opinion papers

Review of Operational Policies and Procedures. The Plan reviewed M/S and MH/SUD operational policies and procedures to confirm comparability and found MH/SUD policies, procedures, and processes to be comparable and no more stringent than M/S policies, procedures, and processes.

The MTAC assesses the safety and efficacy of technologies used to treat M/S conditions. MTAC uses scientifically based clinical evidence and *UHC Hierarchy of Clinical Evidence* in its development, assessment, and approval processes. MTAC conducts its processes in a timely manner to ensure transparency and consistency, and to identify safe and effective M/S technologies for members.

As of April 1, 2023, UMPC began reviewing and validating the medical clinical policies endorsed by MTAC.

The CTAC assesses the safety and efficacy of technologies used to treat MH/SUD conditions. CTAC uses scientifically based clinical evidence and *UHC Hierarchy of Clinical Evidence* in its development, assessment, and approval processes. CTAC conducts its processes in a timely manner to ensure transparency and consistency, and to identify safe and effective MH/SUD technologies for members.

The CQOC reviews and validates behavioral clinical policies endorsed by CTAC.

The Plan reviewed and compared the stated purpose of the *UHC* and *Behavioral Health Hierarchies of Clinical Evidence*. The *UHC Hierarchy of Clinical Evidence* states that its purpose is to define the order of clinical evidence to ensure a transparent and consistent approach within the Plan. The *UHC Hierarchy of Clinical Evidence* further states that the Plan uses scientifically based clinical evidence to identify safe and effective technologies for members. The *Behavioral Health Hierarchy of Clinical Evidence* policy statement reflects that scientifically based clinical evidence is used to evaluate behavioral health treatments, technologies for members, and that the hierarchy is used to determine which technologies are safe and effective and potentially eligible for benefit coverage. CTAC's technology assessment process for MH/SUD technologies, including CTAC's application of the *Behavioral Health Hierarchy of Clinical Evidence*, is comparable to, and applied no more stringently than, MTAC's technology assessment process for M/S technologies, including MTAC's application of the *UHC Hierarchy of Clinical Evidence*.

When assessing the safety and efficacy of technologies used to treat M/S and MH/SUD conditions, both MTAC and CTAC first look for any strong and compelling scientific evidence such as statistically robust, well-designed, randomized, controlled trials, and cohort studies. In addition, MTAC will look for multi-site observational studies and single site observational studies. CTAC

will also look for systematic reviews and meta-analyses, large prospective trials, cross-sectional studies, retrospective studies, surveillance studies, case reviews/case series, anecdotal/editorial statements, and professional opinions.

In the absence of any strong and compelling scientific evidence, MTAC and CTAC assess technologies by looking at any national consensus statements and/or publications by recognized authorities such as clinical position papers published by professional specialty societies and CMS NCDs.

Neither MTAC nor CTAC will deem a technology unproven solely based on a lack of randomized controlled trials, particularly for new and emerging technologies.

M/S and MH/SUD committees use comparable evidentiary standards and sources to evaluate clinical efficacy, safety, appropriateness of the proposed technologies, and whether the technology is unproven treatment for a specified diagnosis to develop or approve medical/behavioral clinical policies.

M/S and MH/SUD technologies assessed by the MTAC and CTAC committees as not being safe, clinically effective, and/or appropriate are determined to be EIU. Once a technology has been assessed, a medical/behavioral clinical policy is developed which outlines the applicable committee's findings. This includes a summary of the clinical evidence and the identification of specific technologies or uses of technologies considered to be EIU. For both M/S and MH/SUD, all medical/behavioral clinical policies are reviewed and/or updated at least once annually.

As part of the Plan's comparative analysis, the Plan reviewed and compared the MTAC and CTAC charters. The Plan first reviewed the mission/role/scope of the committees, as set forth in their charters. MTAC's mission is to review the scientifically based clinical evidence used in the development of medical policies and clinical programs in an effort to ensure transparency and consistency and to identify safe and effective technologies for members. The purpose of CTAC is to provide a framework by which the organization evaluates and addresses new developments in technology and new applications of existing technology. The CTAC charter also states that it reviews the scientifically based clinical evidence utilized in the development of policies and clinical programs in an effort to ensure transparency, consistency and to identify safe and effective technologies for members.

The Plan also reviewed and compared the composition of the MTAC and CTAC committees. Both committees include both voting members and non-voting members. The Plan reviewed each committee's membership requirements for voting members and non-voting members.

The Plan also reviewed the responsibilities/goals of the committees. The responsibilities/goals of MTAC include the development of evidence-based position statements on selected medical technologies; assessments of the evidence supporting new and emerging technologies; and review and approval of clinical criteria within new or existing medical policies. Similarly, the responsibilities/goals of CTAC include evaluating new behavioral health technologies and new applications of existing behavioral health technologies.

In Operation

The Plan compared the strategies, processes, factors, evidentiary standards, and source information MH/SUD uses to assess whether a technology is EIU and develop evidence-based behavioral clinical policies to the strategies, processes, factors, evidentiary standards, and source information M/S uses to assess whether a technology is EIU and develop evidence-based medical clinical policies "in operation."

M/S MTAC assessment of EIU technologies and development of medical clinical policies is reviewed and validated by UMPC. Similarly, CTAC assessment of EIU technologies and development of behavioral clinical policies is reviewed and validated by the CQOC.

M/S and MH/SUD committees both consider the *UHC* and *Behavioral Health Hierarchies of Clinical Evidence* to assess the clinical efficacy, safety, and appropriateness of the proposed technologies.

The Plan also reviewed and compared how the *UHC* and *Behavioral Health Hierarchies of Clinical Evidence* addressed technology assessments where strong and compelling scientific evidence is lacking. In that scenario, both M/S and MH/SUD *UHC* and *Behavioral Health Hierarchies of Clinical Evidence* assess technologies by looking at any national consensus statements and/or publications by recognized authorities, such as clinical position papers published by professional specialty societies and CMS NCD.

Both M/S and MH/SUD UM processes are guided by their respective *Utilization Management Program Descriptions*. Clinical reviewers utilize medical/behavioral clinical policies when making clinical coverage benefit determinations regarding EIU technologies.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The findings of the Plan's analyses confirmed the strategies, processes, factors, evidentiary standards, and source information used to assess EIU technologies and develop MH/SUD behavioral clinical policies were comparable to, and applied no more stringently than, the strategies, processes, factors, evidentiary standards, and source information used to assess EIU technologies and develop the M/S medical clinical policies "as written" and "in operation."

The MH/SUD policies, procedures, and processes were found to be comparable and no more stringent than M/S policies, procedures, and processes.

As discussed above, both M/S and MH/SUD committees follow comparable technology assessment processes, including consideration of comparable hierarchies of clinical evidence.

Conclusions

The Plan concluded the methodologies MH/SUD used to assess whether a technology is EIU and develop evidence-based behavioral clinical policies were comparable to, and applied no more stringently than, the methodologies M/S used to assess whether a technology is EIU and develop evidence-based medical clinical policies, both "as written" and "in operation."

Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical and surgical (M/S) benefits. This generally means that financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements, such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

The out-of-network (OON), out-of-area, geographic service limitation (geographic restrictions requirement) is intended to encourage members to utilize in-network (INN) providers. The geographic restrictions requirement does not limit coverage for OON benefits within the member’s state of residence, nor does it limit INN services nationally. The goal is to promote access to evidence-based care and improved treatment outcomes.

This document includes the following information:

- Geographic restrictions process for both M/S and MH/SUD services
- The description of the NQTL and application (Step 1)
- Factors used to determine which services are subject to the NQTL (Step 2)
- Evidentiary standards and sources used to define, trigger and/or implicate a factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

This analysis refers to the following attachments:

- *Certificates of Coverage - COC23-INS-BIND-2021-LG-GA-UHIC* - Plan document that explains covered services, terms, conditions, and limitations of the member’s policy

The Plan concludes that the geographic restrictions requirements for M/S and MH/SUD are comparable and applied no more stringently for OON benefits both “as written” and “in operation.”

Process

The OON, out-of-area, geographic service limitation (geographic restrictions requirement) is intended to encourage members to utilize INN providers, with the goal being to promote access to evidence-based care and improve treatment outcomes. Health care services from an OON provider for non-emergent, sub-acute inpatient, or outpatient services at any of the following non-hospital facilities: alternate facility, freestanding facility, inpatient rehabilitation facility, or skilled nursing facility received outside of the member’s State of Residence are not covered. This applies to facility based services that could be Inpatient or Outpatient.

A member's request for care is assessed to determine whether the servicing provider is an INN or OON provider and within a level of care subject to the restriction. Service requests within these levels of care, rendered by an OON provider at certain non-hospital, sub-acute, non-emergent facilities, and programs that are out of the member's state of residence, as defined in Plan documents, are denied administratively as a non-covered benefit.

The limitation does not apply in the case of an emergency.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- Geographic Restrictions

Benefit Classification(s)

- OON, inpatient and outpatient services as described in the Plan benefit documents
- Under the Plan benefit documents, services received at the following facilities are subject to the OON geographic restriction:
 - Health care services from an OON provider for non-emergent, sub-acute inpatient, or outpatient services at any of the following non-hospital facilities: alternate facility, freestanding facility, residential treatment facility, inpatient rehabilitation facility, or skilled nursing facility received outside of the member's State of Residence

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHIC)

Plan Terms

The Plan's *Certificate of Coverage* states: "Health care services from an Out-of-Network provider for non-emergent, sub-acute inpatient, or outpatient services at any of the following non-hospital facilities: alternate facility, freestanding facility, residential treatment facility, inpatient rehabilitation facility and skilled nursing facility received outside of the covered person's State of Residence. For the purpose of this exclusion, the 'State of Residence' is the state where the covered person is a legal resident, plus any geographically bordering adjacent state or, for a covered person who is a student, the state where they attend school during the school year. This exclusion does not apply in the case of an Emergency or if authorization through network exception has been obtained in advance."

List of M/S and MH/SUD Services Subject to NQTL

- Health care services from an OON provider for non-emergent, sub-acute inpatient, or outpatient services at any of the following non-hospital facilities: alternate facility, freestanding facility, inpatient rehabilitation facility, or skilled nursing facility received outside of the member's State of Residence.

Step 2 – Factor Used to Determine Geographic Restriction Applies

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

The Plan relies on the following factor to determine whether OON services are subject to geographic restrictions for both M/S and MH/SUD:

- Whether the OON facility is providing non-emergent, sub-acute inpatient and/or outpatient services located outside of the member's state of residence (Qualitative)

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factor used to determine whether OON services are subject to geographic restrictions for both M/S and MH/SUD services:

Factor – Whether the OON facility is providing non-emergent, sub-acute inpatient, and/or outpatient services located outside of the member's state of residence

- The Plan's evidentiary standards that trigger and/or define the factor:
 - Facility is OON; AND
 - Facility provides non-emergent, sub-acute inpatient and/or outpatient services; AND
 - Facility is located outside of the member's state of residence
 - "State of Residence" is defined as:
 - "The state where the member is a legal resident; plus, any geographically bordering adjacent state;" or
 - "For a member who is a student, the state where the student is attending school, during the school year"

The Plan's sources used to define the factor:

- Provider Directory
- Treatment type requested and/or billed, e.g., revenue codes, Healthcare Common Procedure Coding System (HCPCS), etc.
- Facility service location/address
- Member address
- Plan benefit documents

These evidentiary standards and sources apply to both M/S and MH/SUD services. These standards are defined in a qualitative manner.

Step 4 – NQTL "As Written" and "In Operation" Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

As Written

The Plan conducted a comparative analysis of the strategies, processes, factor, evidentiary standards, and source information used to develop the geographic restriction requirement. The Plan identified the shared factor and evidentiary standards used as the basis for subjecting both M/S and MH/SUD benefits to the geographic restrictions for OON services.

The Plan reviewed M/S and MH/SUD the state of residence definitions and triggering events for the geographic restrictions to confirm comparability. In addition, the same sources of information were used to define the factor for both M/S and MH/SUD.

Geographic Restrictions Non-Quantitative Treatment Limitation (NQTL) Analysis

GA Surest - UnitedHealthcare Insurance Company

12/29/2023

In Operation

The Plan compared the shared strategies, processes, factor, evidentiary standards, and source information used to determine which M/S and MH/SUD OON services are subject to geographic restrictions “in operation.”

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The findings of the analysis confirmed the strategies, processes, factor, evidentiary standards, and source information used to subject certain MH/SUD OON services to geographic restrictions were comparable to, and applied no more stringently than, the strategies, processes, factor, evidentiary standards, and source information used to subject certain M/S OON services to geographic restrictions “as written.”

Additionally, the same triggering events for the geographic restrictions were applied to both M/S and MH/SUD services and state of residence was defined similarly for all services. The same sources of information were used to define the factor used to determine whether the geographic restriction applies.

Conclusions

The Plan reviewed the M/S and MH/SUD OON triggering events and state of residence definitions and concluded the methodology used to determine which MH/SUD OON services are subject to geographic restrictions “as written” were comparable to, and applied no more stringently than, the methodology used to determine which M/S OON services are subject to geographic restrictions “as written.” Additionally, the Plan concluded the way in which geographic restrictions were applied to MH/SUD OON services were comparable to, and applied no more stringently than, the way in which geographic restrictions were applied to M/S OON services “as written.”

The Plan concluded that MH/SUD processes, triggering events, definitions, and how the Plan applies geographic restrictions for MH/SUD OON services were comparable to, and applied no more stringently than how the Plan applies geographic restrictions for M/S OON services “in operation.”

Overview

Pursuant to a federal law called the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical and surgical (M/S) benefits. This generally means that financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements, such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

In-network (INN) facility reimbursement is the process by which the Plan establishes reimbursement for INN facility-based services.

This document includes the following information:

- Description of process for negotiating reimbursement rates for INN facility-based services for both M/S and MH/SUD facilities
- Description of the NQTL and application (Step 1)
- Factors used to negotiate reimbursement rates for INN facility-based services for both M/S and MH/SUD facilities (Step 2)
- Evidentiary standards and sources used to define and/or trigger each of the identified factors (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

The analysis refers to the following attachments:

- *Certificate of Coverage*- COC23-INS-BIND-2021-LG-GA-UHIC – Plan document that explains covered services, terms, conditions, and limitations of the member’s policy

The Plan concludes that the INN facility reimbursement requirements for M/S and MH/SUD are comparable and applied no more stringently both “as written” and “in operation.”

Process

Negotiation

For both M/S and MH/SUD facilities, the Plan uses a substantially similar process to negotiate and establish reimbursement rates for INN facility services. The Plan delegates negotiation of reimbursement rates for MH/SUD facility providers to United Behavioral Health d/b/a Optum Behavioral Health (OBH), it’s delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor.

In-Network Facility Reimbursement Non-Quantitative Treatment Limitation (NQTL) Analysis

GA Surest - UnitedHealthcare Insurance Company

12/29/23

Key steps in the INN facility reimbursement negotiation process for both M/S and MH/SUD services include:

- The facility submits a completed application to the Plan to be included in the Plan's provider network
- The Plan reviews the facility reimbursement proposal
- Based on the above, the Plan accepts the reimbursement proposal or negotiates reimbursement rates with the facility using the factors described

Detailed process for the INN facility reimbursement negotiation:

Facilities newly seeking to join the Plan provider network submit a reimbursement proposal to the Plan. The Plan may either accept the facility's proposal or may negotiate reimbursement rates with the facility. Existing market rates are used as the baseline for negotiating rates. For MH/SUD providers, the Plan prepares an analysis of market dynamics that the Plan contracting team may access to inform negotiations. For M/S services, the Plan may document the market dynamic factors that inform a provider-specific negotiation. The Plan does not apply defined formulae to establish base rates or standard fee schedules. Both M/S and MH/SUD facilities that participate in the Plan provider network may negotiate reimbursement adjustments upon contract renewal or changing market circumstances by submitting a reimbursement proposal to the Plan. The Plan may either accept the facility's proposal or may negotiate reimbursement rates with the facility.

For facilities already in the network, the existing facility contract rates are used as the contract negotiation baseline. The Plan may take market dynamics into consideration when negotiating reimbursement rates with facilities. For MH/SUD providers, the Plan prepares an analysis of market dynamics that the Plan contracting team may access to inform negotiations. For M/S services, the Plan may document the market dynamic factors that inform a provider-specific negotiation. The Plan does not apply defined formulae to establish base rates or standard fee schedules.

Inpatient M/S – General Acute Care, Children's, and Long-Term Acute Care Facilities

The Plan contracts for inpatient M/S services using one of four key inpatient reimbursement methodologies: MS-Diagnosis Related Group (DRG), Per Case, Per Diem, and Percentage Payment Rate (PPR). While these methodologies provide a starting point, the rate categories, rate category definitions, and rate types can be modified based on negotiations with facilities.

In addition, a given contract will often feature a combination of inpatient reimbursement methodologies. For example, within a Per Diem contract, it's not uncommon for cases associated with a defined list of cardiac and/or musculoskeletal MS-DRGs to be reimbursed on a per-case basis, while all other M/S cases are reimbursed on a per diem basis.

The following provides an overview of the inpatient reimbursement methodologies used by the Plan:

- **MS-DRG** – The facility is paid using a single, negotiated base rate. The base rate is multiplied by the Centers for Medicare & Medicaid Services (CMS) MS-DRG relative weight for the MS-DRG assigned to the case. Contracts are written to use the current version of the MS-DRGs and relative weights
- **Per Case** – The facility is paid using negotiated M/S case rates. The per case rate is paid for the entire case, regardless of the MS-DRG assigned to the case or the length of stay. There may be separate per case rates for medical cases versus surgical cases. This reimbursement method is rarely used for M/S cases; it's more likely to be used for specific types of cases "carved out" from M/S per diem rates. Examples of services that may be carved out include high-cost drugs, implants, obstetrics, NICU, and outliers
- **Per Diem** – The facility is paid using negotiated M/S per diem rates. The per diem rate is multiplied by the number of days corresponding to the per diem type. There may be separate per diem rates for medical cases versus surgical cases
- **PPR** – The facility is paid a percentage of charges. The PPR rate is multiplied by the eligible charges for the case

In-Network Facility Reimbursement Non-Quantitative Treatment Limitation (NQTL) Analysis

GA Surest - UnitedHealthcare Insurance Company

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In addition, M/S agreements may include negotiated escalators or deflators, which automatically increase or modify rates for subsequent contract years. The escalators or deflators may also be based on quality and efficiency metrics.

Inpatient MH/SUD – Inpatient and Residential

The Plan contracts for inpatient MH/SUD services using the following methodology:

- **Per Diem** – The facility is paid using negotiated MH/SUD per diem rates. The per diem rate is multiplied by the number of days corresponding to the per diem type

In addition, MH/SUD agreements may include negotiated escalators or deflators, which automatically increase or modify rates for subsequent contract years. The escalators or deflators may also be based on quality and efficiency metrics.

Outpatient M/S – General Acute Care, Children’s, and Long-Term Acute Care Facilities

The Plan contracts for outpatient M/S facility services using standardized reimbursement templates, each of which is organized around one of five key outpatient reimbursement methodologies: Ambulatory Payment Classifications (APC), Per Case, Per Visit, Per Unit, and PPR. While these templates provide a starting point, the rate categories, rate category definitions, and rate types reflected in the templates can be modified based on negotiations with providers.

In addition, a given contract will often feature a combination of outpatient reimbursement methodologies. For example, within a fixed outpatient contract, services may be subject to Per Case, Per Visit, and Per Unit reimbursement. At the same time, contract variations would allow any or all services to be subject to PPR reimbursement. It is also possible for a single outpatient claim (except for claims paid on a Per Case basis) to be paid using more than one of these reimbursement methodologies. For example, some services on a given claim may be subject to Per Visit reimbursement, while other services may be subject to Per Unit reimbursement.

The following provides an overview of the outpatient reimbursement methodologies used:

- **APC** – The facility is paid using a single, negotiated APC conversion factor for services subject to such reimbursement under the Medicare outpatient prospective payment system (OPPS). The conversion factor is multiplied by the relative weights for the APCs assigned to the case by the OPPS pricing software. Services not subject to APC payment are paid using facility fee schedules (see Per Unit below). Contracts are written to use the current version of the APCs and relative weights
- **Per Case** – The facility is paid using negotiated per case rates for certain types of outpatient cases, including outpatient surgery, observation, emergency room, and urgent care. All services provided during the encounter are included in the per case payment and are not separately reimbursable
- **Per Visit** – The facility is paid using negotiated per visit rates for certain types of outpatient services. The per visit rate is multiplied by the number of visits billed on a given claim. If a given claim spans multiple dates of service, then the visits on each of the separate days are reimbursable. Examples of services that may be subject to Per Visit reimbursement include, IV therapy, oncology treatment, and dialysis
- **Per Unit** – The facility paid is using a negotiated facility fee schedule for certain types of outpatient services, including laboratory, pathology, and radiology. The per unit rate is multiplied by the number of units billed for a given Current Procedural Technology® (CPT), or Healthcare Common Procedure Coding System (HCPCS) code on a given claim. Facility fee schedules are generally based on a percentage of the CMS rate
- **PPR** – The facility is paid a percentage of charges. The PPR rate is multiplied by the eligible charges for the case

In-Network Facility Reimbursement Non-Quantitative Treatment Limitation (NQTL) Analysis

GA Surest - UnitedHealthcare Insurance Company

12/29/23

M/S agreements may include negotiated escalators or deflators, which automatically increase or modify rates for subsequent contract years. The escalators or deflators may also be based on quality and efficiency metrics.

Outpatient MH/SUD – Intensive Outpatient Programs and Partial Hospitalization Programs

The Plan contracts for outpatient MH/SUD facility services are negotiated and mutually agreed upon with the facility. The starting point is usually a proposal from the engaged facility. The Plan will use other available information including market dynamics and CMS guidelines (when available) as benchmarks to support its negotiation position.

The Plan contracts for MH/SUD services using the following methodology:

- Per Diem – The facility is paid using negotiated MH/SUD per diem rates

In addition, MH/SUD agreements may include negotiated escalators or deflators, which automatically increase or modify rates for subsequent contract years. The escalators or deflators may also be based on quality and efficiency metrics.

Ongoing Monitoring

The Plan convenes ongoing working groups that include representatives from both the M/S and MH/SUD network strategy and pricing teams to align business processes and ensure adherence to as-written standards and comparability in operation.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- INN Facility Reimbursement

Benefit Classification(s)

- INN, facility-based

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHIC)

Plan Terms/Source Document(s)

In each of the plans *Certificate of Coverage*, the following is referenced:

“What Is Our Relationship with Providers and Groups?”

We have agreements in place that govern the relationship between us, our Groups and Network providers, some of which are affiliated providers. Network providers enter into agreements with us to provide Covered Health Care Services to Covered Persons.”

List of M/S and MH/SUD Services Subject to NQTL

- INN acute inpatient
- INN subacute inpatient
- INN facility-based outpatient services

Step 2 – Factors Used in the Design and Application of the NQTL

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/ SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

The Plan relies on the following factors to establish reimbursement rates for M/S and MH/SUD facilities.

For facilities newly seeking to join the network, existing market rates are used as the baseline for negotiating rates. For facilities already in the network, the existing facility contract rates are used as the contract negotiation baseline.

The factors are:

- Facility assessment (Qualitative)
 - Facility's licensure, certification, and/or accreditation (e.g., acute care facility; subacute care facility; ancillary facility, etc.)
- Services and diagnoses/conditions the facility offers (Quantitative)
- Market dynamics (Quantitative and Qualitative)
 - Facility leverage within a given geographic market
 - Network need
 - Facility member volume
 - Facility proposed rate relative to market pricing
 - Market Target Rates
 - Market Prevailing Rates
 - Availability of industry standard value-based reimbursement models

The factors apply to both M/S and MH/SUD services. The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factors used in establishing INN facility reimbursement rates. These evidentiary standards and sources apply to the following:

- I. M/S and MH/SUD inpatient and outpatient facility services

Factor – Facility assessment

- The Plan's evidentiary standards and sources that trigger and/or define the facility assessment factor:
 - Facility's licensure
 - Certification
 - Accreditation

This evidentiary standards and sources apply to both M/S and MH/SUD INN facility reimbursement and are defined in a qualitative manner.

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Factor – Services and diagnoses/conditions the facility purports to offer or treat to offer

- The Plan’s evidentiary standard and source that triggers and/or defines the services and diagnoses/conditions the facility purports to offer or treat factor:
 - Most current version of industry standard code sets, e.g., revenue, MS-DRG (derived by International Classification of Diseases (ICD)/Diagnostic and Statics Manual (DSM), CPT, HCPCS, etc.

This evidentiary standards and sources apply to both M/S and MH/SUD INN facility reimbursement and are defined in a quantitative manner.

Factor – Market dynamics

- The Plan’s evidentiary standards and sources that define and/or trigger the market dynamics factor:
 - Facility leverage: facilities associated with large health systems within a given geographic market generally have more leverage
 - Internal research
 - Network need: supply and demand for a facility service is evaluated by looking at the volume of facilities with the same or similar programs and/or services within the relevant geographic region relative to the Plan’s membership and its network access and/or availability standards
 - Facility directory, state Geographic Access reports and member reported access data
 - Facility member volume: measured by looking at the volume of members treated by the facility, and/or volume of services billed by the facility in a given year relative to the same or similar program types in the same geographic market during the same timeframe
 - Internal claims data
 - Facility proposed rate relative to market pricing, targeted and prevailing rates: internally derived average market pricing based upon available data including internal claims data, state published rates, CMS Prospective Payment System (PPS)
 - Applicable CMS PPS, MS-DRG, state rate, and internal claims data
 - Availability of industry standard and proprietary value-based reimbursement models: value-based programs that reward health care providers with incentive payments for the quality of care they deliver
 - CMS value-based programs
 - Internally developed value-based programs

These evidentiary standards and sources apply to both M/S and MH/SUD INN facility reimbursement and are defined in a qualitative and quantitative manner. In addition, all of these standards are considered and used to define the factors.

The factors and evidentiary standards used as the basis for establishing the Plan’s MH/SUD INN facility reimbursement rates are comparable to, and applied no more stringently than, the factors used as the basis for negotiating and establishing the Plan’s M/S INN facility reimbursement rates “as written” and “in operation.” The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL.

Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the plan’s or issuer’s analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert’s qualifications and the extent to which the plan or issuer ultimately relied upon each expert’s evaluations in setting recommendations regarding both.

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The Plan convenes ongoing working groups that include representatives from both the M/S and MH/SUD network strategy and pricing teams to align business processes and ensure adherence to as-written standards and comparability in operation

As Written

The Plan compared the strategies, processes, factors, evidentiary standards, and source information used to negotiate and establish INN facility reimbursement “as written.”

The Plan identified the shared factors and evidentiary standards used as the basis for determining offered reimbursement rates to M/S and MH/SUD facilities. The factors and evidentiary standards are applied to both M/S and MH/SUD facilities comparably and not more stringently to MH/SUD facilities.

Review of processes by which INN facility reimbursement is established

Both M/S and MH/SUD INN facility reimbursements are established through mutually negotiated rates based on facility assessment, services or programs provided, and market dynamics including facility leverage, network need, facility member volume, facility proposed rate relative to market pricing and/or availability of industry standard, and proprietary value-based reimbursement models.

In Operation

The Plan compared the methodologies and processes used to negotiate and establish MH/SUD INN facility reimbursement to assess whether the methodologies and processes are comparable to, and applied no more stringently than, the methodologies and processes used to negotiate and establish reimbursement for M/S INN facility-based services “in operation.”

Given the variety of reimbursement methodologies used for inpatient M/S services, there is no meaningful basis for a comparative analysis with MH/SUD. Although the median rates for MH/SUD and M/S facility outpatient rates differ, both M/S and MH/SUD INN outpatient facility reimbursements are established through mutually negotiated rates based on facility type, services or programs provided, market dynamics including facility leverage, network need, facility member volume, facility proposed rate relative to market pricing and/or availability of industry standard and proprietary value-based reimbursement models.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the plan's or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the plan or coverage is or is not in compliance with MHPAEA.

Findings

The analysis reviewed the strategies and processes by which INN facility reimbursement is negotiated and established including, what services or programs are provided, what market dynamics may influence negotiation including, facility leverage, supply and demand, facility volume, and/or proposed rates relative to market pricing.

The findings of that analysis confirmed the strategies, processes, factors, evidentiary standards, and source information used to negotiate and establish reimbursements for MH/SUD INN facility services and/or programs were comparable to, and applied no more stringently than, the strategies, processes, factors, evidentiary standards, and source information used to negotiate and establish facility reimbursement for M/S INN facility services and/or programs “as written.”

In-Network Facility Reimbursement Non-Quantitative Treatment Limitation (NQTL) Analysis

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The Plan determined that M/S facility-based services are reimbursed under a variety of different reimbursement models, including MS-DRG, Case Rates, Per Diem rates, and value-based models. Current industry norms for MH/SUD facility-based services are more narrowly limited to the Per Diem reimbursement model only.

Based on the key distinction in the variety of industry standard reimbursement models available for M/S facility-based services as compared to the dominant model, Per Diem reimbursement for MH/SUD facility-based reimbursement, a comparison of M/S and MH/SUD facility-based rates is complex. The Plan continues to collaborate with MH/SUD facility-based providers to explore development of value-based reimbursement models.

The Plan determined that the process to negotiate and establish MS/SUD INN facility reimbursement rates were comparable to, and applied no more stringently than, the process to negotiate and establish M/S INN facility reimbursement rates “in operation.”

Conclusions

Based upon these findings, the Plan concluded the INN facility reimbursement strategy for MH/SUD was comparable to, and applied no more stringently than, the INN facility reimbursement strategy for M/S “as written.”

Additionally, the Plan concluded the factors, evidentiary standards, and source information used to negotiate and establish MH/SUD INN facility reimbursement rates were comparable to, and applied no more stringently than, the factors, evidentiary standards and source information used to negotiate and establish M/S INN facility reimbursement rates “in operation.”

Overview

Pursuant to a federal law called the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical and surgical (M/S) benefits. This generally means that financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

In-network (INN) provider reimbursement is the process by which the Plan establishes reimbursement for INN professional services.

This document includes the following information:

- Process for negotiating and establishing reimbursement rates for INN professional services for both M/S and MH/SUD providers
- Description of the NQTL and application (Step 1)
- Factors used to negotiate reimbursement rates for INN professional services for both M/S and MH/SUD providers (Step 2)
- Evidentiary standards and sources used to define and/or trigger each of the identified factors (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

The analysis refers to the following attachments:

- *Certificates of Coverage* – COC23-INS-BIND-2021-LG-GA-UHIC – Plan document that explains covered services, terms, conditions, and limitations of the member’s policy

The Plan concludes that its methodologies for negotiating and establishing INN reimbursement rates for M/S and MH/SUD professional services are comparable and applied no more stringently for MH/SUD providers than for M/S providers both “as written” and “in operation.”

Process

For both M/S and MH/SUD providers, the Plan uses a comparable process to negotiate and establish reimbursement rate(s) for INN professional services. The Plan delegates negotiation of reimbursement rates for MH/SUD providers to United

Behavioral Health d/b/a Optum Behavioral Health (OBH), its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor.

Key steps in the INN professional services reimbursement negotiation process for both M/S and MH/SUD services include:

- The provider submits a completed application to the Plan to be included in the Plan's provider network
- Based on the above, the Plan offers a contract and reimbursement rate package to the provider for the services/programs the provider intends to offer
- If the provider rejects the contract proposal, the Plan may negotiate with the provider using the factors described

Detailed process for the INN professional services reimbursement negotiation:

For M/S professionals, the Plan contracts for services using standardized reimbursement templates. These templates are organized by Medicare carrier locality and reflect 100% of Geographic Practice Cost Indices (GPCI)-adjusted Centers for Medicare & Medicaid Services (CMS) reimbursement for a given rate year. The Plan uses the following fee sources to create these templates:

- CMS Resource Based Relative Value Scale (RBRVS) is determined by calculating the CMS relative value units (RVU):
 - The CMS RVU for a given service or procedure is derived using the following mathematical formula: $(\text{work RVU} \times \text{work GPCI}) + (\text{PE RVU} \times \text{PE GPCI}) + (\text{MP RVU} \times \text{MP GPCI}) \times \text{CF}$. This is also referred to as the CMS benchmark rate
 - Definitions:
 - Work = Provider work reflects the provider's work when performing a procedure or service including provider's technical skills, physical effort, mental effort and judgment, stress related to patient risk, and the amount of time required to perform the service or procedure
 - PE = Provider Expense reflects the costs for medical supplies, office supplies, clinical and administrative staff, and pro rata costs of building space, utilities, medical equipment, and office equipment
 - MP = Malpractice Insurance expense reflects the cost of professional liability insurance based on an estimate of the relative risk associated with procedure or service
 - CF = Conversion Factor
 - GPCI = Geographic Practice Cost Indices
- Applicable CMS RVU
- FAIR Health Medicare GapFill PLUS database
- CMS Clinical Lab Fee Schedule
- CMS DMEPOS (Durable Medical Equipment, Prosthetics/Orthotics, and Supplies) Fee Schedule
- CMS ASP (Average Sales Pricing) and RJ Health ASP (for drug pricing)
- CMS Ambulance Fee Schedule
- Optum RBRVS (for codes not priced by CMS) M/S providers only
- CMS Carrier Priced Fees (for codes referred to the local carrier for pricing)
- Within these templates, Current Procedural Technology® (CPT), Healthcare Common Procedure Coding System (HCPCS) codes are organized into 54 type of service categories:
 - Evaluation & Management – 4 categories
 - Surgery – 15 categories
 - Radiology – 10 categories
 - Laboratory/Pathology – 3 categories
 - Medicine – 10 categories
 - Obstetrics – 1 category
 - Immunizations/Injectables – 5 categories
 - DME & Supplies – 5 categories
 - Ambulance – 1 category

This standardized structure enables the Plan to tailor fee schedules around specific CPT/HCPSC codes, generally the highest volume codes, billed by different types of providers. Thus, the fee schedules are not specialty-specific; but instead based on the codes most likely to be billed by a particular provider.

Before creating a new fee schedule for a negotiation, the Plan determines if there is an existing fee schedule that will meet the needs of the negotiation; for example, if the negotiation is with a primary care group in Atlanta, the Plan would look to find other primary care group fee schedules for that geographic locality that included the relevant codes. If no existing fee schedule fits the factual scenario, then the creation of a new fee schedule will be approved.

The Plan does not maintain designated “go-out” or “base rate” fee schedules for M/S services. Rather, the Plan begins with the standardized structure described here and then negotiates a percentage of CMS reimbursement with providers for the service categories listed above, applying the factors described in Step 2 and evidentiary sources described in Step 3 below. Any CPT/HCPSC codes not reflected in the fee schedule templates are paid at a negotiated percentage of charges.

For MH/SUD professionals, the Plan follows a comparable process. The Plan starts with the CMS national physician fee schedule rate for the service type and practitioner type at issue and then determines the percentage of CMS reimbursement based upon CMS locality fee schedules and the factors, evidentiary standards, and sources described in Steps 2 and 3 below. The Plan maintains five (5) internally developed standard fee schedules based on the CMS national physician fee schedule rates and the CMS geography-specific rates for the provider’s area. Individual or group MH/SUD care providers are assigned to one of these standardized fee schedules based on their geographic location.

For both M/S and MH/SUD professional providers, the Plan uses CMS annual national RVUs and other data to determine whether routine, non-negotiation-based adjustments to the fee schedules may be necessary. If an RVU is not available for a particular code, the Plan uses other sources such as the FairHealth Medicare Gap Fill Database and then market research to determine an appropriate rate.

Providers already in the network may also negotiate for non-routine adjustments upon contract renewal or changing market circumstances. For both M/S and MH/SUD professional providers, the fee schedule rates are negotiable, and the Plan assesses the market dynamic factors listed in Step 2 to reach agreement with providers.

Ongoing Monitoring

The Plan convenes ongoing working groups that include representatives from both the M/S and MH/SUD network strategy and pricing teams to align business processes and ensure adherence to as-written standards and comparability in operation.

The Plan also compares the allowed amounts for common CPT codes paid to M/S providers and MH/SUD providers relative to Medicare (CMS) rates on an annual basis to assess whether its methodology used to reimburse MH/SUD providers is comparable to, and applied no more stringently than, its methodology used to reimburse M/S providers “in operation.” If MH/SUD providers are not found to be comparable, the Plan works with the Network strategy team to implement applicable MH/SUD reimbursement rate adjustments. Impacts of the adjustment are then assessed during the next annual comparison.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- INN Professional Provider Reimbursement

Benefit Classification(s)

- INN, professional services

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHIC)

Plan Terms/Source Document(s)

In each of the Plan's *Certificate of Coverage*, the following is referenced:

"What Is Our Relationship with Providers and Groups?

We have agreements in place that govern the relationship between us, our Groups and Network providers, some of which are affiliated providers. Network providers enter into agreements with us to provide Covered Health Care Services to Covered Persons."

List of M/S and MH/SUD Services Subject to NQTL

- For M/S, INN professional services rendered by independently licensed health care professionals, e.g., primary care and specialty care
- For MH/SUD, INN professional services rendered by independently licensed behavioral health care professionals, e.g., psychotherapy, medication management, etc.

Step 2 – Factors Used in the Design and Application of the NQTL

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

The Plan relies on the following factors to establish reimbursement rates for M/S and MH/SUD professionals:

- Provider type (Qualitative) (e.g., physician vs. non-physician) and/or specialty including provider licensure, board certification, education, and training
- Services and/or Procedures Provided (Quantitative) is based on 100% of GPCI-adjusted CMS reimbursement for a given rate year

The Plan relies on the following factor in negotiating with professional providers after issuing standard reimbursement rates:

- Market dynamics (Quantitative and Qualitative) that may influence the offered rate include:
 - Provider leverage
 - Network need
 - Provider member volume
 - Market/Specialty Prevailing Rates

The factors apply to both M/S and MH/SUD services. Although the factors are not weighted, the Plan's standard fee schedules are based largely on the services/procedures, by code, a provider is most likely to provide and bill. While that factor is not most important in determining ultimate reimbursement, it does serve as the initial consideration.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factors used in establishing the standard INN professional services reimbursement rates. These evidentiary standards and sources apply to the following:

- I. M/S professional providers (e.g., physician or non-physician)
- II. MH/SUD professional providers (e.g., physician or non-physician)

Factor – Provider type and/or specialty including provider licensure, board certification, education, and training

- The Plan's evidentiary standard and source that triggers and/or defines the provider type factor is:
 - Provider application

This evidentiary standard and source applies to both M/S and MH/SUD providers INN reimbursement and is defined in a qualitative manner.

Factor – Services and/or procedures provided

- The Plan's evidentiary standards and sources that trigger and/or define the identification of the services and/or procedures provided factor (as applicable based on the respective services or procedures):
 - Most current version of industry standard code sets, e.g., CPT, HCPCS, etc.
 - CMS RBRVS
 - CMS RVU for a given service or procedure
 - FairHealth Medicare Gap Fill Database
 - CMS Clinical Lab Fee Schedule
 - CMS Durable Medical Equipment, Prosthetics/Orthotics, and Supplies (DMEPOS) Fee Schedule
 - CMS Average Sales Pricing (ASP) and RJ Health ASP (for drug pricing)
 - CMS Ambulance Fee Schedule
 - Optum RBRVS (for codes not priced by CMS)
 - CMS Carrier Priced Fees (for codes referred to the local carrier for pricing)

These evidentiary standards and sources apply to both M/S and MH/SUD providers INN reimbursement and are defined in a quantitative manner.

Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factors used in negotiating INN professional services reimbursement rates after issuing standard reimbursement rates. These evidentiary standards and sources apply to the following:

- I. M/S professional providers (e.g., physician or non-physician)
- II. MH/SUD professional providers (e.g., physician or non-physician)

Factor – Market dynamics

- The Plan's evidentiary standards and sources that define and/or trigger the identification of market dynamics that may influence the offered rate factor:
 - Provider leverage: providers owned or employed by large health systems within a given geographic market have more leverage than those who are not, e.g., solo practitioner
 - Market research
 - Network need: Supply and demand for a provider type is evaluated by looking at the volume of network providers of the same or similar provider type within the relevant geographic region relative to the Plan's membership and its network access and/or availability standards. Specialists unique to their market may have more leverage due to the network need for that provider type
 - Provider directory, state Quest (f/k/a GeoAccess) reports and member reported access data

- Provider member volume: measured by looking at the volume of members treated by the provider, and/or volume of services billed by the provider, in a given year, relative to the same or similar provider types in the same geographic market during the same timeframe
 - Provider claims data
- Market/Specialty Prevailing Rates: internally derived average market pricing based upon available data including internal claims data and state published rates
 - State rate and internal claims data

These evidentiary standards and sources apply to both M/S and MH/SUD providers INN reimbursement and are defined in a quantitative and qualitative manner. In addition, all of these standards are considered and used to define the factors.

The factors and evidentiary standards used as the basis for negotiating and establishing the Plan's MH/SUD INN professional services reimbursement rates are comparable to, and applied no more stringently than, the factors used as the basis for negotiating and establishing the Plan's M/S INN professional services reimbursement rates "as written" and "in operation." The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL.

Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

The Plan convenes ongoing workgroups that include representatives from both the M/S and MH/SUD network strategy and pricing teams to align business processes and ensure adherence to as-written standards and comparability in operation.

As Written

The Plan compared the strategies, processes, factors, evidentiary standards, and source information used to negotiate and establish INN provider reimbursement for M/S and MH/SUD professional services "as written."

The Plan identified the shared factors and evidentiary standards used as the basis for determining offered reimbursement rates to M/S and MH/SUD providers. The factors and evidentiary standards are applied to both M/S and MH/SUD providers comparably and not more stringently to MH/SUD providers.

Review of processes by which INN reimbursement is established

Both M/S and MH/SUD INN provider reimbursement for professional services are based upon provider type, service and/or procedures provided, including the CMS RVU, and market dynamics including, provider leverage, network need, and/or provider member volume.

In Operation

The Plan compared the allowed amounts for common CPT codes paid to M/S providers and MH/SUD providers relative to 2022 Medicare (CMS) rates to assess whether its methodology used to reimburse MH/SUD providers is comparable to, and applied no more stringently than, its methodology used to reimburse M/S providers for full year (FY) 2022 "in operation."

Data Included in Analysis

FY 2022 INN provider allowed amounts derived from claims reporting.

Provider Type

Rationale as to why Primary Care Physicians (PCPs) were compared to psychiatrists:

- Both are cognitive-based specialties, unlike orthopedic surgeons or gastroenterologists, which are procedure-based specialties. PCPs diagnose, treat, and provide preventive medical care. PCPs commonly diagnose and treat behavioral health conditions, including medication management. Psychiatrists diagnose, treat, and prevent disorders of the mind
- Both PCPs and psychiatrists meet with patients for a period of time, take histories, write prescriptions, refer out to specialists (in the case of PCPs) or psychologists/therapists (in the case of PCPs and psychiatrists), and conduct periodic follow-up
- Both generally bill similar procedure codes, e.g., 99213

Rationale as to why Physician Assistants/Nurse Practitioners were compared to psychologists/therapists:

- All are non-physicians
- Their education and/or training requirements are similar

CPT Codes Included in Analysis

99214, 99213, 90792, 90791, 90834

M/S Physicians & Non-Physicians: 99213 & 99214

- These codes were selected because they are among the highest volume codes billed by medical professionals and are used by primary care physicians, non-physicians, such as physician assistants and nurse practitioners, and psychiatrists
- 99213 is an office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making
- 99214 is an office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making

MH/SUD Physicians: 90792 & 99213

- 90792 is a psychiatric diagnostic interview examination. It is performed at the outset of an illness. It requires elicitation of complete medical and psychiatric history, mental status examination, and establishment of initial diagnosis. Almost every member who utilizes MH/SUD services has one of these visits
- 99213 is an evaluation and management code for an existing patient. It was selected because it is the most common service performed by physician psychiatrists in most states

MH/SUD Non-Physicians: 90791 & 90834

- 90791 is a psychiatric diagnostic interview examination. It is performed at the outset of an illness. It requires elicitation of complete medical and psychiatric history, mental status examination, and establishment of initial diagnosis. Almost every member who utilizes MH/SUD services has one of these visits
- 90834 is a 45-minute therapy session. It was selected because it is the most common service provided by a non-physician licensed mental health provider

Relativities are averaged together to determine a combined relativity for M/S and one for MH/SUD.

Testing Methodology

The Plan developed three tests for evaluating in-network professional services reimbursement statistical comparability. Passing any one test demonstrates that comparability has been met. The Plan compared the median, average, and range of MH/SUD and M/S reimbursement relative to CMS to determine that MH/SUD reimbursement is statistically comparable to M/S reimbursement. No test carries any weight over the other.

In-Network Professional Services Reimbursement Non-Quantitative Treatment Limitation (NQTL) Analysis

GA Surest - UnitedHealthcare Insurance Company

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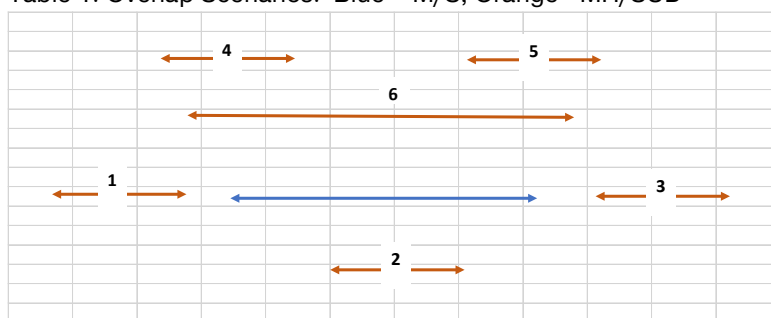
Testing for Comparability

- 1) Median of M/S no greater than 110% of MH/SUD Median = Comparable, or
- 2) Average of M/S no greater than 110% of MH/SUD Average = Comparable, or
- 3) The range between the 25th and 75th percentile is compared. Comparing the ranges produce the following scenarios (see Overlap and Table 1 Overlap scenarios):

Overlap (M/S Range used as base)

1 = MH/SUD < M/S	Not comparable
2 = MH/SUD w/n M/S	Comparable
3 = MH/SUD > M/S	Comparable
4 = MH/SUD overlaps M/S Low	Overlap >80%, then comparable
5 = MH/SUD overlaps M/S High	Comparable
6 = MH/SUD covers M/S range	Comparable

Table 1: Overlap Scenarios. Blue = M/S, Orange =MH/SUD



The chart below demonstrates comparability for plan year 2022 :

State	Georgia	
Test 1: Median Test	MD	Non-MD
M/S Median as % of CMS	87%	80%
BH Median as % of CMS	88%	89%
M/S to BH Ratio	99%	89%
M/S to BH Ratio < 110%	Yes	Yes
Test 2: Range Test	MD	Non-MD
M/S Range as % of CMS	78% - 117%	72% - 96%
BH Range as % of CMS	88% - 88%	89% - 89%
Overlap Scenario*	2 <i>BH w/n Med</i>	2 <i>BH w/n Med</i>
Overlap Percentage	100%	100%
Overlap Percentage > 80%	Yes	Yes
Pass Test 1, Test 2, or Test 3	Yes	Yes

The Plan concludes the above testing and comparison is sufficient to demonstrate comparability in operation.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The analysis reviewed the strategies and processes by which reimbursement for INN professional services is established. The findings of that analysis confirmed the strategies, processes, factors, evidentiary standards, and source information used to negotiate and establish provider reimbursements for MH/SUD INN professional services were comparable to, and applied no more stringently than, the strategies, processes, factors, evidentiary standards, and source information used to negotiate and establish provider reimbursement for M/S INN professional services “as written.”

The findings of the comparative analysis revealed the reimbursement for MH/SUD physicians (psychiatrists) and M/S Physicians were statistically comparable. Reimbursement for MH/SUD non-physicians and M/S non-physicians were statistically comparable “in-operation.” Specifically, for GA providers billing the codes described in Step 4, the median, average, and range of MH/SUD and M/S reimbursement relative to CMS were statistically comparable as evidenced in the comparability chart above (Step 4). Comparable rates between M/S and MH/SUD also demonstrate that the factors used during the reimbursement negotiation (e.g., provider leverage) were applied in a consistent manner.

Conclusions

Based upon these findings, the Plan concluded that the methodologies to negotiate and establish INN provider reimbursement for MH/SUD INN professional services was comparable to, and applied no more stringently than, the methodologies to negotiate and establish the INN provider reimbursement for M/S INN professional services “as written.”

Because the reimbursement for MH/SUD physicians and non-physicians compared to M/S physicians and non-physicians was no more stringent, the Plan’s methodologies to negotiate and establish reimbursement for MH/SUD INN professional services is comparable to, and applied no more stringently than, its methodologies to negotiate and establish reimbursement for M/S INN professional services “in operation.”

Medical Necessity Non-Quantitative Treatment Limitation (NQTL) Analysis

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Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical/surgical (M/S) benefits. This generally means that the financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements such as, deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs, which may limit the scope or duration of benefits for treatment under a plan or coverage.

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

The Plan covers M/S and MH/SUD services/technologies (e.g., services, interventions, devices, medically administered M/S and MH/SUD drugs, etc.) that are medically necessary. Medical necessity refers to the principle that healthcare services, technologies and treatments should be in accordance with generally accepted standards of medical practice, appropriate for the member’s disorder, disease, or symptoms, cost-effective, and essential for diagnosing, preventing, or treating a medical condition. The concept of medical necessity takes into account the best interests of the patient and the evidence-based standards of medical practice. It helps ensure that healthcare resources are allocated efficiently and that patients receive appropriate care based on their medical needs. The Plan makes medical necessity clinical coverage determinations using externally developed, evidence-based clinical criteria (also known as medical necessity criteria) such as InterQual®, MCG®, American Society of Addiction Medicine (ASAM) Criteria¹, Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System-Child and Adolescent Service Intensity Instrument (CALOCUS-CASII), and Early Childhood Service Intensity Instrument (ECSII) guidelines as well as internally developed objective, evidence-based, medical/behavioral clinical policies.

Application of medical necessity criteria is integral to the utilization management (UM) processes of a medical necessity clinical coverage benefit determination.

The Plan publishes its medical necessity criteria, which are available through www.uhcprovider.com (M/S) and www.providerexpress.com (MH/SUD), and upon request.

This document includes the following information:

- Process for developing and approving medical necessity criteria for both M/S and MH/SUD services and technologies
- Description of the NQTL and application (Step 1)
- Factors used to determine which services and technologies are subject to the NQTL (Step 2)
- Evidentiary standards and sources used to define, trigger and/or implicate a factor (Step 3)

¹ Only ASAM Criteria are used to make substance use disorder (SUD) medical necessity coverage determinations, unless otherwise mandated by state law or contract.

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- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

This analysis refers to the following attachments:

- *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions* - M/S policy that defines Medical Necessity
- *Optum National Policy Definitions List* - MH/SUD policy that defines Medical Necessity
- *UnitedHealthcare (UHC) Hierarchy of Clinical Evidence* – M/S policy that defines the hierarchy of clinical evidence to ensure a transparent and consistent approach within UnitedHealthcare
- *Behavioral Health Hierarchy of Clinical Evidence* – MH/SUD policy that defines the hierarchy of clinical evidence to ensure a transparent and consistent approach to the review and development of Optum’s Clinical Technology Assessments and Behavioral Clinical Policies
- *2023 UnitedHealthcare Provider Administrative Guide* - Informs providers of the Prior Authorization process. The *UnitedHealthcare Provider Administrative Guide* can be accessed on the website <https://www.uhcprovider.com/en/admin-guides.html>
- *September 2023 Optum National Network Manual* - Informs providers of the Prior Authorization process. The *Optum National Network Manual* can be accessed on the website <https://public.providerexpress.com/content/optum-network-manual.html>
- *Utilization Management Program Description (UMPD) of United HealthCare Services, Inc. and UnitedHealthcare Insurance Company* - summarizes the philosophy, structure and standards that govern UHC’s medical management, UM and utilization review responsibilities and functions
- *Certificates of Coverage - COC23-INS-BIND-2021-LG-GA-UHIC* - Plan document that explains covered services, terms, conditions, and limitations of the member’s policy
- *Schedule of Benefits - SBN23-Medical-INS-BIND-2021-Choice Plus-LG-GA-UHIC* - Plan document that outlines member responsibilities
- *Utilization Management Program Committee Charter* – document that outlines the purpose, responsibility, functions, and composition of the committee that oversees the M/S utilization management program
- *Clinical Technology Assessment Committee (CTAC) Charter* – document that outlines the purpose, structure, responsibility and membership of the committee that develops internal medical criteria and reviews and approves externally developed criteria for MH/SUD
- *Clinical Quality and Operations Committee (CQOC) Charter* – document that outlines the purpose, structure, responsibility, and membership of the committee that oversees CTAC
- *Applying Benefit Plan and Review Criteria Standard Operating Procedure* - outlines the hierarchy of authorities to be reviewed (i.e., state/federal laws and regulations followed by Benefit Plan criteria) when making coverage determinations
- *Clinical Review Criteria Operational Policy* - The purpose of this operational policy is to document that UHC will use evidence-based clinical review criteria to support clinical review decisions for UM programs, and to ensure that the clinical review process is applied consistently
- *Clinical Criteria Development Selection and Application Policy* - addresses Optum’s selection, development, and use of clinical criteria in making benefit determinations

The Plan concludes that the methodologies used to develop and approve medical necessity criteria and medical/behavioral clinical policies for M/S and MH/SUD services and technologies are comparable and applied no more stringently for MH/SUD both “as written” and “in operation.”

Medical Necessity Non-Quantitative Treatment Limitation (NQL) Analysis

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Process

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Medical Necessity is defined as: “Health care services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms, that are all of the following.

- In accordance with Generally Accepted Standards of Medical Practice.
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.”

The *September 2023, Optum National Network Manual* defines Medical Necessity as “Generally, the evaluation of health care services to determine whether the services meet plan criteria for coverage; are medically appropriate and necessary to meet basic health needs; are consistent with the diagnosis or condition; are rendered in a cost-effective manner; and are consistent with national medical practice guidelines regarding type, frequency and duration of treatment. This definition may vary according to member benefit plans or state laws (also referred to as clinical necessity).”

The Plan delegates UM of MH/SUD services to United Behavioral Health d/b/a Optum Behavioral Health (OBH), its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor.

Both M/S and MH/SUD have UM program descriptions that are the foundation for the objectives and guidelines of the Plan’s UM strategy. Medical necessity criteria or medical/behavioral clinical policies are not included in the UM program descriptions.

The Plan develops internal, objective, evidence-based, clinical policies and approves third-party, externally developed medical necessity criteria. Where available, both M/S and MH/SUD use externally developed evidence-based medical necessity criteria (e.g., InterQual, MCG, ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII) when making clinical coverage determinations. When M/S or MH/SUD technologies (e.g., services, interventions, devices, medically administered drugs, etc.) fall outside the scope of externally developed medical necessity criteria, internally developed, evidence-based, medical/behavioral clinical policies are used when making medical necessity clinical coverage determinations. All M/S and MH/SUD internally developed medical and behavioral clinical policies are reviewed at least annually. The *M/S Clinical Review Criteria Operational Policy* and *MH/SUD Clinical Criteria Development/Selection and Application Policy* outline the processes to ensure medical necessity criteria are developed consistently.

The Plan uses the following standard process to review externally developed medical necessity criteria:

The Medical Technology Assessment Committee (MTAC) assesses externally developed clinical criteria for M/S services and technologies. MTAC uses scientifically based, clinical evidence and the *UHC Hierarchy of Clinical Evidence* in its assessment and approval processes. MTAC conducts its processes in a timely manner to ensure transparency and consistency, and to identify safe and effective M/S services and technologies for members.

MTAC is comprised of, but not limited to, medical directors with diverse medical and surgical specialties and sub-specialties, representatives from business segments, legal services, consumer affairs, medical policy development and operations teams, benefit interpretation team, and other guests, as needed. MTAC voting members include medical directors with the following specialties (note that some doctors have multiple specialties):

- Plastic Surgery
- Internal Medicine (x7)

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- Medical Oncology
- Thoracic and Cardiothoracic Vascular Surgery (x2)
- Preventative Medicine
- Pediatrics
- Diagnostic Radiology and Vascular/Interventional Radiology
- Ophthalmology
- Physical Medicine & Rehabilitation Pain Medicine
- Family Practice
- Emergency Medicine

As of April 1, 2023, the Utilization Management Program Committee (UMPC) began overseeing the M/S UM program. The UMPC is responsible for the development and maintenance of the M/S Prior Authorization, Concurrent Review, and Retrospective Review processes. The UMPC ensures that the UM program considers the factors and evidentiary standards for applying UM. The UMPC is comprised of:

- Chief Medical Officer, Medical Management (Co-Chair)
- Senior Vice President, Clinical Advancement (Co-Chair)
- Chief Medical Officer, UnitedHealthcare
- Senior Vice President, Clinical Appeals & Grievances
- Chief Medical Officer, Clinical Policy
- Chief Medical Officer, UnitedHealthcare Employer & Individual
- Chief Medical Officer, UnitedHealthcare Medicare & Retirement
- Chief Medical Officer, Community & State
- Chief Medical Officer, UnitedHealthcare Individual & Family Plans
- Vice President, Clinical Transformation & Affordability
- Senior Director, Mental Health Parity
- Vice President, Utilization Management Strategy & Implementation

One of the chairs must be an executive leader and a licensed physician. UMPC meets at least six times per year but may meet more frequently if needed. MTAC reports to the UMPC.

The Clinical Quality and Operations Committee (CQOC) assesses and approves the use of externally developed clinical criteria for MH/SUD services. CQOC uses scientifically based, clinical evidence and the *Behavioral Health Hierarchy of Clinical Evidence* in its assessment and approval processes. CQOC conducts its processes in a timely manner to ensure transparency and consistency, and to identify safe and effective MH/SUD services for members. The CQOC is comprised of representatives from sub-committees, representatives from the clinical quality improvement, UM, care engagement, medical operations, medical policy and standards, clinical operations, appeals, product, legal, compliance, network strategy, provider experience, accreditation, and benefits teams. The Chair must be an executive leader, board certified in psychiatry or psychiatric subspecialty, and licensed physician.

The Plan uses the following standard process to develop and approve *internal* medical necessity criteria:

The Plan uses committees to assess technologies and conduct a thorough review of scientifically based clinical evidence and peer-reviewed literature in accordance with the *UHC* and *Behavioral Health Hierarchies of Clinical Evidence* to develop medical/behavioral clinical policies that apply to the technologies.

MTAC develops and approves medical clinical policies for M/S services and technologies when externally developed criteria are not available. MTAC uses scientifically based clinical evidence and the *UHC Hierarchy of Clinical Evidence* in its

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development and approval processes. MTAC conducts its processes in a timely manner to ensure transparency and consistency, and to identify safe and effective M/S services and technologies for members.

When assessing the safety, efficacy, and appropriateness of the services/technologies used to treat M/S conditions, MTAC first looks for any strong and compelling scientific evidence such as statistically robust, well-designed, randomized, controlled, trials and cohort studies. In addition, MTAC will look for multi-site observational studies and single site observational studies.

In the absence of any strong and compelling scientific evidence, MTAC assesses technologies by looking for any national consensus statements and/or publications by recognized authorities such as clinical position papers published by professional specialty societies and Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations (NCD).

MTAC will not deem a technology unproven solely based on a lack of randomized controlled trials, particularly for new and emerging technologies.

As of April 1, 2023, UMPC began reviewing and validating the medical clinical policies endorsed by MTAC. If UMPC determines that any medical clinical policies are not appropriately supported by clinical evidence, then UMPC refers the medical clinical policy back to MTAC.

The CQOC develops and approves behavioral clinical policies for MH/SUD services when externally developed criteria are not available. CQOC uses scientifically based clinical evidence and the *Behavioral Health Hierarchy of Clinical Evidence* in its development and approval processes. CQOC conducts its processes in a timely manner to ensure transparency and consistency, and to identify safe and effective MH/SUD services for members.

The Clinical Technology Assessment Committee (CTAC) is a sub-committee of CQOC and is responsible for reviewing new or evolving technologies and then developing and maintaining evidence-based behavioral clinical policies for behavioral health technologies. CTAC's purpose is to make determinations regarding technologies that may or may not be experimental, investigational, or unproven (EIU). CTAC members include behavioral health medical directors, senior leaders of clinical operations, research and development, clinical review, legal, compliance, and policy. CTAC voting members include six psychiatrists and one licensed independent social worker (LISW), plus two co-chairs, both of whom are psychiatrists. CTAC obtains approval of its determinations from the CQOC.

When assessing the safety efficacy, and appropriateness of services/technologies used to treat MH/SUD conditions, CQOC and CTAC first look for scientifically based clinical evidence and peer reviewed literature. In addition, the committees will look for any strong and compelling scientific evidence such as statistically robust, well-designed, randomized, controlled trials and cohort studies. In addition, CTAC (for EIU) and CQOC will also look for systematic reviews and meta-analyses, large prospective trials, cross-sectional studies, retrospective studies, surveillance studies, case reviews/case series, anecdotal/editorial statements, and professional opinions.

In the absence of any strong and compelling scientific evidence, CQOC (and CTAC for potential EIU technologies) assesses services and technologies by looking for any national consensus statements and/or publications by recognized authorities such as clinical position papers published by professional specialty societies and CMS NCDs.

CQOC (and CTAC for potential EIU technologies) will not deem a service or technology unproven solely based on a lack of randomized controlled trials, particularly for new and emerging technologies.

The CQOC reviews and validates behavioral clinical policies endorsed by CTAC. If CQOC determines that any behavioral clinical policies are not appropriately supported by clinical evidence, then CQOC refers the behavioral clinical policy back to CTAC.

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Internally developed medical and behavioral clinical policies are publicly available here:

- M/S: Medical & Drug Policies and Coverage Determination Guidelines for UnitedHealthcare Commercial Plans | UHCprovider.com (<http://www.uhcprovider.com/en/policies-protocols/clinical-guidelines.html>)
- MH/SUD: Guidelines/Policies/Manuals (<http://www.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies.html>)

The Plan uses the following standard process to apply medical necessity criteria:

M/S and MH/SUD clinical reviewers follow an established process of reviewing state/federal laws and regulations, followed by Plan documents when making medical necessity coverage benefit determinations. The criteria chosen for review are based on the treatment type, diagnosis, and services requested. Where available, both M/S and MH/SUD use externally developed evidence-based medical necessity criteria (e.g., InterQual, MCG, ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII) when making medical necessity coverage benefit determinations. When M/S or MH/SUD technologies (e.g., services, interventions, devices, medically administered drugs, etc.) fall outside the scope of externally developed medical necessity criteria, internally developed, evidence-based, medical/behavioral clinical policies are used when making medical necessity clinical coverage determinations. There is no duplication between internally and externally developed medical necessity criteria. This means that there are either externally developed medical necessity criteria available or there are internally developed medical/behavioral clinical policies available. M/S and MH/SUD clinical reviewers do not have to make a choice between using internal or external medical necessity criteria.

Second level, or peer review, medical necessity coverage benefit determinations include clinical judgment. The M/S *Peer Clinical Review Operational Policy* and the MH/SUD *Management of Behavioral Health Benefits Policy* outline the processes. Clinicians use their clinical judgment when they apply evidence-based medical necessity criteria to each member's specific clinical condition. Clinicians use their independent clinical judgment when they evaluate whether the member's clinical condition meets the medical necessity criteria per the applicable externally developed medical necessity criteria or internal medical/behavioral clinical policies.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- Medical Necessity

Benefit Classification(s)

- In-Network (INN) Inpatient, Out-of-Network (OON) Inpatient, INN Outpatient, and OON Outpatient

Please note that the Prior Authorization, Concurrent Review, and Retrospective Review NQTLs describe the services in scope for UM. These NQTLs also describe the factors and evidentiary standards used to determine whether a covered service is subject to a medical necessity review.

The Plan notes that not all covered services are subject to a medical necessity review.

Plan(s) at Issue

- UnitedHealthcare Insurance Company

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Plan Terms/Source Document(s)

In each of the Plan products, Medically Necessary is the Plan term used to guide UM decision-making for both M/S and MH/SUD services and technologies. Medically Necessary is generally defined as follows:

“Medically Necessary – health care services are all of the following as determined by us or our designee.

- In accordance with *Generally Accepted Standards of Care*.
- Clinically appropriate, in terms of type, frequency, extent, service site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s), service site or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.
- Or, are subject to Bind Coverage with Evidence Development Policy (CED Policy).

Generally Accepted Standards of Care are evidence based independent standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties. Valid, evidence based sources reflecting generally accepted standards of care include credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or nationally recognized clinical practice guidelines may be considered. We have the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be determined by us.

We develop and maintain clinical policies that describe the Generally Accepted Standards of Care scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. [[These clinical policies (as developed by us and revised from time to time), are available to Covered Persons through [MyBind.com] or by calling the telephone number on your ID card.] [They are [also] available to Physicians and other health care professionals on [MyBind.com].]]”

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Medical Necessity is defined as follows:

“Health care services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms, that are all of the following.

- In accordance with Generally Accepted Standards of Medical Practice.
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.”

The *2023 United Healthcare Provider Administrative Guide* Chapter 7 describes Plan medical necessity processes as follows

“We base coverage decisions, including medical necessity decisions, on:

- Member’s benefits.
- State and federal requirements.
- The contract between us and the plan sponsor.

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- Medicare guidelines including NCDs and local coverage determination (LCD) guidelines.
- Medicare Benefit Policy Manual (MA members).
- UnitedHealthcare medical policies, medical benefit drug policies, coverage determination guidelines, utilization review guidelines and MA coverage summaries.

Our employees, contractors and delegates do not receive financial incentives for issuing non-coverage decisions or denials. We and our delegates do not offer incentives for underutilization of care/services or for barriers to care/service. We do not hire, promote or terminate employees or contractors based on whether they deny benefits. We use tools such as UnitedHealthcare medical policies and third-party resources (such as InterQual® criteria and other guidelines), to assist us in administering health benefits and determining coverage. These tools and resources are not equivalent to the practice of medicine or medical advice, and you should use them in addition to independent, qualified medical judgment.”

The *Optum National Policy Definitions List* defers to the definition of Medical Necessity as set forth in member Plan documents: “This term is variable and defined in the member’s applicable Plan or Coverage document.”

The *September 2023, Optum National Network Manual* defines Medical Necessity as:

“Generally, the evaluation of health care services to determine whether the services meet plan criteria for coverage; are medically appropriate and necessary to meet basic health needs; are consistent with the diagnosis or condition; are rendered in a cost-effective manner; and are consistent with national medical practice guidelines regarding type, frequency and duration of treatment. This definition may vary according to Member Benefit Plans or state laws (also referred to as Clinical Necessity).”

List of M/S and MH/SUD Services and Technologies Subject to NQTL

All M/S and MH/SUD INN inpatient, OON inpatient, INN outpatient, and OON outpatient services and technologies subject to UM.

Step 2 – Factor Used to Develop and Approve Medical and Behavioral Clinical Policies

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/ SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

The Plan relies on the following factor to develop and approve medical necessity criteria. This factor applies to both M/S and MH/SUD benefits for the following:

- I. All M/S INN inpatient, OON inpatient, INN outpatient, and OON outpatient services and technologies subject to UM
 - II. All MH/SUD INN inpatient, OON inpatient, INN outpatient, and OON outpatient services and technologies subject to UM
- M/S and MH/SUD Committee Considerations (Qualitative) including clinical efficacy, safety of the service or technology, and appropriateness of the proposed service or technology when developing and approving medical/behavioral clinical policies and medical necessity criteria

This factor applies to M/S and MH/SUD services and technologies.

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Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factor used in developing or approving medical necessity criteria. These evidentiary standards and sources apply for the following:

- I. All M/S INN inpatient, OON inpatient, INN outpatient, and OON outpatient services and technologies subject to UM
- II. All MH/SUD INN inpatient, OON inpatient, INN outpatient, and OON outpatient services and technologies subject to UM

Factor – M/S and MH/SUD Committee Considerations, including clinical efficacy, safety of the service or technology, and appropriateness of the proposed service or technology when developing and approving medical/behavioral clinical policies and medical necessity criteria

- Clinical Effectiveness – Is a characteristic of care that is in accordance with objective, evidence-based clinical criteria, and nationally recognized guidelines as determined by internal medical experts. Clinically appropriate care is more likely to be effective
- Safety of Service or Technology - Is a state in which hazards and conditions leading to physical or psychological harm are minimized to preserve the health and wellbeing of a person receiving health care
- Appropriateness of the Proposed Service or Technology – The service or technology is suitable for the member's clinical presentation and the expected health benefits from the medical service or technology are clinically significant and exceed the expected natural history of recovery and the expected health risks by a sufficient margin
- The Plan's evidentiary standard and sources that define and/or trigger the M/S and MH/SUD Committee Considerations factor:
 - The Plan uses scientifically based clinical evidence and the *UHC* and *Behavioral Health Hierarchies of Clinical Evidence* to determine which M/S and MH/SUD services or technologies are safe and effective and, therefore, eligible for benefit coverage. The *UHC* and *Behavioral Health Hierarchies of Clinical Evidence* detail the hierarchy of clinical evidence that is preferred when assessing which health services or technologies are safe and effective. To be deemed safe and effective, a health service or technology only has to have evidence in at least one category.
 - M/S assesses evidence from the following when developing or approving medical clinical policies/medical necessity criteria:
 - Scientifically based clinical evidence
 - Peer-reviewed literature
 - *UHC Hierarchy of Clinical Evidence*
 - In the absence of strong and compelling scientific evidence, medical policies may be based upon:
 - National guidelines and consensus statements
 - CMS NCDs
 - Clinical position papers based upon rigorous review of scientific evidence or clinical registry data from professional specialty societies when their statements are based upon referenced clinical evidence, e.g., American College of Physicians (ACP), The Society for Post-Acute and Long-Term Care Medicine (AMDA), American Academy of Family Physicians (AAFP), American College of Obstetricians and Gynecologists (ACOG), American College of Cardiology (ACC), etc.
 - InterQual or MCG (for review of external medical necessity criteria)

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- MH/SUD assesses evidence from the following when developing or approving behavioral clinical policies/medical necessity criteria:
 - Scientifically based clinical evidence
 - Peer-reviewed literature
 - *Behavioral Health Hierarchy of Clinical Evidence*
 - In the absence of strong and compelling scientific evidence, behavioral clinical policies/clinical criteria may be based upon:
 - National consensus statements
 - Publications by recognized authorities such as government sources and/or professional societies
- ASAM Criteria, LOCUS, CALOCUS-CASII, and ECSII (for review of external medical necessity criteria)

Note: Anecdotal/editorial statements and professional opinions are only used to support adoption of behavioral clinical policies /clinical criteria when no other source is available.

These evidentiary standards and sources apply to M/S and MH/SUD services and technologies and are defined in a qualitative manner.

The factor and evidentiary standards used as the basis for developing and approving MH/SUD medical necessity criteria are comparable to, and applied no more stringently than, the factor and evidentiary standards used as the basis for developing and approving M/S medical necessity criteria “as written” and “in operation.”

Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

As Written

The Plan conducted a comparative analysis of the strategies, processes, factor, evidentiary standards, and source information MH/SUD uses to

- develop internal, objective, evidence-based, behavioral clinical policies and
- approve third-party, externally developed clinical criteria
- to the strategies, processes, factors, evidentiary standards, and source information M/S uses to:
- develop internal, objective, evidence-based, medical clinical policies and
- approve third-party, externally developed clinical criteria

for use in UM clinical coverage determinations and found they were comparable to, and no more stringently applied than, the strategies, processes, factors, evidentiary standards, and source information used by M/S “as written.”

National internal committees evaluate the applicable factors and standards described in Steps 2 and 3 when developing and approving Medical Necessity criteria.

Review of Factor and Evidentiary Standards

When developing and approving medical and behavioral clinical policies/medical necessity criteria, M/S and MH/SUD committees both consider clinical efficacy, safety, and appropriateness of the proposed services or technologies.

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The M/S and MH/SUD *UHC* and *Behavioral Health Hierarchies of Clinical Evidence* are comparable. Both use the following categories of sources (with source-specific differences if the source is specific to M/S or MH/SUD):

- Well-designed evidence-based studies
- Observational studies
- Case studies
- Consensus statements
- Clinical and professional opinion papers

Review of Operational Policies and Procedures

The Plan reviewed the following M/S and MH/SUD operational policies and procedures to confirm comparability and found MH/SUD policies, procedures, and processes to be comparable and no more stringent than M/S policies, procedures, and processes.

M/S

- *UHC Hierarchy of Clinical Evidence*
 - The purpose of this document is to outline the hierarchy of clinical evidence that is used to determine which M/S health services or technologies are safe and effective and, therefore, eligible for benefit coverage. In developing the hierarchy, UnitedHealthcare uses scientifically based clinical evidence to identify safe and effective health services or technologies for members.
- Utilization Management Program Committee Charter
 - The UMPC is responsible for oversight of the UM program and the development and maintenance of the scope and processes of prior authorization, concurrent review, and retrospective review, including defining the services that require prior authorization, concurrent review, and post-service review
- *Applying Benefit Plan and Review Criteria Standard Operating Procedure*
 - This standard operating procedure outlines the hierarchy of authorities to be reviewed (i.e., state/federal laws and regulations followed by Benefit Plan criteria) when making clinical coverage determinations
- *UMPD of United HealthCare Services, Inc. and UnitedHealthcare Insurance Company*
 - This document summarizes the philosophy, structure and standards that govern UHC's medical management, utilization management and utilization review responsibilities and functions
- *Clinical Review Criteria Operational Policy*
 - The purpose of this operational policy is to document that UHC will use evidence-based clinical review criteria to support clinical review decisions for UM programs, and to ensure that the clinical review process is applied consistently

MH/SUD

- *Behavioral Health Hierarchy of Clinical Evidence*
 - The purpose of this document is to outline the hierarchy of clinical evidence that is used to determine which MH/SUD health services or technologies are safe and effective and, therefore, eligible for benefit coverage. In developing the hierarchy, Optum uses scientifically based clinical evidence to identify safe and effective health services or technologies for members
- *CTAC Charter*
 - CTAC is responsible for reviewing new or evolving technologies and then developing and maintaining evidence-based behavioral clinical policies for behavioral health technologies
- *CQOC Charter*
 - The role and purpose of the CQOC is to review and approve externally developed medical necessity criteria, develop behavioral clinical policies when externally developed criteria is not available, and to review and validate CTAC's assessment of EIU technologies

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- *Management of Behavioral Health Benefits*
 - The purpose of this policy is to describe the mechanisms and processes designed to promote consistency in the management of behavioral health benefits and ensure that members receive appropriate, high quality behavioral health services or technologies in a timely manner
- *Optum Behavioral Health Utilization Management Program Description*
 - This document summarizes the philosophy, structure and standards that govern Optum's medical management, utilization management and utilization review responsibilities and functions
- *Clinical Criteria Development Selection and Application Policy*
 - This document addresses Optum's selection, development, and use of clinical criteria in making benefit determinations. Optum uses written clinical criteria consistent with National Committee for Quality Assurance (NCQA) and Utilization Review Accreditation Commission (URAC) requirements and applicable laws and regulations
 - Optum selects and uses clinical criteria that are consistent with generally accepted standards of care, including objective criteria that are based on sound clinical evidence. Optum uses the criteria to make standardized coverage determinations and to inform discussions about evidence-based practices and discharge planning

Where available, both M/S and MH/SUD use externally developed evidence-based medical necessity criteria (e.g., InterQual, MCG, ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII) when making clinical coverage determinations. When M/S or MH/SUD technologies (e.g., services, interventions, devices, medically administered drugs, etc.) fall outside the scope of externally developed medical necessity criteria, internally developed, evidence-based, medical/behavioral clinical policies are used when making medical necessity clinical coverage determinations.

MTAC and CQOC (and CTAC for EIU) develop internal clinical policies only. MTAC and CQOC review and approve externally developed medical necessity criteria. In either case, a comparable process is followed. In some cases, the Plan is obligated by State regulations to use certain externally developed medical necessity criteria. The committees assess the clinical efficacy, safety, and appropriateness of the proposed services or technologies used for the treatment of health care conditions based upon the scientific evidence. CTAC's technology assessment process for MH/SUD potential EIU technologies, including the *Behavioral Health Hierarchy of Clinical Evidence*, is comparable to, and applied no more stringently than, MTAC's assessment process for M/S technologies including the *UHC Hierarchy of Clinical Evidence*. Additionally, CQOC's assessment process for MH/SUD services, including the *Behavioral Health Hierarchy of Clinical Evidence*, is comparable to, and applied no more stringently than, MTAC's assessment process for M/S services including the *UHC Hierarchy of Clinical Evidence*.

All M/S and MH/SUD medical/behavioral clinical policies are reviewed at least annually.

Review of processes to review *externally* developed medical necessity criteria

A standard and comparable process is followed to review externally developed, third party medical necessity criteria. The MTAC assesses externally developed clinical criteria for M/S services or technologies. MTAC uses scientifically based, clinical evidence and the *UHC Hierarchy of Clinical Evidence* in its assessment and approval processes. MTAC conducts its processes in a timely manner to ensure transparency and consistency, and to identify safe and effective M/S services or technologies for members.

The CQOC assesses externally developed clinical criteria for MH/SUD services. CQOC uses scientifically based clinical evidence and the *Behavioral Health Hierarchy of Clinical Evidence* in its development, assessment, and approval processes. CQOC conducts its processes in a timely manner to ensure transparency and consistency, and to identify safe and effective MH/SUD services for members.

Both M/S and MH/SUD committees use comparable evidentiary standards and sources to evaluate clinical efficacy, safety, and appropriateness of the proposed services or technologies to approve medical/behavioral clinical policies.

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Further, both committees are comprised of licensed clinicians with applicable specialties and are chaired by executive-level medical directors.

ASAM Criteria, LOCUS, CALOCUS-CASII, and ECSII are widely recognized as best-in-class externally developed medical necessity criteria sources. The MH/SUD external medical necessity criteria is developed by nationally recognized organizations. The Plan uses InterQual medical necessity criteria for M/S services or technologies because InterQual monitors more than 3,000 guidelines, guideline issuers and medical societies for newly published medical literature, and an independent clinical review panel drawn from more than 1,000 experts provides authoritative peer review. The M/S and MH/SUD medical necessity criteria sets apply to specific clinical conditions and do not overlap.

Review of processes to develop and approve *internal* medical necessity criteria

MTAC develops and approves medical clinical policies for M/S services or technologies. MTAC uses scientifically based clinical evidence and the *UHC Hierarchy of Clinical Evidence* in its development, assessment, and approval processes. MTAC conducts its processes in a timely manner to ensure transparency and consistency, and to identify safe and effective M/S services or technologies for members.

CQOC (and CTAC for EIU technologies) develops and approves behavioral clinical policies for MH/SUD services and technologies. CQOC/CTAC uses scientifically based clinical evidence and the *Behavioral Health Hierarchy of Clinical Evidence* in its development, assessment, and approval processes. CQOC/CTAC conducts its processes in a timely manner to ensure transparency and consistency, and to identify safe and effective MH/SUD services and technologies for members.

When assessing services and technologies used to treat M/S and MH/SUD conditions, both MTAC and CQOC/CTAC first look for any strong and compelling scientific evidence such as statistically robust, well-designed, randomized, controlled, trials and cohort studies. In addition, MTAC will look for multi-site observational studies and single site observational studies. CQOC/CTAC will also look for systematic reviews and meta-analyses, large prospective trials, cross-sectional studies, retrospective studies, surveillance studies, case reviews/case series, anecdotal/editorial statements, and professional opinions.

In the absence of any strong and compelling scientific evidence, MTAC and CQOC/CTAC assess services and technologies by looking for any national consensus statements and/or publications by recognized authorities such as clinical position papers published by professional specialty societies and CMS NCDs.

Neither MTAC nor CQOC/CTAC will deem a technology unproven solely based on a lack of randomized controlled trials, particularly for new and emerging technologies.

Both M/S and MH/SUD committees use comparable evidentiary standards and sources to evaluate clinical efficacy, safety, and appropriateness of the proposed services and technologies to develop or approve medical/behavioral clinical policies.

Review of Medical Necessity Processes

M/S and MH/SUD clinical reviewers follow a hierarchy of authority when making medical necessity determinations. Both M/S and MH/SUD clinical reviewers follow the established process of reviewing state/federal laws and regulations, followed by Plan documents when making clinical coverage benefit determinations (see enclosed M/S *Applying Benefit Plan and Review Criteria Standard Operating Procedure* and MH/SUD *Clinical Criteria Development Selection and Application Policy*). Internally developed clinical policies or externally developed third party medical necessity criteria are then reviewed. The criteria chosen for review are based on the treatment type, diagnosis, and services requested. As there is no duplication between internally and externally developed medical necessity criteria, M/S and MH/SUD clinical reviewers do not have to make a choice between using internal or external medical necessity criteria.

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The Plan generally assesses the appropriate application of its medical necessity criteria in operation by comparing the results of its mandatory M/S and MH/SUD Inter-Rater Reliability (IRR) assessment outcomes.

In Operation

The Plan conducted a comparative analysis of the strategies, processes, factors, evidentiary standards, and source information MH/SUD uses to

- develop internal, objective, evidence-based, behavioral clinical policies and
- approve third-party, externally developed clinical criteria

to the strategies, processes, factors, evidentiary standards, and source information M/S uses to:

- develop internal, objective, evidence-based, medical clinical policies and
- approve third-party, externally developed clinical criteria

for use in UM clinical coverage determinations and found they were comparable to, and no more stringently applied than, the strategies, processes, factors, evidentiary standards, and source information used by M/S “in operation.”

Review of Factor and Evidentiary Standards

When reviewing and developing medical/behavioral clinical policies and medical necessity criteria, M/S and MH/SUD committees both consider clinical efficacy, safety, and appropriateness of the proposed services and technologies. The *UHC* and *Behavioral Health Hierarchies of Clinical Evidence* are comparable. The factors and evidentiary standards were applied to both M/S and MH/SUD services and technologies comparably and not more stringently to MH/SUD services than to M/S services and technologies “in operation.”

Review of Operational Policies and Procedures

The Plan reviewed M/S and MH/SUD operational policies and procedures to confirm comparability and found MH/SUD policies, procedures, and processes to be comparable and no more stringent than M/S policies, procedures, and processes. The M/S *Clinical Review Criteria Operational Policy* and MH/SUD *Clinical Criteria Development/Selection and Application Policy* outline the processes to ensure medical necessity criteria are developed consistently. Second level, or peer review, determinations include clinical judgment; the M/S *Peer Clinical Review Operational Policy* and the MH/SUD *Management of Behavioral Health Benefits Policy* outline the processes. Clinicians use their clinical judgment when they apply evidence-based medical necessity criteria to each member’s specific clinical condition. Clinicians use their independent clinical judgment when they evaluate whether the member’s clinical condition meets the medical necessity criteria per the applicable externally developed medical necessity criteria or internal medical/behavioral clinical policies. Further, review of the committee charters confirms that both committees are comprised of licensed clinicians with applicable specialties and are chaired by executive-level medical directors.

Review of process to develop and approve medical necessity criteria

The strategy for developing and approving medical necessity criteria is comparable for both M/S and MH/SUD and applied no more stringently to MH/SUD services and technologies. The Plan conducted a review of the M/S and MH/SUD processes to confirm comparability. The review focused on the following aspects of the process for both M/S and MH/SUD:

- The committees follow standard processes outlined in their respective charters and apply their respective *Hierarchies of Clinical Evidence* when developing, assessing, and approving medical/behavioral clinical policies and medical necessity criteria.
 - MTAC reviewed and approved the use of third-party externally developed medical necessity criteria and developed new medical clinical policies when external criteria were not available
 - UMPC reviewed and validated the MTAC assessment and approval of medical necessity criteria.
 - Similarly, CQOC reviewed and approved the use of third-party externally developed medical necessity criteria and developed new behavioral clinical policies when external criteria were not available.
 - CTAC developed behavioral clinical policies for EIU.
 - CQOC reviewed and approved EIU behavioral clinical policies developed by CTAC

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- If UMPC or CQOC determine that any internally developed medical/behavioral clinical policies are not appropriately supported by clinical evidence, then UMPC or CQOC refer the medical necessity criteria back to MTAC or CTAC.

Review of Use of Medical Necessity Criteria

M/S and MH/SUD utilize medical and behavioral clinical policies and medical necessity criteria when making medical necessity clinical coverage benefit determinations related to M/S and MH/SUD services and technologies. All M/S and MH/SUD clinical staff and peer reviewers who make clinical coverage benefit determinations utilizing medical and behavioral clinical policies and medical necessity criteria are required to participate in an IRR assessment to ensure clinical policies and medical necessity criteria are applied in a consistent and appropriate manner “in operation.” Clinical staff are required to achieve a passing score of at least 90%. The IRR assessment process identifies areas of improvement for clinical staff who do not achieve a passing score and additional training is provided on the use and application of the relevant policies. If necessary, remediation planning, and training will be directed by a supervisor/manager.

Second level, or peer review, medical necessity benefit coverage determinations include clinical judgment. The M/S *Peer Clinical Review Operational Policy* and the MH/SUD *Management of Behavioral Health Benefits Policy* outline the processes. Clinicians use their clinical judgment when they apply evidence-based medical necessity criteria to each member’s specific clinical condition. Clinicians use their independent clinical judgment when they evaluate whether the member’s clinical condition meets the medical necessity criteria per the applicable externally developed medical necessity criteria or internal medical/behavioral clinical policies.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan’s or issuer’s findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The findings of the Plan’s analyses confirmed the strategies, processes, factor, evidentiary standards, and source information used to develop MH/SUD medical necessity criteria and behavioral clinical policies and review externally developed criteria were comparable to, and applied no more stringently than, the strategies, processes, factor, evidentiary standards, and source information used to develop the M/S medical necessity criteria and medical clinical policies and review externally developed criteria “as written” and “in operation.”

The MH/SUD policies, procedures, and processes were found to be comparable and no more stringent than M/S policies, procedures, and processes.

The Plan used comparable processes and methodologies to assess and develop internal medical/behavioral clinical policies and externally developed medical necessity criteria.

M/S and MH/SUD clinical reviewers follow the same established process of reviewing state/federal laws and regulations, followed by Plan documents when making clinical coverage benefit determinations. Further, all M/S and MH/SUD clinical staff who recommend or make clinical coverage determinations are required to take and pass an annual IRR assessment on the tools they use. The 2022 IRR M/S results were 97% and MH/SUD results were 96%, demonstrating that M/S and MH/SUD clinical reviewers appropriately applied medical and behavioral clinical policies/medical necessity criteria when making medical necessity clinical coverage determinations.

The Plan’s Medical Necessity definitions for M/S and MH/SUD are the same, as published in the Plan documents. Additionally, both M/S and MH/SUD clinical reviewers follow the established process of reviewing state/federal laws and regulations,

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followed by Plan documents and then medical/behavioral clinical policies when making clinical coverage benefit determinations.

Conclusions

The Plan concluded the methodologies used to develop MH/SUD internal evidence-based behavioral clinical policies and approve MH/SUD externally developed medical necessity criteria for use in medical necessity clinical coverage benefit determinations were comparable to, and applied no more stringently than, the methodologies used to develop M/S internal evidence-based medical clinical policies and approve M/S externally developed medical necessity criteria for use in medical necessity clinical coverage benefit determinations both “as written” and “in operation.”

Overview

Pursuant to a federal law called the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical and surgical (M/S) benefits. This generally means that financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA protections include:

- Financial requirements such as, deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs, which may limit the scope or duration of benefits for treatment under a plan or coverage.

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors considered in the design and application of the NQTL (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTLs

The Plan assesses the adequacy of its network based on regulatory requirements.

This document includes the following information:

- Process for both M/S and MH/SUD network management – network adequacy
- Description of the NQTL and application (Step 1)
- Factors used to facilitate network management – network adequacy for both M/S and MH/SUD (Step 2)
- Evidentiary standards and sources used to define and/or trigger each of the identified factors (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

The Plan concludes M/S and MH/SUD network management – network adequacy processes are comparable and applied to MH/SUD no more stringently both “as written” and “in operation.”

Process

The Plan assesses network adequacy based on access standards that are in accordance with the Centers for Medicare & Medicaid Services (CMS) and/or applicable state laws. When determining whether to recruit providers in a given geographic market (such as a county or metropolitan area), the Plan considers network adequacy and access reports.

Key steps in the network management process for both M/S and MH/SUD services include:

- The Plan determines Time, Distance, and Provider Threshold requirements based on state/federal requirements
- The Plan conducts M/S and MH/SUD network adequacy reporting (by state/county) to determine if Time, Distance, and Provider Threshold requirements are met
- If network adequacy requirements are not met, the Plan actively seeks to add providers to the network in that specialty or provider type

For M/S and MH/SUD, the Plan conducts M/S and MH/SUD network adequacy reporting (by state/county) on a regular basis (no less than quarterly) to determine if Time, Distance, and Provider Threshold requirements are met. The network adequacy report incorporates both M/S and MH/SUD provider specialties. M/S and MH/SUD utilize the network adequacy report and ensure that the Network Variation Tracker (NVT) and Analytics tools are used when inconsistencies are identified.

For M/S, the results of the network adequacy report are sent to the UnitedHealthcare Network (UHN) Regional Director of Network Deficiencies through an NVT. If network gaps are identified, a network recruitment plan is developed by the M/S Provider Relations and Contracting teams.

For MH/SUD, the results of the network adequacy report are sent to the National Quality Improvement Committees (NQIC) as well as the respective Health Plan Oversight Committee through the NVT. The Health Plan Oversight Committee assesses and reviews the results and recommends interventions, as needed. If a network gap is identified, a network recruitment plan is developed by the MH/SUD Provider Relations and Contracting teams.

For M/S and MH/SUD, if there is a validated/confirmed supply gap, the Plan language for both M/S and MH/SUD allows members to seek an exception and receive services from an out-of-network (OON) provider at the in-network (INN) benefit level.

The Plan notes that MH/SUD network adequacy standards are reviewed during the product filing and/or annual reporting process by the regulator as applicable.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- Network Management – Network Adequacy

Benefit Classification(s)

- Applies to all INN, inpatient and outpatient services

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHIC)

Plan Terms/Source Document(s)

Per the Plan's member portal, "UnitedHealthcare networks consist of a variety of primary care and behavioral professionals, specialists, hospitals and other facilities. To help provide members with reasonable access to providers who meet their needs, we look at the number of providers and the types of services offered within a geographic area. Additionally, we conduct an assessment of how well the network meets members' cultural needs and preferences, as well as any special healthcare needs. We make outreach to providers, as needed, in order to recruit them to our network. We also accept requests from employers, members, and providers to accommodate needs and preferences." (<https://www.uhc.com/legal/provider/commercial-plans>)

List of M/S and MH/SUD Benefits Subject to NQTL

Applies to all INN M/S and MH/SUD services

Step 2 – Factors Used in the Design and Application of the NQTLs

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

The Plan relies on the following factors to determine network adequacy. These factors apply to both M/S and MH/SUD benefits in the following classifications:

- I. M/S INN inpatient/outpatient services
 - II. MH/SUD INN inpatient/outpatient services
- State-specific standards (Quantitative)
 - When state regulations identify a quantifiable network adequacy measurement for geographic and numeric availability of providers

Applies to both M/S and MH/SUD services.

- Centers for Medicare & Medicaid Services (CMS)/Health Services Delivery (HSD) table (Quantitative)

Applies to both M/S and MH/SUD services.

The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factors used in determining network adequacy. These evidentiary standards and sources apply to the following benefit classifications:

- I. M/S INN inpatient/outpatient services
- II. MH/SUD INN inpatient/outpatient services

Factor – State-specific standards is defined as state regulations identifying a quantifiable network adequacy measurement for geographic and numeric availability of providers.

The Plan's evidentiary standard and source that defines and/or triggers the identification of the factor:

- Applicable state regulatory requirements

These evidentiary standards and sources apply to both M/S and MH/SUD INN inpatient/outpatient services. This evidentiary standard and source is defined in a quantitative manner.

Factor – Centers for Medicare & Medicaid Services (CMS)/Health Services Delivery (HSD) table is defined as CMS guidance for time/distance standards for various types of providers and facilities.

The Plan's evidentiary standard and source that defines and/or triggers the identification of the factor:

- CMS/HSD table (located under downloads in the following website: cms.gov/medicare/medicare-advantage/medicareadvantageapps)

These evidentiary standards and sources apply to both M/S and MH/SUD INN inpatient/outpatient services. This evidentiary standard and source is defined in a quantitative manner.

These evidentiary standards and sources are applicable to both M/S and MH/SUD services. In addition, all of these standards/sources are considered and used to define the factors.

Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

As Written

The Plan conducted a comparative analysis of the strategies, processes, factors, evidentiary standards, and source information used to determine network adequacy for M/S and MH/SUD “as written.” The Plan identified that the factors and evidentiary standards used as the basis for determining network adequacy apply to both M/S and MH/SUD.

Both M/S and MH/SUD run network adequacy reports no less than quarterly to assess the continued adequacy of the network. These reports compare the provider network against network adequacy standards, which are in accordance with CMS and/or applicable state established time and distance thresholds. If a network adequacy report identifies a potential network gap, both M/S and MH/SUD network teams will work to close the gap through provider recruitment.

Both M/S and MH/SUD have processes in place to authorize benefit coverage at the INN benefit level for services provided by an OON provider upon member or provider request if a validated/confirmed supply gap is identified.

In Operation

The Plan conducted a comparative analysis of the methodology and process MH/SUD used to assess network adequacy to determine whether the methodology and process is comparable to, and applied no more stringently than, the methodology and process M/S used to assess network adequacy “in operation.” The analysis confirmed the methodology and process the Plan used to assess MH/SUD network adequacy is comparable to, and applied no more stringently than, the methodology and process the Plan used to assess M/S network adequacy “in operation.”

M/S and MH/SUD network teams both review network adequacy data no less than quarterly, and if there is a gap identified, both M/S and MH/SUD network teams work to close the gap through provider recruitment.

The outcomes of the network adequacy review are discussed at least quarterly and include findings and subsequent planned actions and interventions for provider recruitment.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The above analysis confirmed the strategies, processes, factors, evidentiary standards, and source information used to determine MH/SUD network adequacy were comparable to, and applied no more stringently than, the strategies, processes, factors, evidentiary standards, and source information used to determine M/S network adequacy “as written.”

Both MH/SUD and M/S run network adequacy reports at least quarterly which are in accordance with CMS and/or state established time and distance thresholds to assess the continued adequacy of the network. Additionally, both M/S and MH/SUD have processes in place to authorize benefit coverage at the INN benefit level for services provided by an OON provider if a network gap is identified. When a network gap is identified, the Plan will work with the member’s network provider to coordinate care through an OON provider.

In addition, the above analysis revealed the process and methodology MH/SUD used to assess network adequacy “in operation” was comparable to, and applied no more stringently than, the process and methodology M/S used to assess network adequacy.

Conclusions

In light of the above findings, the Plan concluded the M/S and MH/SUD network management – network adequacy processes are applied to M/S and MH/SUD networks comparably and are applied no more stringently to MH/SUD both “as written” and “in operation.”

Overview

Pursuant to a federal law called the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical and surgical (M/S) benefits. This generally means that financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA protections include:

- Financial requirements, such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

Out-of-network (OON) emergency care reimbursement is the process by which the Plan establishes reimbursement for OON emergency claims as defined in the member’s plan documents. The methodologies applicable to emergency services reimbursement may also be applicable to reimbursement for out of network services provided in network facilities.

This document includes the following information:

- Process for establishing OON emergency care reimbursement rates for both M/S and MH/SUD services
- The description of the NQTL and application (Step 1)
- Factors used to determine which services are subject to the NQTL (Step 2)
- Evidentiary standards and sources used to define, trigger and/or implicate a factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

The analysis refers to the following attachments:

- *Certificates of Coverage* – COC23-INS-BIND-2021-LG-GA-UHIC – Plan document that explains covered services, terms, conditions, and limitations of the member’s policy
- *Schedule of Benefits* – SBN23-Medical-INS-BIND-2021-Choice Plus-LG-GA-UHIC – Plan document that outlines member responsibilities

The Plan concludes that its methodology for establishing M/S and MH/SUD OON emergency care services reimbursement rates is comparable and applied no more stringently for MH/SUD than for M/S both “as written” and “in operation.”

Process

For both M/S and MH/SUD emergency care services, the Plan uses a comparable process to establish reimbursement rate(s).

Key steps in the OON emergency care reimbursement rate process for both M/S and MH/SUD conditions include:

- OON emergency services reimbursement methodologies are created in accordance with state and federal requirements

Out-of-Network Reimbursement: Out-of-Network Emergency Care Non-Quantitative Treatment

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- The OON emergency services reimbursement methodology is applied as one singular reimbursement structure for OON emergency services for both M/S and MH/SUD conditions
- The Plan adheres to the OON emergency care reimbursement methodology when making an OON claims payment

The Plan determines reimbursements for OON emergency care services in accordance with state and federal regulatory requirements. These requirements may govern reimbursement for OON providers of services at in-network (INN) facilities. The methodology used to reimburse OON emergency care services applies to emergency services rendered for the treatment of both M/S and MH/SUD conditions. The OON reimbursement methodology exists as a singular structure and applies to both M/S and MH/SUD. OON benefit programs are defined in the *Certificate of Coverage* and/or *Schedule of Benefits*.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- OON Emergency Care Reimbursement

Benefit Classification(s)

- OON, emergency care

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHIC)

Plan Terms/Source Documents

The Plan's *Certificate of Coverage* defines emergency health care services.

"Emergency Health Care Services - with respect to an Emergency:

- An appropriate medical screening exam (as required under section 1867 of the *Social Security Act* or as would be required under such section if such section applied to an Independent Freestanding Emergency Department) that is within the capability of the emergency department of a Hospital, or an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency, and
- Such further medical exam and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital or an Independent Freestanding Emergency Department, as applicable, as are required under section 1867 of the *Social Security Act*, or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient. regardless of the department of the Hospital in which such further exam or treatment is provided). For the purpose of this definition, "to stabilize" has the meaning as given such term in section 1867(e)(3) of the *Social Security Act* (42 U.S.C. 1395dd(e)(3)).
- Emergency Health Care Services include items and services otherwise covered under the Policy when provided by an out-of-Network provider or facility (regardless of the department of the Hospital in which the items and services are provided) after the patient is stabilized and as part of outpatient observation, or an Inpatient Stay or outpatient stay that is connected to the original Emergency, unless each of the following conditions are met:
 - a) The attending Emergency Physician or treating provider determines the patient is able to travel using nonmedical transportation or non-Emergency medical transportation to an available Network provider or facility located within a reasonable distance taking into consideration the patient's medical condition.
 - b) The provider furnishing the additional items and services satisfies notice and consent criteria in accordance with applicable law.
 - c) The patient is in such a condition to receive information as stated in b) above and to provide informed consent in accordance with applicable law.

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- d) The provider or facility satisfies any additional requirements or prohibitions as may be imposed by state law.
- e) Any other conditions as specified by the Secretary.

The above conditions do not apply to unforeseen or urgent medical needs that arise at the time the service is provided regardless of whether notice and consent criteria has been satisfied.”

The Plan’s *Schedule of Benefits* informs Members of how OON Emergency Health Care Services are reimbursed.

“Emergency Health Care Services provided by an out-of-Network provider will be reimbursed as set forth under *Allowed Amounts* as described at the end of this *Schedule of Benefits*.

For Emergency Health Care Services provided by an out-of-Network provider, the Allowed Amount is based on one of the following in the order listed below as applicable:

The reimbursement rate as determined by a state *All Payer Model Agreement*.

The reimbursement rate as determined by state law.

The initial payment made by us or the amount subsequently agreed to by the out-of-Network provider and us.

The amount determined by Independent Dispute Resolution (IDR).”

List of M/S and MH/SUD Services Subject to NQTL

- OON facility and professional emergency services for the treatment of M/S and MH/SUD conditions
- OON professional services provided in network facilities

Step 2 – Factors Used in the Design and Application of the NQTLs

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

The Plan relies on the following factor to determine OON emergency care reimbursement rates for M/S and MH/SUD conditions. These factors apply to both M/S and MH/SUD benefits in the following classifications:

- I. OON emergency services for M/S conditions
 - II. OON emergency services for MH/SUD conditions
- State and Federal Regulations (Qualitative)
Applies to both M/S and MH/SUD conditions

As there is only one factor, the weight of the factor is not applicable.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factor used in determining OON emergency care reimbursement rates. The evidentiary standards and sources apply to the following benefit classifications:

- I. OON emergency services for M/S conditions
- II. OON emergency services for MH/SUD conditions

Out-of-Network Reimbursement: Out-of-Network Emergency Care Non-Quantitative Treatment

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Factor – State and Federal Laws and Regulations is defined as a set of rules to establish standards for healthcare transactions

The Plan's evidentiary standards and sources that define and/or trigger the identification of the factor:

- No Surprises Act reimbursement methodology less INN member cost share:
 - An amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act;
 - If there is no such applicable All-Payer Model Agreement, an amount determined by a specified state law; or
 - If there is no such applicable All-Payer Model Agreement or specified state law, the lesser of the billed charge or the Plan's or issuer's median contracted rate (a/k/a qualifying payment amount (QPA)) for the same or similar item or service in the relevant geographic region
- Applicable state law
- Reimbursement amount determined by applicable All-Payer Model Agreement
- Reimbursement amount determined by applicable state law
- Contracted rates for the same or similar items or services provided by facilities of the same or similar facility type in the relevant geographic region

These evidentiary standards and sources apply to both M/S and MH/SUD OON emergency services. These evidentiary standards and sources are defined in a qualitative manner.

The factor and evidentiary standards used as the basis for establishing OON emergency care reimbursement for MH/SUD conditions are comparable to, and applied no more stringently than, the factor and evidentiary standards used as the basis for establishing OON emergency care reimbursement for M/S conditions "as written" and "in operation." As there is only one factor, the weight of the factor is not applicable.

Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

As Written

The Plan conducted a comparative analysis of the strategies, processes, factors, evidentiary standards, and source information used to establish reimbursement for OON emergency care for M/S and MH/SUD conditions “as written.” The Plan identified the factor and evidentiary standards used as the basis for determining M/S and MH/SUD OON emergency care reimbursement.

OON reimbursement is defined in the plan documents. Language defining the OON reimbursement methodologies reflects a singular structure and is inclusive of M/S and MH/SUD conditions. Plan benefits are administered according to the singular structure for all OON services.

The Plan applies the factor, sources, and evidentiary standards for each reimbursement methodology to both M/S and MH/SUD conditions. Both use state and/or federal requirements to establish OON emergency care reimbursement rates.

Out-of-Network Reimbursement: Out-of-Network Emergency Care Non-Quantitative Treatment

Limitations Analysis

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In Operation

The Plan conducted a comparative analysis of the methodology and process used to establish OON reimbursement for MH/SUD emergency care to determine whether the methodology and process is comparable to, and applied no more stringently than, the methodology and process used to establish OON reimbursement for M/S emergency care “in operation.”

The methodology used for determining provider reimbursements for OON emergency care applies to both M/S and MH/SUD conditions.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The findings of the comparative analysis revealed the process and methodology used for OON emergency care reimbursement for MH/SUD conditions “as written” and “in operation” was comparable to, and applied no more stringently than, the process and methodology used for OON emergency care reimbursement for M/S conditions.

Conclusions

Based upon these findings, the Plan concluded the methodology and processes that the Plan uses for OON emergency care reimbursement for MH/SUD conditions was comparable to the methodology and processes that is used for OON emergency care reimbursement for M/S conditions “as written” and “in operation.”

Overview

Pursuant to a federal law called the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical and surgical (M/S) benefits. This generally means that financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA protections include:

- Financial requirements such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage.

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

Out-of-network (OON) inpatient and outpatient reimbursement is the process by which the Plan establishes reimbursement for OON inpatient and outpatient claims as defined in the member’s plan documents.

This document includes the following information:

- OON inpatient and outpatient services reimbursement process for both M/S and MH/SUD services
- The description of the NQTL and application (Step 1)
- Factors used to determine which services are subject to the NQTL (Step 2)
- Evidentiary standards and sources used to define, trigger and/or implicate a factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

The analysis refers to the following attachments:

- *Certificates of Coverage* – COC23-INS-BIND-2021-LG-GA-UHIC – Plan document that explains covered services, terms, conditions, and limitations of the member’s policy
- *Schedule of Benefits* – SBN23-Medical-INS-BIND-2021-Choice Plus-LG-GA-UHIC – Plan document that outlines member responsibilities

The Plan concludes that the OON inpatient and outpatient reimbursement process for M/S and MH/SUD services are comparable and applied no more stringently both “as written” and “in operation.”

Process

Key steps in the non-emergency OON inpatient and outpatient reimbursement process for both M/S and MH/SUD services include:

- OON Reimbursement methodologies are created in accordance with state and federal requirements
- The client/employer group chooses one or more of the OON reimbursement methodologies described below for use by the Plan

- The chosen OON reimbursement methodology is applied as one singular reimbursement structure for both M/S and MH/SUD OON services. For example, if the policy elects the Maximum Non-Network Reimbursement Program (MNRP) at 110%, that is applied to all claims, both M/S and MH/SUD
- The Plan adheres to the selected OON reimbursement methodology for both M/S and MH/SUD claims when making an OON payment

OON benefit programs are defined in the *Certificate of Coverage* and/or *Schedule of Benefits*.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- OON reimbursement: Inpatient and outpatient services

Benefit Classification(s)

- OON, inpatient and outpatient

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHIC)

Plan Terms / Source Document(s)

The Plan's *Schedule of Benefits* notifies members of OON reimbursement processes.

"Out-of-Network Benefits apply to Covered Health Care Services that are provided by an out-of-Network Physician or other out-of-Network provider, or Covered Health Care Services that are provided at an out-of-Network facility.

Covered Health Care Services provided at certain Network facilities by an out-of-Network Physician, when not Emergency Health Care Services, will be reimbursed as set forth under *Allowed Amounts* as described at the end of this *Schedule of Benefits*. For these Covered Health Care Services, "certain Network facility" is limited to a hospital (as defined in 1861(e) of the Social Security Act), a hospital outpatient department, a critical access hospital (as defined in 1861(mm)(1) of the Social Security Act), an ambulatory surgical center as described in section 1833(i)(1)(A) of the Social Security Act, and any other facility specified by the Secretary."

List of M/S and MH/SUD Services Subject to NQTL

- OON inpatient and outpatient services

Step 2 – Factors Used in the Design and Application of the NQTL

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

The Plan relies on the following factors to determine OON reimbursement rates for M/S and MH/SUD inpatient and outpatient services. These factors apply to both M/S and MH/SUD benefits in the following classifications:

- I. M/S OON inpatient/outpatient services
 - II. MH/SUD OON inpatient/outpatient services
- Federal and State Regulations (Qualitative)
 - State or federal law may impact permissible out of network reimbursement options available to customers. This factor is applicable to:

- OON non-emergency inpatient or outpatient services provided in an In-Network (INN), or OON facility rendered for the treatment of M/S or MH/SUD conditions

Applies to both M/S and MH/SUD services.

- Extended Non-Network Reimbursement Program (ENRP) methodology (Quantitative) This factor is applicable to:
 - OON non-emergency inpatient or outpatient services provided in an OON facility rendered for the treatment of M/S or MH/SUD conditions processed at the INN benefit level

Applies to both M/S and MH/SUD services.

- MNRP (Quantitative). This factor is applicable to:
 - OON non-emergency inpatient or outpatient services provided in an OON facility rendered for the treatment of M/S or MH/SUD conditions
 - OON inpatient and outpatient services rendered for the treatment of M/S or MH/SUD conditions

Applies to both M/S and MH/SUD services.

- Shared Savings (Quantitative) This factor is applicable to:
 - OON non-emergency inpatient or outpatient services provided in an INN or OON facility rendered for the treatment of M/S or MH/SUD conditions
 - OON inpatient and outpatient services rendered for the treatment of M/S or MH/SUD conditions

Applies to both M/S and MH/SUD services.

The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factors used in determining OON reimbursement for inpatient and outpatient services. These evidentiary standards and sources apply to the following benefit classifications:

- I. M/S OON inpatient/outpatient services
- II. MH/SUD OON inpatient/outpatient services

Factor – Federal and State Laws and Regulations is defined as a set of rules to establish standards for healthcare transactions.

- The Plan's evidentiary standards and sources that define and/or trigger the identification of the factor:
 - State or federal law may impact the range of permissible out of network reimbursement options.
 - An amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act;
 - If there is no such applicable All-Payer Model Agreement, an amount determined by a specified state law; or

- If there is no such applicable All-Payer Model Agreement or specified state law, the lesser of the billed charge or the Plan's or issuer's median contracted rate (a/k/a qualifying payment amount (QPA)) for the same or similar item or service in the relevant geographic region
- Applicable state law
 - Reimbursement amount determined by applicable All-Payer Model Agreement
 - Reimbursement amount determined by applicable state law
 - Contracted rates for the same or similar items or services provided by facilities of the same or similar facility type in the relevant geographic region

This evidentiary standard and source applies to both M/S and MH/SUD OON inpatient/outpatient services. This evidentiary standard and source is defined in a qualitative manner.

Factor – ENRP methodology is defined as a program that can be used to determine eligible expense(s) when an OON provider is processed under the network benefits. Reimbursement under ENRP is based on a percentage of the Medicare rate.

- The Plan's evidentiary standards and sources that define and/or trigger the identification of the factor:
 - The ENRP reimbursements are based on a percentage of the Centers for Medicare & Medicaid Services (CMS) benchmark rate (e.g., Physician Fee Schedule or CMS diagnosis related group (DRG) rate) for a procedure or service type within a given geographic region
 - CMS Standards and Fee Schedules in relevant geographic market
 - CMS DRG rates allowed by CMS
 - When a rate is not published by CMS for the service, the Plan uses a gap methodology established by OptumInsight and/or a third-party vendor that uses a relative value scale or similar methodology

These evidentiary standards and sources apply to both M/S and MH/SUD OON inpatient/outpatient services. These evidentiary standards and sources are defined in a quantitative manner.

Factor –MNRP is defined as a Medicare-based methodology to reimburse the provider/facility. MNRP reimbursements are based upon a percentage of the CMS benchmark rate (e.g., Physician Fee Schedule or CMS DRG rate) for a procedure or service type within a given geographic region. The CMS Medicare Physician and Facility Fee Schedule generates one rate for each Current Procedural Technology® (CPT)/Healthcare Common Procedure Coding System (HCPCS)/DRG code. If there is no CMS rate for a particular service or facility type, the rate is gap-filled with national industry standard fee source rates. When a rate is not published by CMS for the service and a gap methodology does not apply to the service, the reimbursement rate is based on a percentage of the provider's billed charge.

- The Plan's evidentiary standards and sources that define and/or trigger the identification of the factor:
 - CMS Standards and Fee Schedules in relevant geographic market
 - CMS DRG rates allowed by CMS
 - When a rate is not published by CMS for the service, a gap methodology established by OptumInsight and/or a third-party vendor that national industry standard fee source rate or similar methodology

These evidentiary standards and sources apply to both M/S and MH/SUD OON inpatient/outpatient services. These evidentiary standards and sources are defined in a quantitative manner.

Factor – Shared Savings (MultiPlan Wrap Network) is defined as OON benefits that allow the Plan to obtain a discount off an OON provider's billed charge. It involves OON providers that have contracted with a third-party vendor to allow members access to the discount.

- The Plan's evidentiary standards and sources that define and/or trigger the identification of the factor:
 - MultiPlan (a third-party vendor)

- MultiPlan uses the Data iSight tool to determine the pricing for claims
- The Data iSight tool is used to determine the pricing for claims. The Data iSight tool determines the pricing based on data that is publicly available and also applies common industry-wide modifiers or adjustments. It also takes into account the geographical area, and for professional services, the relative amount of time, level of skill, and intensity of the services performed
- Wrap Network consists of an expansive contracted vendor network
- Fee Negotiation discounts negotiated prior to payment and administered by Multiplan

These evidentiary standards and sources apply to both M/S and MH/SUD OON inpatient/outpatient services. These evidentiary standards and sources are defined in a quantitative manner.

The factors and evidentiary standards used as the basis for determining MH/SUD OON inpatient/outpatient reimbursement are comparable to, and applied no more stringently than, the factors and evidentiary standards used as the basis for subjecting M/S OON inpatient/outpatient reimbursement “as written” and “in operation.”

The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL.

Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

As Written

The Plan conducted a comparative analysis of the strategies, processes, factors, evidentiary standards, and source information used to determine OON reimbursement for M/S and MH/SUD inpatient/outpatient services “as written.” The Plan identified the factors and evidentiary standards used as the basis for determining M/S and MH/SUD OON inpatient/outpatient reimbursement.

OON reimbursement is defined in the Plan documents (*Schedule of Benefits*). Language defining the OON reimbursement methodologies reflect a singular structure and is inclusive of M/S and MH/SUD inpatient/outpatient services. Plan benefits are administered according to the singular structure for all OON services.

The Plan applies the strategies, processes, factors, sources, and evidentiary standards for each reimbursement methodology to both M/S and MH/SUD services. Both use one or more of the following: state, or federal requirements; ENRP, MNRP; Shared Savings; to establish OON reimbursement rates.

In Operation

The Plan compared the strategies, processes, factors, evidentiary standards, and source information used to determine M/S and MH/SUD ONN inpatient/outpatient services reimbursement “in operation.”

The methodologies for determining OON provider reimbursements for services and treatments apply to both MH/SUD and M/S.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The findings of the comparative analysis revealed the process and methodology MH/SUD used to determine OON inpatient and outpatient reimbursement “as written” and “in operation” was comparable to, and applied no more stringently than, the process and methodology M/S used to determine OON inpatient and outpatient reimbursement.

Conclusions

Based upon these findings, the Plan concluded the methodology and processes that M/S and MH/SUD use to determine OON reimbursement was comparable “as written” and “in operation.”

Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical and surgical (M/S) benefits. This generally means that financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits must be comparable to and cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA protections include:

- Financial requirements such as, deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs, which may limit the scope or duration of benefits for treatment under a plan or coverage

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

Prescription Drug List (PDL) a/k/a formulary design is a component of the Plan’s utilization management (UM) program. The goal of PDL/formulary design is to assess the prescription drug’s place in therapy.

This document includes the following information:

- PDL process for both M/S and MH/SUD prescription drugs
- The description of the NQTL and application (Step 1)
- Factors used to determine prescription drugs tier placement and/or benefit coverage (Step 2)
- Evidentiary standards and sources used to define, trigger and/or implicate a factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

This analysis does not refer to any attachments.

The Plan concludes that the PDL/formulary design requirements for M/S and MH/SUD are comparable and applied no more stringently for prescription drug benefits both “as written” and “in operation.”

Process

The Pharmacy & Therapeutics (P&T) Committee assesses a prescription drug’s place in therapy and its relative safety and efficacy in order to provide a clinical recommendation/designation used in determining coverage and tier assignment. The P&T Committee is comprised of individuals from diverse clinical disciplines, including, behavioral health. Additional physician specialists with specific expertise are consulted as part of the clinical evaluation of new and existing drugs.

The Pharmacy & Therapeutics Committee consists of physicians specializing in Obstetrics & Gynecology, Endocrinology/Metabolism, Hematology/Oncology, Rheumatology, Geriatrics, Cardiology, Gastroenterology, Psychiatry, Pediatrics & Internal Medicine, and Internal Medicine. The committee also consists of 4 pharmacists, one of which specializes in Geriatrics & Psychiatry. There is a requirement that the committee consist of at least one physician specializing in psychiatry.

To approve clinical drug policies, the established committee follows a standard process. The P&T Committee evaluates the FDA approved product labeling, peer-reviewed medical literature, published clinical practice guidelines, including randomized clinical trials, drug comparison studies, outcomes research data, pharmacoeconomic studies, comparisons of efficacy, side effects, potential for off-label use and claims data analysis, as relevant, as part of the review and approval process of clinical policies. The P&T Committee assesses external clinical evidence and nationally recognized evidence-based guidelines and benchmarks, as well as a prescription drug's place in therapy, and its relative safety and efficacy to approve clinical drug policies for select M/S and MH/SUD prescription drugs.

The UnitedHealthcare (UHC) Prescription Drug List Management Committee (PDL MC) makes tiering decisions by considering clinical, economic/financial and pharmacoeconomic evidence for populations with an incentive based PDL. The PDL MC makes benefit exclusion decisions using the same types of evidence. This information is provided by UHC Evidence Based Decision Support Committees, including but not limited to, the UHC P&T Committee as outlined above.

PDL a/k/a formulary design is based on the Plan's policy to assign tiers for prescription drugs. Newly launched generic prescription drugs are also reviewed to determine initial tier placement on the PDL and/or benefit coverage. A generic prescription drug includes a prescription drug that is chemically equivalent to a brand drug or that the Plan identifies as a generic based on available data resources including, but not limited to, the daily Medi-Span file load memo that classifies drugs as either brand or generic based on several factors. Generics will be considered for initial tier placement and/or benefit coverage equal to that of the current placement of the brand prescription drug.

The Plan reviews the number of M/S and MH/SUD prescription drugs by tier on a tri-annual basis. The results are reviewed with the UM Committee to determine if any changes should be made in the PDL/formulary design.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- PDL a/k/a Formulary Design

Benefit Classification(s)

- Prescription Drugs

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHC)

Plan Terms

- Prescription Drug List - a list that places into tiers medications or products that have been approved by the U.S. Food and Drug Administration (FDA). This list is subject to our review and change from time to time. You may find out to which tier a particular Prescription Drug Product has been placed by [visiting [benefits.surest.com]] [or] [calling the telephone number on your ID card] for the most up-to-date tier placement.

List of M/S and MH/SUD Services Subject to NQTL

- All prescription drugs are part of the Plan's PDL a/k/a formulary design
- The PDLs generally contain brand and generics that provide the highest overall value on Tiers 1 and 2, with brand and generics that provide the lowest overall value on Tier 3

Step 2 – Factors Used to Determine Formulary Design Applies

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

The Plan relies on the following factors to determine the PDL for both M/S and MH/SUD prescription drugs:

- Assessment of the prescription drug's place in therapy (Qualitative)
 - Goal is to promote optimal drug use based on review of FDA approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off-label use and claims data analysis

Applies to M/S and MH/SUD prescription drugs

- Relative safety and efficacy (Qualitative)
 - Goal is to promote optimal drug use by performing a comprehensive efficacy comparison as well as reviewing the type and frequency of side effects and potential drug interactions among alternative drug products

Applies to M/S and MH/SUD prescription drugs

- Available therapeutic equivalent prescription drugs (Quantitative)
 - Goal is to promote optimal drug use in therapeutic classes with several alternative drug products. A trial of clinically appropriate, lower cost alternative(s) may be appropriate prior to coverage of a more expensive alternative

Applies to M/S and MH/SUD prescription drugs

The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL. The factors apply to both M/S and MH/SUD prescription drugs.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factors used in determining the PDL. These evidentiary standards and sources apply to both M/S and MH/SUD prescription drugs.

Factor – Assessment of the prescription drug's place in therapy

- The Plan's evidentiary standard and source that defines and/or triggers the assessment of the prescription drug's place in therapy factor:
 - FDA-approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off-label use, and claims data analysis as relevant

This evidentiary standard and source applies to both M/S and MH/SUD prescription drugs and is defined in a qualitative manner.

Factor – Relative safety and efficacy

- The Plan's evidentiary standard and source that defines and/or triggers the relative safety and efficacy factor:

- FDA approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off label use and claims data analysis as relevant

This evidentiary standard and source applies to both M/S and MH/SUD prescription drugs and is defined in a qualitative manner.

Factor – Available therapeutic equivalent prescription drugs

- The Plan's evidentiary standard and source that defines and/or triggers the available therapeutic equivalent prescription drugs factor:
 - FDA-approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off-label use, and claims data analysis as relevant

This evidentiary standard and source applies to both M/S and MH/SUD prescription drugs and is defined in a quantitative manner.

The factors and evidentiary standards used as the basis for determining the PDL for MH/SUD prescription drugs are comparable to, and applied no more stringently than, the factors used as the basis for determining the PDL for M/S prescription drugs "as written" and "in operation." The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL.

Step 4 – NQTL "As Written" and "In Operation" Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

As Written

The Plan compared the strategies, processes, factors, evidentiary standards, and source information used to determine which M/S and MH/SUD prescription drugs are subject to PDL a/k/a formulary design "as written."

The Plan identified the shared factors and evidentiary standards used as the basis for subjecting M/S and MH/SUD benefits to formulary design for prescription drugs. The factors and evidentiary standards are applied to both M/S and MH/SUD prescription drugs comparably and not more stringently to MH/SUD prescription drugs.

Review of Operational Policies and Procedures

The P&T Committee assesses the prescription drug's place in therapy and its relative safety and efficacy in order to provide a clinical recommendation/designation used in determining coverage and tier assignment. The UHC PDL MC makes tiering and benefit exclusion decisions by considering clinical, economic/financial and pharmacoeconomic evidence for populations with an incentive based PDL. The PDL MC makes benefit exclusion decisions using the same types of evidence.

The P&T Committee is comprised of individuals from diverse clinical disciplines including, behavioral health. Additional physician specialists with specific expertise are consulted as part of the clinical evaluation of new and existing drugs.

The P&T Committee consists of physicians specializing in Obstetrics & Gynecology, Endocrinology/Metabolism, Hematology/Oncology, Rheumatology, Geriatrics, Cardiology, Gastroenterology, Psychiatry, Pediatrics & Internal Medicine, and Internal Medicine. The committee also consists of 4 pharmacists, one of which specializes in Geriatrics & Psychiatry.

Physician specialists with specific expertise are consulted for clinical evaluation of a drug using P&T committee members if the specific specialty is represented and outside consultants are used if the specialty is not represented in the P&T committee. As part of the clinical evaluation of new drugs or for some existing drugs with new evidence, these consults are routinely done.

In Operation

The Plan compared the strategies, processes, factors, evidentiary standards, and source information used to determine which M/S and MH/SUD prescription drugs are subject to formulary design “in operation.”

The Plan reviewed the number of M/S and MH/SUD prescription drugs by tier on a tri-annual basis. The results are reviewed by the UHC UM Committee to determine if any changes should be made in the PDL/formulary design.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The findings of the analysis revealed the strategies, processes, factors, evidentiary standards, and source information the Plan used to administer the PDL a/k/a formulary design for MH/SUD prescription drugs were comparable to, and applied no more stringently than, the strategies, processes, factors, evidentiary standards, and source information used to administer the PDL a/k/a formulary design for M/S prescription drugs “as written.”

Further, both M/S and MH/SUD utilize generally accepted types of data, evidentiary sources, and trend analyses to create and maintain the PDL/formulary design.

The Plan evaluates the number of M/S and MH/SUD prescription drugs by tier on a tri-annual basis.

The findings of the analysis revealed for all prescription drugs covered under the pharmacy benefit, the Plan uses the same PDL MC to determine tier placement and/or benefit coverage. The Committee does not distinguish between M/S and MH/SUD prescription drugs, and the processes are administered in the same fashion and not applied more stringently to MH/SUD prescription drugs. The tiering for M/S and MH/SUD prescription drugs shows the majority are placed on Tiers 1 and 2 allowing for easier access and is in compliance with MHPAEA.

The findings of the Prescription Drug Tier Analysis (see data below) indicated the percent of prescription drugs by tiers for MH/SUD prescription drugs were comparable to the percent of prescription drugs by tiers for M/S prescription drugs. Data is for (January, May, and September 2022). The Plan also notes that the U.S. Department of Labor has indicated generally that outcomes data are not dispositive of parity compliance.

The following are results of each analysis in 2022:

- January 2022 –
 - 59.0% of MH/SUD drugs are on Tiers 1 and 2
 - 53.3% of M/S drugs are on Tiers 1 and 2
- May 2022 –
 - 57.9% of MH/SUD drugs are on Tiers 1 and 2
 - 52.9% of M/S drugs are on Tiers 1 and 2
- September 2022 –
 - 56.9% of MH/SUD drugs are on Tiers 1 and 2
 - 52.8% of M/S drugs are on Tiers 1 and 2

These evaluations were based on the Advantage PDL, which is the most commonly used PDL.

Conclusions

Based upon these findings, the Plan concluded that the methodologies to administer the PDL a/k/a formulary design for MH/SUD prescription drugs were comparable to, and applied no more stringently than, the methodologies to administer the PDL a/k/a formulary design for M/S prescription drugs “as written.”

Based on the above review and data, the Plan concluded the methodologies to administer the PDL a/k/a formulary design for MH/SUD prescription drugs were comparable to, and applied no more stringently than, the methodologies to administer the PDL a/k/a formulary design for M/S prescription drugs “in operation.”

Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical and surgical (M/S) benefits. This generally means that financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits are comparable to and no more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA protections include:

- Financial requirements such as, deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs, which may limit the scope or duration of benefits for treatment under a plan or coverage

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

Per the Outpatient Prescription Drug *Schedule of Benefits*, “Before certain Prescription Drug Products are dispensed to you, your Physician, your pharmacist or you are required to obtain prior authorization from us or our designee. The reason for obtaining prior authorization from us is to determine whether the Prescription Drug Product, in accordance with our approved guidelines, is each of the following:

- It meets the definition of a Covered Health Care Service.
- It is not an Experimental or Investigational or Unproven Service.”

The *Certificate of Coverage* defines Covered Health Care Service as “health care services, including supplies or Pharmaceutical Products, which we determine to be all of the following:

- Provided for the purpose of preventing, evaluating, diagnosing or treating a sickness, injury, mental illness, substance-related and addictive disorders, condition, disease or its symptoms.
- Medically Necessary
- Described as a Covered Health Care Service in the Certificate under Section 1: Covered Health Care Services and in the Schedule of Benefits
- Not excluded in the Certificate under Section 2: Exclusions and Limitations”

Prior Authorization is a component of the Plan’s utilization management (UM) program that helps members receive appropriate coverage based on their specific clinical status and health care needs. The process is designed to achieve optimal clinical outcomes by applying objective, evidence-based clinical criteria and nationally recognized guidelines and best practices.

Prior Authorization for prescription drugs commences prior to a drug being covered. Prior Authorization is a UM process that involves applying clinical criteria to member clinical information in order to render a clinical coverage benefit determination.

The goal of Prior Authorization, Step Therapy, and Quantity Limits is to ensure cost-effective and clinically effective prescription drugs are covered to achieve a positive clinical outcome. Prior Authorization, Step Therapy, and Quantity Limits apply to prescription drugs provided to a member at the point-of-sale. Drug products are selected for Quantity Limits to encourage Food and Drug Administration (FDA) labeling, prevent abuse, address safety concerns, prevent pharmacy billing errors and encourage dose optimization.

Prior Authorization, Step Therapy, and Quantity Limits for prescription drugs begin after a provider or member requests

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coverage for a prescription drug and receipt of clinical information. The provider or member's submission of a request (notification) triggers the Prior Authorization, Step Therapy, and Quantity Limits process. Quantity Limits trigger a Prior Authorization if the member is seeking more than the quantity limit set.

Note: The comparative analysis "as written" and "in operation" are the same for Prior Authorization, Step Therapy and Quantity Limits; therefore, the analysis has been combined.

This document includes the following information:

- Prior Authorization, Step Therapy, and Quantity Limits process for both M/S and MH/SUD prescription drugs
- The description of the NQTL and application (Step 1)
- Factors used to determine which prescription drugs are subject to the NQTL (Step 2)
- Evidentiary standards and sources used to define, trigger, and/or implicate a factor (Step 3)
- NQTL "as written" and "in operation" comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

This analysis refers to the following attachments:

- *UnitedHealthcare Provider Administrative Guide* - [2023 UnitedHealthcare Care Provider Administrative Guide \(uhcprovider.com\)](https://uhcprovider.com) - Informs providers of the Prior Authorization process
- *Certificates of Coverage - COC23-INS-BIND-2021-LG-GA-UHIC* - Plan document that explains covered services, terms, conditions, and limitations of the member's policy
- *Schedule of Benefits - SBN23-Pharmacy-INS-BIND-2021-Pharmacy Network-LG-GA-UHIC* - Plan document that outlines member responsibilities
- Drugs with Clinical Programs dated 12/01/2023

The Plan concludes that the Prior Authorization, Step Therapy, and Quantity Limit requirements for M/S and MH/SUD are comparable and applied no more stringently for M/S or MH/SUD prescription drug benefits both "as written" and "in operation."

Process

For all prescription drugs covered under the pharmacy benefit, the Plan uses the same policies and procedures to create clinical criteria and develop clinical drug policies through a single Pharmacy & Therapeutics (P&T) Committee.

The P&T Committee is comprised of individuals from diverse clinical disciplines including, behavioral health. Additional physician specialists with specific expertise are consulted as part of the clinical evaluation of new and existing drugs.

The Pharmacy & Therapeutics Committee consists of physicians specializing in Obstetrics & Gynecology, Endocrinology/Metabolism, Hematology/Oncology, Rheumatology, Geriatrics, Cardiology, Gastroenterology, Psychiatry, Pediatrics & Internal Medicine, and Internal Medicine. The committee also consists of 4 pharmacists, one of which specializes in Geriatrics & Psychiatry. There is a requirement that the committee consist of at least one physician specializing in psychiatry.

To approve clinical drug policies, the established committee follows a standard process. The P&T Committee evaluates the FDA approved product labeling, peer-reviewed medical literature, published clinical practice guidelines, including randomized clinical trials, drug comparison studies, outcomes research data, pharmacoeconomic studies, comparisons of efficacy, side effects, potential for off-label use and claims data analysis, as relevant, as part of the review and approval process of clinical policies. The P&T Committee assesses external clinical evidence and nationally recognized evidence-based guidelines and benchmarks, as well as a prescription drug's place in therapy, and its relative safety and efficacy to approve clinical drug policies for select M/S and MH/SUD prescription drugs.

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Per the *Outpatient Prescription Drug Schedule of Benefits*, “before certain prescription drugs are covered, the member, their physician, or their pharmacist are required to obtain Prior Authorization from UnitedHealthcare. The reason for obtaining Prior Authorization is to determine whether the prescription drug, in accordance with our approved guidelines, is each of the following:

- It meets the definition of a Covered Health Care Service.
- It is not an Experimental or Investigational or Unproven Service”

The *Certificate of Coverage* defines Covered Health Care Service as “health care services, including supplies or Pharmaceutical Products, which we determine to be all of the following:

- Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms.
- Medically Necessary
- Described as a Covered Health Care Service in the Certificate under Section 1: Covered Health Care Services and in the Schedule of Benefits
- Not excluded in the Certificate under Section 2: Exclusions and Limitations”

The Plan structures prescription drug Prior Authorization processes to be compliant with all applicable federal and state laws, as well as the National Committee for Quality Assurance (NCQA) accreditation standards. NCQA confirms that Plan operations and policies identify appropriate time frames for decisions, requires decision-making by appropriate personnel, and governs communication of adverse benefit determinations. In addition, Prior Authorization is governed at both the state and federal level, which includes consumer protections such as external review for adverse benefit determinations after internal appeals options are exhausted, as applicable.

Prior Authorization, Step Therapy and Quantity Limits review of M/S and MH/SUD prescription drugs consists of the following:

Prior Authorization, Step Therapy, and Quantity Limits for prescription drugs begin after a provider or member requests coverage for a prescription drug and receipt of clinical information. The provider or member’s submission of a request (notification) triggers the Prior Authorization, Step Therapy, and Quantity Limits process. Quantity Limits trigger a Prior Authorization if the member is seeking more than the quantity limit set. A Prior Authorization (including Quantity Limits) or Step Therapy request may be submitted by telephone or electronically. The Plan confirms receipt of the Prior Authorization, Step Therapy or Quantity Limit request. Non-clinical staff confirm member eligibility and benefit plan coverage. The Plan can administratively deny cases for lack of eligibility or benefit coverage.

Determinations. Clinical reviewers (Medical Director or healthcare professional) consult clinical drug policies when making clinical coverage benefit determinations. The clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical drug policies in the case review to assess whether a prescription drug should be covered. The Prior Authorization, Step Therapy, or Quantity Limit request is approved based on whether the member’s clinical condition meets criteria for coverage as determined by the application of clinical drug policies. Only qualified clinical reviewers (e.g., physicians or pharmacists) can issue adverse benefit determinations. If an adverse benefit determination is issued, then the adverse benefit determination and appeal rights are communicated to the member and provider.

Adverse Benefit Determinations. For prescription drugs, an adverse benefit determination is an administrative or clinical review decision resulting in a reduction or termination, non-coverage or non-certification of a prescription drug. Adverse benefit determinations are recorded as administrative denials when member eligibility and benefit coverage cannot be confirmed, or benefits are exhausted. Adverse benefit determinations are recorded as clinical denials when they are based on clinical drug policies and member clinical information

Clinical Criteria. Clinical reviewers base Prior Authorization clinical coverage benefit determinations on objective, evidence-based clinical drug policies.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- Prescription Drug Prior Authorization, Step Therapy, and/or Quantity Limits

Benefit Classification(s)

- Prescription Drugs

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHIC)

Plan Terms/Source Document(s)

The Plan's *Certificates of Coverage* notify members of the Prior Authorization requirements. Members or providers are required to comply with UM protocols established by the Plan.

Per the *Outpatient Prescription Drug Schedule of Benefits*, "before certain prescription drugs are covered, the member, their physician, or their pharmacist are required to obtain Prior Authorization from UnitedHealthcare. The reason for obtaining Prior Authorization is to determine whether the prescription drug, in accordance with our approved guidelines, is each of the following:

- It meets the definition of a Covered Health Care Service.
- It is not an Experimental or Investigational or Unproven Service"

The *Certificate of Coverage* defines Covered Health Care Service as "health care services, including supplies or Pharmaceutical Products, which we determine to be all of the following:

- Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms.
- Medically Necessary
- Described as a Covered Health Care Service in the Certificate under Section 1: Covered Health Care Services and in the Schedule of Benefits
- Not excluded in the Certificate under Section 2: Exclusions and Limitations"

The *2023 UnitedHealthcare Care Provider Administrative Guide* notifies providers of the Prior Authorization requirements. In-network providers are required to comply with UM protocols established by the Plan.

"We develop medical policies, medical benefit drug policies, coverage determination guidelines, and utilization review guidelines to support the administration of medical benefits. You may request a copy of our medical policies and guidelines by calling our care management team at 1-877-842-3210 or 1-888-478-4760 (Individual Exchange Plans). They are only for informational purposes; they are not medical advice. You are responsible for deciding what care to give our members. Members should talk to their health care providers before making medical decisions. Drug policies for commercial members covered under the pharmacy benefit are on uhcprovider.com/pharmacy.

Benefit coverage is determined by the following:

- Laws that may require coverage
- The member's benefit plan document
 - Summary Plan Description
 - Schedule of Benefits
 - Certificate of Coverage

The member's benefit plan document identifies which services are covered, which are excluded, and which are subject to limitations. If there is a conflict, the member's benefit plan document supersedes our policies and guidelines.

We develop our policies and guidelines as needed. We regularly review and update them. They are subject to change. We believe the information in these policies and guidelines is accurate and current as of the publication date. We also use tools developed by third parties, such as InterQual criteria, to help us manage health benefits. If you believe we should consider new or additional clinical evidence pertaining to a specific medical policy, complete this form for UnitedHealthcare medical policy review. Do not submit protected health information using this form. If you have questions or concerns about a specific service for a member, refer to the appropriate benefits, claims or prior authorization/notification process."

List of M/S and MH/SUD Services Subject to NQTL

See list of Drugs with Clinical Programs dated 12/01/2023

Step 2 – Factors Used to in the Design and Application of the NQTL

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

The Plan relies on the following factors to determine whether prescription drugs are subject to Prior Authorization, Step Therapy, or Quantity Limits for both M/S and MH/SUD:

- **Assessment of the prescription drug's place in therapy (Qualitative)**
 - Goal is to promote optimal drug use based on review of FDA approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off-label use and claims data analysis

Applies to M/S and MH/SUD prescription drugs.

- **Availability of clinically similar lower cost medications to treat the condition (Quantitative)**
 - Goal is to promote optimal drug use in therapeutic classes with several alternative drug products. A trial of clinically appropriate, lower cost alternative(s) may be appropriate prior to coverage of a more expensive alternative

Applies to M/S and MH/SUD prescription drugs.

- **Value to implement Prior Authorization/ Step Therapy (Qualitative)**
 - Goal is to evaluate whether inclusion of contingency edits or inclusion in Diagnosis to Prescription match (Dx2Rx) or Silent Authorization is appropriate or whether a coverage review is required to determine whether conditions of coverage are met. Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class

Applies to M/S and MH/SUD prescription drugs.

- **Relative safety and efficacy (Qualitative)**
 - Goal is to promote optimal drug use by performing a comprehensive efficacy comparison as well as reviewing the type and frequency of side effects and potential drug interactions among alternative drug products

Applies to M/S and MH/SUD prescription drugs.

- Prevention of off-label use or unproven uses (Qualitative)
 - Goal is to promote optimal drug use by evaluating the potential for the drug to be used for indications other than what is included on FDA approved product labeling

Applies to M/S and MH/SUD prescription drugs.

The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL. The factors apply to both M/S and MH/SUD prescription drugs.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below are the sources and evidentiary standards used to define, trigger, and/or implicate the factor used in designing or applying the Plan's Prior Authorization, Step Therapy, or Quantity Limits requirement to prescription drugs.

Factor – Assessment of the prescription drug's place in therapy - Goal is to promote optimal drug use based on review of FDA approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off-label use and claims data analysis.

- The Plan's evidentiary standards and sources that define and/or trigger the assessment of the prescription drug's place in therapy factor:
 - State and/or Federal regulations and guidelines
 - FDA-approved product labeling
 - Review of external clinical evidence
 - FDA-approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off-label use, and claims data analysis as relevant
 - Nationally recognized evidence-based guidelines and benchmarks
 - FDA-approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off-label use, and claims data analysis as relevant

These evidentiary standards and sources apply to both M/S and MH/SUD prescription drugs. These evidentiary standards and sources are defined in a qualitative manner.

Factor – Availability of clinically similar lower cost medications to treat the condition - Goal is to promote optimal drug use in therapeutic classes with several alternative drug products. A trial of clinically appropriate, lower cost alternative(s) may be appropriate prior to coverage of a more expensive alternative.

- The Plan's evidentiary standards and sources that define and/or trigger the availability of clinically similar lower cost medications to treat the condition factor:

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- State and/or Federal regulations and guidelines
 - FDA-approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off-label use, and claims data analysis as relevant
- Review of external clinical evidence
 - FDA-approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off-label use, and claims data analysis as relevant
- Nationally recognized evidence-based guidelines and benchmarks
 - FDA-approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off-label use, and claims data analysis as relevant

These evidentiary standards and sources apply to both M/S and MH/SUD prescription drugs. These evidentiary standards and sources are defined in a quantitative manner.

Factor – Value to implement Prior Authorization/Step Therapy - Goal is to evaluate whether inclusion of contingency edits or inclusion in Diagnosis to Prescription match (Dx2Rx) or Silent Authorization is appropriate or whether a coverage review is required to determine whether conditions of coverage are met. Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.

- The Plan's evidentiary standards and sources that define and/or trigger the value to implement Prior Authorization/Step Therapy factor:
 - State and/or Federal regulations and guidelines
 - FDA-approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off-label use, and claims data analysis as relevant
 - Review of external clinical evidence
 - FDA-approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off-label use, and claims data analysis as relevant
 - Nationally recognized evidence-based guidelines and benchmarks
 - FDA-approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off-label use, and claims data analysis as relevant

These evidentiary standards and sources apply to both M/S and MH/SUD prescription drugs. These evidentiary standards and sources are defined in a qualitative manner.

Factor – Relative safety and efficacy - Goal is to promote optimal drug use by performing a comprehensive efficacy comparison as well as reviewing the type and frequency of side effects and potential drug interactions among alternative drug products.

- The Plan's evidentiary standards and sources that define and/or trigger the Relative safety and efficacy factor:
 - State and/or Federal regulations and guidelines
 - FDA-approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off-label use, and claims data analysis as relevant
 - Review of external clinical evidence
 - FDA-approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off-label use, and claims data analysis as relevant
 - Nationally recognized evidence-based guidelines and benchmarks
 - FDA-approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off-label use, and claims data analysis as relevant

These evidentiary standards and sources apply to both M/S and MH/SUD prescription drugs. These evidentiary standards and sources are defined in a qualitative manner.

Factor – Prevention of off-label use or unproven uses - Goal is to promote optimal drug use by evaluating the potential for the drug to be used for indications other than what is included on FDA approved product labeling.

- The Plan's evidentiary standards and sources that define and/or trigger the Prevention of off-label use or unproven uses factor:
 - State and/or Federal regulations and guidelines
 - FDA-approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off-label use, and claims data analysis as relevant
 - Review of external clinical evidence
 - FDA-approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off-label use, and claims data analysis as relevant
 - Nationally recognized evidence-based guidelines and benchmarks
 - FDA-approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off-label use, and claims data analysis as relevant

These evidentiary standards and sources apply to both M/S and MH/SUD prescription drugs. These evidentiary standards and sources are defined in a qualitative manner.

These are the factors and evidentiary standards used in designing or applying the Plan's Prior Authorization, Step Therapy, or Quantity Limits requirement to prescription drugs. The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL.

Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

As Written

The Plan conducted a comparative analysis of the strategies, processes, factors, evidentiary standards, and source information used to determine which M/S and MH/SUD prescription drugs are subject to Prior Authorization, Step Therapy, or Quantity Limits and how Prior Authorization, Step Therapy, or Quantity Limits are administered “as written.” The Plan identified the factors and evidentiary standards used as the basis for subjecting M/S and MH/SUD prescription drugs to Prior Authorization, Step Therapy, or Quantity Limits for each benefit classification.

Review of Factors and Evidentiary Standards

For each prescription drug subject to Prior Authorization, Step Therapy, or Quantity Limits the Plan reviewed the factors that trigger a prescription drug to be subject to Prior Authorization, Step Therapy, or Quantity Limits. The factors and evidentiary standards were applied to both M/S and MH/SUD prescription drugs comparably and not more stringently to MH/SUD prescription drugs than to M/S prescription drugs.

Review of Operational Policies and Procedures

For all prescription drugs covered under the pharmacy benefit, the Plan uses the same policies and procedures to create clinical criteria and develop clinical drug policies through a single P&T Committee.

- **Committee Review.** The P&T Committee is comprised of individuals from diverse clinical disciplines including behavioral health. Additional physician specialists with specific expertise are consulted as part of the clinical evaluation of new and existing drugs. To approve clinical drug policies, the established committee follows a standard process. The P&T Committee evaluates FDA-approved product labeling, peer-reviewed medical literature, published clinical practice guidelines, including randomized clinical trials, drug comparison studies, outcomes research data, pharmacoeconomic studies, comparisons of efficacy, side effects, potential for off-label use, and claims data analysis as relevant as part of the review and approval process of medical and clinical policies. The P&T Committee assesses external clinical evidence and nationally recognized evidence-based guidelines and benchmarks, as well as a prescription drug's place in therapy, and its relative safety and efficacy to approve clinical drug policies for select M/S and MH/SUD prescription drugs.
- **Clinical Criteria.** Clinical reviewers and peer clinical reviewers base Prior Authorization clinical coverage benefit determinations on objective, evidence-based clinical drug policies. The criteria utilized to administer the Prior Authorization, Step Therapy, or Quantity Limit requirements are the same for MH/SUD and M/S prescription drugs.
- **Determinations.** The process for administering Prior Authorization, Step Therapy, or Quantity Limits is the same for M/S and MH/SUD prescription drugs. Clinical reviewers (Medical Director or healthcare professional) consult clinical drug policies when making clinical coverage benefit determinations. The clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical drug policies in the case review to assess whether a prescription drug should be covered. The Prior Authorization, Step Therapy, or Quantity Limit request is approved based on whether the member's clinical condition meets criteria for coverage as determined by the application of clinical drug policy. Only qualified clinical reviewers (e.g., physicians or pharmacists) can issue adverse benefit determinations. If an adverse benefit determination is issued, then the adverse benefit determination and appeal rights are communicated to the member and provider, as applicable.
- **Adverse Benefit Determination.** For prescription drugs, an adverse benefit determination is an administrative or clinical review decision resulting in a reduction or termination, non-coverage, or non-certification of a prescription drug. Adverse benefit determinations are recorded as clinical denials when they are based on clinical drug policies

and member clinical information and are recorded as administrative denials when member eligibility and benefit coverage cannot be confirmed, or benefits are exhausted.

In Operation

The Plan compared the shared strategies, processes, factors, evidentiary standards, and source information used to determine which M/S and MH/SUD prescription drugs are subject to Prior Authorization, Step Therapy, or Quantity Limits and how Prior Authorization, Step Therapy, or Quantity Limits are administered “in operation.”

The Plan requires members or providers to submit requests for approval of M/S and MH/SUD prescription drugs. Clinical reviews included confirmation of member eligibility and benefit availability for the requested prescription. Clinical reviewers applied benefit plan documents and clinical drug policies to member clinical information to make a benefit determination. Only qualified peer clinical reviewers issued adverse benefit determinations. The Plan communicated all adverse benefit determinations for M/S and MH/SUD prescription drugs that did not meet applicable clinical drug policies consistent with state, federal, and accreditation requirements, including appeal rights, as applicable.

The Plan reviewed the percentage of M/S and MH/SUD prescription drugs subject to various NQTLs on a tri-annual basis. The results are reviewed with the UM Committee to determine if any changes should be made in the NQTLs. The UM Committee is comprised of internal clinicians who review clinical guidelines and recommend changes before going to the P&T Committee.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The findings of the analyses confirmed the strategies, processes, factors, evidentiary standards, and source information used to subject certain MH/SUD prescription drugs to Prior Authorization, Step Therapy, or Quantity Limits were comparable to, and applied no more stringently than, the strategies, processes, factors, evidentiary standards, and source information used to subject certain M/S prescription drugs to Prior Authorization, Step Therapy, or Quantity Limits “as written.”

Both M/S and MH/SUD utilize FDA-approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmaco-economic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off-label use, and claims data to develop prescription drug clinical policies.

In addition, both M/S and MH/SUD utilize the same generally accepted types of data, evidentiary sources, and trend analysis in order to create and maintain a Prior Authorization, Step Therapy, or Quantity Limit requirement.

The findings of the prescription drug Prior Authorization, Step Therapy, or Quantity Limits outcomes analysis for each Plan (see data below) indicated the percentage of prescription drugs subject to Prior Authorization, Step Therapy, and/or Quantity Limits for MH/SUD prescription drugs were comparable to the percentage of prescription drugs subject to Prior Authorization, Step Therapy, and/or Quantity Limits for M/S prescription drugs. Data is for (January, May, and September 2022). The Plan notes that the U.S. Department of Labor has indicated generally that outcomes data are not dispositive of parity compliance.

The following are results of each analysis in 2022:

- January 2022 – 30.6% (182) of MH/SUD drugs are subject to Prior Authorization, Step Therapy, and/or Quantity Limits, while 19.6% (1,513) of M/S drugs are subject to these programs
- May 2022 – 32.5% (197) of MH/SUD drugs are subject to Prior Authorization, Step Therapy, and/or Quantity Limits, while 19.8% (1,532) of M/S drugs are subject to these programs
- September 2022 – 32.7% (201) of MH/SUD drugs are subject to Prior Authorization, Step Therapy, and/or Quantity

Limits, while 20.4% (1,577) of M/S drugs are subject to these programs

Conclusions

The Plan reviewed the M/S and MH/SUD processes and noted the Plan uses a single P&T committee which follows a standard process to create clinical criteria and develop clinical drug policies for M/S and MH/SUD prescription drugs. From review of the Prior Authorization Step Therapy, or Quantity Limit policies and procedures, the Plan concluded the methodology used to determine which MH/SUD prescription drugs are subject to Prior Authorization Step Therapy, or Quantity Limits “as written” were comparable to, and applied no more stringently than, the methodology used to determine which M/S prescription drugs are subject to Prior Authorization, Step Therapy, or Quantity Limits “as written.” Additionally, the Plan concluded how Prior Authorization, Step Therapy, or Quantity Limits is applied to MH/SUD prescription drugs was comparable to, and applied no more stringently than, how Prior Authorization, Step Therapy, or Quantity Limits was applied to M/S prescription drugs “as written.”

The Plan notes that the percentage of MH/SUD drugs subject to Prior Authorization, Step Therapy, and/or Quantity Limits is higher than the percentage of M/S drugs subject to Prior Authorization, Step Therapy, and/or Quantity Limits. The Plan concluded this was due to the following contributing factors: a smaller pool of MH/SUD products to evaluate, a broader range of strengths for MH/SUD products, and an increased risk of abuse and diversion of MH/SUD products explain the variance. The Plan concluded this does not indicate a parity concern, but rather is an indicator of patient safety in disbursing MH/SUD drugs.

The Plan reviewed the M/S and MH/SUD processes and noted the Plan uses the same policies and procedures to create clinical criteria and develop clinical drug policies for both M/S and MH/SUD prescription drugs. The Plan also reviewed the percentage of M/S and MH/SUD prescription drugs which are subject to Prior Authorization, Step Therapy, or Quantity Limits and concluded the methodology used to determine which MH/SUD prescription drugs are subject to Prior Authorization, Step Therapy, or Quantity Limits and how Prior Authorization, Step Therapy, or Quantity Limits were applied were comparable to, and applied no more stringent than, the methodology used to determine which M/S prescription drugs were subject to Prior Authorization, Step Therapy, or Quantity Limits “in operation.”

Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical/surgical (M/S) benefits. This generally means that financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements, such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage.

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Prior Authorization is defined as: “A required or mandatory clinical assessment for proposed service(s) based on clinical information provided and the terms of the health plan benefits before the service(s) are performed or delivered. Clinical and medical necessity requirements, level of care appropriateness, and the terms of the health plan benefits must be met in order for services to be covered by the member’s plan.” The *Optum National Policy Definitions List* defines pre-authorization (aka Prior Authorization) as “a form of prospective utilization review of health care services proposed to be provided to a member.”

Prior Authorization is a component of the Plan’s Utilization Management (UM) program that helps ensure members receive appropriate coverage based on their specific clinical status and health care needs. The process is designed to achieve optimal clinical outcomes by applying objective, evidence-based clinical criteria, and nationally recognized guidelines and best practices.

Prior Authorization for inpatient services commences prior to a service being delivered. Prior Authorization is a UM process that involves applying the benefit plan language and/or clinical criteria to make the most appropriate clinical coverage benefit determination.

This document includes the following information:

- Prior Authorization process for M/S and MH/SUD inpatient services
- Description of the NQTL and application (Step 1)
- Factors used to determine which services are subject to the NQTL (Step 2)
- Evidentiary standards and sources used to define, trigger and/or implicate a factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

This analysis refers to the following attachments:

- *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions* - M/S policy that defines Prior Authorization
- *Optum National Policy Definitions List* - MH/SUD policy that defines Prior Authorization

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- *Utilization Management Program Description (UMPD) of United HealthCare Services, Inc. and UnitedHealthcare Insurance Company* - Summarizes the philosophy, structure and standards that govern UHC's medical management, UM and utilization review responsibilities and functions
- *Management of Behavioral Health Benefits Policy* - Describes the mechanisms and processes designed to promote consistency in the management of behavioral health benefits and to ensure that members receive appropriate, high quality behavioral health services in a timely manner
- *Core Principles and Practices* - MH/SUD policy that outlines the core principles and practices that should be used by personnel in their interactions with members, authorized member representatives, practitioners and facilities, related to the management of behavioral health benefits, coverage determinations and appeals/grievances of non-coverage determinations.
- *Performance Assessment and Incentives* - M/S policy confirming that clinical reviewers are not incented to make denials for financial reasons
- *2023 UnitedHealthcare Provider Administrative Guide* – Informs M/S providers of the Prior Authorization process. The *UnitedHealthcare Provider Administrative Guide* can be accessed on the website <https://www.uhcprovider.com/en/admin-guides.html>
- *September 2023 Optum National Network Manual* - Informs MH/SUD providers of the Prior Authorization process. The *Optum National Network Manual* can be accessed on the website <https://public.providerexpress.com/content/optum-provexpr/us/en/clinical-resources/guidelines-policies/optum-network-manual.html>
- *Schedule of Benefits - SBN23-Medical-INS-BIND-2021-Choice Plus-LG-GA-UHIC* - Plan document that outlines member responsibilities

The Plan concludes that the Prior Authorization requirements for M/S and MH/SUD are comparable and applied no more stringently for MH/SUD in-network (INN) inpatient benefits, both “as written” and “in operation.”

Process

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Prior Authorization is defined as: “A required or mandatory clinical assessment for proposed service(s) based on clinical information provided and the terms of the health plan benefits before the service(s) are performed or delivered. Clinical and medical necessity requirements, level of care appropriateness, and the terms of the health plan benefits must be met in order for services to be covered by the member's plan.” The *Optum National Policy Definitions List* defines pre-authorization (aka Prior Authorization) as “a form of prospective utilization review of health care services proposed to be provided to a member.”

The Plan structures inpatient Prior Authorization processes to be compliant with all applicable federal and state requirements. Prior Authorization is governed at both the state and federal level, which includes consumer protections such as external review for adverse benefit determinations after internal appeal options are exhausted.

The Plan delegates management of MH/SUD inpatient services, including Prior Authorization, to United Behavioral Health d/b/a Optum Behavioral Health (OBH), its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor.

The Plan has national committees that approve M/S and MH/SUD services to be subject to Prior Authorization. The Plan publishes the services subject to Prior Authorization on the provider portal(s) ([Advance Notification and Clinical Submission Requirements | UHCprovider.com](#) for M/S and [Optum - Provider Express Home](#) for MH/SUD). Members can learn what services are subject to Prior Authorization in their benefit plan document, through myuhc.com, or by contacting customer service.

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Prior Authorization Review of M/S inpatient admissions consists of the following:

The Plan requires INN facilities and providers to submit a Prior Authorization request for services on the Prior Authorization list prior to rendering the service. There may be some INN benefits for which the member is responsible for obtaining Prior Authorization. These are identified in the member's benefit plan document (i.e., *Schedule of Benefits*). The INN provider's submission of a request (notification) triggers the Prior Authorization process.

INN providers can submit Prior Authorization requests through the secure provider portal (www.uhcprovider.com), their connected electronic medical record, by telephone, or by fax (where required). Members may submit Prior Authorization requests by telephone, fax, or mail, in accordance with Plan requirements. Providers and members communicate basic information to create a case. As outlined in the *UnitedHealthcare Care Provider Administrative Guide*, providers must submit advance notification with supporting documentation as soon as possible, but at least two weeks before the planned service, unless otherwise stated.

The Plan confirms receipt of the Prior Authorization request. Non-clinical staff confirm member eligibility and benefit coverage upon receipt of the notification. Non-clinical staff review cases to ensure availability of accurate and thorough case information. Non-clinical staff may approve coverage requests in scenarios where the member's plan documents allow and if a clinical review is not required. Non-clinical staff will also approve a coverage request if the facility's contract does not allow for clinical reviews. Requests that are submitted through the secure provider portal may also be approved based on the benefit plan coverage criteria, member diagnosis, and the clinical information submitted. Non-clinical staff may administratively deny coverage when a member's benefits are exhausted. Non-clinical staff refer coverage requests that they cannot approve or administratively deny to initial clinical reviewers.

First Level Clinical Review/Initial Review. Clinical reviewers (nurses or physicians) consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether the inpatient admission is medically necessary by reviewing the member's clinical information, the applicable clinical criteria or guidelines, and the Plan benefit terms. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs to determine whether the applicable clinical criteria are met or may access clinical information in the provider's electronic medical record (EMR) if the provider has given the Plan access. The clinical reviewer may approve cases that meet applicable clinical criteria.

Second Level Clinical Review/Peer Review. The initial clinical reviewer refers cases to a second level/peer clinical reviewer if the case cannot be approved. Peer clinical reviewers (physician or mid-level practitioner) consult clinical criteria when making clinical coverage benefit determinations. Peer clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. The peer clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. If a peer clinical reviewer issues an adverse benefit determination, then the Plan communicates the adverse benefit determination and appeal rights and offers a peer-to-peer conversation consistent with state and federal requirements.

Adverse Benefit Determination. For M/S, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction, or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when member benefits are exhausted. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials. Modified coverage requests that are approved are recorded as partial denials.

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Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based medical clinical policies and use clinical criteria from third-party sources such as InterQual® or MCG® guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that inpatient Prior Authorization determinations are appropriate.

M/S monitors clinical reviewer and peer clinical reviewer application of clinical criteria through an annual inter-rater reliability (IRR) assessment that is provided by InterQual. Clinical reviewers and peer clinical reviewers are required to pass the IRR assessment with a score of 90% or better through three attempts. After a second failed IRR assessment, staff enter a remediation period and are required to review all cases with a supervisor for 30 days, or until 90% is achieved on the assessment. If the clinical reviewer achieves a passing score within the 30-day period, supervisors review a minimum of one case per week for the remainder of the 30-day period.

The Plan also conducts end-to-end case audits that are designed and approved by clinical leadership each year. The end-to-end audits include all stages of a case review, from intake through appeal. These audits are conducted monthly and approximately 1500 cases are reviewed per month. Results are reported to an oversight team. All deficiencies are remediated. Remediation may include corrective actions and/or additional education, as indicated.

The Plan routinely monitors Prior Authorization performance through its clinical performance oversight functions. Outcomes are monitored against timeliness compliance, performance guarantees, and for potential trends, including overall utilization.

As of April 1, 2023, the Utilization Management Program Committee (UMPC) began overseeing the M/S UM program. The UMPC is responsible for the development and maintenance of the M/S Prior Authorization processes. The UMPC ensures that the UM program considers the factors and evidentiary standards for applying UM. The UMPC is comprised of:

- Chief Medical Officer, Medical Management (Co-Chair)
- Senior Vice President, Clinical Advancement (Co-Chair)
- Chief Medical Officer, UnitedHealthcare
- Senior Vice President, Clinical Appeals & Grievances
- Chief Medical Officer, Clinical Policy
- Chief Medical Officer, UnitedHealthcare Employer & Individual
- Chief Medical Officer, UnitedHealthcare Medicare & Retirement
- Chief Medical Officer, Community & State
- Chief Medical Officer, UnitedHealthcare Individual & Family Plans
- Vice President, Clinical Transformation & Affordability
- Senior Director, Mental Health Parity
- Vice President, Utilization Management Strategy & Implementation

One of the chairs must be an executive leader and a licensed physician. UMPC meets at least six times per year but may meet more frequently if needed.

Per the M/S policy entitled *Performance Assessment and Incentives*, at no time are initial clinical reviewers or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons.

M/S generally structures UM processes to comply with federal Employee Retirement Income Security Act of 1974 (ERISA) requirements, and state law where applicable.

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Prior Authorization review of MH/SUD inpatient admissions consists of the following:

The Plan delegates management of MH/SUD inpatient services, including Prior Authorization, to United Behavioral Health d/b/a OBH, its delegated MH/SUD MBHO vendor.

The Plan requires INN providers and facilities to submit a Prior Authorization request for services on the Prior Authorization list prior to rendering the service. There may be some INN benefits for which the member is responsible for obtaining Prior Authorization. These are identified in the member's benefit plan document (i.e., *Schedule of Benefits*). The INN provider's submission of a request (notification) triggers the inpatient Prior Authorization process.

INN providers may submit Prior Authorization requests through the secure provider portal (www.providerexpress.com), by telephone, or by fax (where required). Providers communicate basic information to create a case. As outlined in the *Optum National Network Manual*, inpatient behavioral health services require an initial Prior Authorization or notification in advance of the service.

As described in the *Management of Behavioral Health Benefits Policy*, the Plan confirms receipt of the Prior Authorization request. Non-clinical staff confirm member eligibility and benefit coverage. Non-clinical staff may approve coverage requests that do not require clinical evaluation or interpretation based on the member's diagnosis and the clinical information submitted by providers. Non-clinical staff may administratively deny coverage when member benefits are exhausted. Non-clinical staff refer cases that they cannot approve or administratively deny to initial clinical reviewers.

First Level Clinical Review/Initial Review. Clinical decisions are made by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse benefit determinations are made by Medical Directors. Clinical reviewers consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether an inpatient admission is medically necessary by reviewing the member's clinical information, the applicable clinical criteria or guidelines, and the Plan benefit terms. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for certification, related diagnostic results, and history of related treatment and services to determine whether the applicable clinical criteria are met. The clinical reviewer may approve the admission based on their review.

Second Level Clinical Review/Peer Review. The initial clinical reviewer refers cases to a peer clinical reviewer for a peer-to-peer discussion if the case cannot be approved. The requesting provider is offered the opportunity to discuss the case with the peer clinical reviewer, consistent with state and federal requirements before an adverse benefit determination is issued. Only qualified peer clinical reviewers (e.g., Medical Directors) can issue adverse benefit determinations. Peer clinical reviewers apply clinical criteria to member clinical information to determine coverage for an inpatient admission. If the requesting provider fails to complete the peer-to-peer discussion, the peer clinical reviewer makes a determination based on the information available. If a peer clinical reviewer issues an adverse benefit determination (e.g., the admission is not medically necessary and is not approved), then the Plan timely communicates the adverse benefit determination, including appeal rights, to the member and provider consistent with applicable state and federal requirements.

Adverse Benefit Determination. For MH/SUD, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction, or termination of a benefit. Adverse benefit determinations are recorded as a clinical denial when it is based on clinical criteria and member clinical information and is recorded as an administrative denial when member benefits are excluded.

Platinum Designation. The Plan offers a Platinum Designation program to MH/SUD facilities based on facilities' quantitative practice patterns (effectiveness and efficiency benchmarks). The Platinum Designation program's effectiveness and efficiency benchmarks include targeted 30- and 90-day readmission rates, 7- and 30-day follow up after hospitalization, outlier length of stay, and outlier behavioral health episode spend. INN MH/SUD facilities that meet the Platinum Designation are required to

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notify the Plan of admissions and provide member information. The Plan covers the first 8 to 21 days of a stay depending on the specific level of care without review. The Plan evaluates INN MH/SUD facilities performance annually as described in the *Optum National Network Manual*.

Clinical Criteria. Initial clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based behavioral clinical policies or use clinical criteria from third-party sources such as American Society of Addiction Medicine (ASAM) Criteria®, Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System-Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) and Early Childhood Service Intensity Instrument (ECSII) guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that inpatient Prior Authorization determinations are appropriate.

MH/SUD monitors clinical reviewer and peer clinical reviewer application of clinical criteria through an annual IRR assessment. Clinical reviewers and peer clinical reviewers are required to pass the IRR assessment with a score of 90% or better through three attempts. After a second failed IRR assessment, the reviewer enters a remediation period and is required to review all cases with a supervisor for 30 days, or until 90% is achieved on the assessment. If the clinical reviewer achieves a passing score within the 30-day period, supervisors review a minimum of one case per week for the remainder of the 30-day period.

The Plan also conducts monthly quality audits of individual non-clinical staff, clinical reviewers, and peer clinical reviewers, including staff performing appeal functions. These audits are designed and approved by clinical leadership each year. A minimum of two audits are completed per staff, per month. The results of these real-time audits are shared with supervisors for staff oversight, and all findings are remediated. Remediation may include corrective actions and/or additional education, as warranted.

The Plan routinely monitors Prior Authorization performance through its clinical performance oversight functions. Outcomes are monitored against timeliness requirements, performance guarantees, and for potential trends, including overall utilization.

The Plan's national Clinical Quality & Operations Committee (CQOC) annually reviews UM program outcomes, including inpatient Prior Authorization outcomes, to confirm overall utilization is appropriate. The CQOC is comprised of representatives from sub-committees, and representatives from the clinical quality improvement, UM, care engagement, medical operations, medical policy and standards, clinical operations, appeals, product, legal, compliance, network strategy, provider experience, accreditation, and benefits teams. The Chair of the CQOC must be an executive leader, board certified in psychiatry or psychiatric subspecialty and a licensed physician.

Per the MH/SUD policy entitled, *Core Principles and Practices*, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons.

MH/SUD generally structures UM processes to comply with federal ERISA requirements and state law where applicable.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- Prior Authorization

Benefit Classification(s)

- INN, inpatient

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Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHC)

Plan Terms/Source Document(s)

In each of the Plan products, “Medically Necessary” is the Plan term used to guide Prior Authorization decision-making for both M/S and MH/SUD services. “Medically Necessary” is generally defined as follows:

“Medically Necessary – health care services are all of the following as determined by us or our designee.

- In accordance with *Generally Accepted Standards of Care*.
- Clinically appropriate, in terms of type, frequency, extent, service site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s), service site or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.
- Or, are subject to Bind Coverage with Evidence Development Policy (CED Policy).

Generally Accepted Standards of Care are evidence based independent standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties. Valid, evidence based sources reflecting generally accepted standards of care include credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or nationally recognized clinical practice guidelines may be considered. We have the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be determined by us.

We develop and maintain clinical policies that describe the Generally Accepted Standards of Care scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. [[These clinical policies (as developed by us and revised from time to time), are available to Covered Persons through [MyBind.com] or by calling the telephone number on your ID card.] [They are [also] available to Physicians and other health care professionals on [MyBind.com].]]”

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Prior Authorization is defined as:

“A required or mandatory clinical assessment for proposed service(s) based on clinical information provided and the terms of the health plan benefits before the service(s) are performed or delivered. Clinical and medical necessity requirements, level of care appropriateness, and the terms of the health plan benefits must be met in order for services to be covered by the member's plan.”

The *Optum National Policy Definitions List* defines pre-authorization (aka Prior Authorization) as “a form of prospective utilization review of health care services proposed to be provided to a member.”

The Plan’s *Schedule of Benefits* notify members of the Prior Authorization requirements:

“We require prior authorization for certain Covered Health Care Services. Network providers are responsible for obtaining prior authorization before they provide these services to you. [\[Benefits for conditional coverage do not require Network provider prior authorization, with the exception of a pre-admission notification for Covered Health Care Services for Inpatient Stays.\]](#)

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We recommend that you confirm with us that all Covered Health Care Services have been prior authorized as required. Before receiving these services from a Network provider, you may want to call us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they do not prior authorize as required. You can call us at the telephone number on your ID card.

When you choose to receive certain Covered Health Care Services from out-of-Network providers, you are responsible for obtaining prior authorization before you receive these services. Note that your obligation to obtain prior authorization is also applicable when an out-of-Network provider intends to admit you to a Network facility or to an out-of-Network facility or refers you to other Network or out-of-Network providers. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization. Services for which you are required to obtain prior authorization are shown in the Schedule of Benefits table within each Covered Health Care Service category.

To obtain prior authorization, call the telephone number on your ID card. This call starts the utilization review process.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the Schedule of Benefits table to find out how far in advance you must obtain prior authorization.

For Covered Health Care Services that do not require you to obtain prior authorization, when you choose to receive services from out-of-Network providers, we urge you to confirm with us that the services you plan to receive are Covered Health Care Services. That's because in some instances, certain procedures may not be Medically Necessary or may not otherwise meet the definition of a Covered Health Care Service, and therefore are excluded. In other instances, the same procedure may meet the definition of Covered Health Care Services. By calling before you receive treatment, you can check to see if the service is subject to limitations or exclusions.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those received, our final coverage determination will be changed to account for those differences, and we will only pay Benefits based on the services delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Care Service, you will be responsible for paying all charges and no Benefits will be paid.”

The *2023 UnitedHealthcare Care Provider Administrative Guide* notifies providers of the Prior Authorization requirements. INN providers are required to comply with UM protocols established by the Plan:

““We require prior authorization for all MA benefit plans and some commercial benefit plans. Prior authorization requests allow us to verify if services are medically necessary and covered. After you notify us of a planned service listed on the Advance Notification/Prior Authorization List, we tell you if a clinical coverage review is required, as part of our prior authorization process, and what additional information we need to proceed. We notify you of our coverage decision within the time required by law. Just because we require notification for a service, does not mean it is covered. We determine coverage by the member's benefit plan.

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If there is a conflict or inconsistency between applicable regulations and the notification requirements in this guide, the applicable regulations govern.

Physicians, health care professionals and ancillary care providers are responsible for:

- Providing advance notification or requesting prior authorization for services on the Advance Notification/Prior Authorization List, including for non-emergent air transport services.
- Directing members to use care providers within their network. Members may be required to obtain prior authorization for out-of-network services.

Facilities are responsible for:

- Obtaining prior authorization for non-emergent, fixed-wing transportation services and using in-network, fixed-wing air ambulance providers.
- Obtaining prior authorization for inpatient admission to skilled nursing facility, acute inpatient rehabilitation and/or long-term acute care.
- Confirming coverage approval is on file (for services requiring advance notification/prior authorization) prior to the date of service.
- Providing admission and discharge notification for inpatient services, even if coverage approval is on file

If you perform multiple procedures for a member in one day, and at least one service requires prior authorization, you must obtain Prior authorization for any of the services to be paid.

If you do not follow these requirements, we may deny claims. In that case, you cannot bill the member. Advance notification or prior authorization is valid only for the date of service or date range listed on it. If services have not been rendered and the specified date of service or date range has passed, you must contact us to update the date of service or date range. When you contact us, we will advise if we will require a new submission.

- Giving us advance notification, or receiving prior authorization from us, is not a guarantee of payment, unless required by law or Medicare guidelines. This includes regulations about health care providers on a sanction or excluded list, the Medicare preclusion list and/or health care providers not included in the Medicare Provider Enrollment Chain and Ownership System (PECOS)* list. Payment of covered services is based on:
 - The member's benefit plan,
 - If you are eligible for payment,
 - Claim processing requirements,
 - Your Agreement.

Information required for advance notification/prior authorization requests Your request must have the following information:

- Member name and member health plan ID number
- Ordering health care provider name and TIN or NPI
- Rendering health care provider name and TIN or NPI
- ICD-10-CM diagnosis code
- All applicable procedure codes
- Anticipated date(s) of service
- Type of service (primary and secondary) procedure code(s) and, if relevant, the volume of service
- Place of service
- Facility name and TIN or NPI where service will be performed (when applicable)
- Original start date of dialysis (End Stage Renal Disease [ESRD] only)

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If the member's benefit plan requires a clinical coverage review, we may request additional information, as described in more detail in the Clinical coverage review section.

The list of services that require advance notification and prior authorization is the same. The process for providing notification and submitting a prior authorization request is the same. Services that require Prior authorization require a clinical coverage review based on medical necessity.

View the most current and complete advance notification requirements, including procedure codes and associated services, at uhcprovider.com/priorauth > Advance Notification and Plan Requirement Resources.

Advance notification/prior authorization lists are subject to change. We will inform you of changes on uhcprovider.com/news. Sign up to receive email updates at uhcprovider.com/subscribe. If you need a paper copy of the requirements, contact your UnitedHealthcare Network Management representative or provider advocate at uhcprovider.com > Contact us.

We recommend that you submit advance notification with supporting documentation as soon as possible, but at least 2 weeks before the planned service (unless the Advance Notification Requirements states otherwise). Following a facility discharge, advance notification for home health services and durable medical equipment is required within 48 hours after the start of service."

The *Optum National Network Manual*, September 2023 notifies providers of the Prior Authorization requirements. INN providers are required to comply with UM protocols established by the Plan:

"In most cases, inpatient admissions will be directed only to participating hospitals and attending psychiatrists.

All inpatient and sub-acute level of care admissions require notification or pre-authorization by the network provider or facility. Optum requires notification within one business day after an admission for a facility to request a pre-authorization unless a longer period is required by contract or state specific requirements. This includes, but is not limited to, mental health or substance abuse disorder services delivered as inpatient treatment, partial/day hospitalization or residential treatment.

Network providers are solely responsible for completing prior notification or obtaining preauthorization prior to providing inpatient or sub-acute level of care services. This includes timely provision of information necessary for concurrent review of continued stay or ongoing care requests prior to the delivery of services.

Should a provider fail to obtain or otherwise follow the required administrative procedures for notification or pre-authorization, Optum may, in accordance with applicable law, apply a reduction of payment to the network provider up to 100% of provider's reimbursement rate. Network provider payment reductions for failure to complete notification or obtain pre-authorization are solely the network provider's liability (i.e., the member cannot be billed for these reductions in payment)."

The role of the Plan's delegate, United Behavioral Health d/b/a OBH, is discussed in the *UMPD*:

"United Behavioral Health (UBH) performs the review of requests for coverage of behavioral health services (i.e., substance abuse, and mental health requests for services). UBH provides comprehensive behavioral health care delivery for members through a network of behavioral health practitioners, ancillary care providers, hospitals, and other facilities.

For mental health, substance-related disorder services, and wraparound services, UBH uses its Clinical Criteria (see below), behavioral clinical policies, and best practice guidelines to make coverage determinations. UBH adopts externally-developed clinical criteria, and creates internally-developed Clinical Criteria, where appropriate, based on its

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assessment of relevant guidance. UBH develops clinical criteria that supersedes its standard set or adopts externally-developed clinical criteria when required to do so by contract or regulation.

- Clinical Criteria (Level of Care Utilization System-LOCUS) – Standardized level of care assessment tool developed by the American Association of Community Psychiatrists used to make clinical determinations and placement decisions for mental health disorder benefits for adults ages 19 and older when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (Child and Adolescent Level of Care/Service Intensity Utilization System-CALOCUS-CASII) - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry (AACAP) and the American Association for Community Psychiatry (AACP) used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children and adolescents ages 6-18 when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (Early Childhood Service Intensity Instrument-ECSII) - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children ages 0-5 when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (State or Contract Specific Level of Care Guidelines) – Criteria used to make medical necessity determinations for mental health disorder benefits when there are explicit mandates or contractual requirements.
- Clinical Criteria (American Society of Addiction Medicine [ASAM]) - Criteria developed by the American Society of Addiction Medicine used to make clinical determinations for substance-related disorder benefits.
- Clinical Criteria (Optum Developed)
 - Optum Behavioral Clinical Policies: Criteria that stem from evaluation of new services or treatments or new applications of existing services or treatments and are used to make clinical determinations regarding proven or unproven services and treatments.

Licensed practitioners conduct all reviews with a focus on measurable outcome goals and objectives for treatment. A senior UBH Medical Director is responsible for directing and implementing behavioral health utilization management programs. A referral is sent to UBH when a member is identified as potentially benefiting from behavioral health services during a “medical event”.

The UBH UM Program is staffed by clinical, non-clinical and administrative personnel. All clinical denials or adverse decisions are made by board certified psychiatrists, or, if the health plans choose, by a panel of other appropriate health care service reviewers. If the health plan chooses to use a panel to make adverse decisions, the panel contains at least one physician who is board certified in psychiatry. When the health care service under review is a mental health or substance abuse service, the adverse decision is made by a licensed physician who is board certified in psychiatry. All potential clinical denials are referred to a physician who is board certified in psychiatry for final determination. An evaluation of the overall effectiveness of the Behavioral Health UM Program is conducted annually to determine how well resources have been deployed to improve UM activities and the clinical care and service provided to members.”

The Plan’s terms require services to be medically necessary for coverage. INN providers are required to comply with the Plan’s UM protocols including complying with Prior Authorization requirements.

List of M/S and MH/SUD Services Subject to NQTL

The M/S and MH/SUD INN inpatient services subject to prior authorization are below:

M/S:

- Acute Care Hospitalizations
- Critical Access Hospitals
- Inpatient Acute Inpatient rehabilitation (AIR)
- Inpatient Long Term Acute Care (LTAC)
- Inpatient Skilled Nursing Facility (SNF)

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MH/ SUD:

- MH Non-Emergent Acute Inpatient
- MH Subacute Residential Treatment
- SUD Acute Inpatient Detoxification
- SUD Acute Inpatient Rehabilitation
- SUD Subacute Residential Treatment

Step 2 – Factors Used to Determine Prior Authorization

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

When Surest (Bind) plans first launched in 2016, the Plans were designed to offer a simpler and more transparent way for people to access the system. The Plan included coverage for services with the option to buy-up specific benefits based on member need.

In 2022, UnitedHealthcare acquired Surest (Bind) and agreed to adopt the existing list of services Bind had identified to be subject to Prior Authorization. The Plan has determined that Clinical Appropriateness is one of the factors that is determinative in imposing the Prior Authorization limitation. At this time, the Plan is assessing the value of managing the services, the consistency of adherence to evidence-based guidelines, and volume of services utilized to further refine which INN Inpatient services are subject to Prior Authorization. As a result, the Plan is evaluating the factors to be utilized to determine which INN Inpatient services are subject to Prior Authorization.

The Plan relies on the following factor to determine which INN inpatient benefits will be subject to Prior Authorization. This factor applies to M/S and MH/SUD benefits for the following:

- I. M/S: INN inpatient services
 - II. MH/SUD: INN inpatient services
- Clinical Appropriateness (Qualitative)
 - Whether the application of Prior Authorization promotes optimal clinical outcomes

Applies to M/S and MH/SUD services.

Meeting Clinical Appropriateness is determinative in imposing the limitation. All Prior Authorization reviews are subject to Clinical Appropriateness and must have medical necessity criteria.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below is the evidentiary standard and source used to define, trigger, and/or implicate the factor used to add services to the Plan's Prior Authorization requirement for INN inpatient services. This evidentiary standard and source applies to benefits for the following:

- I. M/S: INN inpatient services
- II. MH/SUD: INN inpatient services

Factor – Clinical Appropriateness is defined as those inpatient services that are determined by internal medical experts to be in accordance with objective, evidence-based, clinical criteria, and nationally recognized guidelines.

- The Plan’s evidentiary standards and sources that trigger and/or define the Clinical Appropriateness factor are:
 - Clinical criteria from nationally recognized third-party sources (e.g., InterQual for M/S services, and ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines for MH/SUD services)
 - Clinical Technology Assessment Committee (CTAC) and Medical Technology and Assessment Committee (MTAC) review
 - Objective, evidence-based medical/behavioral clinical policies, and nationally recognized guidelines approved by professional healthcare associations (e.g., clinical guidance from the American Medical Association, American Psychiatric Association, etc.)

These evidentiary standards and sources apply to M/S and MH/SUD INN inpatient services and are defined in a qualitative manner.

Meeting Clinical Appropriateness is determinative in imposing the limitation.

The factor and evidentiary standard used as the basis for subjecting MH/SUD INN inpatient benefits to Prior Authorization are comparable to, and applied no more stringently than, the factor and evidentiary standard used as the basis for subjecting M/S INN inpatient benefits to Prior Authorization “as written” and “in operation.”

Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer’s analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert’s qualifications and the extent to which the Plan or issuer ultimately relied upon each expert’s evaluations in setting recommendations regarding both.

As Written

The Plan conducted a comparative analysis of the strategies, processes, factor, evidentiary standard, and source information used to determine which M/S and MH/SUD INN inpatient services are subject to Prior Authorization and how Prior Authorization is applied to M/S and MH/SUD INN inpatient services “as written.” The Plan identified the factor and evidentiary standard used as the basis for subjecting M/S and MH/SUD benefits to Prior Authorization.

National internal committees apply the factor and standard described in Steps 2 and 3 to M/S and MH/SUD services when determining whether the services should be included on the Prior Authorization list.

Review of Factors and Evidentiary Standards

The Plan reviewed the factor that triggers an INN inpatient service to be subject to Prior Authorization. The factor and evidentiary standard were applied to M/S and MH/SUD services comparably and not more stringently to MH/SUD services than to M/S services.

Review of Operational Policies and Procedures

The Plan reviewed M/S and MH/SUD operational policies and procedures, IRR assessment processes, and UM annual oversight to confirm comparability and found MH/SUD policies, procedures, and processes to be comparable and no more stringent than M/S policies, procedures, and processes.

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- Medical management operational policies and procedures establish the standards for how the Plan conducts inpatient Prior Authorization. The policies and procedures are consistent with state and federal law governing Prior Authorization. Timeframes for decisions, content of adverse benefit determinations, appeal rights, and external review are all governed by state and federal law.
- The IRR assessment measures the consistency with which clinical reviewers and peer clinical reviewers apply the Plan's clinical criteria. IRR assessment processes apply to M/S and MH/SUD inpatient services.
- UM oversight monitors and evaluates UM processes by reviewing program outcomes, clinical appeals, IRR assessments, and under- and over-utilization.

Review of Inpatient Prior Authorization Processes

The strategy for applying Prior Authorization to INN inpatient services is comparable for M/S and MH/SUD services and is applied no more stringently to MH/SUD INN inpatient services. The Plan conducted a review of the M/S and MH/SUD Prior Authorization processes to confirm comparability. The review focused on the following aspects of the process for both M/S and MH/SUD:

- **Prior Authorization Request.** INN M/S and MH/SUD facilities and providers are contractually responsible for submitting Prior Authorization requests. The provider can submit the Prior Authorization request through the secure provider portal, by telephone, or by fax (where required). The member is responsible for obtaining Prior Authorization for certain services that are identified in the member Plan document.
- **Timeframe to Submit.** *The UnitedHealthcare Administrative Guide* (for M/S) and *Optum National Network Manual* (for MH/SUD) were reviewed for notification timeframes. The timeframes for the provider or member to notify of an inpatient admission were reviewed and determined that MH/SUD was comparable and no more stringent.
 - M/S – As outlined in the *UnitedHealthcare Administrative Guide*, providers must submit advance notification with supporting documentation as soon as possible, but at least two weeks before the planned service, unless otherwise stated.
 - Unplanned or emergency admissions are not subject to Prior Authorization.
 - MH/SUD – As outlined in *Optum National Network Manual*, MH/SUD requires notification within one business day after an inpatient admission to a facility unless a longer period is required by contract or state-specific requirements.
 - Unplanned or emergency services are not subject to Prior Authorization.
- **Clinical Reviews.** For M/S and MH/SUD inpatient Prior Authorization requests, clinical reviewers may gather more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for certification, related diagnostic results, history of related treatment and services, and photographs. The clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. The clinical reviewer may approve cases that meet applicable clinical criteria.
- **Review Timeframes.** M/S and MH/SUD inpatient Prior Authorization determination timeframes are defined by state and federal requirements. The same determination timeframes apply to M/S and MH/SUD determinations.
- **Determinations and Non-Clinical Reviews, First Level Clinical Reviews, and Second Level Peer Clinical Reviews.**
 - Non-clinical staff refer coverage requests that they cannot approve or administratively deny to clinical reviewers. Clinical reviewers consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether an inpatient admission is medically necessary. The clinical reviewer may approve the admission based on their review. The clinical reviewer refers cases to a peer clinical reviewer for a peer-to-peer discussion if the case cannot be approved. Only qualified peer clinical reviewers (e.g., Medical Directors) may issue adverse benefit determinations. Peer-to-peer discussions are offered as required.
 - **Platinum Designation.** Providers that meet the Platinum Designation are required to notify the Plan of admissions and provide member information. The Plan covers the first 13 days of a mental health inpatient admission and 8 days of a substance use disorder inpatient admission without review.
- **Adverse Benefit Determinations and Peer-to-Peer Conversations.** The Plan offers INN inpatient facilities and providers the opportunity to discuss a potential adverse benefit determination before the Plan issues such determination. This process allows INN inpatient facilities and providers the opportunity to provide additional

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information and/or modify their request prior to an adverse benefit determination being issued. Only M/S and MH/SUD peer clinical reviewers (e.g., Medical Directors) may issue adverse benefit determinations for coverage of M/S and MH/SUD inpatient services.

- Notification of Decisions to Providers and Members. The Plan notifies M/S and MH/SUD INN facilities, providers, and members of approvals and adverse benefit determinations, including applicable appeal rights, consistent with state and federal requirements.
 - INN inpatient M/S and MH/SUD services:
 - An adverse benefit determination is recorded as a clinical denial when it is based on clinical criteria and member clinical information and is recorded as an administrative denial when member benefits are exhausted.
- Review of Staff Qualifications. For M/S and MH/SUD, clinical staff qualifications align with the type of clinical review and state and federal requirements.
 - M/S is staffed by clinical, non-clinical, and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., nurses, physicians, etc.) and all adverse benefit determinations are made by Medical Directors.
 - MH/SUD is staffed by clinical, non-clinical, and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse determinations are made by Medical Directors.
- Clinical Criteria. For M/S and MH/SUD, clinical reviewers and peer clinical reviewers base determinations on the objective, evidence-based, medical/behavioral clinical policies and use clinical criteria from third party sources such as InterQual, MCG®, ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines.

In Operation

The Plan compared the strategies, processes, factor, evidentiary standard, and source information used to determine which M/S and MH/SUD INN inpatient services are subject to Prior Authorization and how Prior Authorization is applied “in operation.”

The Plan required INN M/S and MH/SUD providers to submit requests for approval of inpatient services for which the Plan requires Prior Authorization. The Plan publishes the services subject to Prior Authorization on the provider portal(s) (www.uhcprovider.com for M/S and www.providerexpress.com for MH/SUD). Members can learn what services are subject to Prior Authorization in their benefit plan document (i.e., *Schedule of Benefits*), through myuhc.com, or by contacting customer service. Notification triggered the Prior Authorization process for INN M/S and MH/SUD inpatient admissions.

M/S and MH/SUD inpatient Prior Authorization reviews included confirmation of member eligibility and benefit availability for the requested services. For M/S and MH/SUD INN inpatient services, non-clinical staff approved coverage for inpatient admissions that did not require clinical review or interpretation and where member's plan documents allowed. Non-clinical staff also approved coverage requests if the facility's contract did not allow for clinical reviews.

M/S and MH/SUD inpatient cases that were not administratively approved in initial administrative review were referred to a clinical reviewer for further research and evaluation. The M/S and MH/SUD clinical reviewers applied benefit plan documents and medical necessity criteria to member clinical information. M/S and MH/SUD clinical reviewers requested additional clinical information if they were unable to approve cases based on the available member clinical information. The clinical reviewers approved the admission based on their review when clinical criteria were met.

If the requested clinical information was not received or if the case could not be approved, M/S and MH/SUD clinical reviewers referred cases to a peer clinical reviewer. The Plan offered peer-to-peer conversations so the INN provider could provide additional clinical information prior to issuance of an adverse benefit determination. Only qualified peer clinical reviewers issued M/S and MH/SUD adverse benefit determinations.

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The Plan communicated all adverse benefit determinations for M/S and MH/SUD inpatient cases that did not meet applicable clinical criteria consistent with state and federal requirements, including appeal rights, as applicable.

The Plan monitored M/S and MH/SUD clinical and peer clinical reviewers' application of clinical criteria through annual IRR assessments. The Plan also conducted quality audits of cases. The Plan routinely monitors Prior Authorization performance through its clinical performance oversight functions. In addition to comparing these "in operation" processes, the Plan reviewed medical necessity approval and denial rates, internal appeals outcomes, and external appeals outcomes related to Prior Authorization determinations for M/S and MH/SUD INN inpatient services. The results of these analyses are discussed in greater detail in Step 5.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The findings of the Plan's comparative analyses confirmed the strategies, processes, factor, evidentiary standard, and source information used to determine the MH/SUD INN inpatient services subject to Prior Authorization were comparable to, and applied no more stringently than, the strategies, processes, factors, evidentiary standards, and source information used to determine the M/S INN inpatient services subject to Prior Authorization "as written."

The Plan found the factor used to determine the MH/SUD INN inpatient services subject to Prior Authorization was comparable to, and applied no more stringently than, the factor used to determine the M/S INN inpatient services subject to Prior Authorization. INN M/S and MH/SUD inpatient services that met the Clinical Appropriateness were subject to Prior Authorization review "in operation." Certain MH/SUD facilities that attained Platinum Designation were exempt from inpatient Prior Authorization.

The Plan used comparable processes to conduct Prior Authorization review of INN M/S and MH/SUD inpatient admissions. The Plan required M/S and MH/SUD INN facilities and providers to timely submit Prior Authorization requests. The Plan used qualified staff to confirm member eligibility and benefit availability, and to request additional information if necessary. The Plan issued approvals for M/S and MH/SUD inpatient admissions that met applicable clinical criteria or guidelines. Only qualified M/S and MH/SUD peer clinical reviewers issued adverse benefit determinations. The Plan gave INN facilities and providers the opportunity to discuss potential adverse benefit determinations with qualified peer clinical reviewers prior to issuing adverse benefit determinations. This afforded INN providers the opportunity to provide additional information or alter the initial request.

The Plan operated monitoring and oversight programs to ensure that clinical reviewers and peer clinical reviewers rendered appropriate determinations. Both M/S and MH/SUD required clinical reviewers, including peer clinical reviewers, to successfully complete the annual IRR assessment. Clinical reviewers were required to pass the IRR assessment with a score of 90% or better to render UM decisions independently. 2023 IRR M/S and MH/SUD results are not available. The M/S and MH/SUD clinical reviewers application of medical necessity criteria when making utilization review determinations will be assessed for comparability when the results are available.

INN inpatient medical necessity approval and denial rates and appeals outcomes data from 01/01/2022 – 12/31/2022 were evaluated where a minimum threshold of 100 cases were available to ensure a valid data set for analysis. The Plan has established that a minimum of at least 100 M/S and MH/SUD cases are required within each classification for a comparative analysis. Meaningful conclusions cannot be reached when there are fewer than 100 cases within each classification because the data is subject to variability.

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Because Georgia Surest Plan became effective on 7/2023 there is minimal membership and as a result an insufficient number of cases from 01/01/2022 – 12/31/2022 to support an in operation analysis. While the Plan notes that the U.S. Department of Labor has indicated generally that outcomes data are not dispositive of parity compliance, the Plan will conduct a comparative analysis of outcomes data, including medical necessity approval and denial rates and appeals outcomes, when there is a minimum of 100 cases available to ensure a valid data set for analysis.

Conclusions

The Plan reviewed the M/S and MH/SUD Prior Authorization operational policies and procedures and concluded the methodology used to determine which MH/SUD INN inpatient services are subject to Prior Authorization “as written” were comparable to, and applied no more stringently than, the methodology used to determine which M/S INN inpatient services are subject to Prior Authorization “as written.” Additionally, the Plan concluded that how Prior Authorization is applied to MH/SUD INN inpatient services was comparable to, and applied no more stringently than, how Prior Authorization is applied to M/S INN inpatient services “as written.”

The Plan reviewed the M/S and MH/SUD processes including responsibility for submission, timeframes for submission and review, notification to members and providers, clinical standards for review, and staff qualifications and concluded how the Plan conducts Prior Authorization for MH/SUD INN inpatient services “in operation” was comparable to, and applied no more stringently than, how the Plan conducts Prior Authorization for M/S INN inpatient services “in operation.”

Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical/surgical (M/S) benefits. This generally means that financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements, such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage.

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth the findings and conclusions both “as written” and “in operation” (Step 5).

Specific NQTL

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Prior Authorization is defined as: “A required or mandatory clinical assessment for proposed service(s) based on clinical information provided and the terms of the health plan benefits before the service(s) are performed or delivered. Clinical and medical necessity requirements, level of care appropriateness, and the terms of the health plan benefits must be met in order for services to be covered by the member’s plan.” The *Optum National Policy Definitions List* defines pre-authorization (aka Prior Authorization) as “a form of prospective utilization review of health care services proposed to be provided to a member.”

Prior Authorization is a component of the Plan’s Utilization Management (UM) program that helps ensure members receive appropriate coverage based on their specific clinical status and health care needs. The process is designed to achieve optimal clinical outcomes by applying objective, evidence-based clinical criteria and nationally recognized guidelines and best practices.

Prior Authorization for outpatient services commences prior to a service being delivered. Prior Authorization is a UM process that involves applying the benefit plan language and/or clinical criteria to make the most appropriate clinical coverage benefit determination.

This document includes the following information:

- Prior Authorization process for M/S and MH/SUD outpatient services
- Description of the NQTL and application (Step 1)
- Factors used to determine which services are subject to the NQTL (Step 2)
- Evidentiary standards and sources used to define, trigger and/or implicate a factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

This analysis refers to the following attachments:

- *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions* - M/S policy that defines Prior Authorization
- *Optum National Policy Definitions List* - MH/SUD policy that defines Prior Authorization

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- *Utilization Management Program Description (UMPD) of United HealthCare Services, Inc. and UnitedHealthcare Insurance Company* - Summarizes the philosophy, structure and standards that govern UHC's medical management, UM and utilization review responsibilities and functions
- *Management of Behavioral Health Benefits Policy* - Describes the mechanisms and processes designed to promote consistency in the management of behavioral health benefits and to ensure that members receive appropriate, high quality behavioral health services in a timely manner
- *Core Principles and Practices* - MH/SUD policy that outlines the core principles and practices that should be used by personnel in their interactions with members, authorized member representatives, practitioners and facilities, related to the management of behavioral health benefits, coverage determinations and appeals/grievances of non-coverage determinations.
- *Performance Assessment and Incentives* - M/S policy confirming that clinical reviewers are not incented to make denials for financial reasons
- *2023 UnitedHealthcare Provider Administrative Guide* – Informs M/S providers of the Prior Authorization process. The *UnitedHealthcare Provider Administrative Guide* can be accessed on the website <https://www.uhcprovider.com/en/admin-guides.html>
- *September 2023 Optum National Network Manual* - Informs MH/SUD providers of the Prior Authorization process. The *Optum National Network Manual* can be accessed on the website <https://public.providerexpress.com/content/optum-provexpr/us/en/clinical-resources/guidelines-policies/optum-network-manual.html>
- *Schedule of Benefits - SBN23-Medical-INS-BIND-2021-Choice Plus-LG-GA-UHIC* - Plan document that outlines member responsibilities

The Plan concludes that the Prior Authorization requirements for M/S and MH/SUD are comparable and applied no more stringently for MH/SUD in-network (INN) outpatient benefits both "as written" and "in operation."

Process

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Prior Authorization is defined as: "A required or mandatory clinical assessment for proposed service(s) based on clinical information provided and the terms of the health plan benefits before the service(s) are performed or delivered. Clinical and medical necessity requirements, level of care appropriateness, and the terms of the health plan benefits must be met in order for services to be covered by the member's plan." The *Optum National Policy Definitions List* defines pre-authorization (aka Prior Authorization) as "a form of prospective utilization review of health care services proposed to be provided to a member."

The Plan structures outpatient Prior Authorization processes to be compliant with all applicable federal and state requirements. Prior Authorization is governed at both the state and federal level, which includes consumer protections such as external review for adverse benefit determinations after internal appeals options are exhausted.

The Plan delegates management of MH/SUD outpatient services, including Prior Authorization, to United Behavioral Health d/b/a Optum Behavioral Health (OBH), its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor.

The Plan has national committees that approve M/S and MH/SUD outpatient services to be subject to Prior Authorization. Additionally, the Plan has a standard process for assessing the services that are subjected to Prior Authorization and whether they should be retained or removed from the Prior Authorization list. The Plan publishes the services subject to Prior Authorization on the provider portal(s) ([Advance Notification and Clinical Submission Requirements | UHCprovider.com](#) for M/S and [Optum - Provider Express Home](#) for MH/SUD). Members can learn what services are subject to Prior Authorization in their benefit plan document, through <https://member.uhc.com/myuhc>, myuhc.com, or by contacting customer service.

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Prior Authorization review of M/S outpatient services consists of the following:

The Plan requires INN providers to submit a Prior Authorization request for services on the Prior Authorization list prior to rendering the service. There may be some INN benefits for which the member is responsible for obtaining Prior Authorization. These are identified in the member's benefit plan document (i.e., *Schedule of Benefits*). The INN provider's submission of a request (notification) triggers the Prior Authorization process.

INN providers may submit Prior Authorization requests through the secure provider portal (www.uhcprovider.com), their connected electronic medical record, by telephone, or by fax (where required). Members may submit Prior Authorization requests by phone, fax, or mail, in accordance with Plan requirements. Providers and members communicate basic information to create a case. As outlined in the *UnitedHealthcare Care Provider Administrative Guide*, providers must submit advance notification with supporting documentation as soon as possible, but at least two weeks before the planned service, unless otherwise stated.

The Plan confirms receipt of the Prior Authorization request. Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. Non-clinical staff review cases to ensure availability of accurate and thorough case information. Non-clinical staff may approve coverage requests in scenarios where the member's plan documents allow and if a clinical review is not required. Requests that are submitted through the secure provider portal may also be approved based on the benefit plan coverage criteria, member diagnosis, and the clinical information submitted. Non-clinical staff may administratively deny coverage when a member's benefits are exhausted. Non-clinical staff refer cases that they cannot approve or administratively deny to the initial clinical reviewers for medical necessity review.

First Level Clinical Review/Initial Review. Clinical reviewers (nurses) consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs to determine whether the applicable clinical criteria are met. The clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. The clinical reviewer can approve cases that meet applicable clinical criteria.

Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Peer clinical reviewers (physician or mid-level practitioner) consult clinical criteria when making clinical coverage benefit determinations. Peer clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs. The peer clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If a peer clinical reviewer issues an adverse benefit determination, then the Plan communicates the adverse benefit determination, including appeal rights, and offers a peer-to-peer conversation consistent with state and federal requirements.

Adverse Benefit Determination. For M/S an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction, or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when member benefits are exhausted. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials. Modified coverage requests that are approved are recorded as partial denials.

Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based, medical clinical policies or use clinical criteria from third-party sources such as InterQual® or MCG® guidelines.

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Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that outpatient Prior Authorization determinations are appropriate.

M/S monitors clinical reviewer and peer clinical reviewer application of clinical criteria through an annual inter-rater reliability (IRR) assessment that is provided by InterQual. Clinical reviewers and peer clinical reviewers are required to pass the IRR assessment with a score of 90% or better through three attempts. After a second failed IRR assessment, staff enter a remediation period and are required to review all cases with a supervisor for 30 days, or until 90% is achieved on the assessment. If the clinical reviewer achieves a passing score within the 30-day period, supervisors review a minimum of one case per week for the remainder of the 30-day period.

The Plan also conducts end-to-end case audits that are designed and approved by clinical leadership each year. The end-to-end audits include all stages of a case review, from intake through appeal. These audits are conducted monthly and approximately 1500 cases are reviewed per month. Results are reported to an oversight team. All deficiencies are remediated. Remediation may include corrective actions and/or additional education, as indicated.

The Plan routinely monitors Prior Authorization performance through its clinical performance oversight functions. Outcomes are monitored against timeliness compliance, performance guarantees, and for potential trends, including overall utilization.

As of April 1, 2023, the Utilization Management Program Committee (UMPC) began overseeing the M/S UM program. The UMPC is responsible for the development and maintenance of the M/S Prior Authorization processes. The UMPC ensures that the UM program considers the factors and evidentiary standards for applying UM. The UMPC is comprised of:

- Chief Medical Officer, Medical Management (Co-Chair)
- Senior Vice President, Clinical Advancement (Co-Chair)
- Chief Medical Officer, UnitedHealthcare
- Senior Vice President, Clinical Appeals & Grievances
- Chief Medical Officer, Clinical Policy
- Chief Medical Officer, UnitedHealthcare Employer & Individual
- Chief Medical Officer, UnitedHealthcare Medicare & Retirement
- Chief Medical Officer, Community & State
- Chief Medical Officer, UnitedHealthcare Individual & Family Plans
- Vice President, Clinical Transformation & Affordability
- Senior Director, Mental Health Parity
- Vice President, Utilization Management Strategy & Implementation

One of the chairs must be an executive leader and a licensed physician. UMPC meets at least six times per year but may meet more frequently if needed.

Per the M/S policy entitled, *Performance Assessment and Incentives*, at no time are initial or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons.

M/S generally structures UM processes to comply with federal Employee Retirement Income Security Act of 1974 (ERISA) requirements, and state law where applicable.

Prior Authorization review of MH/SUD outpatient services consists of the following:

The Plan delegates management of MH/SUD outpatient services, including Prior Authorization, to United Behavioral Health d/b/a OBH, its delegated MH/SUD MBHO vendor.

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The Plan requires INN providers to submit a Prior Authorization request for services on the Prior Authorization list prior to rendering the service. There may be some INN benefits for which the member is responsible for obtaining Prior Authorization. These are identified in the member's benefit plan document (i.e., *Schedule of Benefits*).

INN providers may submit Prior Authorization requests through the secure provider portal (www.providerexpress.com), by telephone, or by fax (where required). Providers and members communicate basic information to create a case. As outlined in the *Optum National Network Manual*, most routine outpatient behavioral health services do not require an initial pre-authorization or notification in advance of the service. The INN provider's submission of a request (notification) triggers the Prior Authorization process.

As described in the *Management of Behavioral Health Benefits Policy*, the Plan confirms receipt of the Prior Authorization request. Non-clinical staff confirm member eligibility and benefit plan coverage. Non-clinical staff may approve cases that do not require clinical evaluation or interpretation based on the member's diagnosis and the clinical information submitted by providers. Non-clinical staff may administratively deny coverage when member benefits are exhausted. Non-clinical staff refer cases that they cannot approve or administratively deny to the initial clinical reviewers.

First Level Clinical Review/Initial Review. Clinical decisions are made by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse benefit determinations are made by Medical Directors or psychologists. Clinical reviewers consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether a service is medically necessary by reviewing the member's clinical information, the applicable clinical criteria or guidelines, and the Plan benefit terms. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for certification, related diagnostic results, and history of related treatment and services. The clinical reviewer may approve cases that meet applicable clinical criteria.

Second Level Clinical Review/Peer Review. The initial clinical reviewer refers cases to a peer clinical reviewer for a peer-to-peer discussion if the case cannot be approved. The requesting provider is offered the opportunity to discuss the case with the peer clinical reviewer, consistent with state and federal requirements, before an adverse benefit determination is issued. Only qualified peer clinical reviewers (e.g., Medical Directors or psychologists) can issue adverse benefit determinations. Peer clinical reviewers apply clinical criteria to member clinical information to determine coverage. If the requesting provider fails to complete the peer-to-peer discussion, the peer clinical reviewer makes a determination based on the information available. If a peer clinical reviewer issues an adverse benefit determination (e.g., the number of treatments are not authorized), then the Plan timely communicates the adverse benefit determination including appeal rights, to the member and provider consistent with applicable state and federal requirements.

Adverse Benefit Determination. For MH/SUD, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction, or termination of a benefit. Adverse benefit determinations are recorded as a clinical denial when it is based on clinical criteria and member clinical information and is recorded as an administrative denial when member benefits are excluded.

Platinum Designation. The Plan offers a Platinum Designation program to MH/SUD providers based on facilities' quantitative practice patterns (effectiveness and efficiency benchmarks). The Platinum Designation program's effectiveness and efficiency benchmarks include targeted 30- and 90-day readmission rates, 7- and 30-day follow up after hospitalization, outlier length of stay, and outlier behavioral health episode spend. INN MH/SUD facilities that meet the Platinum Designation are required to notify the Plan of admissions to Partial Hospitalization Program (PHP) and provide member information. The Plan covers the first 17 days of admission to PHP without review. Facilities notify the Plan if additional days are needed. The Plan evaluates INN MH/SUD facilities' performance annually as described in the *Optum National Network Manual*.

Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity clinical coverage determinations on objective, evidence-based behavioral clinical policies or use clinical criteria from third-party sources such as American Society

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of Addiction Medicine (ASAM) Criteria®, Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System-Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) and Early Childhood Service Intensity Instrument (ECSII) guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that outpatient Prior Authorization determinations are appropriate.

MH/SUD monitors clinical reviewer and peer clinical reviewer application of clinical criteria through an annual IRR assessment. Clinical reviewers and peer clinical reviewers are required to pass the IRR assessment with a score of 90% or better through three attempts. After a second failed IRR assessment, the reviewer enters a remediation period and is required to review all cases with a supervisor for 30 days, or until 90% is achieved on the assessment. If the clinical reviewer achieves a passing score within the 30-day period, supervisors review a minimum of one case per week for the remainder of the 30-day period.

The Plan also conducts monthly quality audits of individual non-clinical staff, clinical reviewers, and peer clinical reviewers, including staff performing appeal functions. These audits are designed and approved by clinical leadership each year. A minimum of two audits are completed per staff, per month. The results of these real-time audits are shared with supervisors for staff oversight, and all findings are remediated. Remediation may include corrective actions and/or additional education, as indicated.

The Plan routinely monitors Prior Authorization performance through its clinical performance oversight functions. Outcomes are monitored against timeliness compliance, performance guarantees, and for potential trends, including overall utilization.

The Plan's national Clinical Quality & Operations Committee (CQOC) annually reviews overall UM program outcomes, including outpatient Prior Authorization outcomes, to confirm overall utilization is appropriate. The national CQOC is comprised of representatives from sub-committees, and representatives from the clinical quality improvement, UM, care engagement, medical operations, medical policy and standards, clinical operations, appeals, product, legal, compliance, network strategy, provider experience, accreditation, and benefits teams. The Chair of the CQOC must be an executive leader, board certified in psychiatry or psychiatric subspecialty and a licensed physician.

Per the MH/SUD policy entitled, *Core Principles and Practices*, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse clinical coverage benefit determinations (clinical denials) for financial reasons.

MH/SUD generally structures UM processes to comply with federal ERISA requirements and state law where applicable.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- Prior Authorization

Benefit Classification(s)

- INN, outpatient

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHIC)

Plan Terms/Source Document(s)

In each of the Plan products, “Medically Necessary” is the Plan term used to guide Prior Authorization decision-making for both M/S and MH/SUD services. “Medically Necessary” is generally defined as follows:

“Medically Necessary – health care services are all of the following as determined by us or our designee.

- In accordance with *Generally Accepted Standards of Care*.
- Clinically appropriate, in terms of type, frequency, extent, service site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s), service site or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.
- Or, are subject to Bind Coverage with Evidence Development Policy (CED Policy).

Generally Accepted Standards of Care are evidence based independent standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties. Valid, evidence based sources reflecting generally accepted standards of care include credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or nationally recognized clinical practice guidelines may be considered. We have the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be determined by us.

We develop and maintain clinical policies that describe the Generally Accepted Standards of Care scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. [[These clinical policies (as developed by us and revised from time to time), are available to Covered Persons through [MyBind.com] or by calling the telephone number on your ID card.] [They are [also] available to Physicians and other health care professionals on [MyBind.com].]]”

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Prior Authorization is defined as:

“A required or mandatory clinical assessment for proposed service(s) based on clinical information provided and the terms of the health plan benefits before the service(s) are performed or delivered. Clinical and medical necessity requirements, level of care appropriateness, and the terms of the health plan benefits must be met in order for services to be covered by the member's plan.”

The *Optum National Policy Definitions List* defines pre-authorization (aka Prior Authorization) as “a form of prospective utilization review of health care services proposed to be provided to a member.”

The Plan's *Schedule of Benefits* notify members of the Prior Authorization requirements:

“We require prior authorization for certain Covered Health Care Services. Network providers are responsible for obtaining prior authorization before they provide these services to you. [\[Benefits for conditional coverage do not require Network provider prior authorization, with the exception of a pre-admission notification for Covered Health Care Services for Inpatient Stays.\]](#)

We recommend that you confirm with us that all Covered Health Care Services have been prior authorized as required. Before receiving these services from a Network provider, you may want to call us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities

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and Network providers cannot bill you for services they do not prior authorize as required. You can call us at the telephone number on your ID card.

When you choose to receive certain Covered Health Care Services from out-of-Network providers, you are responsible for obtaining prior authorization before you receive these services. Note that your obligation to obtain prior authorization is also applicable when an out-of-Network provider intends to admit you to a Network facility or to an out-of-Network facility or refers you to other Network or out-of-Network providers. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization. Services for which you are required to obtain prior authorization are shown in the Schedule of Benefits table within each Covered Health Care Service category.

To obtain prior authorization, call the telephone number on your ID card. This call starts the utilization review process.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the Schedule of Benefits table to find out how far in advance you must obtain prior authorization.

For Covered Health Care Services that do not require you to obtain prior authorization, when you choose to receive services from out-of-Network providers, we urge you to confirm with us that the services you plan to receive are Covered Health Care Services. That's because in some instances, certain procedures may not be Medically Necessary or may not otherwise meet the definition of a Covered Health Care Service, and therefore are excluded. In other instances, the same procedure may meet the definition of Covered Health Care Services. By calling before you receive treatment, you can check to see if the service is subject to limitations or exclusions.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those received, our final coverage determination will be changed to account for those differences, and we will only pay Benefits based on the services delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Care Service, you will be responsible for paying all charges and no Benefits will be paid.”

The *2023 UnitedHealthcare Care Provider Administrative Guide* notifies providers of the Prior Authorization requirements. INN providers are required to comply with UM protocols established by the Plan:

“We require prior authorization for all MA benefit plans and some commercial benefit plans. Prior authorization requests allow us to verify if services are medically necessary and covered. After you notify us of a planned service listed on the Advance Notification/Prior Authorization List, we tell you if a clinical coverage review is required, as part of our prior authorization process, and what additional information we need to proceed. We notify you of our coverage decision within the time required by law. Just because we require notification for a service, does not mean it is covered. We determine coverage by the member’s benefit plan.

If there is a conflict or inconsistency between applicable regulations and the notification requirements in this guide, the applicable regulations govern.

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Physicians, health care professionals and ancillary care providers are responsible for:

- Providing advance notification or requesting prior authorization for services on the Advance Notification/Prior Authorization List, including
- for non-emergent air transport services.
- Directing members to use care providers within their network. Members may be required to obtain prior authorization for out-of-network services.

Facilities are responsible for:

- Obtaining prior authorization for non-emergent, fixed-wing transportation services and using in-network, fixed-wing air ambulance providers.
- Obtaining prior authorization for inpatient admission to skilled nursing facility, acute inpatient rehabilitation and/or long-term acute care.
- Confirming coverage approval is on file (for services requiring advance notification/prior authorization) prior to the date of service.
- Providing admission and discharge notification for inpatient services, even if coverage approval is on file

If you perform multiple procedures for a member in one day, and at least one service requires prior authorization, you must obtain Prior authorization for any of the services to be paid.

If you do not follow these requirements, we may deny claims. In that case, you cannot bill the member. Advance notification or prior authorization is valid only for the date of service or date range listed on it. If services have not been rendered and the specified date of service or date range has passed, you must contact us to update the date of service or date range. When you contact us, we will advise if we will require a new submission.

- Giving us advance notification, or receiving prior authorization from us, is not a guarantee of payment, unless required by law or Medicare guidelines. This includes regulations about health care providers on a sanctions or excluded list, the Medicare preclusion list and/or health care providers not included in the Medicare Provider Enrollment Chain and Ownership System (PECOS)* list. Payment of covered services is based on:
 - The member's benefit plan,
 - If you are eligible for payment,
 - Claim processing requirements, and
 - Your Agreement.

Information required for advance notification/prior authorization requests Your request must have the following information:

- Member name and member health plan ID number
- Ordering health care provider name and TIN or NPI
- Rendering health care provider name and TIN or NPI
- ICD-10-CM diagnosis code
- All applicable procedure codes
- Anticipated date(s) of service
- Type of service (primary and secondary) procedure code(s) and, if relevant, the volume of service
- Place of service
- Facility name and TIN or NPI where service will be performed (when applicable)
- Original start date of dialysis (End Stage Renal Disease [ESRD] only)

If the member's benefit plan requires a clinical coverage review, we may request additional information, as described in more detail in the Clinical coverage review section.

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The list of services that require advance notification and prior authorization is the same. The process for providing notification and submitting a prior authorization request is the same. Services that require Prior authorization require a clinical coverage review based on medical necessity.

View the most current and complete advance notification requirements, including procedure codes and associated services, at uhcprovider.com/priorauth > Advance Notification and Plan Requirement Resources.

Advance notification/prior authorization lists are subject to change. We will inform you of changes on uhcprovider.com/news. Sign up to receive email updates at uhcprovider.com/subscribe. If you need a paper copy of the requirements, contact your UnitedHealthcare Network Management representative or provider advocate at uhcprovider.com > Contact us.

We recommend that you submit advance notification with supporting documentation as soon as possible, but at least 2 weeks before the planned service (unless the Advance Notification Requirements states otherwise). Following a facility discharge, advance notification for home health services and durable medical equipment is required within 48 hours after the start of service.”

The *Optum National Network Manual*, September 2023 Edition notifies providers of the Prior Authorization requirements. INN providers are required to comply with UM protocols established by the Plan:

“In accordance with the Participation Agreement and many benefit plans, most routine outpatient behavioral health services do not require an initial pre-authorization or notification.

Some non-routine outpatient services require ongoing authorization prior to providing services. These include:

- Applied Behavioral Analysis for the treatment of Autism

Authorization for some non-routine services may be requested through either the Provider Express website, the Provider Express secure portal:

- [ABA services: Autism Corner](#): Autism/ABA Information
 - [ABA Assessment Portal](#) (electronic authorization request submissions)
 - ABA Treatment Request Documents (please review webpage for specific forms)

The role of the Plan’s delegate, United Behavioral Health d/b/a OBH, is discussed in the UMPD:

“United Behavioral Health (UBH) performs the review of requests for coverage of behavioral health services (i.e., substance abuse, and mental health requests for services). UBH provides comprehensive behavioral health care delivery for members through a network of behavioral health practitioners, ancillary care providers, hospitals and other facilities.

For mental health, substance-related disorder services, and wraparound services, UBH uses its Clinical Criteria (see below), behavioral clinical policies, and best practice guidelines to make coverage determinations. UBH adopts externally-developed clinical criteria, and creates internally-developed Clinical Criteria, where appropriate, based on its assessment of relevant guidance. UBH develops clinical criteria that supersedes its standard set or adopts externally-developed clinical criteria when required to do so by contract or regulation.

- Clinical Criteria (Level of Care Utilization System-LOCUS) – Standardized level of care assessment tool developed by the American Association of Community Psychiatrists used to make clinical determinations and placement decisions for mental health disorder benefits for adults ages 19 and older when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (Child and Adolescent Level of Care/Service Intensity Utilization System-CALOCUS-CASII) - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry (AACAP) and the American Association for Community Psychiatry (AACP) used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children and adolescents ages 6-18 when State or Contract Specific Level of Care Guidelines do not apply.

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- Clinical Criteria (Early Childhood Service Intensity Instrument-ECSII) - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children ages 0-5 when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (State or Contract Specific Level of Care Guidelines) – Criteria used to make medical necessity determinations for mental health disorder benefits when there are explicit mandates or contractual requirements.
- Clinical Criteria (American Society of Addiction Medicine [ASAM]) - Criteria developed by the American Society of Addiction Medicine used to make clinical determinations for substance-related disorder benefits.
- Clinical Criteria (Optum Developed)
 - Optum Behavioral Clinical Policies: Criteria that stem from evaluation of new services or treatments or new applications of existing services or treatments and are used to make clinical determinations regarding proven or unproven services and treatments.

Licensed practitioners conduct all reviews with a focus on measurable outcome goals and objectives for treatment. A senior UBH Medical Director is responsible for directing and implementing behavioral health utilization management programs. A referral is sent to UBH when a member is identified as potentially benefiting from behavioral health services during a “medical event”.

The UBH UM Program is staffed by clinical, non-clinical and administrative personnel. All clinical denials or adverse decisions are made by board certified psychiatrists, or, if the health plans choose, by a panel of other appropriate health care service reviewers. If the health plan chooses to use a panel to make adverse decisions, the panel contains at least one physician who is board certified in psychiatry. When the health care service under review is a mental health or substance abuse service, the adverse decision is made by a licensed physician who is board certified in psychiatry. All potential clinical denials are referred to a physician who is board certified in psychiatry for final determination. An evaluation of the overall effectiveness of the Behavioral Health UM Program is conducted annually to determine how well resources have been deployed to improve UM activities and the clinical care and service provided to members.”

The Plan’s terms require services to be medically necessary for coverage.

List of M/S and MH/SUD Services Subject to NQTL

The M/S and MH/SUD INN outpatient services subject to prior authorization are below:

M/ S:

- Arthroplasty
- Arthroscopy
- Bariatric surgery
- Bone Growth Stimulator
- Breast Reconstruction (non-mastectomy)
- Cancer supportive care
- Cardiovascular
- Cartilage Implants
- Chemotherapy Services
- Clinical Trials
- Cochlear Implants and Other Auditory Implants
- Congenital Heart Disease
- Continuous Glucose Monitoring
- Cosmetic and reconstructive procedures
- Durable Medical Equipment (DME) over \$1,000
- End-stage Renal Disease / Dialysis
- Foot Surgery
- Functional Endoscopic Sinus Surgery (FESS)
- Gender Dysphoria Treatment
- Genetic and Molecular Testing to include BRCA gene testing

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- Home Health Care – Non-nutritional
- Hysterectomy (abdominal and laparoscopic surgeries)
- Injectable Medications
- MR-guided focused ultrasound (MRgFUS) to treat uterine fibroid
- Non-Emergency Air Transport
- Orthognathic Surgery
- Orthotics over \$1,000
- Potentially unproven services (including experimental/investigational and/or linked services)
- Prosthetics over \$1,000
- Radiation Therapy
- Rhinoplasty
- Sinuplasty
- Sleep Apnea Procedures & Surgeries
- Sleep Studies
- Spinal Cord Stimulators
- Spinal Surgery
- Stimulators – not related to spine
- Transplant
- Vein Procedures

MH/ SUD:

- Applied Behavior Analysis (ABA)
- Partial Hospitalization/Day Treatment

Step 2 – Factors Used in the Design and Application of the NQTL

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

When Surest (Bind) plans first launched in 2016, the Plans were designed to offer a simpler and more transparent way for people to access the system. The Plan included coverage for services with the option to buy-up specific benefits based on member need.

In 2022, UnitedHealthcare acquired Surest (Bind) and agreed to adopt the existing list of services that had been identified to be subject to Prior Authorization. The Plan has determined that Clinical Appropriateness is one of the factors that is determinative in imposing the Prior Authorization limitation. At this time, the Plan is assessing the value of managing the services, the consistency of adherence to evidence-based guidelines, and volume of services utilized to further refine which INN Inpatient services are subject to Prior Authorization. As a result, the Plan is evaluating additional factors to be utilized to determine which INN Inpatient services are subject to Prior Authorization.

The Plan relies on the following factor to determine which INN outpatient services are added to the Prior Authorization list. This factor applies to M/S and MH/SUD benefits for the following:

- I. M/S INN outpatient services
- II. MH/SUD INN outpatient services
 - Clinical Appropriateness (Qualitative)
 - Whether the application of Prior Authorization promotes optimal clinical outcomes

Applies to M/S and MH/SUD services.

Meeting Clinical Appropriateness is determinative in imposing the limitation.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below is the evidentiary standard and source used to define, trigger, and/or implicate the factor used to add services to the Plan's Prior Authorization list for INN outpatient services. This evidentiary standard and source applies to benefits for the following:

- I. M/S INN outpatient services
- II. MH/SUD INN outpatient services

Factor – Clinical Appropriateness is defined as those outpatient services that are determined by internal medical experts to be in accordance with objective, evidence-based clinical criteria, and nationally recognized guidelines.

- The Plan's evidentiary standards and sources that define and/or trigger the Clinical Appropriateness factor are:
 - Clinical criteria from nationally recognized, third-party sources (e.g., InterQual or MCG for M/S services, and ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines for MH/SUD services)
 - Clinical Technology Assessment Committee (CTAC) and Medical Technology and Assessment Committee (MTAC) review
 - Objective, evidence-based medical/behavioral clinical policies and nationally recognized guidelines approved by professional healthcare associations (e.g., clinical guidance from the American Medical Association, American Psychiatric Association, etc.)

These evidentiary standards and sources apply to M/S and MH/SUD INN outpatient services and are defined in a qualitative manner.

Meeting Clinical Appropriateness is determinative in imposing the limitation.

The factor and evidentiary standard used as the basis for subjecting MH/SUD INN outpatient benefits to Prior Authorization are comparable to, and applied no more stringently than, the factor and evidentiary standard used as the basis for subjecting M/S INN outpatient benefits to Prior Authorization "as written" and "in operation."

Step 4 – NQTL "As Written" and "In Operation" Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

As Written

The Plan conducted a comparative analysis of the strategies, processes, factor, evidentiary standard, and source information used to determine which M/S and MH/SUD INN outpatient services are subject to Prior Authorization and how Prior Authorization is applied to M/S and MH/SUD INN outpatient services "as written." The Plan identified the factor and evidentiary standard used as the basis for subjecting M/S and MH/SUD INN outpatient benefits to Prior Authorization.

National internal committees apply the factor and standards described in Steps 2 and 3 to M/S and MH/SUD services when determining whether the services should be subjected to Prior Authorization.

Review of Factors and Evidentiary Standards

The Plan reviewed the factor that triggers an INN outpatient service to be added to on the Prior Authorization list. The factor and evidentiary standard were applied to M/S and MH/SUD services comparably and not more stringently to MH/SUD services than to M/S services.

Review of Operational Policies and Procedures

The Plan reviewed M/S and MH/SUD operational policies and procedures, IRR assessment processes, and UM annual oversight to confirm comparability and found MH/SUD policies, procedures, and process to be comparable and no more stringent than M/S policies, procedures, and processes.

- Medical management operational policies and procedures establish the standards for how the Plan conducts outpatient Prior Authorization. The policies and procedures are consistent with state and federal law
- governing Prior Authorization. Timeframes for decisions, content of adverse benefit determinations, appeal rights and external review are all governed by state and federal law requirements.
- The IRR assessment measures the consistency with which clinical reviewers and peer clinical reviewers apply the Plan's clinical criteria. IRR assessment processes apply to M/S and MH/SUD outpatient services.
- UM oversight monitors and evaluates UM processes by reviewing program outcomes, clinical appeals, IRR assessments, and under- and over-utilization.

Review of Outpatient Prior Authorization Processes

The strategy for applying Prior Authorization to INN outpatient services is comparable for M/S and MH/SUD services and is applied no more stringently to MH/SUD INN outpatient services. The Plan conducted a review of the M/S and MH/SUD Prior Authorization processes to confirm comparability. The review focused on the following aspects of the process for both M/S and MH/SUD:

- **Prior Authorization Request.** INN M/S and MH/SUD providers are contractually responsible for submitting Prior Authorization requests. The provider can submit the Prior Authorization request through the secure provider portal, by telephone, or by fax (where required). The member is responsible for obtaining Prior Authorization for certain services that are identified in the Plan document.
- **Timeframe to Submit.** The timeframes for the provider or member to submit the Prior Authorization request were reviewed and it was determined that MH/SUD was comparable and no more stringent. INN providers must submit Prior Authorization requests for M/S outpatient services at least two weeks before the planned service. INN providers must submit Prior Authorization requests for MH/SUD outpatient services any time prior to receiving services.
- **Clinical Reviews.** For M/S and MH/SUD outpatient Prior Authorization requests, clinical reviewers may gather more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for certification, related diagnostic results, history of related treatment and services, and photographs. The clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. The clinical reviewer may approve cases that meet applicable clinical criteria.
- **Review Timeframes.** M/S and MH/SUD outpatient Prior Authorization determination timeframes are defined by state, federal requirements for both urgent and non-urgent outpatient services. The same determination timeframes apply to M/S and MH/SUD determinations.
- **Determinations and Non-Clinical Reviews, First Level Clinical Reviews, and Second Level/Peer Clinical Reviews.** For M/S and MH/SUD outpatient Prior Authorization, non-clinical staff may approve cases that do not require clinical evaluation or interpretation. Non-clinical staff may administratively deny cases when member benefits are exhausted. M/S INN outpatient cases that are submitted through the provider portal may also be approved based on the member diagnosis and the clinical information submitted.
 - Non-clinical staff refer coverage requests that they cannot approve or administratively deny to clinical reviewers. Clinical reviewers consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers

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determine whether an outpatient service is medically necessary. The clinical reviewer may approve the service based on their review. The clinical reviewer refers cases to a peer clinical reviewer for a peer-to-peer discussion if the case cannot be approved. Only qualified peer clinical reviewers (e.g., Medical Directors) may issue adverse benefit determinations. Peer-to-peer discussions are offered as required. For MH/SUD INN outpatient Prior Authorization there are programs through which providers who would otherwise need to request Prior Authorization are not required to do so.

- **Adverse Benefit Determination and Peer to Peer Conversations.** The Plan offers INN outpatient providers the opportunity to discuss a potential adverse benefit determination before the Plan issues such determination. This process allows INN outpatient providers the opportunity to provide additional information prior to an adverse benefit determination being issued.
 - **INN outpatient M/S and MH/SUD services**
 - An adverse benefit determination is recorded as a clinical denial when it is based on clinical criteria and member clinical information and is recorded as an administrative denial when member benefits are exhausted.
- **Notification of Decisions to Providers and Members.** The Plan notifies M/S and MH/SUD INN providers and members of approvals and adverse benefit determinations, including applicable appeal rights, consistent with state and federal requirements.
- **Review of Staff Qualifications.** For M/S and MH/SUD, clinical staff qualifications align with the type of clinical review and state and federal requirements.
 - M/S is staffed by clinical, non-clinical, and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., nurses, physicians, etc.) and all adverse benefit determinations are made by a physician or other appropriate health care professionals.
 - MH/SUD is staffed by clinical, non-clinical, and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse benefit determinations are made by Medical Directors or psychologists.
- **Clinical Criteria.** For M/S and MH/SUD, clinical reviewers and peer clinical reviewers' base determinations on the objective, evidence-based medical/behavioral clinical policies and use clinical criteria from third party sources such as InterQual, MCG, ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines.

In Operation

The Plan compared the strategies, processes, factor, evidentiary standard, and source information used to determine which M/S and MH/SUD INN outpatient services are subject to Prior Authorization and how Prior Authorization is applied "in operation."

The Plan required INN M/S and MH/SUD providers to submit requests for approval of outpatient services for which the Plan requires Prior Authorization. The Plan publishes the services subject to Prior Authorization on the provider portal(s) (www.uhcprovider.com for M/S and www.providerexpress.com for MH/SUD). Members can learn what services are subject to Prior Authorization in their benefit plan document (i.e., *Schedule of Benefits*), through myuhc.com, or by contacting customer service. Notification triggered the Prior Authorization process for INN M/S and MH/SUD outpatient services.

M/S and MH/SUD outpatient Prior Authorization reviews included confirmation of member eligibility and benefit availability for the requested services. For M/S and MH/SUD INN outpatient services, non-clinical staff approved coverage for outpatient services that did not require clinical review or interpretation.

M/S and MH/SUD outpatient cases that were not administratively approved in initial review were referred to a clinical reviewer for further research and evaluation. The M/S and MH/SUD clinical reviewers applied benefit plan documents and medical necessity criteria to member clinical information. M/S and MH/SUD clinical reviewers could request additional clinical information if they were unable to approve cases based on the available member clinical information. The clinical reviewers may approve services based on their review.

If the requested clinical information was not received or if the case could not be approved, M/S and MH/SUD clinical reviewers referred cases to a peer clinical reviewer. The Plan offered peer-to-peer conversations so the INN provider could provide additional clinical information prior to issuance of an adverse benefit determination. Only qualified peer clinical reviewers issued M/S and MH/SUD adverse benefit determinations.

The Plan communicated all adverse benefit determinations for M/S and MH/SUD outpatient cases that did not meet applicable clinical criteria consistent with state and federal requirements, including appeal rights, as applicable.

The Plan monitors M/S and MH/SUD clinical and peer clinical reviewers' application of clinical criteria through annual IRR assessments. The Plan also conducts monthly quality audits of individual non-clinical staff, clinical reviewers, and peer clinical reviewers, including staff performing appeal functions. The Plan routinely monitors Prior Authorization performance through its clinical performance oversight functions. In addition to comparing these "in operation" processes, the Plan reviewed medical necessity approval and denial rates, internal appeals outcomes, and external appeals outcomes related to Prior Authorization determinations for M/S and MH/SUD INN outpatient services. The results of these analyses are discussed in greater detail in Step 5.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan's or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The findings of the Plan's comparative analyses confirmed the strategies, processes, factor, evidentiary standard, and source information used to determine the MH/SUD INN outpatient services subject to Prior Authorization were comparable to, and applied no more stringently than, the strategies, processes, factors, evidentiary standards, and source information used to determine the M/S INN outpatient services subject to Prior Authorization "as written."

The Plan found the factor used to add MH/SUD INN outpatient services to the Prior Authorization list was comparable to, and applied no more stringently than, the factor used to add M/S INN outpatient services to the Prior Authorization list. INN M/S and MH/SUD outpatient services that met the applicable factor(s) were subject to Prior Authorization "in operation."

The Plan used comparable processes to conduct outpatient Prior Authorization review of INN M/S and MH/SUD providers' requests. The Plan required M/S and MH/SUD INN providers to timely submit Prior Authorization requests. The Plan used qualified staff to confirm member eligibility and benefit availability, and to request additional information if necessary. The Plan issued approvals for M/S and MH/SUD outpatient services that met applicable clinical criteria or guidelines. Only qualified M/S and MH/SUD peer clinical reviewers issued adverse benefit determinations. The Plan gave INN providers the opportunity to discuss potential adverse benefit determinations with qualified peer clinical reviewers prior to issuing adverse benefit determinations. This afforded INN providers the opportunity to provide additional information.

The Plan operated monitoring and oversight programs to ensure that clinical reviewers and peer clinical reviewers rendered appropriate determinations. Both M/S and MH/SUD required clinical reviewers, including peer clinical reviewers, to successfully complete the annual IRR assessment. Clinical reviewers were required to pass the IRR assessment with a score of 90% or better to render UM decisions independently. 2023 IRR M/S and MH/SUD results are not available. The M/S and MH/SUD clinical reviewers' application of medical necessity criteria when making utilization review determinations will be assessed for comparability when the results are available.

INN outpatient medical necessity approval and denial rates and appeals outcomes data from 01/01/2022 – 12/31/2022 were evaluated where a minimum threshold of 100 cases were available to ensure a valid data set for analysis. The Plan has established that a minimum of at least 100 M/S and MH/SUD cases are required within each classification for a comparative

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analysis. Meaningful conclusions cannot be reached when there are fewer than 100 cases within each classification this is because the data is subject to variability.

Because Georgia Surest Plan became effective on 07/2023 there is a minimal membership and as a result an insufficient number of cases from 01/01/2022 – 12/31/2022 to support an in operation analysis. While the Plan notes that the U.S. Department of Labor has indicated generally that outcomes data are not dispositive of parity compliance, the Plan will conduct a comparative analysis of outcomes data, including medical necessity approval and denial rates and appeals outcomes, when there is a minimum of 100 cases available to ensure a valid data set for analysis.

Conclusions

The Plan reviewed the M/S and MH/SUD Prior Authorization policies and procedures and concluded the methodology used to determine which MH/SUD INN outpatient services are subject to Prior Authorization “as written” were comparable to, and applied no more stringently than, the methodology used to determine which M/S INN outpatient services are subject to Prior Authorization “as written.” Additionally, the Plan concluded that how Prior Authorization is applied to MH/SUD INN outpatient services was comparable to, and applied no more stringently than, how Prior Authorization is applied to M/S INN outpatient services “as written.”

The Plan reviewed the M/S and MH/SUD processes including responsibility for submission, timeframes for submission and review, notification to members and providers, clinical standards for review, and staff qualifications and concluded how the Plan conducts Prior Authorization for MH/SUD INN outpatient services “in operation” was comparable to, and applied no more stringently than, how the Plan conducts Prior Authorization for M/S INN outpatient services “in operation.”

Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical/surgical (M/S) benefits. This generally means that the financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements, such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage.

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Prior Authorization is defined as: “A required or mandatory clinical assessment for proposed service(s) based on clinical information provided and the terms of the health plan benefits before the service(s) are performed or delivered. Clinical and medical necessity requirements, level of care appropriateness, and the terms of the health plan benefits must be met in order for services to be covered by the member's plan.” The *Optum National Policy Definitions List* defines pre-authorization (aka Prior Authorization) as “a form of prospective utilization review of health care services proposed to be provided to a member.”

Prior Authorization is a component of the Plan’s Utilization Management (UM) program that helps ensure members receive appropriate coverage based on their specific clinical status and health care needs. The process is designed to achieve optimal clinical outcomes by applying objective, evidence-based clinical criteria, and nationally recognized guidelines and best practices.

Prior Authorization for inpatient services commences prior to a service being delivered. Prior Authorization is a UM process that involves applying the benefit plan language and/or clinical criteria to make the most appropriate clinical coverage benefit determination.

This document includes the following information:

- Prior Authorization process for M/S and MH/SUD inpatient services
- Description of the NQTL and application (Step 1)
- Factors used to determine which services are subject to the NQTL (Step 2)
- Evidentiary standards and sources used to define, trigger and/or implicate a factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

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This analysis refers to the following attachments:

- *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions* - M/S policy that defines Prior Authorization
- *Optum National Policy Definitions List* - MH/SUD policy that defines Prior Authorization
- *Utilization Management Program Description (UMPD) of United HealthCare Services, Inc. and UnitedHealthcare Insurance Company* - Summarizes the philosophy, structure and standards that govern UHC's medical management, UM and utilization review responsibilities and functions
- *Management of Behavioral Health Benefits Policy* - Describes the mechanisms and processes designed to promote consistency in the management of behavioral health benefits and to ensure that members receive appropriate, high quality behavioral health services in a timely manner
- *Core Principles and Practices* - MH/SUD policy that outlines the core principles and practices that should be used by personnel in their interactions with members, authorized member representatives, practitioners and facilities, related to the management of behavioral health benefits, coverage determinations and appeals/grievances of non-coverage determinations.
- *Performance Assessment and Incentives* - M/S policy confirming that clinical reviewers are not incented to make denials for financial reasons
- *Schedule of Benefits - SBN23-Medical-INS-BIND-2021-Choice Plus-LG-GA-UHIC* - Plan document that outlines member responsibilities

The Plan concludes that the Prior Authorization requirements for M/S and MH/SUD are comparable and applied no more stringently for MH/SUD for out-of-network (OON) inpatient benefits, both “as written” and “in operation.”

Process

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Prior Authorization is defined as: “A required or mandatory clinical assessment for proposed service(s) based on clinical information provided and the terms of the health plan benefits before the service(s) are performed or delivered. Clinical and medical necessity requirements, level of care appropriateness, and the terms of the health plan benefits must be met in order for services to be covered by the member's plan.” The *Optum National Policy Definitions List* defines pre-authorization (aka Prior Authorization) as “a form of prospective utilization review of health care services proposed to be provided to a member.”

The Plan structures inpatient Prior Authorization processes to be compliant with all applicable federal and state requirements. Prior Authorization is governed at both the state and federal level, which includes consumer protections such as external review for adverse benefit determinations after internal appeals options are exhausted.

The Plan delegates management of MH/SUD inpatient services, including Prior Authorization, to United Behavioral Health d/b/a Optum Behavioral Health (OBH), its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor.

The Plan has national committees that approve M/S and MH/SUD services to be subject to Prior Authorization. Members can learn what services are subject to Prior Authorization in their benefit plan document, through myuhc.com, or by contacting customer service.

Prior Authorization review of M/S inpatient admissions consists of the following:

Members are responsible for obtaining Prior Authorization for services rendered by OON facilities and providers. The member's benefit plan document (i.e., *Schedule of Benefits*) identify the services for which the member is responsible for

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obtaining Prior Authorization and the required timeframe(s). The member or OON provider's submission of a request (notification) triggers the Prior Authorization process.

Members may submit Prior Authorization requests by phone, fax, or mail, in accordance with Plan requirements. OON providers may submit Prior Authorization requests on behalf of the member by phone or by fax (where required). Members or providers communicate basic information to create a case.

The Plan confirms receipt of the Prior Authorization request. Non-clinical staff confirm member eligibility and benefit coverage upon receipt of the notification. Non-clinical staff review cases to ensure availability of accurate and thorough case information. Non-clinical staff may approve coverage requests in scenarios where the member's plan documents allow and if a clinical review is not required. Non-clinical staff may administratively deny coverage when a member's benefits are exhausted. Non-clinical staff refer coverage requests that they cannot approve or administratively deny to the initial clinical reviewers.

First Level Clinical Review/Initial Review. Clinical reviewers (nurses or physicians) consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether the inpatient admission is medically necessary by reviewing the member's clinical information, the applicable clinical criteria or guidelines, and the Plan benefit terms. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs to determine whether the applicable clinical criteria are met. The clinical reviewer may approve cases that meet applicable clinical criteria.

Second Level Clinical Review/Peer Review. The initial clinical reviewer refers cases to a second level/peer clinical reviewer if the case cannot be approved. Peer clinical reviewers (physician or mid-level practitioner) consult clinical criteria when making clinical coverage benefit determinations. Peer clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. The peer clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. If a peer clinical reviewer issues an adverse benefit determination, then the Plan communicates the adverse benefit determination, including appeal rights, and offers a peer-to-peer conversation consistent with state and federal requirements.

Adverse Benefit Determination. For M/S, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when member benefits are exhausted. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials. Modified coverage requests that are approved are recorded as partial denials.

Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based medical clinical policies and use clinical criteria from third-party sources such as InterQual® or MCG® guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that inpatient Prior Authorization determinations are appropriate.

M/S monitors clinical reviewer and peer clinical reviewer application of clinical criteria through an annual inter-rater reliability (IRR) assessment that is provided by InterQual. Clinical reviewers and peer clinical reviewers are required to pass the IRR

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assessment with a score of 90% or better through three attempts. After a second failed IRR assessment, staff enter a remediation period and are required to review all cases with a supervisor for 30 days, or until 90% is achieved on the assessment. If the clinical reviewer achieves a passing score within the 30-day period, supervisors review a minimum of one case per week for the remainder of the 30-day period.

The Plan also conducts end-to-end case audits that are designed and approved by clinical leadership each year. The end-to-end audits include all stages of a case review, from intake through appeal. These audits are conducted monthly and approximately 1500 cases are reviewed per month. Results are reported to an oversight team. All deficiencies are remediated. Remediation may include corrective actions and/or additional education, as indicated.

The Plan routinely monitors Prior Authorization performance through its clinical performance oversight functions. Outcomes are monitored against timeliness compliance, performance guarantees, and for potential trends, including overall utilization.

As of April 1, 2023, the Utilization Management Program Committee (UMPC) began overseeing the M/S UM program. The UMPC is responsible for the development and maintenance of the M/S Prior Authorization processes. The UMPC ensures that the UM program considers the factors and evidentiary standards for applying UM. The UMPC is comprised of:

- Chief Medical Officer, Medical Management (Co-Chair)
- Senior Vice President, Clinical Advancement (Co-Chair)
- Chief Medical Officer, UnitedHealthcare
- Senior Vice President, Clinical Appeals & Grievances
- Chief Medical Officer, Clinical Policy
- Chief Medical Officer, UnitedHealthcare Employer & Individual
- Chief Medical Officer, UnitedHealthcare Medicare & Retirement
- Chief Medical Officer, Community & State
- Chief Medical Officer, UnitedHealthcare Individual & Family Plans
- Vice President, Clinical Transformation & Affordability
- Senior Director, Mental Health Parity
- Vice President, Utilization Management Strategy & Implementation

One of the chairs must be an executive leader and a licensed physician. UMPC meets at least six times per year but may meet more frequently if needed.

Per the M/S policy entitled, *Performance Assessment and Incentives*, at no time are initial or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons.

M/S generally structures UM processes to comply with federal Employee Retirement Income Security Act of 1974 (ERISA) requirements, and state law where applicable.

Prior Authorization review of MH/SUD inpatient admissions consists of the following:

The Plan delegates management of MH/SUD inpatient services, including Prior Authorization, to United Behavioral Health d/b/a OBH, its delegated MH/SUD MBHO vendor.

Members are responsible for ensuring Prior Authorization is obtained by the OON provider administering the service. The OON provider must provide clinical information on the member's behalf. The member's benefit plan document (i.e., *Schedule of Benefits*) identifies the services for which the member is responsible for ensuring Prior Authorization is obtained. As outlined in the Plan document, OON providers must submit the Prior Authorization request before inpatient MH/SUD services are received. OON provider's submission of a request (notification) triggers the Prior Authorization process.

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OON providers may submit Prior Authorization requests on behalf of the member by telephone, or by fax (where required). Providers communicate basic information to create a case.

As described in the *Management of Behavioral Health Benefits Policy*, the Plan confirms receipt of the Prior Authorization request. Non-clinical staff confirm member eligibility and benefit coverage. Non-clinical staff may approve coverage requests that do not require clinical evaluation or interpretation based on the member's diagnosis and the clinical information submitted by providers. Non-clinical staff may administratively deny coverage when member benefits are exhausted. Non-clinical staff refer cases that they cannot approve or administratively deny to the initial clinical reviewers.

First Level Clinical Review/Initial Review. Clinical decisions are made by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse benefit determinations are made by Medical Directors. Clinical reviewers consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether an inpatient admission is medically necessary by reviewing the member's clinical information, the applicable clinical criteria or guidelines, and the Plan benefit terms. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for certification, related diagnostic results, and history of related treatment and services to determine whether the applicable clinical criteria are met. The clinical reviewer may approve the admission based on their review.

Second Level Clinical Review/Peer Review. The initial clinical reviewer refers cases to a peer clinical reviewer for a peer-to-peer discussion if the case cannot be approved. The requesting provider is offered the opportunity to discuss the case with the peer clinical reviewer, consistent with state and federal requirements before an adverse benefit determination is issued. Only qualified peer clinical reviewers (e.g., Medical Directors) can issue adverse benefit determinations. Peer clinical reviewers apply clinical criteria to member clinical information to determine coverage for an inpatient admission. If the requesting provider fails to complete the peer-to-peer discussion, the peer clinical reviewer makes a determination based on the information available. If a peer clinical reviewer issues an adverse benefit determination (e.g., the admission is not medically necessary and is not approved), then the Plan timely communicates the adverse benefit determination, including appeal rights, to the member and provider consistent with applicable state and federal requirements.

Adverse Benefit Determination. For MH/SUD, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as a clinical denial when it is based on clinical criteria and member clinical information and is recorded as an administrative denial when member benefits are excluded.

Clinical Criteria. Initial clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based behavioral clinical policies or use clinical criteria from third-party sources such as American Society of Addiction Medicine (ASAM) Criteria®, Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System-Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) and Early Childhood Service Intensity Instrument (ECSII) guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that inpatient Prior Authorization determinations are appropriate.

MH/SUD monitors clinical reviewer and peer clinical reviewer application of clinical criteria through an annual IRR assessment. Clinical reviewers and peer clinical reviewers are required to pass the IRR assessment with a score of 90% or better through three attempts. After a second failed IRR assessment, the reviewer enters a remediation period and is required to review all cases with a supervisor for 30 days, or until 90% is achieved on the assessment. If the clinical reviewer achieves a passing score within the 30-day period, supervisors review a minimum of one case per week for the remainder of the 30-day period.

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The Plan also conducts monthly quality audits of individual non-clinical staff, clinical reviewers, and peer clinical reviewers, including staff performing appeal functions. These audits are designed and approved by clinical leadership each year. A minimum of two audits are completed per staff, per month. The results of these real-time audits are shared with supervisors for staff oversight, and all findings are remediated. Remediation may include corrective actions and/or additional education, as indicated.

The Plan routinely monitors Prior Authorization performance through its clinical performance oversight functions. Outcomes are monitored against timeliness requirements, performance guarantees, and for potential trends, including overall utilization.

The Plan's national Clinical Quality & Operations Committee (CQOC) annually reviews UM program outcomes, including inpatient Prior Authorization outcomes, to confirm overall utilization is appropriate. The CQOC is comprised of representatives from sub-committees, and representatives from the clinical quality improvement, UM, care engagement, medical operations, medical policy and standards, clinical operations, appeals, product, legal, compliance, network strategy, provider experience, accreditation, and benefits teams. The Chair of the Clinical Quality & Operations Committee must be an executive leader, board certified in psychiatry or psychiatric subspecialty and a licensed physician.

Per the MH/SUD policy entitled, *Core Principles and Practices*, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons.

MH/SUD generally structures UM processes to comply with federal ERISA requirements and state law where applicable.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- Prior Authorization

Benefit Classification(s)

- OON, inpatient

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHC)

Plan Terms/Source Document(s)

In each of the Plan products, "Medically Necessary" is the Plan term used to guide Prior Authorization decision-making for both M/S and MH/SUD services. "Medically Necessary" is generally defined as follows:

- "Medically Necessary – health care services are all of the following as determined by us or our designee.
- In accordance with *Generally Accepted Standards of Care*.
 - Clinically appropriate, in terms of type, frequency, extent, service site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms.
 - Not mainly for your convenience or that of your doctor or other health care provider.
 - Not more costly than an alternative drug, service(s), service site or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.
 - Or, are subject to Bind Coverage with Evidence Development Policy (CED Policy).

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Generally Accepted Standards of Care are evidence based independent standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties. Valid, evidence based sources reflecting generally accepted standards of care include credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or nationally recognized clinical practice guidelines may be considered. We have the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be determined by us.

We develop and maintain clinical policies that describe the Generally Accepted Standards of Care scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. [[These clinical policies (as developed by us and revised from time to time), are available to Covered Persons through [MyBind.com] or by calling the telephone number on your ID card.] [They are [also] available to Physicians and other health care professionals on [MyBind.com].]]"

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Prior Authorization is defined as:

"A required or mandatory clinical assessment for proposed service(s) based on clinical information provided and the terms of the health plan benefits before the service(s) are performed or delivered. Clinical and medical necessity requirements, level of care appropriateness, and the terms of the health plan benefits must be met in order for services to be covered by the member's plan."

The *Optum National Policy Definitions List* defines pre-authorization (aka Prior Authorization) as "a form of prospective utilization review of health care services proposed to be provided to a member."

The Plan's *Schedule of Benefits* notify members of the Prior Authorization requirements:

"We require prior authorization for certain Covered Health Care Services. Network providers are responsible for obtaining prior authorization before they provide these services to you. [\[Benefits for conditional coverage do not require Network provider prior authorization, with the exception of a pre-admission notification for Covered Health Care Services for Inpatient Stays.\]](#)

We recommend that you confirm with us that all Covered Health Care Services have been prior authorized as required. Before receiving these services from a Network provider, you may want to call us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they do not prior authorize as required. You can call us at the telephone number on your ID card.

When you choose to receive certain Covered Health Care Services from out-of-Network providers, you are responsible for obtaining prior authorization before you receive these services. Note that your obligation to obtain prior authorization is also applicable when an out-of-Network provider intends to admit you to a Network facility or to an out-of-Network facility or refers you to other Network or out-of-Network providers. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization. Services for which you are required to obtain prior authorization are shown in the Schedule of Benefits table within each Covered Health Care Service category.

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To obtain prior authorization, call the telephone number on your ID card. This call starts the utilization review process.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the Schedule of Benefits table to find out how far in advance you must obtain prior authorization.

For Covered Health Care Services that do not require you to obtain prior authorization, when you choose to receive services from out-of-Network providers, we urge you to confirm with us that the services you plan to receive are Covered Health Care Services. That's because in some instances, certain procedures may not be Medically Necessary or may not otherwise meet the definition of a Covered Health Care Service, and therefore are excluded. In other instances, the same procedure may meet the definition of Covered Health Care Services. By calling before you receive treatment, you can check to see if the service is subject to limitations or exclusions.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those received, our final coverage determination will be changed to account for those differences, and we will only pay Benefits based on the services delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Care Service, you will be responsible for paying all charges and no Benefits will be paid.”

The role of the Plan’s delegate, United Behavioral Health d/b/a OBH, is discussed in the *UMPD*:

“United Behavioral Health (UBH) performs the review of requests for coverage of behavioral health services (i.e., substance abuse, and mental health requests for services). UBH provides comprehensive behavioral health care delivery for members through a network of behavioral health practitioners, ancillary care providers, hospitals and other facilities.

For mental health, substance-related disorder services, and wraparound services, UBH uses its Clinical Criteria (see below), behavioral clinical policies, and best practice guidelines to make coverage determinations. UBH adopts externally-developed clinical criteria, and creates internally-developed Clinical Criteria, where appropriate, based on its assessment of relevant guidance. UBH develops clinical criteria that supersedes its standard set or adopts externally-developed clinical criteria when required to do so by contract or regulation.

- Clinical Criteria (Level of Care Utilization System-LOCUS) – Standardized level of care assessment tool developed by the American Association of Community Psychiatrists used to make clinical determinations and placement decisions for mental health disorder benefits for adults ages 19 and older when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (Child and Adolescent Level of Care/ Service Intensity Utilization System-CALOCUS-CASII) - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry (AACAP) and the American Association for Community Psychiatry (AACP) used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children and adolescents ages 6-18 when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (Early Childhood Service Intensity Instrument-ECSI) - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children ages 0-5 when State or Contract Specific Level of Care Guidelines do not apply.

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- Clinical Criteria (State or Contract Specific Level of Care Guidelines) – Criteria used to make medical necessity determinations for mental health disorder benefits when there are explicit mandates or contractual requirements.
- Clinical Criteria (American Society of Addiction Medicine [ASAM]) - Criteria developed by the American Society of Addiction Medicine used to make clinical determinations for substance-related disorder benefits.
- Clinical Criteria (Optum Developed)
 - Optum Behavioral Clinical Policies: Criteria that stem from evaluation of new services or treatments or new applications of existing services or treatments and are used to make clinical determinations regarding proven or unproven services and treatments.

Licensed practitioners conduct all reviews with a focus on measurable outcome goals and objectives for treatment. A senior UBH Medical Director is responsible for directing and implementing behavioral health utilization management programs. A referral is sent to UBH when a member is identified as potentially benefiting from behavioral health services during a “medical event”.

The UBH UM Program is staffed by clinical, non-clinical and administrative personnel. All clinical denials or adverse decisions are made by board certified psychiatrists, or, if the health plans choose, by a panel of other appropriate health care service reviewers. If the health plan chooses to use a panel to make adverse decisions, the panel contains at least one physician who is board certified in psychiatry. When the health care service under review is a mental health or substance abuse service, the adverse decision is made by a licensed physician who is board certified in psychiatry. All potential clinical denials are referred to a physician who is board certified in psychiatry for final determination. An evaluation of the overall effectiveness of the Behavioral Health UM Program is conducted annually to determine how well resources have been deployed to improve UM activities and the clinical care and service provided to members.”

The Plan’s terms require services to be medically necessary for coverage.

List of M/S and MH/SUD Services Subject to NQTL

The M/S and MH/SUD OON inpatient services subject to prior authorization are below:

M/S:

- Acute Care Hospitalizations
- Acute Inpatient Rehabilitation (AIR)
- Critical Access Hospitals
- Long-Term Acute Care (LTAC)
- Skilled Nursing Facilities (SNF)

MH/SUD:

- MH Non-Emergent Acute Inpatient
- MH Subacute Residential Treatment
- SUD Acute Inpatient Detoxification
- SUD Acute Inpatient Rehabilitation
- SUD Subacute Residential Treatment

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Step 2 – Factors Used to Determine the Listed Services are Subject to Prior Authorization

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

When Surest (Bind) plans first launched in 2016, the Plans were designed to offer a simpler and more transparent way for people to access the system. The Plan included coverage for services with the option to buy-up specific benefits based on member need.

In 2022, UnitedHealthcare acquired Surest (Bind) and agreed to adopt the existing list of services that had been identified to be subject to Prior Authorization. The Plan has determined that Clinical Appropriateness is one of the factors that is determinative in imposing the Prior Authorization limitation. At this time, the Plan is assessing the value of managing the services, the consistency of adherence to evidence-based guidelines, and volume of services utilized to further refine which INN Inpatient services are subject to Prior Authorization. As a result, the Plan is evaluating the factors to be utilized to determine which INN Inpatient services are subject to Prior Authorization.

The Plan relies on the following factor to determine which OON inpatient benefits will be subject to Prior Authorization. This factor applies to M/S and MH/SUD benefits for the following:

- I. M/S: OON inpatient services
 - II. MH/SUD: OON inpatient services
- Clinical Appropriateness (Qualitative)
 - Whether the application of Prior Authorization promotes optimal clinical outcomes

Applies to M/S and MH/SUD services.

Meeting Clinical Appropriateness is determinative in imposing the limitation. All Prior Authorization reviews are subject to Clinical Appropriateness and must have medical necessity criteria.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below are the evidentiary standard and source used to define, trigger, and/or implicate the factor used to add services to the Plan's Prior Authorization requirement for OON inpatient services. This evidentiary standard and source applies to benefits for the following:

- I. M/S: OON inpatient services
- II. MH/SUD: OON inpatient services

Factor – Clinical Appropriateness is defined as those inpatient services that are determined by internal medical experts to be in accordance with objective, evidence-based clinical criteria, and nationally recognized guidelines.

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- The Plan’s evidentiary standards and sources that trigger and/or define the Clinical Appropriateness factor are:
 - Clinical criteria from nationally recognized third-party sources (e.g., InterQual for M/S services, and ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines for MH/SUD services)
 - Clinical Technology and Assessment Committee (CTAC) and Medical Technology and Assessment Committee (MTAC) review
 - Objective, evidence-based medical/behavioral clinical policies, and nationally recognized guidelines approved by professional healthcare associations (e.g., clinical guidance from the American Medical Association, American Psychiatric Association, etc.)

These evidentiary standards and sources apply to M/S and MH/SUD services and are defined in a qualitative manner.

Meeting Clinical Appropriateness is determinative in imposing the limitation.

The factor and evidentiary standard used as the basis for subjecting MH/SUD OON inpatient benefits to Prior Authorization are comparable to, and applied no more stringently than, the factor and evidentiary standard used as the basis for subjecting M/S OON inpatient benefits to Prior Authorization “as written” and “in operation.”

Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer’s analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert’s qualifications and the extent to which the Plan or issuer ultimately relied upon each expert’s evaluations in setting recommendations regarding both.

As Written

The Plan conducted a comparative analysis of the strategies, processes, factor, evidentiary standard, and source information used to determine which M/S and MH/SUD OON inpatient services are subject to Prior Authorization and how Prior Authorization is applied to M/S and MH/SUD OON inpatient services “as written.” The Plan identified the factor and evidentiary standard used as the basis for subjecting M/S and MH/SUD benefits to Prior Authorization.

National internal committees apply the factor and standard described in Steps 2 and 3 to M/S and MH/SUD services when determining whether the services should be included on the Prior Authorization list.

Review of Factors and Evidentiary Standards

The Plan reviewed the factor that triggers an OON inpatient service to be subject to Prior Authorization. The factor and evidentiary standard were applied to M/S and MH/SUD services comparably and not more stringently to MH/SUD services than to M/S services.

Review of Operational Policies and Procedures

The Plan reviewed M/S and MH/SUD operational policies and procedures, IRR assessment processes, and UM annual oversight to confirm comparability and found MH/SUD policies, procedures, and processes to be comparable and no more stringent than M/S policies, procedures, and processes.

- Medical management operational policies and procedures establish the standards for how the Plan conducts inpatient Prior Authorization. The policies and procedures are consistent with state and federal law requirements

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under public records or other applicable laws.

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governing Prior Authorization. Timeframes for decisions, content of adverse benefit determinations, appeal rights, and external review are all governed by state and federal law requirements.

- The IRR assessment measures the consistency with which clinical reviewers and peer clinical reviewers apply the Plan's clinical criteria. IRR assessment processes apply to M/S and MH/SUD inpatient services.
- UM oversight monitors and evaluates UM processes by reviewing program outcomes, clinical appeals, IRR assessments, and under- and over-utilization.

Review of Inpatient Prior Authorization Processes

The strategy for applying Prior Authorization to OON inpatient services is comparable for M/S and MH/SUD services and is applied no more stringently to MH/SUD OON inpatient services. The Plan conducted a review of the M/S and MH/SUD Prior Authorization processes to confirm comparability. The review focused on the following aspects of the process for both M/S and MH/SUD:

- **Prior Authorization Request.** For M/S and MH/SUD OON services, the member is responsible for ensuring the OON provider or facility submits Prior Authorization requests. For M/S services, the member can contact the telephone number on their member ID card, mail, or fax to request a Prior Authorization. For M/S and MH/SUD the OON provider can request Prior Authorization on behalf of the member or submit clinical information via telephone or fax (where required).
- **Timeframe to Submit.** The timeframes for the member or OON provider on behalf of the member to submit the Prior Authorization request were reviewed and it was determined that MH/SUD was no more stringent.
 - M/S – Per the member's Plan documents, the timeframes vary depending upon the services requested from as soon as possible to six months prior to the OON service.
 - Unplanned or emergency services are not subject to Prior Authorization
 - MH/SUD – Per the member's Plan documents, the Prior Authorization should be requested before OON services are received.
 - Unplanned or emergency services are not subject to Prior Authorization
- **Clinical Reviews.** For M/S and MH/SUD inpatient Prior Authorization requests, clinical reviewers may gather more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for certification, related diagnostic results, history of related treatment and services, and photographs. The clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. The clinical reviewer may approve cases that meet applicable clinical criteria.
- **Review Timeframes.** M/S and MH/SUD inpatient Prior Authorization determination timeframes are defined by state and federal requirements for both urgent and non-urgent services. The same determination timeframes apply to M/S and MH/SUD determinations.
- **Determinations and Non-Clinical Reviews, First Level Clinical Reviews, and Second Level Peer Clinical Reviews.**
 - Non-clinical staff refer coverage requests that they cannot approve or administratively deny to clinical reviewers. Clinical reviewers consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether an inpatient admission is medically necessary. The clinical reviewer may approve the admission based on their review. The clinical reviewer refers cases to a peer clinical reviewer for a peer-to-peer discussion if the case cannot be approved. Only qualified peer clinical reviewers (e.g., Medical Directors) may issue adverse benefit determinations. Peer-to-peer discussions are offered as required.
- **Adverse Benefit Determinations and Peer-to-Peer Conversations.** The Plan offers OON inpatient facilities and providers the opportunity to discuss a potential adverse benefit determination before the Plan issues such determination. This process allows OON inpatient facilities and providers the opportunity to provide additional information and/or modify their request prior to an adverse benefit determination being issued. Only M/S and MH/SUD peer clinical reviewers (e.g., Medical Director) may issue adverse benefit determinations for coverage of M/S and MH/SUD inpatient services.

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- Notification of Decisions to Providers and Members. The Plan notifies M/S and MH/SUD OON facilities, providers, and members of approvals and adverse benefit determinations, including applicable appeal rights, consistent with state and federal requirements.
 - OON inpatient M/S and MH/SUD services:
 - An adverse benefit determination is recorded as a clinical denial when it is based on clinical criteria and member clinical information and is recorded as an administrative denial when member benefits are exhausted.
- Review of Staff Qualifications For M/S and MH/SUD, clinical staff qualifications align with the type of clinical review and state and federal requirements.
 - M/S is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., nurses, physicians, etc.) and all adverse determinations are made by Medical Directors.
 - MH/SUD is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse determinations are made by Medical Directors.
- Clinical Criteria. For M/S and MH/SUD, clinical reviewers and peer clinical reviewers base determinations on the objective, evidence-based, medical/behavioral clinical policies and use clinical criteria from third party sources such as InterQual®, MCG®, ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines.

In Operation

The Plan compared the strategies, processes, factor, evidentiary standard, and source information used to determine which M/S and MH/SUD OON inpatient services are subject to Prior Authorization and how Prior Authorization is applied “in operation.”

M/S and MH/SUD members, or OON providers on the members behalf, submit requests for approval of inpatient services for which the Plan requires Prior Authorization. Members can learn what services are subject to Prior Authorization in their benefit plan document (i.e., *Schedule of Benefits*) or by contacting customer service. Notification triggered the Prior Authorization process for OON M/S and MH/SUD inpatient admissions.

M/S and MH/SUD inpatient Prior Authorization reviews included confirmation of member eligibility and benefit availability for the requested services. For M/S and MH/SUD OON inpatient services, non-clinical staff approved coverage for inpatient admissions that did not require clinical review or interpretation and where member plan documents allowed.

M/S and MH/SUD inpatient cases that were not administratively approved in initial review were referred to a clinical reviewer for further research and evaluation. The M/S and MH/SUD clinical reviewers applied benefit plan documents and medical necessity criteria to member clinical information. M/S and MH/SUD clinical reviewers requested additional clinical information if they were unable to approve cases based on the available member clinical information. The clinical reviewers approved the admission based on their review when clinical criteria were met.

If the requested clinical information was not received or if the case could not be approved, M/S and MH/SUD clinical reviewers referred cases to a peer clinical reviewer. The Plan offered peer-to-peer conversations so the OON provider could provide additional clinical information prior to issuance of an adverse benefit determination. Only qualified peer clinical reviewers issued M/S and MH/SUD adverse benefit determinations.

The Plan communicated all adverse benefit determinations for M/S and MH/SUD inpatient cases that did not meet applicable clinical criteria consistent with state and federal requirements, including appeal rights, as applicable.

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The Plan monitored M/S and MH/SUD clinical and peer clinical reviewers' application of clinical criteria through annual IRR assessments. The Plan also conducted quality audits of cases. The Plan routinely monitors Prior Authorization performance through its clinical performance oversight functions. In addition to comparing these "in operation" processes, the Plan reviewed medical necessity approval and denial rates, internal appeals outcomes, and external appeals outcomes related to Prior Authorization determinations for M/S and MH/SUD OON inpatient services. The results of these analyses are discussed in greater detail in Step 5.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The findings of the Plan's comparative analysis confirmed the strategies, processes, factor, evidentiary standard, and source information used to determine the MH/SUD OON inpatient services subject to Prior Authorization were comparable to, and applied no more stringently than, the strategies, processes, factor, evidentiary standard, and source information used to determine the M/S OON inpatient services subject to Prior Authorization "as written."

The Plan found the factor used to determine the MH/SUD OON inpatient services subject to Prior Authorization were comparable to, and applied no more stringently than, the factor used to determine the M/S OON inpatient services subject to Prior Authorization. OON M/S and MH/SUD inpatient services that met the Clinical Appropriateness were subject to Prior Authorization review "in operation."

The Plan used comparable processes to conduct Prior Authorization review of OON M/S and MH/SUD inpatient admissions. The Plan required members, or OON providers on behalf of the member, to timely submit Prior Authorization requests. The Plan used qualified staff to confirm member eligibility and benefit availability, and to request additional information if necessary. The Plan issued approvals for M/S and MH/SUD inpatient services that met applicable clinical criteria or guidelines. Only qualified M/S and MH/SUD peer clinical reviewers issued adverse benefit determinations. The Plan gave OON facilities and providers the opportunity to discuss potential adverse benefit determinations with qualified peer clinical reviewers prior to issuing adverse benefit determinations. This afforded OON providers the opportunity to provide additional information or alter the initial request.

The Plan operated monitoring and oversight programs to ensure that clinical reviewers and peer clinical reviewers rendered appropriate determinations. Both M/S and MH/SUD required clinical reviewers, including peer clinical reviewers, to successfully complete the annual IRR assessment. Clinical reviewers were required to pass the IRR assessment with a score of 90% or better to render UM decisions independently. 2023 IRR M/S and MH/SUD results are not available. The M/S and MH/SUD clinical reviewers application of medical necessity criteria when making utilization review determinations will be assessed for comparability when the results are available.

OON inpatient medical necessity approval and denial rates and appeals outcomes data from 01/01/2022 – 12/31/2022 were evaluated where a minimum threshold of 100 cases were available to ensure a valid data set for analysis. The Plan has established that a minimum of at least 100 M/S and MH/SUD cases are required within each classification for a comparative analysis. Meaningful conclusions cannot be reached when there are fewer than 100 cases within each classification this is because the data is subject to variability.

Prior Authorization –Out-of-Network Inpatient Non-Quantitative Treatment Limitation (NQTL) Analysis

GA Surest - UnitedHealthcare Insurance Company

12/29/2023

Because Georgia Surest Plan became effective on 07/2023 there is minimal membership and as a result an insufficient number of cases from 01/01/2022 – 12/31/2022 to support an in operation analysis. While the Plan notes that the U.S. Department of Labor has indicated generally that outcomes data are not dispositive of parity compliance, the Plan will conduct a comparative analysis of outcomes data, including medical necessity approval and denial rates and appeals outcomes, when there is a minimum of 100 cases available to ensure a valid data set for analysis.

Conclusions

The Plan reviewed the M/S and MH/SUD Prior Authorization operational policies and procedures and concluded the methodology used to determine which MH/SUD OON inpatient services are subject to Prior Authorization “as written” were comparable to, and applied no more stringently than, the methodology used to determine which M/S OON inpatient services are subject to Prior Authorization “as written.” Additionally, the Plan concluded that how Prior Authorization is applied to MH/SUD OON inpatient services was comparable to, and applied no more stringently than, how Prior Authorization is applied to M/S OON inpatient services “as written.”

The Plan reviewed the M/S and MH/SUD processes including responsibility for submission, timeframes for submission and review, notification to members and providers, clinical standards for review, and staff qualifications and concluded how the Plan conducts Prior Authorization for MH/SUD OON inpatient services “in operation” was comparable to, and applied no more stringently than, how the Plan conducts Prior Authorization for M/S OON inpatient services “in operation.”

Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical/surgical (M/S) benefits. This generally means that the financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements, such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage.

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth the findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Prior Authorization is defined as: “A required or mandatory clinical assessment for proposed service(s) based on clinical information provided and the terms of the health plan benefits before the service(s) are performed or delivered. Clinical and medical necessity requirements, level of care appropriateness, and the terms of the health plan benefits must be met in order for services to be covered by the member’s plan.” The *Optum National Policy Definitions List* defines pre-authorization (aka Prior Authorization) as “a form of prospective utilization review of health care services proposed to be provided to a member.”

Prior Authorization is a component of the Plan’s Utilization Management (UM) program that helps ensure members receive appropriate coverage based on their specific clinical status and health care needs. The process is designed to achieve optimal clinical outcomes by applying objective, evidence-based clinical criteria and nationally recognized guidelines and best practices.

Prior Authorization for outpatient services commences prior to a service being delivered. Prior Authorization is a UM process that involves applying the benefit plan language and/or clinical criteria to make the most appropriate clinical coverage benefit determination.

This document includes the following information:

- Prior Authorization process for M/S and MH/SUD outpatient services
- Description of the NQTL and application (Step 1)
- Factors used to determine which services are subject to the NQTL (Step 2)
- Evidentiary standards and sources used to define, trigger and/or implicate a factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

This analysis refers to the following attachments:

- *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions* - M/S policy that defines Prior Authorization
- *Optum National Policy Definitions List* - MH/SUD policy that defines Prior Authorization

- *Utilization Management Program Description (UMPD) of United HealthCare Services, Inc. and UnitedHealthcare Insurance Company* - Summarizes the philosophy, structure and standards that govern UHC's medical management, UM and utilization review responsibilities and functions
- *Management of Behavioral Health Benefits Policy* - Describes the mechanisms and processes designed to promote consistency in the management of behavioral health benefits and to ensure that members receive appropriate, high quality behavioral health services in a timely manner
- *Core Principles and Practices* - MH/SUD policy that outlines the core principles and practices that should be used by personnel in their interactions with members, authorized member representatives, practitioners and facilities, related to the management of behavioral health benefits, coverage determinations and appeals/grievances of non-coverage determinations.
- *Performance Assessment and Incentives* - M/S policy confirming that clinical reviewers are not incented to make denials for financial reasons
- *2023 UnitedHealthcare Provider Administrative Guide* – Informs M/S providers of the Prior Authorization process. The *UnitedHealthcare Provider Administrative Guide* can be accessed on the website <https://www.uhcprovider.com/en/admin-guides.html>
- *September 2023 Optum National Network Manual* - Informs MH/SUD providers of the Prior Authorization process. The *Optum National Network Manual* can be accessed on the website <https://public.providerexpress.com/content/optum-provexpr/us/en/clinical-resources/guidelines-policies/optum-network-manual.html>
- *Schedule of Benefits - SBN23-Medical-INS-BIND-2021-Choice Plus-LG-GA-UHIC* - Plan document that outlines member responsibilities

The Plan concludes that the Prior Authorization requirements for M/S and MH/SUD are comparable and applied no more stringently for MH/SUD out-of-network (OON) outpatient benefits both "as written" and "in operation."

Process

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Prior Authorization is defined as: "A required or mandatory clinical assessment for proposed service(s) based on clinical information provided and the terms of the health plan benefits before the service(s) are performed or delivered. Clinical and medical necessity requirements, level of care appropriateness, and the terms of the health plan benefits must be met in order for services to be covered by the member's plan." The *Optum National Policy Definitions List* defines pre-authorization (aka Prior Authorization) as "a form of prospective utilization review of health care services proposed to be provided to a member."

The Plan structures outpatient Prior Authorization processes to be compliant with all applicable federal and state requirements. Prior Authorization is governed at both the state and federal level, which includes consumer protections such as external review for adverse benefit determinations after internal appeals options are exhausted.

The Plan delegates management of MH/SUD outpatient services, including Prior Authorization, to United Behavioral Health d/b/a Optum Behavioral Health (OBH), its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor.

The Plan has national committees that approve M/S and MH/SUD outpatient services to be subject to Prior Authorization. Additionally, the Plan has a standard process for assessing the services that are subjected to Prior Authorization and whether they should be retained or removed from the Prior Authorization list. The Plan publishes the services subject to Prior Authorization on the provider portal(s) ([Advance Notification and Clinical Submission Requirements | UHCprovider.com](#) for M/S and [Optum - Provider Express Home](#) for MH/SUD). Members can learn what services are subject to Prior Authorization in their benefit plan document, through <https://member.uhc.com/myuhc>, myuhc.com, or by contacting customer service.

Prior Authorization review of M/S outpatient services consists of the following:

Members are responsible for obtaining Prior Authorization for services rendered by OON providers. The member's benefit plan document (i.e., *Schedule of Benefits*) identifies the services for which the member is responsible for obtaining Prior Authorization and the required timeframe(s). The member or OON provider's submission of a request (notification) triggers the Prior Authorization process.

Members may submit Prior Authorization requests by phone, fax, or mail, in accordance with Plan requirements. OON providers may submit Prior Authorization requests on behalf of the member by phone, online or by fax (where required). Members or providers communicate basic information to create a case.

The Plan confirms receipt of the Prior Authorization request. Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. Non-clinical staff review cases to ensure availability of accurate and thorough case information. Non-clinical staff may approve coverage requests in scenarios where the member's plan documents allow and if a clinical review is not required. Non-clinical staff may administratively deny coverage when a member's benefits are exhausted. Non-clinical staff refer cases that they cannot approve or administratively deny to clinical reviewers.

First Level Clinical Review/Initial Review. Clinical reviewers (nurses) consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs. The clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. The clinical reviewer can approve cases that meet applicable clinical criteria.

Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Peer clinical reviewers (physician or mid-level practitioner) consult clinical criteria when making clinical coverage benefit determinations. Peer clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs. The peer clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If a peer clinical reviewer issues an adverse benefit determination, then the Plan communicates the adverse benefit determination, including appeal rights, and offers a peer-to-peer conversation consistent with state and federal requirements.

Adverse Benefit Determination. For M/S an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction, or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when member benefits are exhausted. Modified coverage requests that are approved are recorded as partial denials.

Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based medical clinical policies and use clinical criteria from third-party sources such as InterQual® or MCG® guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that outpatient Prior Authorization determinations are appropriate.

M/S monitors clinical reviewer and peer clinical reviewer application of clinical criteria through an annual inter-rater reliability (IRR) assessment that is provided by InterQual. Clinical reviewers and peer clinical reviewers are required to pass the IRR assessment with a score of 90% or better through three attempts. After a second failed IRR assessment, staff enter a remediation period and are required to review all cases with a supervisor for 30 days, or until 90% is achieved on the

assessment. If the clinical reviewer achieves a passing score within the 30-day period, supervisors review a minimum of one case per week for the remainder of the 30-day period.

The Plan also conducts end-to-end case audits that are designed and approved by clinical leadership each year. The end-to-end audits include all stages of a case review, from intake through appeal. These audits are conducted monthly and approximately 1500 cases are reviewed per month. Results are reported to an oversight team. All deficiencies are remediated. Remediation may include corrective actions and/or additional education, as indicated.

The Plan routinely monitors Prior Authorization performance through its clinical performance oversight functions. Outcomes are monitored against timeliness compliance, performance guarantees, and for potential trends, including overall utilization.

As of April 1, 2023, the Utilization Management Program Committee (UMPC) began overseeing the M/S UM program. The UMPC is responsible for the development and maintenance of the M/S Prior Authorization processes. The UMPC ensures that the UM program considers the factors and evidentiary standards for applying UM. The UMPC is comprised of:

- Chief Medical Officer, Medical Management (Co-Chair)
- Senior Vice President, Clinical Advancement (Co-Chair)
- Chief Medical Officer, UnitedHealthcare
- Senior Vice President, Clinical Appeals & Grievances
- Chief Medical Officer, Clinical Policy
- Chief Medical Officer, UnitedHealthcare Employer & Individual
- Chief Medical Officer, UnitedHealthcare Medicare & Retirement
- Chief Medical Officer, Community & State
- Chief Medical Officer, UnitedHealthcare Individual & Family Plans
- Vice President, Clinical Transformation & Affordability
- Senior Director, Mental Health Parity
- Vice President, Utilization Management Strategy & Implementation

One of the chairs must be an executive leader and a licensed physician. UMPC meets at least six times per year but may meet more frequently if needed.

Per the M/S policy entitled, *Performance Assessment and Incentives*, at no time are initial or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons.

M/S generally structures UM processes to comply with federal Employee Retirement Income Security Act of 1974 (ERISA) requirements, and state law where applicable.

Prior Authorization review of MH/SUD outpatient services consists of the following:

The Plan delegates management of MH/SUD outpatient services, including Prior Authorization, to United Behavioral Health d/b/a OBH, its delegated MH/SUD MBHO vendor.

Members are responsible for ensuring Prior Authorization is obtained by the OON provider administering the service. The OON provider must provide clinical information on the member's behalf. The member's benefit plan document (i.e., *Schedule of Benefits*) identifies the services for which the member is responsible for ensuring Prior Authorization is obtained. As outlined in the Plan document, OON providers must submit the Prior Authorization request before outpatient MH/SUD services are received.

OON providers may submit Prior Authorization requests on behalf of the member by telephone, online (for certain services) or by fax (where required). Providers communicate basic information to create a case. OON provider's submission of a request (notification) triggers the Prior Authorization process.

As described in the *Management of Behavioral Health Benefits Policy*, the Plan confirms receipt of the Prior Authorization request. Non-clinical staff confirm member eligibility and benefit coverage. Non-clinical staff may administratively deny coverage when member benefits are exhausted. Non-clinical staff may approve coverage requests that do not require clinical evaluation or interpretation based on the member's diagnosis and the clinical information submitted by providers. Non-clinical staff refer cases that they cannot approve or administratively deny to the initial clinical reviewers.

First Level Clinical Review/Initial Review. Clinical decisions are made by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse benefit determinations are made by Medical Directors or psychologists. Clinical reviewers consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether a service is medically necessary by reviewing the member's clinical information, the applicable clinical criteria or guidelines, and the Plan benefit terms. Clinical reviewers may request additional clinical information including, but not limited to, office or facility medical records, consultations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for certification, related diagnostic results, and history of related treatment and services. The clinical reviewer may approve cases that meet applicable clinical criteria.

Second Level Clinical Review/Peer Review. The initial clinical reviewer refers cases to a peer clinical reviewer for a peer-to-peer discussion if the case cannot be approved. The requesting provider is offered the opportunity to discuss the case with the peer clinical reviewer, consistent with state and federal requirements before an adverse benefit determination is issued. Only qualified peer clinical reviewers (e.g., Medical Directors or psychologists) can issue adverse benefit determinations. Peer clinical reviewers apply clinical criteria to member clinical information to determine coverage. If the requesting provider fails to complete the peer-to-peer discussion, the peer clinical reviewer makes a determination based on the information available. If a peer clinical reviewer issues an adverse benefit determination (e.g., number of treatments are not authorized), then the Plan timely communicates the adverse benefit determination, including appeal rights, to the member and provider consistent with applicable state and federal requirements.

Adverse Benefit Determination. For MH/SUD, an adverse benefit determination is recorded as a clinical denial when it is based on clinical criteria and member clinical information and is recorded as an administrative denial when member benefits are exhausted.

Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity clinical coverage determinations on objective, evidence-based behavioral clinical policies or use clinical criteria from third-party sources such as American Society of Addiction Medicine (ASAM) Criteria®, Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System-Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) and Early Childhood Service Intensity Instrument (ECSII) guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that outpatient Prior Authorization determinations are appropriate.

MH/SUD monitors clinical reviewer and peer clinical reviewer application of clinical criteria through an annual IRR assessment. Clinical reviewers and peer clinical reviewers are required to pass the IRR assessment with a score of 90% or better through three attempts. After a second failed IRR assessment, the reviewer enters a remediation period and is required to review all cases with a supervisor for 30 days, or until 90% is achieved on the assessment. If the clinical reviewer achieves a passing score within the 30-day period, supervisors review a minimum of one case per week for the remainder of the 30-day period.

The Plan also conducts monthly quality audits of individual non-clinical staff, clinical reviewers, and peer clinical reviewers, including staff performing appeal functions. These audits are designed and approved by clinical leadership each year. A

minimum of two audits are completed per staff, per month. The results of these real-time audits are shared with supervisors for staff oversight, and all findings are remediated. Remediation may include corrective actions and/or additional education, as indicated.

The Plan routinely monitors Prior Authorization performance through its clinical performance oversight functions. Outcomes are monitored against timeliness compliance, performance guarantees, and for potential trends, including overall utilization.

The Plan's national Clinical Quality & Operations Committee (CQOC) annually reviews overall UM program outcomes, including outpatient Prior Authorization outcomes, to confirm overall utilization is appropriate. The national CQOC is comprised of representatives from sub-committees, and representatives from the clinical quality improvement, UM, care engagement, medical operations, medical policy and standards, clinical operations, appeals, product, legal, compliance, network strategy, provider experience, accreditation, and benefits teams. The Chair of the CQOC must be an executive leader, board certified in psychiatry or psychiatric subspecialty and a licensed physician.

Per the MH/SUD policy entitled, *Core Principles and Practices*, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse clinical coverage benefit determinations (clinical denials) for financial reasons.

MH/SUD generally structures UM processes to comply with federal ERISA requirements and state law where applicable.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- Prior Authorization

Benefit Classification(s)

- OON, outpatient

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHC)

Plan Terms/Source Document(s)

In each of the Plan products, "Medically Necessary" is the Plan term used to guide Prior Authorization decision-making for both M/S and MH/SUD services. "Medically Necessary" is generally defined as follows:

"Medically Necessary – health care services are all of the following as determined by us or our designee.

- In accordance with *Generally Accepted Standards of Care*.
- Clinically appropriate, in terms of type, frequency, extent, service site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s), service site or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.
- Or, are subject to Bind Coverage with Evidence Development Policy (CED Policy).

Generally Accepted Standards of Care are evidence based independent standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties. Valid, evidence based sources reflecting generally accepted standards of care include credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or nationally recognized clinical practice guidelines may be considered. We have the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be determined by us.

We develop and maintain clinical policies that describe the Generally Accepted Standards of Care scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. [[These clinical policies (as developed by us and revised from time to time), are available to Covered Persons through [MyBind.com] or by calling the telephone number on your ID card.] [They are [also] available to Physicians and other health care professionals on [MyBind.com].]]”

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Prior Authorization is defined as:

“A required or mandatory clinical assessment for proposed service(s) based on clinical information provided and the terms of the health plan benefits before the service(s) are performed or delivered. Clinical and medical necessity requirements, level of care appropriateness, and the terms of the health plan benefits must be met in order for services to be covered by the member's plan.”

The *Optum National Policy Definitions List* defines pre-authorization (aka Prior Authorization) as “a form of prospective utilization review of health care services proposed to be provided to a member.”

The Plan's *Schedule of Benefits* notify members of the Prior Authorization requirements:

“We require prior authorization for certain Covered Health Care Services. Network providers are responsible for obtaining prior authorization before they provide these services to you. [\[Benefits for conditional coverage do not require Network provider prior authorization, with the exception of a pre-admission notification for Covered Health Care Services for Inpatient Stays.\]](#)

We recommend that you confirm with us that all Covered Health Care Services have been prior authorized as required. Before receiving these services from a Network provider, you may want to call us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they do not prior authorize as required. You can call us at the telephone number on your ID card.

When you choose to receive certain Covered Health Care Services from out-of-Network providers, you are responsible for obtaining prior authorization before you receive these services. Note that your obligation to obtain prior authorization is also applicable when an out-of-Network provider intends to admit you to a Network facility or to an out-of-Network facility or refers you to other Network or out-of-Network providers. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization. Services for which you are required to obtain prior authorization are shown in the Schedule of Benefits table within each Covered Health Care Service category.

To obtain prior authorization, call the telephone number on your ID card. This call starts the utilization review process.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the Schedule of Benefits table to find out how far in advance you must obtain prior authorization.

For Covered Health Care Services that do not require you to obtain prior authorization, when you choose to receive services from out-of-Network providers, we urge you to confirm with us that the services you plan to receive are Covered Health Care Services. That's because in some instances, certain procedures may not be Medically Necessary or may not otherwise meet the definition of a Covered Health Care Service, and therefore are excluded. In other instances, the same procedure may meet the definition of Covered Health Care Services. By calling before you receive treatment, you can check to see if the service is subject to limitations or exclusions.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those received, our final coverage determination will be changed to account for those differences, and we will only pay Benefits based on the services delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Care Service, you will be responsible for paying all charges and no Benefits will be paid.”

The role of the Plan's delegate, United Behavioral Health d/b/a OBH, is discussed in the UMPD:

“United Behavioral Health (UBH) performs the review of requests for coverage of behavioral health services (i.e., substance abuse, and mental health requests for services). UBH provides comprehensive behavioral health care delivery for members through a network of behavioral health practitioners, ancillary care providers, hospitals and other facilities.

For mental health, substance-related disorder services, and wraparound services, UBH uses its Clinical Criteria (see below), behavioral clinical policies and best practice guidelines to make coverage determinations. UBH adopts externally-developed clinical criteria, and creates internally-developed Clinical Criteria, where appropriate, based on its assessment of relevant guidance. UBH develops clinical criteria that supersedes its standard set or adopts externally-developed clinical criteria when required to do so by contract or regulation.

- Clinical Criteria (Level of Care Utilization System-LOCUS) – Standardized level of care assessment tool developed by the American Association of Community Psychiatrists used to make clinical determinations and placement decisions for mental health disorder benefits for adults ages 19 and older when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (Child and Adolescent Level of Care/Service Intensity Utilization System-CALOCUS-CASII) - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry (AACAP) and the American Association for Community Psychiatry (AACP) used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children and adolescents ages 6-18 when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (Early Childhood Service Intensity Instrument-ECSII) - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children ages 0-5 when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (State or Contract Specific Level of Care Guidelines) – Criteria used to make medical necessity determinations for mental health disorder benefits when there are explicit mandates or contractual requirements.
- Clinical Criteria (American Society of Addiction Medicine [ASAM]) - Criteria developed by the American Society of Addiction Medicine used to make clinical determinations for substance-related disorder benefits.
- Clinical Criteria (Optum Developed)
 - Optum Behavioral Clinical Policies: Criteria that stem from evaluation of new services or treatments or new applications of existing services or treatments and are used to make clinical determinations regarding proven or unproven services and treatments.

Licensed practitioners conduct all reviews with a focus on measurable outcome goals and objectives for treatment. A senior UBH Medical Director is responsible for directing and implementing behavioral health utilization management programs. A

referral is sent to UBH when a member is identified as potentially benefiting from behavioral health services during a “medical event”.

The UBH UM Program is staffed by clinical, non-clinical and administrative personnel. All clinical denials or adverse decisions are made by board certified psychiatrists, or, if the health plans choose, by a panel of other appropriate health care service reviewers. If the health plan chooses to use a panel to make adverse decisions, the panel contains at least one physician who is board certified in psychiatry. When the health care service under review is a mental health or substance abuse service, the adverse decision is made by a licensed physician who is board certified in psychiatry. All potential clinical denials are referred to a physician who is board certified in psychiatry for final determination. An evaluation of the overall effectiveness of the Behavioral Health UM Program is conducted annually to determine how well resources have been deployed to improve UM activities and the clinical care and service provided to members.”

The Plan’s terms require services to be medically necessary for coverage.

List of M/S and MH/SUD Services Subject to NQTL

The M/S and MH/SUD OON outpatient services subject to prior authorization are below:

M/S:

- Clinical Trials
- Diabetes Services
- Durable Medical Equipment (DME), Orthotics Prosthetic Devices, and Supplies – That cost more than \$1,000 (either retail purchase cost or cumulative retail rental cost of a single item)
- Gender Dysphoria – Non-Surgical Treatment
- Gender Dysphoria – Surgical Treatment
- Habilitative Services
- Home Health Care
- Hospice Care
- Lab, X-Ray and Diagnostic – Outpatient
- Major Diagnostic and Imaging – Outpatient
- Pregnancy – Maternity Services
- Preimplantation Genetic Testing (PGT) and Related Services
- Reconstructive Procedures
- Scopic Procedures – Outpatient Diagnostic and Therapeutic
- Surgery – Outpatient
- Temporomandibular Joint (TJ) Services and Orthognathic Surgery
- Therapeutic Treatments – Outpatient

MH/SUD:

- Applied Behavior Analysis (ABA)
- Partial Hospitalization/Day Treatment

Step 2 – Factors Used in the Design and Application of the NQTL

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH /SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

When Surest (Bind) plans first launched in 2016, the Plans were designed to offer a simpler and more transparent way for people to access the system. The Plan included coverage for services with the option to buy-up specific benefits based on member need.

In 2022, UnitedHealthcare acquired Surest (Bind) and agreed to adopt the existing list of services that had been identified to be subject to Prior Authorization. The Plan has determined that Clinical Appropriateness is one of the factors that is determinative in imposing the Prior Authorization limitation. At this time, the Plan is assessing the value of managing the services, the consistency of adherence to evidence-based guidelines, and volume of services utilized to further refine which INN Inpatient services are subject to Prior Authorization. As a result, the Plan is evaluating the factors to be utilized to determine which INN Inpatient services are subject to Prior Authorization.

The Plan relies on the following factor to determine which OON outpatient services are added to the Prior Authorization list. This factor applies to M/S and MH/SUD benefits for the following:

- I. M/S OON outpatient services
 - II. MH/SUD OON outpatient services
- Clinical Appropriateness (Qualitative)
 - Whether the application of Prior Authorization promotes optimal clinical outcomes

Applies to M/S and MH/SUD services

Meeting Clinical Appropriateness is determinative in imposing the limitation.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below is the evidentiary standard and source used to define, trigger, and/or implicate the factor used to add services to the Plan's Prior Authorization requirement for OON outpatient services. This evidentiary standard and source applies to benefits for the following:

- I. M/S OON outpatient services
- II. MH/SUD OON outpatient services

Factor – Clinical Appropriateness is defined as those outpatient services that are determined by internal medical experts to be in accordance with objective, evidence-based clinical criteria, and nationally recognized guidelines.

- The Plan's evidentiary standards and sources that define and/or trigger the Clinical Appropriateness factor are:
 - Clinical criteria from nationally recognized, third-party sources (e.g., InterQual or MCG for M/S services, and ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines for MH/SUD services)
 - Clinical Technology and Assessment Committee (CTAC) and Medical Technology and Assessment Committee (MTAC) review
 - Objective, evidence-based medical/behavioral clinical policies and nationally recognized guidelines approved by professional healthcare associations (e.g., clinical guidance from the American Medical Association, American Psychiatric Association, etc.)

These evidentiary standards and sources apply to M/S and MH/SUD OON outpatient services and are defined in a qualitative manner.

Meeting Clinical Appropriateness is determinative in imposing the limitation.

The factor and evidentiary standard used as the basis for subjecting MH/SUD OON outpatient benefits to Prior Authorization are comparable to, and applied no more stringently than, the factor and evidentiary standard used as the basis for subjecting M/S OON outpatient benefits to Prior Authorization “as written” and “in operation.”

Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

As Written

The Plan conducted a comparative analysis of the strategies, processes, factor, evidentiary standard, and source information used to determine which M/S and MH/SUD OON outpatient services are subject to Prior Authorization and how Prior Authorization is applied to M/S and MH/SUD OON outpatient services “as written.” The Plan identified the factor and evidentiary standard used as the basis for subjecting M/S and MH/SUD benefits to Prior Authorization.

National internal committees apply the applicable factor and standard described in Steps 2 and 3 to M/S and MH/SUD services when determining whether the services should be subjected to Prior Authorization.

Review of Factors and Evidentiary Standards

The Plan reviewed the factor that triggers an OON outpatient service to be added to the Prior Authorization list. The factor and evidentiary standard were applied to M/S and MH/SUD services comparably and not more stringently to MH/SUD services than to M/S services.

Review of Operational Policies and Procedures

The Plan reviewed M/S and MH/SUD operational policies and procedures, IRR assessment processes, and UM annual oversight to confirm comparability and found MH/SUD policies, procedures, and process to be comparable and no more stringent than M/S policies, procedures, and processes.

- Medical management operational policies and procedures establish the standards for how the Plan conducts outpatient Prior Authorization. The policies and procedures are consistent with state and federal law governing Prior Authorization. Timeframes for decisions, content of adverse benefit determinations, appeal rights and external review are all governed by state and federal law.
- The IRR measures the consistency with which clinical reviewers and peer clinical reviewers apply the Plan's clinical criteria. IRR assessment processes apply to M/S and MH/SUD outpatient services.
- UM oversight monitors and evaluates UM processes by reviewing program outcomes, clinical appeals, IRR assessments, and under- and over-utilization.

Review of Outpatient Prior Authorization Processes

The strategy for applying Prior Authorization to OON outpatient services is comparable for M/S and MH/SUD services and is applied no more stringently to MH/SUD OON outpatient services. The Plan conducted a review of the M/S and MH/SUD Prior Authorization processes to confirm comparability. The review focused on the following aspects of the process for both M/S and MH/SUD:

- Prior Authorization Request. For M/S and MH/SUD OON services, the member is responsible for ensuring the OON provider submits Prior Authorization requests. For M/S services, the member can contact the telephone number on their member ID card, mail, or fax to request a Prior Authorization. For M/S and MH/SUD, the OON provider can request Prior Authorization on behalf of the member, or submit clinical information, via telephone, online form (for certain services) or fax (where required).

- **Timeframe to Submit.** The timeframes for the member, or OON provider on behalf of the member, to submit the Prior Authorization request were reviewed and it was determined that MH/SUD was no more stringent.
 - **M/S:** Per the member's Plan documents, the timeframes vary depending upon the services requested from as soon as possible to six months prior to the OON service
 - Unplanned or emergency services are not subject to Prior Authorization
 - **MH/SUD:** Per the member's Plan documents, the Prior Authorization should be requested before OON services are received.
 - Unplanned or emergency services are not subject to Prior Authorization
- **Clinical Reviews.** For M/S and MH/SUD outpatient Prior Authorization requests, clinical reviewers may gather more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for certification, related diagnostic results, history of related treatment and services, and photographs. The clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. The clinical reviewer may approve cases that meet applicable clinical criteria.
- **Review Timeframes.** M/S and MH/SUD outpatient Prior Authorization determination timeframes are defined by state, federal requirements for both urgent and non-urgent services. The same determination timeframes apply to M/S and MH/SUD determinations.
- **Determinations and Non-Clinical Reviews, First Level Clinical Reviews, and Second Level/Peer Clinical Reviews.** For M/S and MH/SUD outpatient Prior Authorization, non-clinical staff may approve cases that do not require clinical evaluation or interpretation. Non-clinical staff may administratively deny cases when member benefits are exhausted.
 - Non-clinical staff refer coverage requests that they cannot approve or administratively deny to clinical reviewers. Clinical reviewers consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether an outpatient service is medically necessary. The clinical reviewer may approve the service based on their review. The clinical reviewer refers cases to a peer clinical reviewer for a peer-to-peer discussion if the case cannot be approved. Only qualified peer clinical reviewers (e.g., Medical Directors) may issue adverse benefit determinations. Peer-to-peer discussions are offered as required.
- **Adverse Benefit Determination and Peer to Peer Conversations.** The Plan offers OON outpatient providers the opportunity to discuss a potential adverse benefit determination before the Plan issues such determination. This process allows OON outpatient MH/SUD facilities and providers the opportunity to provide additional information prior to an adverse benefit determination being issued.
 - OON outpatient M/S and MH/SUD services
 - An adverse benefit determination is recorded as a clinical denial when it is based on clinical criteria and member clinical information and is recorded as an administrative denial when member benefits are exhausted.
- **Notification of Decisions to Providers and Members.** The Plan notifies M/S and MH/SUD OON providers and members of approvals and adverse benefit determinations, including applicable appeal rights, consistent with state and federal requirements.
- **Review of Staff Qualifications.** For M/S and MH/SUD, clinical staff qualifications align with the type of clinical review and with state and federal requirements.
 - M/S is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., nurses, physicians, etc.) and all adverse determinations are made by a physician or other appropriate health care professionals.
 - MH/SUD is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse determinations are made by medical directors or psychologists.
- **Clinical Criteria.** For M/S and MH/SUD, clinical reviewers and peer reviewers base determinations on the objective, evidence-based, medical/behavioral clinical policies and use clinical criteria from third party sources such as InterQual, MCG, ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines.

In Operation

The Plan compared the strategies, processes, factor, evidentiary standard, and source information used to determine which M/S and MH/SUD OON outpatient services are subject to Prior Authorization and how Prior Authorization is applied “in operation.”

M/S and MH/SUD members, or OON providers on the member’s behalf submit requests for approval of outpatient services for which the Plan requires Prior Authorization. Members can learn what services are subject to Prior Authorization in their benefit plan document (i.e., *Schedule of Benefits*), or by contacting customer service. Notification triggered the Prior Authorization process for OON M/S and MH/SUD outpatient services.

M/S and MH/SUD outpatient Prior Authorization reviews included confirmation of member eligibility and benefit availability for the requested services. For M/S and MH/SUD OON outpatient services, non-clinical staff approved coverage for outpatient services that did not require clinical review or interpretation.

M/S and MH/SUD outpatient cases that were not administratively approved in initial review, were referred to a clinical reviewer for further research and evaluation. The M/S and MH/SUD clinical reviewers applied benefit plan documents and medical necessity criteria to member clinical information. M/S and MH/SUD clinical reviewers could request additional clinical information if they were unable to approve cases based on the available member clinical information. The clinical reviewers may approve cases based on their review.

If the requested clinical information was not received or if the case could not be approved, M/S and MH/SUD clinical reviewers referred cases to a peer clinical reviewer. The Plan offered peer-to-peer conversations so the OON provider could provide additional clinical information prior to issuance of an adverse benefit determination. Only qualified peer clinical reviewers issued M/S and MH/SUD adverse benefit determinations.

The Plan communicated all adverse benefit determinations for M/S and MH/SUD outpatient cases that did not meet applicable clinical criteria consistent with state and federal requirements, including appeal rights, as applicable.

The Plan monitors M/S and MH/SUD clinical and peer clinical reviewers’ application of clinical criteria through annual IRR assessments. The Plan also conducts monthly quality audits of individual non-clinical staff, clinical reviewers, and peer clinical reviewers, including staff performing appeal functions. The Plan routinely monitors Prior Authorization performance through its clinical performance oversight functions. In addition to comparing these “in operation” processes, the Plan reviewed medical necessity approval and denial rates, internal appeals outcomes, and external appeals outcomes related to Prior Authorization determinations for M/S and MH/SUD OON outpatient services. The results of these analyses are discussed in greater detail in Step 5.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan’s or issuer’s findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The findings of the Plan’s comparative analyses confirmed the strategies, processes, factor, evidentiary standard, and source information used to determine the MH/SUD OON outpatient services subject to Prior Authorization were comparable to, and applied no more stringently than, the strategies, processes, factors, evidentiary standards, and source information used to determine the M/S OON outpatient services subject to Prior Authorization “as written.”

The Plan found the factor used to add MH/SUD OON outpatient services to the Prior Authorization list was comparable to, and applied no more stringently than, the factor used to add M/S OON outpatient services to the Prior Authorization list. OON M/S and MH/SUD outpatient services that met the applicable factor(s) were subject to Prior Authorization review “in operation.”

The Plan used comparable processes to conduct outpatient Prior Authorization review of member and OON providers’ requests. The Plan required members, or OON providers on behalf of the member, to timely submit Prior Authorization requests. The Plan used qualified staff to confirm member eligibility and benefit availability, and to request additional information if necessary. The Plan issued approvals for M/S and MH/SUD outpatient services that met applicable clinical criteria or guidelines. Only qualified M/S and MH/SUD peer clinical reviewers issued adverse benefit determinations. The Plan gave OON providers the opportunity to discuss potential adverse benefit determinations with qualified peer clinical reviewers prior to issuing adverse benefit determinations. This afforded INN MH/SUD providers the opportunity to provide additional information.

The Plan operated monitoring and oversight programs to ensure that clinical reviewers and peer clinical reviewers rendered appropriate determinations. Both M/S and MH/SUD required clinical reviewers, including peer clinical reviewers, to successfully complete the annual IRR assessment. Clinical reviewers were required to pass the IRR assessment with a score of 90% or better to render UM decisions independently. 2023 IRR M/S and MH/SUD results are not available. The M/S and MH/SUD clinical reviewers application of medical necessity criteria when making utilization review determinations will be assessed for comparability when the results are available

OON outpatient medical necessity approval and denial rates and appeals outcomes data from 01/01/2022 – 12/31/2022 were evaluated where a minimum threshold of 100 cases were available to ensure a valid data set for analysis. The Plan has established that a minimum of at least 100 M/S and MH/SUD cases are required within each classification for a comparative analysis. Meaningful conclusions cannot be reached when there are fewer than 100 cases within each classification this is because the data is subject to variability.

Because Georgia Surest Plan became effective on 07/2023 there is minimal membership and as a result an insufficient number of cases from 01/01/2022 – 12/31/2022 to support an in operation analysis. While the Plan notes that the U.S. Department of Labor has indicated generally that outcomes data are not dispositive of parity compliance, the Plan will conduct a comparative analysis of outcomes data, including medical necessity approval and denial rates and appeals outcomes, when there is a minimum of 100 cases available to ensure a valid data set for analysis.

Conclusions

The Plan reviewed the M/S and MH/SUD Prior Authorization policies and procedures and concluded the methodology used to determine which MH/SUD OON outpatient services are subject to Prior Authorization “as written” were comparable to, and applied no more stringently than, the methodology used to determine which M/S OON outpatient services are subject to Prior Authorization “as written.” Additionally, the Plan concluded that how Prior Authorization is applied to MH/SUD OON outpatient services was comparable to, and applied no more stringently than, how Prior Authorization is applied to M/S OON outpatient services “as written.”

The Plan reviewed the M/S and MH/SUD processes including responsibility for submission, timeframes for submission and review, notification to members and providers, clinical standards for review, and staff qualifications and concluded how the Plan conducts Prior Authorization for MH/SUD OON outpatient services “in operation” was comparable to, and applied no more stringently than, how the Plan conducts Prior Authorization for M/S OON outpatient services “in operation.”

Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical/surgical (M/S) benefits. This generally means that the financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements, such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage.

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

Per the Plan’s *Certificate of Coverage*, the Plan reviews and determines benefits in accordance with reimbursement policies. Reimbursement policies are developed in accordance with:

- The most recent edition of the Current Procedural Terminology® (CPT), a publication of the American Medical Association (AMA), and/or the Centers for Medicare and Medicaid Services (CMS)
- As reported by generally recognized professionals or publications
- As used for Medicare
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that we accept

Reimbursement policies are applied to provider billings concurrent with the Plan’s Fraud, Waste, Abuse, and Error (FWAE) processes.

In-network (INN) providers adhere to *UnitedHealthcare’s (UHC) Provider Administrative Guide* (M/S) and the *Optum National Network Manual* (MH/SUD), while out-of-network (OON) providers are guided by the member’s Plan documents.

This document includes the following information:

- Process for the development and application of reimbursement policies for both M/S and MH/SUD
- Description of the NQTL and application (Step 1)
- Factors used to develop and apply reimbursement policies for both M/S and MH/SUD (Step 2)
- Evidentiary standards and sources used to define, trigger and/or implicate a factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

This analysis refers to the following attachments:

- *2023 UnitedHealthcare Provider Administrative Guide* – Describes requirement to timely submit complete claims with accurate coding. The *UnitedHealthcare Provider Administrative Guide* can be accessed on the website <https://www.uhcprovider.com/en/admin-guides.html>

Reimbursement Policy-Coding Edits Non-Quantitative Treatment Limitation (NQTL) Analysis

GA Surest - UnitedHealthcare Insurance Company
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- *September 2023 Optum National Network Manual* - Describes requirement to timely submit complete claims with accurate coding. The *Optum National Network Manual* can be accessed on the website <https://public.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/optum-network-manual.html>
- *UHC Commercial Reimbursement Policies* (<https://www.uhcprovider.com/en/policies-protocols/commercial-policies/commercial-reimbursement-policies.html>) - General reference resource regarding UnitedHealthcare's reimbursement policies
- *Optum Reimbursement Policies* (<https://www.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/reimbursement-policies.html>) - General reference resource regarding Optum's reimbursement policies
- *Certificate of Coverage – COC23-INS-BIND-2021-LG-GA-UHIC* – Plan document that explains covered services, terms, conditions, and limitations of the member's policy

Process

Per the M/S *UHC Provider Administrative Guide* and the MH/SUD *Optum National Network Manual*, providers are required to timely submit complete claims with accurate coding. For example, coding must comply with nationally recognized CMS' Correct Coding Initiative (CCI) standards. UHC Plan documents reflect M/S and MH/SUD coverage determinations are made in accordance with the Plan's reimbursement policies.

Both M/S *UnitedHealthcare Commercial Reimbursement Policies* and MH/SUD *Optum Reimbursement Policies* are publicly available to providers through the respective provider portals (M/S: (<https://www.uhcprovider.com/en/policies-protocols/commercial-policies/commercial-reimbursement-policies.html>) and MH/SUD: <https://www.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/reimbursement-policies.html>). Providers are made aware of changes to these policies on [UHCprovider.com/networknews](https://www.uhcprovider.com/networknews) > Network Bulletin.

Reimbursement Policy Development

The Plan develops reimbursement policies to ensure accurate coding, billing and administration of claims for M/S and MH/SUD conditions. The Plan considers various elements including industry-standard reimbursement logic, regulatory requirements, and benefits design when developing the reimbursement policies.

The M/S and MH/SUD reimbursement policies apply to all INN and OON professionals who deliver health care services.

The Plan uses industry standards and third-party sources (e.g., AMA's CPT, CMS' Healthcare Common Procedure Coding System (HCPCS), CMS' CCI publications, etc.) in drafting reimbursement policy content. The Plan's M/S and MH/SUD reimbursement policies are supported by third-party external sources for policy creation and implementation using five phases of development in order to be approved for use:

1. Triage/Prioritization: Triaging consists of confirming the criteria and elements available to support a reimbursement policy
2. Research/Analysis: The Plan will request input from other M/S and MH/SUD business areas related to potential provider and/or member impact or concerns.
3. Governance: The reimbursement policies are reviewed and approved by the Plan
4. Communication: Providers are notified of new reimbursement policies through external provider portals, according to regulatory requirements. Additional provider communications may be released based on provider impact
5. Deployment: The Plan develops the system programming to support the published reimbursement policy. Based upon applicable regulatory requirements, claims may be paid upon auto-adjudication; pending to request

additional information from the provider; or administratively denied for various reasons such as unbundling code combinations, incorrect or missing modifiers, exceeding daily frequency limitations, etc.

The Plan reviews M/S and MH/SUD reimbursement policies on a quarterly basis for coding updates and on an annual basis to validate sourcing. Reimbursement policies may be reviewed and updated more frequently when there is new information relevant to reimbursement of the service or to provide clarification.

The M/S Reimbursement Policy Oversight Committee oversees the development of, provides approval for, and disseminates reimbursement policies. The Reimbursement Policy Oversight Committee is comprised of voting members representing areas such as Payment Integrity, United Clinical Services, UnitedHealth Networks Team and other shared services.

Similarly, the MH/SUD Payment Integrity Oversight and Governance Committee oversees the development of and provides approval for reimbursement policies. The Payment Integrity Oversight and Governance Committee is comprised of voting members representing areas such as Program and Network Integrity, Clinical Services, Benefits and Services, Network Pricing Team, Claims, Value and Healthcare Optimization.

Claims Processing

Providers may submit claims electronically or via hard copy. Both M/S and MH/SUD claims are routed to the Ingenix Claims Edit System (iCES).

iCES is a system application that automates application of the M/S and MH/SUD reimbursement policies to providers' claims. iCES utilizes rules which are based on the M/S and MH/SUD reimbursement policies and general health care claims industry standard coding requirements. iCES rules are maintained by the M/S clinicians at UnitedHealthcare Networks (UHN) Reimbursement Unit (RPU) and MH/SUD clinicians at OptumInsight.

Upon receiving a claim, iCES identifies the claim service lines containing CPT and HCPCS codes and identifies the member's associated claims history iCES then applies industry standard claims requirements to make a reimbursement disposition. iCES disposition codes reflect the action taken by iCES on each service line, such as closure, rejection, pending, adjustment, or no change.

Claims are returned to the claims processing system once iCES dispositions are complete. The claims processing system acts on the iCES disposition codes appropriately, by auto adjudicating the claim or placing it in a work queue for processing. Claims placed in work queues are manually reviewed against the M/S or MH/SUD reimbursement policies, along with industry standard coding requirements. Claims for M/S and MH/SUD services are paid, denied, or paid in part and denied in part generally within 30 days of receipt of the claim. The Plan communicates claims payments to providers and members via provider remittance notices and explanation of benefits respectively.

Providers are notified of the claims process via the *UHC Provider Administrative Guide*, which is available for M/S on UHCprovider.com, (<https://www.uhcprovider.com/en/admin-guides.html>) and via the *Optum National Network Manual* for MH/SUD on Provider Express (<https://public.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/optum-network-manual.html>)

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, plan terms, and policies at issue. Identification of the specific MH/SUD and medical/surgical benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as medical/surgical.

Specific NQTL

- Development and application of reimbursement policies

Reimbursement Policy-Coding Edits Non-Quantitative Treatment Limitation (NQTL) Analysis

GA Surest - UnitedHealthcare Insurance Company

12/29/2023

Benefit Classification(s)

- Applies to all benefit classifications

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHC)

Plan Terms/Source Document(s)

The following language is reflected in the Plan's Certificate of Coverage document:

Review and Determine Benefits in Accordance with our Reimbursement Policies

"We develop our reimbursement policy guidelines, as we determine, in accordance with one or more of the following methodologies:

- As shown in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS).
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that we accept.

Following evaluation and validation of certain provider billings (e.g., error, abuse, and fraud reviews), reimbursement policies are applied to provider billings. We share our reimbursement policies with Physicians and other providers in our Network through our provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by our reimbursement policies) and the billed charge. However, out-of-Network providers may bill you for any amounts we do not pay, including amounts that are denied because one of our reimbursement policies does not reimburse (in whole or in part) for the service billed. [You may get copies of our reimbursement policies for yourself or to share with your out-of-Network Physician or provider by \[visiting \[benefits.surest.com\]\(#\)\] or\] calling the telephone number on your ID card.\]"](#)

INN providers adhere to the Plan's *UHC Provider Administrative Guide (M/S)* and the *Optum National Network Manual (MH/SUD)*, while OON providers are guided by the member's Plan documents. The *UHC Provider Administrative Guide (M/S)* states:

Reimbursement policies:

"We apply reimbursement policies. Our reimbursement policies are available online at:

- [uhcprovider.com/policies](#) > For Commercial Plans > Reimbursement Policies for UnitedHealthcare Commercial Plans.
- [uhcprovider.com/policies](#) > For Medicare Advantage Plans > Reimbursement Policies for Medicare Advantage Plans.
- [uhcprovider.com/policies](#) > For Exchange Plans > Reimbursement Policies for UnitedHealthcare Individual Exchange Plans.

We use the terms "reimbursement policies" and "payment policies" interchangeably."

The *Optum National Network Manual (MH/SUD)* indicates:

The *Optum National Network Manual (MH/SUD)* houses MH/SUD Reimbursement Policies here: [Reimbursement Policies \(\[providerexpress.com\]\(#\)\)](#)

List of M/S and MH/SUD Services Subject to NQTL

All covered M/S and MH/SUD services are subject to reimbursement policies as described in the Plan documents and reimbursement policies.

Step 2 – Factors Used in the Design and Application of the NQTL

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH or SUD benefits and medical or surgical benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

The Plan relies on several factors to develop reimbursement policies for both M/S and MH/SUD. The factors are:

- State and Federal Regulatory Requirements (Qualitative)
 - The State and Federal rules established as the standards for healthcare transactions
- Benefit Design (Qualitative)
 - Rules that structure how members access the Plan's benefits

The Plan relies on several factors to apply reimbursement policies under iCES for both M/S and MH/SUD. The factors are:

- Industry-standard reimbursement logic (Qualitative)
- iCES logic to include:
 - Valid CPT/HCPCS Coding (Quantitative)
 - Identifies all the items and services included within certain designated health services (DHS) categories or that may qualify for certain exceptions
 - Correct Coding (Quantitative)
 - Promotes national correct coding methodologies and reduces improper coding, with the overall goal of reducing improper payments

The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL. Meeting any one or more factors may be determinative. All covered M/S and MH/SUD services are subject to reimbursement policies.

Providers are required to timely submit complete claims with accurate coding. For example, coding must comply with nationally recognized CMS' Correct Coding Initiative (CCI) standards. UHC Plan documents reflect M/S and MH/SUD coverage determinations are made in accordance with the Plan's reimbursement policies.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and medical/surgical benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factors used in designing the Plan's M/S and MH/SUD reimbursement policies.

Factor – State and Federal Regulatory Requirements is defined as a set of rules to establish standards for healthcare transactions.

- The Plan's evidentiary standard and source that defines and/or triggers the State and Federal Regulatory requirements factor:
 - Relevant federal and state laws govern proper claims coding and reimbursement

Factor – Benefit Design is defined as rules that structure how members access the Plan's benefits.

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- The Plan's evidentiary standard and source that defines and/or triggers the Benefit Design factor:
 - Governing plan document, e.g., COC, SPD

Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factors used in applying the Plan's M/S and MH/SUD reimbursement policies:

Factor – Industry Standard Reimbursement Logic is defined as standard reimbursement terminology that appears in managed care plan requirements (e.g., the administrative guide).

- The Plan's evidentiary standards and sources that define and/or trigger the Industry Standard Reimbursement factor:
 - CMS
 - Clinical Laboratory Fee Schedule (CLFS)
 - Medicare Administrative Contractors (MACs)

Factor – Valid CPT Coding is defined as the items and services included within certain DHS categories or that may qualify for certain exceptions.

- The Plan's evidentiary standards and sources that define and/or trigger the Valid CPT Coding factor:
 - AMA
 - CPT
 - Associated publications and services

Factor – Valid HCPCS Coding is defined as the items and services included within certain DHS categories or that may qualify for certain exceptions.

- The Plan's evidentiary standards and sources that define and/or trigger the Valid HCPCS Coding factor:
 - CMS
 - HCPCS
 - HCPCS Release and Code Sets

Factor – Correct Coding is defined as national correct coding methodologies to reduce improper coding, with the overall goal of reducing improper payments.

- The Plan's evidentiary standards and sources that define and/or trigger the Correct Coding factor:
 - CMS
 - NCCI publications

These evidentiary standards and sources apply to both M/S and MH/SUD services.

The factors and evidentiary standards used as the basis for subjecting MH/SUD benefits to reimbursement policies are comparable to, and applied no more stringently than, the factors and evidentiary standards used as the basis for subjecting M/S benefits to reimbursement policies "as written" and "in operation." The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL.

Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

As Written

The Plan conducted a comparative analysis of the strategies, processes, factors, evidentiary standards, and source information used to develop M/S and MH/SUD reimbursement policies “as written.”

Review of Process for Developing of Reimbursement Policies

For both M/S and MH/SUD, the Plan uses industry standards and third-party sources (e.g., AMA's CPT, CMS' HCPCS, CMS' NCCI publications) in drafting reimbursement policy content. The Plan's M/S and MH/SUD reimbursement policies are both supported by third-party external sources for policy creation and implementation using five phases of development (described in the Process section) in order to be approved for use. These phases of development include confirming the criteria and elements available to support a reimbursement policy and requesting input from M/S and MH/SUD business areas related to potential provider and/or member impact or concerns.

The M/S Reimbursement Policy Oversight Committee oversees the development of, provides approval for, and disseminates reimbursement policies. The Reimbursement Policy Oversight Committee is comprised of voting members representing areas such as Payment Integrity, United Clinical Services, UnitedHealth Networks and other shared services.

Similarly, the MH/SUD Payment Integrity Oversight and Governance Committee oversees the development of and provides approval for reimbursement policies. The Payment Integrity Oversight and Governance Committee is comprised of voting members representing areas such as Program and Network Integrity, Clinical Services, Benefits and Services, Network Pricing Team, Claims, Value and Healthcare Optimization.

M/S and MH/SUD providers are notified of new reimbursement policies through external provider portals, according to regulatory requirements. (M/S: <https://www.uhcprovider.com/en/policies-protocols/commercial-policies/commercial-reimbursement-policies.html> MH/SUD: <https://www.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/reimbursement-policies.html>). Additional provider communications may be released based on provider impact.

The Plan develops the claims system programming to support the published reimbursement policies for both M/S and MH/SUD. Based upon applicable regulatory requirements, claims may be paid upon auto-adjudication, pending to request additional information from the provider, or administratively denied for various reasons such as unbundling code combinations, incorrect or missing modifiers, exceeding daily frequency limitations, etc.

Review of Process for Applying Reimbursement Policies

The strategy for applying the reimbursement policies is comparable for both M/S and MH/SUD. The Plan conducted a review of the M/S and MH/SUD reimbursement policy processes to confirm comparability. The review focused on the following aspects of the process for both M/S and MH/SUD:

- Claims process. Providers are notified of the claims process via the *UHC Provider Administrative Guide*, which is available for M/S on UHCprovider.com, (<https://www.uhcprovider.com/en/admin-guides.html>) and via the *Optum National Network Manual* for MH/SUD on Provider Express (<https://public.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/optum-network-manual.html>) For both M/S and MH/SUD, providers may submit claims electronically or via paper claim form

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- Both M/S and MH/SUD claims are routed to the iCES. iCES applies claims edits based on the M/S and MH/SUD reimbursement policies
- Claims are returned to the claims processing system once iCES dispositions are complete
- Timeframe for Processing. Claims for M/S and MH/SUD are generally adjudicated within 30 days of receipt of the claim
- Determinations. For both M/S and MH/SUD, iCES disposition codes reflect the action taken by iCES on each claim service line, such as closure, rejection, pending, adjustment, or no change. The claims processing system acts on the iCES disposition codes appropriately, by auto adjudicating the claim or placing it in a work queue for processing. Claims placed in work queues are manually reviewed against the M/S or MH/SUD policies, along with industry standard coding requirements
- Determination Communications. The Plan notifies providers and members of benefit determinations via provider remittance notices and explanation of benefits respectively, consistent with state, federal, and accreditation requirements

In Operation

The Plan conducted a comparative analysis of the strategies, processes, factors, evidentiary standards, and source information used to apply the M/S and MH/SUD reimbursement policies “in operation.” The findings and conclusion from this analysis are discussed in greater detail in Step 5 below.

The comparative analysis revealed the CPT, HCPC, and Correct Coding logic used to identify services that meet industry standards are comparable for M/S and MH/SUD. The analysis further indicated that the reimbursement policies supporting the claims logic for both M/S and MH/SUD are reviewed on a quarterly basis for coding updates and on an annual basis to validate sourcing. Reimbursement policies may be reviewed and updated more frequently when there is new information relevant to reimbursement of the service or to provide clarification.

In addition, the Plan reviewed data regarding the application of claims edits to claims received. The data indicates that M/S claims are more frequently subject to claims edits, indicating a stricter application to M/S services. For example, for laboratory claims, there are on average more than 25,000 M/S lab claims compared to 20 MH/SUD lab claims subject to coding edits monthly.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the plan's or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the plan or coverage is or is not in compliance with MHPAEA.

Findings

The findings of the Plan's analysis confirmed the strategies, processes, factors, evidentiary standards, and source information used to develop the MH/SUD reimbursement policies were comparable to, and applied no more stringently than, the strategies, processes, factors, evidentiary standards, and source information used to develop the M/S reimbursement policies.

The Plan adhered to a 5-phase process for the development of reimbursement policies for both M/S and MH/SUD, which included triage/prioritization, research/analysis, governance, provider communication, and claims platform deployment.

The Plan used comparable processes in applying the M/S and MH/SUD reimbursement policies. For both M/S and MH/SUD, providers may submit claims electronically or via hard copy. Both M/S and MH/SUD claims are then routed to iCES. The claims processing system acts on the iCES disposition codes by auto adjudicating the claim or placing it in a work queue for processing. Claims placed in work queues are manually reviewed against the M/S or MH/SUD reimbursement policies, along

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with industry standard coding requirements. Claims for M/S and MH/SUD services are generally adjudicated within 30 days of receipt of the claim. The Plan communicates claims payments to providers and members via provider remittance notices and explanation of benefits respectively, consistent with state, federal, and accreditation requirements.

The comparative analysis revealed the CPT, HCPC, and Correct Coding claims logic used to identify services that meet industry standards are comparable for M/S and MH/SUD. The analysis further indicated that reimbursement policies supporting the claims logic for both M/S and MH/SUD are reviewed on a quarterly basis for coding updates and on an annual basis to validate sourcing.

Conclusions

The Plan reviewed the M/S and MH/SUD reimbursement policies and procedures and concluded the methodology used to develop the MH/SUD reimbursement policies “as written” was comparable to, and applied no more stringently than, the methodology used to develop the M/S reimbursement policies “as written.” Additionally, the Plan concluded that the MH/SUD reimbursement policies were applied no more stringently than, the M/S reimbursement policies were applied “as written.”

The Plan reviewed the M/S and MH/SUD processes for applying the reimbursement policies and found they were comparable and no more stringently applied for MH/SUD. Additionally, from review of the M/S and MH/SUD processes for applying the reimbursement policies, including notification, timeframes for processing, determinations, and determination communications, the Plan concluded the methodology used to apply the MH/SUD reimbursement policies “in operation” was comparable to, and applied no more stringently than, the methodology used to apply the M/S reimbursement policies “in operation.”

Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical/surgical (M/S) benefits. This generally means that the financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements, such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage.

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

Retrospective Review is a component of the Plan’s Utilization Management (UM) program. Medical directors and other clinical staff review services in order to detect and better manage over- and under-utilization and determine whether the services reviewed are consistent with the member’s coverage, medically appropriate, and consistent with evidence-based guidelines. Retrospective Review assesses the appropriateness of services on a case-by-case basis after the service has been provided but prior to payment for services. Retrospective Reviews are based on established review guidelines and may include:

- Review of medical necessity
- Appropriateness of level of care
- Identifying claims issues
- Eligibility determination
- Initiation of appropriate follow-up actions for utilization and quality issues

The Plan conducts medical necessity Retrospective Review of claims/requests for certain inpatient services that have not previously been reviewed as part of the Prior Authorization or Concurrent Review processes. The Plan may conduct Retrospective Review if the service or procedure codes do not match a diagnosis code, if services are experimental, investigational, or unproven (EIU), or if the services are subject to benefit limits/exclusions. The Plan conducts medical necessity Retrospective Review for inpatient services where Prior Authorization was required, but not obtained upon claim submission. INN M/S providers may also request Retrospective Review of inpatient claims that are denied.

This document includes the following information:

- The Retrospective Review process for M/S and MH/SUD inpatient services
- The description of the NQTL and application (Step 1)
- Factor used to determine which services are subject to the NQTL (Step 2)
- Evidentiary standards and sources used to define, trigger and/or implicate the factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

This comparative analysis refers to the following attachments:

- *Utilization Management Program Description (UMPD) of United HealthCare Services, Inc. and UnitedHealthcare Insurance Company* - Summarizes the philosophy, structure and standards that govern UHC's medical management, UM and utilization review responsibilities and functions
- *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions* - M/S policy that defines Retrospective Review
- *Optum National Policy Definitions List* - MH/SUD policy that defines Retrospective Review
- *M/S Retrospective Review Codes* - Excel document that lists M/S codes that may be subject to Retrospective Review
- *Schedule of Benefits - SBN23-Medical-INS-BIND-2021-Choice Plus-LG-GA-UHIC* - Plan document that outlines member responsibilities
- *Core Principles and Practices* - MH/SUD policy that outlines the core principles and practices that should be used by personnel in their interactions with members, authorized member representatives, practitioners, and facilities, related to the management of behavioral health benefits, coverage determinations and appeals/grievances of non-coverage determinations
- *Performance Assessment and Incentives* - M/S policy confirming that clinical reviewers are not incented to make denials for financial reasons
- *2023 UnitedHealthcare Provider Administrative Guide* - Informs M/S providers of the Prior Authorization process. The *UnitedHealthcare Provider Administrative Guide* can be accessed on the website <https://www.uhcprovider.com/en/admin-guides.html>
- *September 2023 Optum National Network Manual* - Informs MH/SUD providers of the Prior Authorization process. The *Optum National Network Manual* can be accessed on the website <https://public.providerexpress.com/content/open-provexpr/us/en/clinical-resources/guidelines-policies/optum-network-manual.html>
- *Medical Necessity NQTL* - Comparative analysis that describes the processes, strategies, evidentiary standards and other factors used to apply medical necessity to M/S and MH/SUD services in accordance with MHPAEA and other regulatory guidance

The Plan concludes that the Retrospective Review requirements for M/S and MH/SUD are comparable and applied no more stringently to MH/SUD in-network (INN) inpatient benefits both "as written" and "in operation."

Process

The Plan structures inpatient Retrospective Review processes to be compliant with all applicable federal and state laws. Retrospective Review is governed at both the state and federal level, which includes consumer protections such as external review for adverse benefit determinations after internal appeals options are exhausted.

The Plan delegates management of MH/SUD inpatient services, including Retrospective Review to United Behavioral Health d/b/a Optum Behavioral Health (OBH), its delegated MH/SUD Managed Behavioral Healthcare Organization (MBHO) vendor.

Retrospective Review of M/S Inpatient Admissions consists of the following:

Retrospective Review for certain inpatient services begins after the Plan receives claims or notification of inpatient admission post discharge from an INN facility. The Plan conducts medical necessity Retrospective Review of claims/requests for certain inpatient services that have not previously been reviewed as part of the Prior Authorization or Concurrent Review processes. The Plan may conduct Retrospective Review if the service or procedure codes do not match a diagnosis code, if services EIU, or if the services are subject to benefit limits/exclusions. The Plan conducts medical necessity Retrospective Review for inpatient services where Prior Authorization was required but not obtained upon claim submission.

Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. If needed, non-clinical staff request medical records for claims containing services that are subject to Retrospective Review. When medical records are received, the case is referred to clinical reviewers to assess medical necessity.

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First Level Clinical Review/Initial Review. The clinical reviewer (physicians or nurses) reviews the claim to determine if the inpatient service billed meets clinical criteria for coverage based on application of objective, evidence-based clinical criteria, nationally recognized guidelines, and the member's benefit plan documents. Clinical reviewers either approve claims for payment or refer claims to peer clinical reviewers (e.g., Medical Directors).

Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If a peer clinical reviewer determines that a service was not medically necessary, then an adverse benefit determination will be issued for the claim. The Plan communicates the adverse benefit determination, including applicable appeal rights, and offers a peer-to-peer conversation consistent with state and federal requirements. Appeal rights are set forth in the member's benefit plan document (*Certificate of Coverage*). The Plan communicates results of Retrospective Review within 30 days of receipt of a claim.

Adverse Benefit Determination. For M/S, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction, or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when benefits are exhausted. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials.

Clinical Criteria: Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based medical clinical policies or use clinical criteria from third party sources such as InterQual® or MCG® guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that Retrospective Review determinations are appropriate.

The Plan conducts end-to-end case audits that are designed and approved by clinical leadership each year. The end-to-end audits include all stages of a case review, from intake through appeal. These audits are conducted monthly and approximately 1500 cases are reviewed per month. Results are reported to an oversight team. All deficiencies are remediated. Remediation may include corrective actions and/or additional education, as indicated.

The Plan routinely monitors Retrospective Review performance through its clinical performance oversight functions. Outcomes are monitored against timeliness requirements, performance guarantees, and for potential trends, including overall utilization.

As of April 1, 2023, the Utilization Management Program Committee (UMPC) began overseeing the M/S UM program. The UMPC is responsible for the development and maintenance of the M/S Prior Authorization processes. The UMPC ensures that the UM program considers the factors and evidentiary standards for applying UM. The UMPC is comprised of:

- Chief Medical Officer, Medical Management (Co-Chair)
- Senior Vice President, Clinical Advancement (Co-Chair)
- Chief Medical Officer, UnitedHealthcare
- Senior Vice President, Clinical Appeals & Grievances
- Chief Medical Officer, Clinical Policy
- Chief Medical Officer, UnitedHealthcare Employer & Individual
- Chief Medical Officer, UnitedHealthcare Medicare & Retirement
- Chief Medical Officer, Community & State
- Chief Medical Officer, UnitedHealthcare Individual & Family Plans
- Vice President, Clinical Transformation & Affordability
- Senior Director, Mental Health Parity
- Vice President, Utilization Management Strategy & Implementation

One of the chairs must be an executive leader and a licensed physician. UMPC meets at least six times per year but may meet more frequently if needed.

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Per the M/S policy entitled, *Performance Assessment and Incentives*, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons.

M/S generally structures UM processes to comply with federal Employee Retirement Income Security Act of 1974 (ERISA) requirements, and state law where applicable.

Retrospective Review of MH/SUD Inpatient Admissions consist of the following:

The Plan delegates management of MH/SUD inpatient services, including Retrospective Review to United Behavioral Health d/b/a OBH, its delegated MH/SUD MBHO vendor.

MH/SUD claims/requests for inpatient services submitted by INN providers may be subject to Retrospective Review if the service or procedure code required Prior Authorization or Concurrent Review, but that review was not conducted and there is a mitigating circumstance. Additionally, claims may be subject to Retrospective Review if the billed services or procedure codes do not match the authorized codes or if services are EIU.

Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. If needed, non-clinical staff request medical records for requests or claims containing services that are subject to Retrospective Review. When medical records are received, the case is referred to clinical reviewers to assess medical necessity.

First Level Clinical Review/Initial Review. The clinical reviewer (e.g., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) review the claim to determine if the inpatient admission billed meets clinical criteria for coverage based on application of objective, evidence-based, clinical criteria, or nationally recognized guidelines. Clinical reviewers either approve requests for payment or refer requests to peer clinical reviewers (Medical Directors).

Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If the peer clinical reviewer determines that an admission was not medically necessary, then an adverse benefit determination will be issued for the claim. The Plan communicates the adverse benefit determination, including applicable appeal rights. Appeal rights are set forth in the member's benefit plan document (*Certificate of Coverage*). The Plan communicates results of Retrospective Review within 30 days of receipt of a request/claim.

Adverse Benefit Determination. For MH/SUD, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction, or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when benefits are exhausted. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials.

Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based behavioral clinical policies or use clinical criteria from third party sources such as American Society of Addiction Medicine (ASAM) Criteria®, Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System-Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) and Early Childhood Service Intensity Instrument (ECSII) guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that inpatient Retrospective Review determinations are appropriate.

The Plan conducts monthly quality audits of individual non-clinical staff, clinical reviewers, and peer clinical reviewers, including staff performing appeal functions. These audits are designed and approved by clinical leadership each year. A minimum of two audits are completed per staff, per month. The results of these real-time audits are shared with supervisors for

staff oversight, and all findings are remediated. Remediation may include corrective actions and/or additional education, as indicated.

The Plan routinely monitors Retrospective Review performance through its clinical performance oversight functions. Outcomes are monitored against timeliness requirements, performance guarantees, and for potential trends, including overall utilization.

The Plan's national Clinical Quality & Operations Committee (CQOC) annually reviews overall UM program outcomes, including inpatient Retrospective Review outcomes, to confirm overall utilization is appropriate. The national CQOC is comprised of representatives from sub-committees, and representatives from the clinical quality improvement, UM, care engagement, medical operations, medical policy and standards, clinical operations, appeals, product, legal, compliance, network strategy, provider experience, accreditation, and benefits teams. The Chair of the CQOC must be an executive leader, board certified in psychiatry or psychiatric subspecialty, and a licensed physician.

Per the MH/SUD policy entitled, *Core Principles and Practices*, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse clinical coverage benefit determinations (clinical denials) for financial reasons.

MH/SUD generally structures UM processes to comply with federal ERISA requirements and state law where applicable.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- Retrospective Review

Benefit Classification(s)

- INN, inpatient

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHIC)

Plan Terms

The Plan's *Schedule of Benefits* notify members of Retrospective Review requirements.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

The *Utilization Management Program Description (UMPD)* discusses Post-Service Reviews and indicates:

Post-service review assesses the appropriateness of medical services on a case-by-case basis after the service has been provided but prior to payment for services. Post-service reviews are based on established review guidelines and includes:

- Review of medical necessity;
- Appropriateness of level of care;
- Identifying claims issues;
- Eligibility determination;
- Initiation of appropriate follow-up actions for utilization and quality issues; and
- Identifying appropriateness and administrative issues such as physician notification, emergency status of admission.

The Plan's delegate, United Behavioral Health d/b/a OBH, is discussed in the *UMPD*:

United Behavioral Health (UBH) performs the review of requests for coverage of behavioral health services (i.e., substance abuse, and mental health requests for services). UBH provides comprehensive behavioral health care delivery for members through a network of behavioral health practitioners, ancillary care providers, hospitals, and other facilities.

For mental health, substance-related disorder services, and wraparound services, UBH uses its Clinical Criteria (see below), behavioral clinical policies, and best practice guidelines to make coverage determinations. UBH adopts externally-developed clinical criteria, and creates internally-developed Clinical Criteria, where appropriate, based on its assessment of relevant guidance. UBH develops clinical criteria that supersedes its standard set or adopts externally-developed clinical criteria when required to do so by contract or regulation.

- Clinical Criteria (Level of Care Utilization System-LOCUS) – Standardized level of care assessment tool developed by the American Association of Community Psychiatrists used to make clinical determinations and placement decisions for mental health disorder benefits for adults ages 19 and older when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (Child and Adolescent Level of Care/Service Intensity Utilization System-CALOCUS-CASII)- Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry (AACAP) and the American Association for Community Psychiatry (AACP) used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children and adolescents ages 6-18 when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (Early Childhood Service Intensity Instrument-ECSII) – Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children ages 0-5 when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (State or Contract Specific Level of Care Guidelines) - Criteria used to make medical necessity determinations for mental health disorder benefits when there are explicit mandates or contractual requirements.
- Clinical Criteria (American Society of Addiction Medicine [ASAM]) - Criteria developed by the American Society of Addiction Medicine used to make clinical determinations for substance-related disorder benefits.
- Clinical Criteria (Optum Developed)
 - Optum Behavioral Clinical Policies: Criteria that stem from evaluation of new services or treatments or new applications of existing services or treatments and are used to make clinical determinations regarding proven or unproven services and treatments.

Licensed practitioners conduct all reviews with a focus on measurable outcome goals and objectives for treatment. A senior UBH Medical Director is responsible for directing and implementing behavioral health utilization management programs. A referral is sent to UBH when a member is identified as potentially benefiting from behavioral health services during a “medical event.”

The UBH UM Program is staffed by clinical, non-clinical and administrative personnel. All clinical denials or adverse decisions are made by board certified psychiatrists, or, if the health plans choose, by a panel of other appropriate health care service reviewers. If the health plan chooses to use a panel to make adverse decisions, the panel contains at least one physician who is board certified in psychiatry. When the health care service under review is a mental health or substance abuse service, the adverse decision is made by a licensed physician who is board certified in psychiatry. All potential clinical denials are referred to a physician who is board certified in psychiatry for final determination. An evaluation of the overall effectiveness of the Behavioral Health UM Program is conducted annually to determine how well resources have been deployed to improve UM activities and the clinical care and service provided to members.

The Plan's terms require services to be medically necessary for coverage. INN providers are required to comply with the Plan's UM protocols including complying with Retrospective Review requirements.

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List of M/S and MH/SUD Services Subject to NQTL

- Services that have not previously been reviewed in Prior Authorization or Concurrent Review
- M/S Claims that are denied, if requested by an INN facility
- Services where the service or procedure codes do not match a diagnosis code
- EIU services
- Services that are subject to benefit limits/exclusions
- Codes identified by the Plan as subject to Retrospective Review
- Please see the file *M/S Retrospective Review Codes* for the list of M/S codes that may be subject to Retrospective Review
- MH/SUD claims/requests that include the following services are subject to Retrospective Review:
 - MH Non-Emergent Acute Inpatient
 - MH Subacute Residential Treatment
 - SUD Acute Inpatient Detoxification
 - SUD Acute Inpatient Rehabilitation
 - SUD Subacute Residential Treatment

Step 2 – Factors Used to Determine Retrospective Review Applies

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

The Plan relies on the following factor to determine which INN inpatient admissions are subject to Retrospective Review. This factor applies to M/S and MH/SUD for the following:

- I. M/S INN inpatient admissions
 - II. MH/SUD INN inpatient admissions
- Consistency with Clinical Criteria (Qualitative):
 - Whether the application of Retrospective Review promotes optimal clinical outcomes

This factor applies to M/S and MH/SUD services. Meeting Consistency with Clinical Criteria is determinative in imposing the limitation.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factor used in designing or applying the Plan's Retrospective Review requirement to INN inpatient services. These evidentiary standards and sources apply to the following:

- I. M/S INN inpatient admissions
- II. MH/SUD INN inpatient admissions

Factor: Consistency with Clinical Criteria is defined as whether the application of Retrospective Review promotes optimal clinical outcomes.

- The Plan's evidentiary standards and sources that define and/or trigger the Consistency with Clinical Criteria factor:
 - Clinical criteria from nationally recognized, third-party sources (e.g., InterQual or MCG for M/S services, and ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines for MH/SUD services)

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- Clinical Technology Assessment Committee (CTAC) and Medical Technology and Assessment Committee (MTAC) review
- Objective, evidence-based medical/behavioral clinical policies and nationally recognized guidelines approved by professional healthcare associations (e.g., clinical guidance from the American Medical Association, American Psychiatric Association, etc.)

The *Medical Necessity NQTL* describes the process for determining how internally developed medical/behavioral clinical policies are developed and how externally developed third-party guidelines are reviewed and approved.

The Plan's evidentiary standards and sources apply to M/S and MH/SUD services. The Consistency with Clinical Criteria factor, evidentiary standards, and sources are defined in a qualitative manner.

The factor and evidentiary standards used as the basis for subjecting MH/SUD INN inpatient benefits to Retrospective Review are comparable to, and applied no more stringently than, the factor and evidentiary standards used as the basis for subjecting M/S INN inpatient benefits to Retrospective Review "as written" and "in operation."

Step 4 – NQTL "As Written" and "In Operation" Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

As Written

The Plan conducted a comparative analysis of the strategies, processes, factor, evidentiary standards, and source information used to determine which M/S and MH/SUD INN inpatient services are subject to Retrospective Review "as written." The Plan identified the factor and evidentiary standards used as the basis for subjecting M/S and MH/SUD benefits to Retrospective Review for each benefit classification.

Review of Factors and Evidentiary Standards

The Plan reviewed the factor that triggers an INN inpatient service to be subject to Retrospective Review. The factor and evidentiary standards were applied to M/S and MH/SUD services comparably and not more stringently to MH/SUD services than M/S services.

Review of Operational Policies and Procedures

The Plan reviewed M/S and MH/SUD operational policies and procedures and UM annual oversight to confirm comparability and found MH/SUD policies, procedures, and processes to be comparable and no more stringent than M/S policies, procedures and processes.

- Medical management operational policies and procedures establish the standards for how the Plan conducts inpatient Retrospective Review. The policies and procedures are consistent with state and federal law governing Retrospective Review. Timeframes for decisions, content of adverse benefit determinations, appeal rights and external review are all governed by state and federal requirements
- UM oversight monitors and evaluates UM processes by reviewing denial rates, clinical appeals, and under- and over-utilization.

Review of Inpatient Retrospective Review Processes

The strategy for applying Retrospective Review to INN inpatient claims/requests is comparable for M/S and MH/SUD services and applied no more stringently to MH/SUD INN inpatient services. The Plan conducted a review of the M/S and MH/SUD

Retrospective Review processes to confirm comparability. The review focused on the following aspects of the processes for both M/S and MH/SUD:

- **Responsibility.** INN M/S and MH/SUD facilities are contractually responsible for requesting Retrospective Review for inpatient services.
- **Timeframe to submit.** The *UnitedHealthcare Administrative Guide* (for M/S) and *Optum National Network Manual* (for MH/SUD) were reviewed for requirements related to timeliness of notification to the Plan and it was determined that MH/SUD was no more stringent.
 - For M/S, facilities must request the Retrospective Review within the requirements outlined in their provider contract
 - For MH/SUD, facilities have 180 days after the service is rendered to request a Retrospective Review
- **Clinical Reviews.** For M/S and MH/SUD claims/requests, the Plan may request clinical information and refer the claim/request to a clinical reviewer for a Retrospective Review. The clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. The clinical reviewer either approves cases that meet applicable clinical criteria or refers the case to a peer clinical reviewer.
- **Review Timeframes.** M/S and MH/SUD Retrospective Review determination timeframes are defined by state, and federal requirements. The same determination timeframes apply to M/S and MH/SUD determinations.
- **Determinations, First Level Clinical Review, and Second Level/Peer Clinical Reviews.** Clinical reviewers determine whether an inpatient admission is medically necessary. The clinical reviewer may approve the admission based on their review. The clinical reviewer refers cases they cannot approve to a peer clinical reviewer. If the peer clinical reviewer determines that an admission was not medically necessary and will not be covered, an adverse benefit determination will be issued. Only qualified peer clinical reviewers may issue adverse benefit determinations.
- **Adverse Benefit Determinations.** An adverse benefit determination is recorded as a clinical denial when it is based on clinical criteria and member clinical information and is recorded as an administrative denial when member benefits are exhausted.
- **Notification of Decisions to Providers and Members.** The Plan notifies M/S and MH/SUD INN facilities and members of approvals and adverse benefit determinations, including applicable appeal rights consistent with state and federal requirements.
- **Review of Staff Qualifications.** For M/S and MH/SUD, clinical staff qualifications align with the type of clinical review and state and federal requirements.
 - M/S is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are conducted by clinical staff (nurses, physicians) and all adverse benefit determinations are made by a physician or other appropriate health care professionals.
 - MH/SUD is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse benefit determinations are made by Medical Directors.
- **Clinical Criteria.** For M/S and MH/SUD, clinical reviewers and peer clinical reviewers base determinations on objective, evidence-based medical/behavioral clinical policies or use clinical criteria from third party sources such as InterQual, MCG, ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines.

In Operation

The Plan compared the strategies, processes, factor, evidentiary standards, and source information used to determine which M/S and MH/SUD INN inpatient services are subject to Retrospective Review and how Retrospective Review is applied “in operation.”

The Plan subjected claims/requests for M/S and MH/SUD inpatient admissions to Retrospective Review that were not reviewed in the Prior Authorization or Concurrent Review process. Additionally, M/S claims/requests for inpatient services submitted by INN providers were subject to Retrospective Review if the services or procedure codes did not match a diagnosis code, if services were EIU, or if the services had benefit limits/exclusions. Claims/requests for inpatient services submitted by INN providers may be subject to Retrospective Review if the service or procedure code required Prior Authorization or Concurrent Review, but that review was not conducted and there is a mitigating circumstance. Additionally, claims may be

subject to Retrospective Review if the billed services or procedure codes do not match the authorized codes or if services are EIU.

The Plan may have request member clinical information for M/S and MH/SUD inpatient claims/requests and referred them to a clinical reviewer. The clinical reviewer reviewed applicable member clinical information, benefit plan documents, and clinical criteria in the case review. The clinical reviewer approved cases that met applicable clinical criteria or referred cases to peer clinical reviewers. If an appropriately qualified peer clinical reviewer determined that a service was not medically necessary and would not be covered, an adverse benefit determination was issued for the claim.

The Plan communicated all adverse benefit determinations for M/S and MH/SUD inpatient claims/requests that did not meet applicable clinical criteria, including appeal rights, consistent with state and federal requirements.

The Plan conducted monthly quality audits of individual non-clinical staff, clinical reviewers, including staff performing appeal functions. The Plan routinely monitored Retrospective Review performance through its clinical performance oversight functions. In addition to comparing these “in operation” processes, the Plan reviewed medical necessity approval and denial rates, internal appeals outcomes, and external appeals outcomes related to Retrospective Review determinations for M/S and MH/SUD INN inpatient services.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The findings of the Plan's comparative analyses confirmed the strategies, processes, factor, evidentiary standards, and source information used to subject certain MH/SUD INN inpatient services to Retrospective Review were comparable to, and applied no more stringently than, the strategies, processes, factor, evidentiary standards, and source information used to subject certain M/S INN inpatient services to Retrospective Review “as written.”

The Plan found the factor used to subject INN MH/SUD inpatient services to Retrospective Review was comparable to and applied no more stringently than the factor used to subject INN M/S inpatient services to Retrospective Review “in operation.” All M/S and MH/SUD inpatient admissions were subject to Retrospective Review if they were not reviewed via Prior Authorization or Concurrent Review. Additionally, M/S and MH/SUD claims for inpatient services submitted by INN providers were subject to Retrospective Review if the services or procedure codes did not match a diagnosis code, if services were EIU, or if the services had benefit limits/exclusions. Claims/requests for inpatient services submitted by INN providers may be subject to Retrospective Review if the service or procedure code required Prior Authorization or Concurrent Review, but that review was not conducted and there is a mitigating circumstance.

The Plan used comparable processes to conduct Retrospective Review of claims/requests for M/S and MH/SUD inpatient services. The Plan may have requested clinical information if necessary. The Plan approved M/S and MH/SUD claims/requests for inpatient services that met applicable clinical criteria or guidelines. The Plan issued an adverse benefit determination for M/S and MH/SUD INN provider claims/requests for inpatient services that did not meet applicable clinical criteria or guidelines.

INN inpatient medical necessity approval and denial rates and appeals outcomes data from 01/01/2022 – 12/31/2022 were evaluated where a minimum threshold of 100 cases were available to ensure a valid data set for analysis. The Plan has established that a minimum of at least 100 M/S and MH/SUD cases are required within each classification for a comparative analysis. Meaningful conclusions cannot be reached when there are fewer than 100 cases within each classification because the data is subject to variability.

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Because Georgia Surest Plan became effective on 07/2023 there is minimal membership and as a result is an insufficient number of cases from 01/01/2022 – 12/31/2022 to support an in operation analysis. While the Plan notes that the U.S. Department of Labor has indicated generally that outcomes data are not dispositive of parity compliance, the Plan will conduct a comparative analysis of outcomes data, including medical necessity approval and denial rates and appeals outcomes, when there is a minimum of 100 cases available to ensure a valid data set for analysis.

Conclusions

The Plan concluded that how Retrospective Review is applied to MH/SUD INN inpatient services was comparable to, and applied no more stringently than, how Retrospective Review is applied to M/S INN inpatient services “as written.”

The Plan reviewed the M/S and MH/SUD processes including responsibility for submission, timeframes for submission and review, notification to members and providers, clinical standards for review, and staff qualifications and concluded how the Plan conducts Retrospective Review for MH/SUD INN inpatient services “in operation” was comparable to, and applied no more stringently than, how the Plan conducts Retrospective Review for M/S INN inpatient services “in operation.”

Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical/surgical (M/S) benefits. This generally means that financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements, such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage.

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

Retrospective Review is a component of the Plan’s Utilization Management (UM) program. Medical directors and other clinical staff review services in order to detect and better manage over- and under-utilization and determine whether the services reviewed are consistent with the member’s coverage, medically appropriate, and consistent with evidence-based guidelines. Retrospective Review assesses the appropriateness of services on a case-by-case basis after the service has been provided, but prior to payment for services. Retrospective Reviews are based on established review guidelines and may include:

- Review of medical necessity
- Appropriateness of level of care
- Identifying claims issues
- Eligibility determination
- Initiation of appropriate follow-up actions for utilization and quality issues

The Plan conducts medical necessity Retrospective Review of claims/requests for certain outpatient services that have not previously been reviewed as part of the Prior Authorization or Concurrent Review processes. The Plan may conduct Retrospective Review if the service or procedure codes do not match a diagnosis code, if services are experimental, investigational, or unproven (EIU), or if the services are subject to benefit limits/exclusion. The Plan conducts medical necessity Retrospective Review for outpatient services where Prior Authorization was required, but not obtained upon claim submission. INN M/S providers may also request Retrospective Review of outpatient claims that are denied.

This document includes the following information:

- The Retrospective Review process for M/S and MH/SUD outpatient services
- The description of the NQTL and application (Step 1)
- Factor used to determine which services are subject to the NQTL (Step 2)
- Evidentiary standards and sources used to define, trigger and/or implicate a factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

This comparative analysis refers to the following attachments:

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- *Utilization Management Program Description (UMPD) of United HealthCare Services, Inc. and UnitedHealthcare Insurance Company* - Summarizes the philosophy, structure and standards that govern UHC's medical management, UM and utilization review responsibilities and functions
- *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions* - M/S policy that defines Retrospective Review
- *Optum National Policy Definitions List* - MH/SUD policy that defines Retrospective Review
- *M/S Retrospective Review Codes* - Excel document that lists M/S codes that may be subject to Retrospective Review
- *Schedule of Benefits - SBN23-Medical-INS-BIND-2021-Choice Plus-LG-GA-UHIC* - Plan document that outlines member responsibilities
- *Core Principles and Practices* - MH/SUD policy that outlines the core principles and practices that should be used by personnel in their interactions with members, authorized member representatives, practitioners, and facilities, related to the management of behavioral health benefits, coverage determinations and appeals/grievances of non-coverage determinations
- *Performance Assessment and Incentives* - M/S policy confirming that clinical reviewers are not incented to make denials for financial reasons
- *2023 UnitedHealthcare Provider Administrative Guide* - Informs M/S providers of the Prior Authorization process. The *UnitedHealthcare Provider Administrative Guide* can be accessed on the website <https://www.uhcprovider.com/en/admin-guides.html>
- *September 2023 Optum National Network Manual* - Informs MH/SUD providers of the Prior Authorization process. The *Optum National Network Manual* can be accessed on the website <https://public.providerexpress.com/content/optum-network-manual.html>
- *Medical Necessity NQTL* - Comparative analysis that describes the processes, strategies, evidentiary standards and other factors used to apply medical necessity to M/S and MH/SUD services in accordance with MHPAEA and other regulatory guidance

The Plan concludes that the Retrospective Review requirements for M/S and MH/SUD are comparable and applied no more stringently to MH/SUD in-network (INN) outpatient benefits both “as written” and “in operation.”

Process

The Plan structures outpatient Retrospective Review processes to be compliant with all applicable federal and state laws. Retrospective Review is governed at both the state and federal level, which includes consumer protections such as external review for adverse benefit determinations after internal appeals options are exhausted.

The Plan delegates management of MH/SUD outpatient services, including Retrospective Review to United Behavioral Health d/b/a Optum Behavioral Health (OBH), its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor.

Retrospective Review of M/S Outpatient Services consists of the following:

Retrospective Review for certain outpatient services begins after the Plan receives claims from INN providers. The Plan conducts medical necessity Retrospective Review of claims/requests for certain outpatient services that have not previously been reviewed as part of the Prior Authorization or Concurrent Review processes. The Plan may conduct Retrospective Review if the service or procedure codes do not match a diagnosis code, if services are EIU, or if the services are subject to benefit limits/exclusion. The Plan also conducts medical necessity Retrospective Review for outpatient services where Prior Authorization was required, but not obtained upon claim submission. INN providers may also request Retrospective Review of outpatient claims that are denied.

Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. If needed, non-clinical staff request medical records for claims containing services that are subject to Retrospective Review. When medical records are received, the case is referred to clinical reviewers to assess medical necessity.

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First Level Clinical Review/Initial Review. The clinical reviewer (physician or nurse) reviews the claim to determine if the outpatient service billed meets clinical criteria for coverage based on application of objective, evidence-based clinical criteria, nationally recognized guidelines, and the member's benefit plan documents. Clinical reviewers either approve claims for payment or refer claims to peer clinical reviewers (Medical Directors).

Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If a peer clinical reviewer determines that a service was not medically necessary, then an adverse benefit determination will be issued for the claim. The Plan communicates the adverse benefit determination, including applicable appeal rights, and offers a peer-to-peer conversation consistent with state and federal requirements. Appeal rights are set forth in the member's benefit plan document (*Certificate of Coverage*). The Plan communicates results of Retrospective Review within 30 days of receipt of a claim.

Adverse Benefit Determination. For M/S, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when benefits are exhausted. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials.

Clinical Criteria: Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based medical clinical policies or use clinical criteria from third party sources such as InterQual® or MCG® guidelines.

Monitoring/Quality Oversight: The Plan conducts a variety of activities that ensure that Retrospective Review determinations are appropriate.

The Plan conducts end-to-end case audits that are designed and approved by clinical leadership each year. The end-to-end audits include all stages of a case review, from intake through appeal. These audits are conducted monthly and approximately 1500 cases are reviewed per month. Results are reported to an oversight team. All deficiencies are remediated. Remediation may include corrective actions and/or additional education, as indicated.

The Plan routinely monitors Retrospective Review performance through its clinical performance oversight functions. Outcomes are monitored against timeliness requirements, performance guarantees, and for potential trends, including overall utilization.

As of April 1, 2023, the Utilization Management Program Committee (UMPC) began overseeing the M/S UM program. The UMPC is responsible for the development and maintenance of the M/S Prior Authorization processes. The UMPC ensures that the UM program considers the factors and evidentiary standards for applying UM. The UMPC is comprised of:

- Chief Medical Officer, Medical Management (Co-Chair)
- Senior Vice President, Clinical Advancement (Co-Chair)
- Chief Medical Officer, UnitedHealthcare
- Senior Vice President, Clinical Appeals & Grievances
- Chief Medical Officer, Clinical Policy
- Chief Medical Officer, UnitedHealthcare Employer & Individual
- Chief Medical Officer, UnitedHealthcare Medicare & Retirement
- Chief Medical Officer, Community & State
- Chief Medical Officer, UnitedHealthcare Individual & Family Plans
- Vice President, Clinical Transformation & Affordability
- Senior Director, Mental Health Parity
- Vice President, Utilization Management Strategy & Implementation

One of the chairs must be an executive leader and a licensed physician. UMPC meets at least six times per year but may meet more frequently if needed.

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Per the M/S policy entitled, *Performance Assessment and Incentives*, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons.

M/S generally structures UM processes to comply with federal Employee Retirement Income Security Act of 1974 (ERISA) requirements and state law where applicable.

Retrospective Review of MH/SUD Outpatient Services consists of the following:

The Plan delegates management of MH/SUD outpatient services, including Retrospective Review to United Behavioral Health d/b/a OBH, its delegated MH/SUD MBHO vendor.

MH/SUD claims/requests for outpatient services submitted by INN providers may be subject to Retrospective Review if the service or procedure code required Prior Authorization or Concurrent Review, but that review was not conducted and there is a mitigating circumstance. Additionally, claims may be subject to Retrospective Review if the billed services or procedure codes do not match the authorized codes or if services are EIU.

Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. If needed, non-clinical staff request medical records for claims containing services that are subject to Retrospective Review. When medical records are received, the case is referred to clinical reviewers to assess medical necessity.

First Level Clinical Review/Initial Review. The clinical reviewer (e.g., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) reviews the request or claim to determine if the outpatient service meets clinical criteria for coverage based on application of objective, evidence-based clinical criteria, or nationally recognized guidelines. Clinical reviewers either approve claims for payment or refer claims to peer clinical reviewers (Medical Directors or psychologists).

Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If the peer clinical reviewer determines that a service was not medically necessary, then an adverse benefit determination is issued. The Plan communicates the adverse benefit determination, including appeal rights, and offers a peer-to-peer conversation consistent with state and federal requirements. Appeal rights are set forth in the member's benefit plan document (*Certificate of Coverage*). The Plan communicates results of Retrospective Review within 30 days of receipt of a request/claim.

Adverse Benefit Determination. For MH/SUD, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when benefits are excluded. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials.

Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based behavioral clinical policies, or use clinical criteria from third party sources such as American Society of Addiction Medicine (ASAM) Criteria®, Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System-Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) and Early Childhood Service Intensity Instrument (ECSII) guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that outpatient Retrospective Review determinations are appropriate.

The Plan conducts monthly quality audits of individual non-clinical staff, clinical reviewers, and peer clinical reviewers, including staff performing appeal functions. These audits are designed and approved by clinical leadership each year. A minimum of two audits are completed per staff, per month. The results of these real-time audits are shared with supervisors for staff oversight, and all findings are remediated. Remediation may include corrective actions and/or additional education, as indicated.

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The Plan routinely monitors Retrospective Review performance through its clinical performance oversight functions. Outcomes are monitored against timeliness requirements, performance guarantees, and for potential trends, including overall utilization.

The Plan's national Clinical Quality & Operations Committee (CQOC) annually reviews overall UM program outcomes, including outpatient Retrospective Review outcomes, to confirm overall utilization is appropriate. The national CQOC is comprised of representatives from sub-committees, and representatives from the clinical quality improvement, UM, care engagement, medical operations, medical policy and standards, clinical operations, appeals, product, legal, compliance, network strategy, provider experience, accreditation, and benefits teams. The Chair of the CQOC must be an executive leader, board certified in psychiatry or psychiatric subspecialty, and a licensed physician.

Per the MH/SUD policy entitled, *Core Principles and Practices*, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse clinical coverage benefit determinations (clinical denials) for financial reasons.

MH/SUD generally structures UM processes to comply with federal ERISA requirements and state law where applicable.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- Retrospective Review

Benefit Classification(s)

- INN, outpatient

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHC)

Plan Terms

The Plan's *Schedule of Benefits* notify members of Retrospective Review requirements.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

The *Utilization Management Program Description (UMPD)* discusses Post-Service Reviews and indicates:

Post-service review assesses the appropriateness of medical services on a case by-case basis after the service has been provided but prior to payment for services. Post-service reviews are based on established review guidelines and includes:

- Review of medical necessity
- Appropriateness of level of care
- Identifying claims issues
- Eligibility determination
- Initiation of appropriate follow-up actions for utilization and quality issues
- Identifying appropriateness and administrative issues such as physician notification, emergency status of admission

The role of the Plan's delegate, United Behavioral Health d/b/a OBH, is discussed in the *UMPD*.

United Behavioral Health (UBH) performs the review of requests for coverage of behavioral health services (i.e., substance abuse, and mental health requests for services). UBH provides comprehensive behavioral health care delivery for members through a network of behavioral health practitioners, ancillary care providers, hospitals and other facilities.

For mental health, substance-related disorder services, and wraparound services, UBH uses its Clinical Criteria (see below), behavioral clinical policies, and best practice guidelines to make coverage determinations. UBH adopts externally-developed clinical criteria, and creates internally-developed Clinical Criteria, where appropriate, based on its assessment of relevant guidance. UBH develops clinical criteria that supersedes its standard set or adopts externally-developed clinical criteria when required to do so by contract or regulation.

- Clinical Criteria (Level of Care Utilization System-LOCUS) – Standardized level of care assessment tool developed by the American Association of Community Psychiatrists used to make clinical determinations and placement decisions for mental health disorder benefits for adults ages 19 and older when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (Child and Adolescent Level of Care/Service Intensity Utilization System-CALOCUS-CASII) - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry (AACAP) and the American Association for Community Psychiatry (AAP) used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children and adolescents ages 6-18 when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (Early Childhood Service Intensity Instrument-ECSI) – Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children ages 0-5 when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (State or Contract Specific Level of Care Guidelines) - Criteria used to make medical necessity determinations for mental health disorder benefits when there are explicit mandates or contractual requirements.
- Clinical Criteria (American Society of Addiction Medicine [ASAM]) - Criteria developed by the American Society of Addiction Medicine used to make clinical determinations for substance-related disorder benefits.
- Clinical Criteria (Optum Developed)
 - Optum Behavioral Clinical Policies: Criteria that stem from evaluation of new services or treatments or new applications of existing services or treatments and are used to make clinical determinations regarding proven or unproven services and treatments.

Licensed practitioners conduct all reviews with a focus on measurable outcome goals and objectives for treatment. A senior UBH Medical Director is responsible for directing and implementing behavioral health utilization management programs. A referral is sent to UBH when a member is identified as potentially benefiting from behavioral health services during a “medical event.”

The UBH UM Program is staffed by clinical, non-clinical and administrative personnel. All clinical denials or adverse decisions are made by board certified psychiatrists, or, if the health plans choose, by a panel of other appropriate health care service reviewers. If the health plan chooses to use a panel to make adverse decisions, the panel contains at least one physician who is board certified in psychiatry. When the health care service under review is a mental health or substance abuse service, the adverse decision is made by a licensed physician who is board certified in psychiatry. All potential clinical denials are referred to a physician who is board certified in psychiatry for final determination. An evaluation of the overall effectiveness of the Behavioral Health UM Program is conducted annually to determine how well resources have been deployed to improve UM activities and the clinical care and service provided to members.

The Plan's terms require services to be medically necessary for coverage. INN providers are required to comply with UM protocols established by the Plan including complying with Retrospective Review requirements.

List of M/S and MH/SUD Services Subject to NQTL

- Services that have not previously been reviewed in Prior Authorization or Concurrent Review
- Claims that are denied, if requested by INN provider
- Services where the service or procedure codes do not match a diagnosis code
- EIU services
- Services that are subject to benefit limits/exclusions
- Codes identified by the Plan as subject to Retrospective Review
 - Please see the file *M/S Retrospective Review Codes* for the list of M/S codes that may be subject to Retrospective Review
- MH/SUD claims/requests that include the following services are subject to Retrospective Review:
 - Partial Hospitalization Program (PHP)/Day Treatment
 - Applied Behavioral Analysis (ABA)

Step 2 – Factors Used to Determine Retrospective Review Applies

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

The Plan relies on the following factor to determine which INN outpatient services are subject to Retrospective Review. This factor applies to M/S and MH/SUD for the following:

- M/S INN outpatient services
 - MH/SUD INN outpatient services
- Consistency with Clinical Criteria (Qualitative):
 - Whether the application of Retrospective Review promotes optimal clinical outcomes

This factor applies to M/S and MH/SUD services. Meeting Consistency with Clinical Criteria is determinative in imposing the limitation.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factor used in designing or applying the Plan's Retrospective Review requirement to INN outpatient services. These evidentiary standards and sources apply to the following:

- M/S INN outpatient services
- MH/SUD INN outpatient services

Factor - Consistency with Clinical Criteria is defined as whether the application of Retrospective Review promotes optimal clinical outcomes

- The Plan's evidentiary standards and sources that define and/or trigger the Consistency with Clinical Criteria factor:
 - Clinical criteria from nationally recognized, third-party sources (e.g., InterQual or MCG for M/S services, and ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines for MH/SUD services)
 - Clinical Technology Assessment Committee (CTAC) and Medical Technology and Assessment Committee (MTAC) review

- Objective, evidence-based medical/behavioral clinical policies and nationally recognized guidelines approved by professional healthcare associations (e.g., clinical guidance from the American Medical Association, American Psychiatric Association, etc.)

The *Medical Necessity NQTL* describes the process for determining how internally developed medical/behavioral clinical policies are developed and how externally developed third party guidelines are reviewed and approved.

The Plan's evidentiary standards and sources apply to M/S and MH/SUD services. The Consistency with Clinical Criteria factor, evidentiary standards, and sources are defined in a qualitative manner.

The factor and evidentiary standards used as the basis for subjecting MH/SUD INN outpatient benefits to Retrospective Review are comparable to, and applied no more stringently than, the factor and evidentiary standards used as the basis for subjecting M/S INN outpatient benefits to Retrospective Review "as written" and "in operation."

Step 4 – NQTL "As Written" and "In Operation" Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

As Written

The Plan conducted a comparative analysis of the strategies, processes, factor, evidentiary standards, and source information used to determine which M/S and MH/SUD INN outpatient services are subject to Retrospective Review "as written." The Plan identified the factor and evidentiary standards used as the basis for subjecting M/S and MH/SUD benefits to Retrospective Review for each benefit classification.

Review of Factors and Evidentiary Standards

The Plan reviewed the factor that triggers an INN outpatient services to be subject to Retrospective Review. The factor and evidentiary standards were applied to M/S and MH/SUD services comparably and not more stringently to MH/SUD services than M/S services.

Review of Operational Policies and Procedures

The Plan reviewed M/S and MH/SUD operational policies and procedures, and UM annual oversight to confirm comparability and found MH/SUD policies, procedures, and processes to be comparable and no more stringent than M/S policies, procedures, and processes.

- Medical management operational policies and procedures establish the standards for how the Plan conducts outpatient Retrospective Review. The policies and procedures are consistent with state and federal law governing Retrospective Review. Timeframes for decisions, content of adverse benefit determinations, appeal rights, and external review are all governed by state and federal requirements.
- UM oversight monitors and evaluates UM processes by reviewing denial rates, clinical appeals, and under- and over-utilization.

Review of Outpatient Retrospective Review Processes

The strategy for applying Retrospective Review to INN outpatient claims/requests is comparable for M/S and MH/SUD services and applied no more stringently to MH/SUD INN outpatient services. The Plan conducted a review of the M/S and MH/SUD Retrospective Review processes to confirm comparability. The review focused on the following aspects of the process for M/S and MH/SUD:

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- Responsibility. INN M/S and MH/SUD providers are contractually responsible for requesting Retrospective Review for outpatient services.
- Timeframe to submit. The *UnitedHealthcare Administrative Guide* (for M/S) and *Optum National Network Manual* (for MH/SUD) were reviewed for requirements relating to timeliness of notification to the Plan and it was determined MH/SUD was no more stringent.
 - For M/S, providers must request the Retrospective Review within the requirements outlined in their provider contract
 - For MH/SUD, providers have 180 days after the service is rendered to request a Retrospective Review
- Clinical Reviews. For M/S and MH/SUD requests and claims, the Plan may request clinical information and refer the claim to a clinical reviewer for a Retrospective Review. The clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. The clinical reviewer may approve cases that meet applicable clinical criteria or refer claims to peer clinical reviewers.
- Review Timeframes. M/S and MH/SUD Retrospective Review determination timeframes are defined by state and federal requirements. The same determination timeframes apply to M/S and MH/SUD determinations
- Determinations, First Level Clinical Review, and Second Level/Peer Clinical Reviews. Clinical reviewers determine whether an outpatient service is medically necessary. The clinical reviewer may approve the services based on their review. The clinical reviewer refers cases they cannot approve to a peer clinical reviewer. If the peer clinical reviewer determines that a service was not medically necessary and will not be covered, an adverse benefit determination will be issued. Only qualified peer clinical reviewers may issue adverse benefit determinations.
- Adverse Benefit Determinations. An adverse benefit determination is recorded as a clinical denial when it is based on clinical criteria and member clinical information and is recorded as an administrative denial when member benefits are exhausted.
- Notification of Decisions to Providers and Members. The Plan notifies M/S and MH/SUD INN providers and members of approvals and adverse benefit determinations, including applicable appeal rights, consistent with state and federal requirements.
- Review of Staff Qualifications. For M/S and MH/SUD, clinical staff qualifications align with the type of clinical review and state and federal requirements.
 - M/S is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are conducted by clinical staff (nurses) and all adverse benefit determinations are made by a physician or other appropriate health care professionals.
 - MH/SUD is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are conducted by clinical staff (physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse benefit determinations are made by Medical Directors or psychologists.
- Clinical Criteria. For M/S and MH/SUD, clinical reviewers and peer clinical reviewers base determinations on objective, evidence-based, medical/behavioral clinical policies or use clinical criteria from third party sources such as InterQual, MCG, ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines.

In Operation

The Plan compared the strategies, processes, factor, evidentiary standards, and source information used to determine which M/S and MH/SUD INN outpatient services are subject to Retrospective Review and how Retrospective Review is applied “in operation.”

The Plan subjected claims/requests for M/S and MH/SUD outpatient services to Retrospective Review that were not reviewed in the Prior Authorization or Concurrent Review process. Additionally, M/S claims for outpatient services submitted by INN providers were subject to Retrospective Review if the services or procedure codes did not match a diagnosis code, if services were EIU, or if the services had benefits limits. MH/SUD claims/requests for outpatient services submitted by INN providers may be subject to Retrospective Review if the service or procedure code required Prior Authorization or Concurrent Review, but that review was not conducted and there is a mitigating circumstance. Additionally, claims may be subject to Retrospective Review if the billed services or procedure codes do not match the authorized codes or if services are EIU.

The Plan may request member clinical information for M/S and MH/SUD outpatient claims and refer claims to a clinical reviewer. The clinical reviewer reviewed applicable member clinical information, benefit plan documents, and clinical criteria in the case review. The clinical reviewer approved cases that met applicable clinical criteria or referred cases to peer clinical reviewers. If an appropriately qualified peer clinical reviewer determined that a service was not medically necessary and would not be covered, an adverse benefit determination was issued for the claim.

The Plan communicated all adverse benefit determinations for M/S and MH/SUD outpatient claims/requests that did not meet applicable clinical criteria, including appeal rights, consistent with state and federal requirements.

The Plan conducted monthly quality audits of individual non-clinical staff, clinical reviewers, including staff performing appeal functions. The Plan routinely monitors Retrospective Review performance through its clinical performance oversight functions. In addition to comparing these “in operation” processes, the Plan reviewed medical necessity approval and denial rates, internal appeals outcomes, and external appeals outcomes related to Retrospective Review determinations for M/S and MH/SUD INN outpatient services.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The findings of the Plan's comparative analyses confirmed the strategies, processes, factor, evidentiary standards, and source information used to subject certain MH/SUD INN outpatient services to Retrospective Review were comparable to, and applied no more stringently than, the strategies, processes, factor, evidentiary standards, and source information used to subject certain M/S INN outpatient services to Retrospective Review “as written.”

The Plan found the factor used to subject INN MH/SUD outpatient services to Retrospective Review was comparable to and applied no more stringently than the factor used to subject INN M/S outpatient services to Retrospective Review “in operation.”

All M/S outpatient services were subject to Retrospective Review if they were not reviewed via Prior Authorization or Concurrent Review processes. Additionally, M/S claims for outpatient services submitted by INN providers were subject to Retrospective Review if the services or procedure codes did not match a diagnosis code, if services were EIU, or if the services had benefit limits. MH/SUD claims/requests for outpatient services submitted by INN providers may be subject to Retrospective Review if the service or procedure code required Prior Authorization or Concurrent Review, but that review was not conducted and there is a mitigating circumstance. Additionally, claims may be subject to Retrospective Review if the billed services or procedure codes do not match the authorized codes or if services are EIU.

The Plan used comparable processes to conduct Retrospective Review of claims/requests for M/S and MH/SUD outpatient services. The Plan may request clinical information if necessary. The Plan approved M/S and MH/SUD claims/requests for outpatient services that met applicable clinical criteria or guidelines. The Plan issued an adverse benefit determination for M/S and MH/SUD INN provider claims/requests for outpatient services that did not meet applicable clinical criteria or guidelines.

INN outpatient medical necessity approval and denial rates and appeals outcomes data from 01/01/2022 – 12/31/2022 were evaluated where a minimum threshold of 100 cases were available to ensure a valid data set for analysis. The Plan has established that a minimum of at least 100 M/S and MH/SUD cases are required within each classification for a comparative analysis. Meaningful conclusions cannot be reached when there are fewer than 100 cases within each classification because the data is subject to variability.

Because Georgia Surest Plan became effective on 07/2023 there is minimal membership and as a result an insufficient number of cases from 01/01/2022 – 12/31/2022 to support an in operation analysis. While the Plan notes that the U.S.

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Department of Labor has indicated generally that outcomes data are not dispositive of parity compliance, the Plan will conduct a comparative analysis of outcomes data, including medical necessity approval and denial rates and appeals outcomes, when there is a minimum of 100 cases available to ensure a valid data set for analysis.

Conclusions

The Plan concluded that how Retrospective Review is applied to MH/SUD INN outpatient services was comparable to, and applied no more stringently than, how Retrospective Review is applied to M/S INN outpatient services “as written.”

The Plan reviewed the M/S and MH/SUD processes including responsibility for submission, timeframes for submission and review, notification to members and providers, clinical standards for review, and staff qualifications and concluded how the Plan conducts Retrospective Review for MH/SUD INN outpatient services “in operation” was comparable to, and applied no more stringently than, how the Plan conducts Retrospective Review for M/S INN outpatient services “in operation.”

Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical/surgical (M/S) benefits. This generally means that the financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements, such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage.

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

Retrospective Review is a component of the Plan’s Utilization Management (UM) program. Medical directors and other clinical staff review services in order to detect and better manage over- and under-utilization and determine whether the services reviewed are consistent with the member’s coverage, medically appropriate, and consistent with evidence-based guidelines. Retrospective Review assesses the appropriateness of services on a case-by-case basis after the service has been provided but prior to payment for services. Retrospective Reviews are based on established review guidelines and may include:

- Review of medical necessity
- Appropriateness of level of care
- Identifying claims issues
- Eligibility determination
- Initiation of appropriate follow-up actions for utilization and quality issues

The Plan conducts medical necessity Retrospective Review of claims/requests for certain inpatient services that have not previously been reviewed as part of the Prior Authorization or Concurrent Review processes. The Plan may conduct Retrospective Review if the service or procedure codes do not match a diagnosis code, if services are experimental, investigational, or unproven (EIU), or if the services are subject to benefit limits/exclusions. The Plan conducts medical necessity Retrospective Review for inpatient services where Prior Authorization was required but not obtained upon claim submission.

This document includes the following information:

- The Retrospective Review process for M/S and MH/SUD inpatient services
- The description of the NQTL and application (Step 1)
- Factor used to determine which services are subject to the NQTL (Step 2)
- Evidentiary standards and sources used to define, trigger and/or implicate the factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

This comparative analysis refers to the following attachments:

- *Utilization Management Program Description (UMPD) of United HealthCare Services, Inc. and UnitedHealthcare Insurance Company* - summarizes the philosophy, structure and standards that govern UHC’s medical management, UM and utilization review responsibilities and functions

- *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions* - M/S policy that defines Retrospective Review
- *Optum National Policy Definitions List* - MH/SUD policy that defines Retrospective Review
- *M/S Retrospective Review Codes* – Excel document that lists M/S codes that may be subject to Retrospective Review
- *Schedule of Benefits - SBN23-Medical-INS-BIND-2021-Choice Plus-LG-GA-UHIC* - Plan document that outlines member responsibilities
- *Core Principles and Practices* - MH/SUD policy that outlines the core principles and practices that should be used by personnel in their interactions with members, authorized member representatives, practitioners, and facilities, related to the management of behavioral health benefits, coverage determinations and appeals/grievances of non-coverage determinations
- *Performance Assessment and Incentives* - M/S policy confirming that clinical reviewers are not incented to make denials for financial reasons
- *Medical Necessity NQTL* – Comparative analysis that describes the processes, strategies, evidentiary standards and other factors used to apply medical necessity to M/S and MH/SUD services in accordance with MHPAEA and other regulatory guidance

The Plan concludes that the Retrospective Review requirements for M/S and MH/SUD are comparable and applied no more stringently to MH/SUD out-of-network (OON) inpatient benefits both “as written” and “in operation.”

Process

The Plan structures inpatient Retrospective Review processes to be compliant with all applicable federal and state laws. Retrospective Review is governed at both the state and federal level, which includes consumer protections such as external review for adverse benefit determinations after internal appeals options are exhausted.

The Plan delegates management of MH/SUD Inpatient services, including Retrospective Review to United Behavioral Health d/b/a Optum Behavioral Health (OBH), its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor.

Retrospective Review of M/S Inpatient Admissions consist of the following:

Retrospective Review for certain inpatient services begins after the Plan receives claims or notification of an inpatient admission post discharge from an OON facility. The Plan conducts medical necessity Retrospective Review of claims/requests for certain inpatient services that have not previously been reviewed as part of the Prior Authorization or Concurrent Review processes. The Plan may conduct Retrospective Review if the service or procedure codes do not match a diagnosis code, if services EIU, or if the services are subject to benefit limits/exclusions. The Plan conducts medical necessity Retrospective Review for inpatient services where Prior Authorization was required but not obtained upon claim submission.

Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. If needed, non-clinical staff request medical records for claims containing services that are subject to Retrospective Review. When medical records are received, cases are referred to clinical reviewers to assess medical necessity.

First Level Clinical Review/Initial Review. The clinical reviewer (physicians or nurses) reviews the claim to determine if the inpatient service billed meets clinical criteria for coverage based on application of objective, evidence-based clinical criteria, nationally recognized guidelines, and the member’s benefit plan documents. Clinical reviewers either approve claims for payment or refer claims to peer clinical reviewers (Medical Directors).

Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If a peer clinical reviewer determines that a service was not medically necessary, then an adverse benefit determination will be issued for the claim. The Plan communicates the adverse benefit determination, including applicable

appeal rights, and offers a peer-to-peer conversation consistent with state and federal requirements. Appeal rights are set forth in the member's benefit plan document (*Certificate of Coverage*). The Plan communicates results of Retrospective Review within 30 days of receipt of a claim.

Adverse Benefit Determination. For M/S, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when benefits are exhausted. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials.

Clinical Criteria: Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based medical clinical policies or use clinical criteria from third party sources such as InterQual® or MCG® Guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that Retrospective Review determinations are appropriate.

The Plan conducts end-to-end case audits that are designed and approved by clinical leadership each year. The end-to-end audits include all stages of a case review, from intake through appeal. These audits are conducted monthly and approximately 1500 cases are reviewed per month. Results are reported to an oversight team. All deficiencies are remediated. Remediation may include corrective actions and/or additional education, as indicated.

The Plan routinely monitors Retrospective Review performance through its clinical performance oversight functions. Outcomes are monitored against timeliness requirements, performance guarantees, and for potential trends, including overall utilization.

As of April 1, 2023, the Utilization Management Program Committee (UMPC) began overseeing the M/S UM program. The UMPC is responsible for the development and maintenance of the M/S Prior Authorization processes. The UMPC ensures that the UM program considers the factors and evidentiary standards for applying UM. The UMPC is comprised of:

- Chief Medical Officer, Medical Management (Co-Chair)
- Senior Vice President, Clinical Advancement (Co-Chair)
- Chief Medical Officer, UnitedHealthcare
- Senior Vice President, Clinical Appeals & Grievances
- Chief Medical Officer, Clinical Policy
- Chief Medical Officer, UnitedHealthcare Employer & Individual
- Chief Medical Officer, UnitedHealthcare Medicare & Retirement
- Chief Medical Officer, Community & State
- Chief Medical Officer, UnitedHealthcare Individual & Family Plans
- Vice President, Clinical Transformation & Affordability
- Senior Director, Mental Health Parity
- Vice President, Utilization Management Strategy & Implementation

One of the chairs must be an executive leader and a licensed physician. UMPC meets at least six times per year but may meet more frequently if needed.

Per the M/S policy entitled, *Performance Assessment and Incentives*, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons.

M/S generally structures UM processes to comply with federal Employee Retirement Income Security Act of 1974 (ERISA) requirements, and state law where applicable.

Retrospective Review of MH/SUD Inpatient Admissions consist of the following:

The Plan delegates management of MH/SUD inpatient services, including Retrospective Review to United Behavioral Health d/b/a OBH, its delegated MH/SUD MBHO vendor.

MH/SUD claims/requests for inpatient services submitted by OON providers may be subject to Retrospective Review if the service or procedure code required Prior Authorization or Concurrent Review, but that review was not conducted and there is a mitigating circumstance. Additionally, claims may be subject to Retrospective Review if the billed services or procedure codes do not match the authorized codes, or if services are EIU.

Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. If needed, non-clinical staff request medical records for requests or claims containing services that are subject to Retrospective Review. When medical records are received, the case is referred to clinical reviewers to assess medical necessity.

First Level Clinical Review/Initial Review. The clinical reviewer (e.g., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) review the claim to determine if the inpatient admission billed meets clinical criteria for coverage based on application of objective, evidence-based, clinical criteria, or nationally recognized guidelines. Clinical reviewers either approve claims for payment or refer claims to peer clinical reviewers (Medical Directors).

Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If the peer clinical reviewer determines that an admission was not medically necessary, then an adverse benefit determination will be issued for the claim. The Plan communicates the adverse benefit determination, including applicable appeal rights. Appeal rights are set forth in the member's benefit plan document (*Certificate of Coverage*). The Plan communicates results of Retrospective Review within 30 days of receipt of a request/claim.

The OON provider may bill non-reimbursable charges to the member.

Adverse Benefit Determination. For MH/SUD, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when benefits are exhausted. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials

Clinical Criteria: Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based behavioral clinical policies or use clinical criteria from third party sources such as American Society of Addiction Medicine (ASAM) Criteria®, Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System-Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) and Early Childhood Service Intensity Instrument (ECSII) guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that inpatient Retrospective Review determinations are appropriate.

The Plan conducts monthly quality audits of individual non-clinical staff, clinical reviewers, and peer clinical reviewers, including staff performing appeal functions. These audits are designed and approved by clinical leadership each year. A minimum of two audits are completed per staff, per month. The results of these real-time audits are shared with supervisors for staff oversight, and all findings are remediated. Remediation may include corrective actions and/or additional education, as indicated.

The Plan routinely monitors Retrospective Review performance through its clinical performance oversight functions. Outcomes are monitored against timeliness requirements, performance guarantees, and for potential trends, including overall utilization.

The Plan's national Clinical Quality & Operations Committee (CQOC) annually reviews overall UM program outcomes, including inpatient Retrospective Review outcomes, to confirm overall utilization is appropriate. The national CQOC is comprised of representatives from sub-committees, and representatives from the clinical quality improvement, UM, care engagement, medical operations, medical policy and standards, clinical operations, appeals, product, legal, compliance, network strategy, provider experience, accreditation, and benefits teams. The Chair of the CQOC must be an executive leader, board certified in psychiatry or psychiatric subspecialty, and a licensed physician.

Per the MH/SUD policy entitled, *Core Principles and Practices*, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse clinical coverage benefit determinations (clinical denials) for financial reasons.

MH/SUD generally structures UM processes to comply with federal ERISA requirements and state law where applicable.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- Retrospective Review

Benefit Classification(s)

- OON, inpatient

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHIC)

Plan Terms

The Plan's *Schedule of Benefits* notify members of Retrospective Review requirements.

"The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs."

The *Utilization Management Program Description (UMPD)* discusses Post-Service Reviews and indicates:

"Post-service review assesses the appropriateness of medical services on a case-by-case basis after the service has been provided but prior to payment for services. Post- service reviews are based on established review guidelines and includes:

- Review of medical necessity;
- Appropriateness of level of care;
- Identifying claims issues;
- Eligibility determination;
- Initiation of appropriate follow-up actions for utilization and quality issues; and
- Identifying appropriateness and administrative issues such as physician notification, emergency status of admission."

The Plan's delegate, United Behavioral Health d/b/a OBH, is discussed in the *UMPD*:

"United Behavioral Health (UBH) performs the review of requests for coverage of behavioral health services (i.e., substance abuse, and mental health requests for services). UBH provides comprehensive behavioral health care delivery for members through a network of behavioral health practitioners, ancillary care providers, hospitals and other facilities.

For mental health, substance-related disorder services, and wraparound services, UBH uses its Clinical Criteria (see below), behavioral clinical policies, and best practice guidelines to make coverage determinations. UBH adopts externally-developed clinical criteria, and creates internally-developed Clinical Criteria, where appropriate, based on its assessment of relevant guidance. UBH develops clinical criteria that supersedes its standard set or adopts externally-developed clinical criteria when required to do so by contract or regulation.

- Clinical Criteria (Level of Care Utilization System-LOCUS) – Standardized level of care assessment tool developed by the American Association of Community Psychiatrists used to make clinical determinations and placement decisions for mental health disorder benefits for adults ages 19 and older when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (Child and Adolescent Level of Care/Service Intensity Utilization System-CALOCUS-CASII)- Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry (AACAP) and the American Association for Community Psychiatry (AAP) used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children and adolescents ages 6-18 when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (Early Childhood Service Intensity Instrument-ECSII) - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children ages 0-5 when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (State or Contract Specific Level of Care Guidelines): Criteria used to make medical necessity determinations for mental health disorder benefits when there are explicit mandates or contractual requirements.
- Clinical Criteria (American Society of Addiction Medicine [ASAM]): Criteria developed by the American Society of Addiction Medicine used to make clinical determinations for substance-related disorder benefits.
- Clinical Criteria (Optum Developed)
 - Optum Behavioral Clinical Policies: Criteria that stem from evaluation of new services or treatments or new applications of existing services or treatments and are used to make clinical determinations regarding proven or unproven services and treatments.

Licensed practitioners conduct all reviews with a focus on measurable outcome goals and objectives for treatment. A senior UBH Medical Director is responsible for directing and implementing behavioral health utilization management programs. A referral is sent to UBH when a member is identified as potentially benefiting from behavioral health services during a “medical event.”

The UBH UM Program is staffed by clinical, non-clinical and administrative personnel. All clinical denials or adverse decisions are made by board certified psychiatrists, or, if the health plans choose, by a panel of other appropriate health care service reviewers. If the health plan chooses to use a panel to make adverse decisions, the panel contains at least one physician who is board certified in psychiatry. When the health care service under review is a mental health or substance abuse service, the adverse decision is made by a licensed physician who is board certified in psychiatry. All potential clinical denials are referred to a physician who is board certified in psychiatry for final determination. An evaluation of the overall effectiveness of the Behavioral Health UM Program is conducted annually to determine how well resources have been deployed to improve UM activities and the clinical care and service provided to members.”

The Plan’s terms require services to be medically necessary for coverage.

M/S and MH/SUD Services Subject to NQTL

- Services that have not previously been reviewed in Prior Authorization or Concurrent Review
- Services where the service or procedure codes do not match a diagnosis code
- EIU services
- Services that are subject to benefit limits/exclusions
- Codes identified by the Plan as subject to Retrospective Review

- Please see the file *M/S Retrospective Review Codes* for the list of M/S codes that may be subject to Retrospective Review
- MH/SUD claims/requests that include the following services are subject to Retrospective Review:
 - Inpatient (non-emergent) MH Acute Care
 - Inpatient Detoxification
 - Inpatient Rehabilitation
 - Residential Detoxification
 - Residential Rehabilitation
 - Residential MH Treatment

Step 2 – Factors Used to Determine Retrospective Review Applies

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

The Plan relies on the following factor to determine which OON inpatient admissions are subject to Retrospective Review. This factor applies to M/S and MH/SUD for the following:

- M/S OON inpatient admissions
 - MH/SUD OON inpatient admissions
- Consistency with Clinical Criteria (Qualitative):
 - Whether the application of Retrospective Review promotes optimal clinical outcomes.

This factor applies to M/S and MH/SUD services. Meeting Consistency with Clinical Criteria is determinative in imposing the limitation.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factor used in designing or applying the Plan's Retrospective Review requirements to OON inpatient services. These evidentiary standards and sources apply to the following:

- M/S OON inpatient admissions
- MH/SUD OON inpatient admissions

Factor: Consistency with Clinical Criteria is defined as whether the application of Retrospective Review promotes optimal clinical outcomes.

- The Plan's evidentiary standards and sources that define and/or trigger the Consistency with Clinical Criteria factor:
 - Clinical criteria from nationally recognized, third-party sources (e.g., InterQual or MCG for M/S services, and ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines for MH/SUD services)
 - Clinical Technology Assessment Committee (CTAC) and Medical Technology and Assessment Committee (MTAC) review
 - Objective, evidence-based medical/behavioral clinical policies and nationally recognized guidelines approved by professional healthcare associations (e.g., clinical guidance from the American Medical Association, American Psychiatric Association, etc.)

The *Medical Necessity NQTL* describes the process for determining how internally developed medical/behavioral clinical policies are developed and how externally developed third-party guidelines are reviewed and approved.

The Plan's evidentiary standards and sources apply to M/S and MH/SUD services. The Consistency with Clinical Criteria factor, evidentiary standards, and sources are defined in a qualitative manner.

The factor and evidentiary standards used as the basis for subjecting MH/SUD OON inpatient benefits to Retrospective Review are comparable to, and applied no more stringently than, the factor and evidentiary standards used as the basis for subjecting M/S OON inpatient benefits to Retrospective Review "as written" and "in operation."

Step 4 – NQTL "As Written" and "In Operation" Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

As Written

The Plan conducted a comparative analysis of the strategies, processes, factor, evidentiary standards, and source information used to determine which M/S and MH/SUD OON inpatient services are subject to Retrospective Review "as written." The Plan identified the factors and evidentiary standards used as the basis for subjecting M/S and MH/SUD benefits to Retrospective Review for each benefit classification.

Review of Factor and Evidentiary Standards

The Plan reviewed the factor that triggers an OON inpatient service to be subject to Retrospective Review. The factor and evidentiary standards were applied to M/S and MH/SUD services comparably and not more stringently to MH/SUD services than M/S services.

Review of Operational Policies and Procedures

The Plan reviewed M/S and MH/SUD operational policies and procedures and UM annual oversight to confirm comparability and found MH/SUD policies, procedures, and processes to be comparable and no more stringent than M/S policies, procedures, and processes.

- Medical management operational policies and procedures establish the standards for how the Plan conducts inpatient Retrospective Review. The policies and procedures are consistent with state and federal law governing Retrospective Review. Timeframes for decisions, content of adverse benefit determinations, appeal rights and external review are all governed by state and federal requirements
- UM oversight monitors and evaluates UM processes by reviewing denial rates, clinical appeals, and under- and over-utilization.

Review of Inpatient Retrospective Review Processes

The strategy for applying Retrospective Review to OON inpatient claims/requests is comparable for M/S and MH/SUD services and applied no more stringently to MH/SUD OON inpatient services. The Plan conducted a review of the M/S and MH/SUD Retrospective Review processes to confirm comparability. The review focused on the following aspects of the processes for both M/S and MH/SUD:

- Responsibility. The member is responsible for notifying the Plan of an inpatient admission to an OON provider or advising of a change to procedure for both M/S and MH/SUD. OON providers may submit notification on behalf of the member.
- Timeframe to submit. The timeframe for the member to submit the Retrospective Review request was reviewed and it was determined that MH/SUD was no more stringent.

- For M/S, members must notify the Plan within timely filing requirements
- For MH/SUD, members have 180 days after the service is rendered to request a Retrospective Review
- **Clinical Reviews.** For M/S and MH/SUD claims/requests, the Plan may request clinical information and refers the claim/request to a clinical reviewer for Retrospective Review. The clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. The clinical reviewer either approves cases that meet applicable clinical criteria or refers the case to a peer clinical reviewer.
- **Review Timeframes.** M/S and MH/SUD Retrospective Review determination timeframes are defined by state and federal requirements. The same determination timeframes apply to M/S and MH/SUD determinations.
- **Determinations, First Level Clinical Review, and Second Level/Peer Clinical Reviews.** Clinical reviewers determine whether an inpatient admission is medically necessary. The clinical reviewer may approve the admission based on their review. The clinical reviewer refers cases they cannot approve to a peer clinical reviewer. If the peer clinical reviewer determines that an admission was not medically necessary and will not be covered, an adverse benefit determination will be issued. Only qualified peer clinical reviewers may issue adverse benefit determinations.
- **Adverse Benefit Determinations.** An adverse benefit determination is recorded as a clinical denial when it is based on clinical criteria and member clinical information and is recorded as an administrative denial when member benefits are exhausted.
- **Notification of Decisions to Providers and Members.** The Plan notifies M/S and MH/SUD OON facilities and members of approvals and adverse benefit determinations, including applicable appeal rights consistent with state and federal requirements.
- **Review of Staff Qualifications.** For M/S and MH/SUD, clinical staff qualifications align with the type of clinical review and state and federal requirements.
 - M/S is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are conducted by clinical staff (nurses, physicians) and all adverse benefit determinations are made by a physician or other appropriate health care professionals.
 - MH/SUD is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse benefit determinations are made by Medical Directors.
- **Clinical Criteria.** For M/S and MH/SUD, clinical reviewers and peer clinical reviewers base determinations on objective, evidence-based medical/behavioral clinical policies or use clinical criteria from third party sources such as InterQual, MCG, ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines.

In Operation

The Plan compared the strategies, processes, factor, evidentiary standards, and source information used to determine which M/S and MH/SUD OON inpatient services are subject to Retrospective Review and how Retrospective Review is applied “in operation.”

The Plan subjected claims/requests for M/S and MH/SUD inpatient admissions to Retrospective Review that were not reviewed via Prior Authorization or Concurrent Review. Additionally, M/S claims/requests for inpatient services submitted by OON providers were subject to Retrospective Review if the services or procedure codes did not match a diagnosis code, if services were EIU, or if the services had benefit limits/exclusions. Claims/requests for inpatient services submitted by OON providers may be subject to Retrospective Review if the service or procedure code required Prior Authorization or Concurrent Review, but that review was not conducted and there is a mitigating circumstance. Additionally, claims may be subject to Retrospective Review if the billed services or procedure codes do not match the authorized codes or if services are EIU.

The Plan may have requested member clinical information for M/S and MH/SUD inpatient claims/requests and referred them to a clinical reviewer. The clinical reviewer reviewed applicable member clinical information, benefit plan documents, and clinical criteria in the case review. The clinical reviewer approved cases that met applicable clinical criteria or referred cases to peer clinical reviewers. If an appropriately qualified peer clinical reviewer determined that a service was not medically necessary and would not be covered, an adverse benefit determination was issued for the claim.

The Plan communicated all adverse benefit determinations for M/S and MH/SUD inpatient claims/requests that did not meet applicable clinical criteria, including appeal rights, consistent with state and federal requirements.

The Plan conducted monthly quality audits of individual non-clinical staff, clinical reviewers, including staff performing appeal functions. The Plan routinely monitored Retrospective Review performance through its clinical performance oversight functions. In addition to comparing these “in operation” processes, the Plan reviewed medical necessity approval and denial rates, internal appeals outcomes, and external appeals outcomes related to Retrospective Review determinations for M/S and MH/SUD INN inpatient services.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The findings of the Plan's comparative analyses confirmed the strategies, processes, factor, evidentiary standards, and source information used to subject certain MH/SUD OON inpatient services to Retrospective Review were comparable to, and applied no more stringently than, the strategies, processes, factor, evidentiary standards, and source information used to subject certain M/S OON inpatient services to Retrospective Review “as written.”

The Plan found the factor used to subject OON MH/SUD inpatient services to Retrospective Review was comparable to and applied no more stringently than the factor used to subject ONN M/S inpatient services to Retrospective Review “in operation.” All M/S and MH/SUD inpatient admissions were subject to Retrospective Review if they were not reviewed via Prior Authorization or Concurrent Review. Additionally, M/S and MH/SUD claims for inpatient services submitted by OON providers were subject to Retrospective Review if the services or procedure codes did not match a diagnosis code, if services were EIU, or if the services had benefit limits/exclusions. Claims/requests for inpatient services submitted by OON providers may be subject to Retrospective Review if the service or procedure code required Prior Authorization or Concurrent Review, but that review was not conducted and there is a mitigating circumstance.

The Plan used comparable processes to conduct Retrospective Review of claims/requests for M/S and MH/SUD inpatient services. The Plan may have requested clinical information if necessary. The Plan approved M/S and MH/SUD claims/requests for inpatient services that met applicable clinical criteria or guidelines. The Plan issued an adverse benefit determination for M/S and MH/SUD OON provider claims/requests for inpatient services that did not meet applicable clinical criteria or guidelines.

OON inpatient medical necessity approval and denial rates and appeals outcomes data from 01/01/2022 – 12/31/2022 were evaluated where a minimum threshold of 100 cases were available to ensure a valid data set for analysis. The Plan has established that a minimum of at least 100 M/S and MH/SUD cases are required within each classification for a comparative analysis. Meaningful conclusions cannot be reached when there are fewer than 100 cases within each classification because the data is subject to variability.

Because Georgia Surest Plan became effective on 07/2023 there is minimal membership and as a result is an insufficient number of cases from 01/01/2022 – 12/31/2022 to support an in operation analysis. While the Plan notes that the U.S. Department of Labor has indicated generally that outcomes data are not dispositive of parity compliance, the Plan will conduct a comparative analysis of outcomes data, including medical necessity approval and denial rates and appeals outcomes, when there is a minimum of 100 cases available to ensure a valid data set for analysis.

Conclusions

The Plan concluded that how Retrospective Review is applied to MH/SUD OON inpatient services was comparable to, and applied no more stringently than, how Retrospective Review is applied to M/S OON inpatient services “as written.”

Retrospective Review – Out-of-Network Inpatient Non-Quantitative Treatment Limitation (NQTL) Analysis

GA Surest - UnitedHealthcare Insurance Company

12/29/2023

The Plan reviewed the M/S and MH/SUD processes including responsibility for submission, timeframes for submission and review, notification to members and providers, clinical standards for review, and staff qualifications and concluded how the Plan conducts Retrospective Review for MH/SUD OON inpatient services “in operation” was comparable to, and applied no more stringently than, how the Plan conducts Retrospective Review for M/S OON inpatient services “in operation.”

Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical/surgical (M/S) benefits. This generally means that financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements, such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage.

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

Retrospective Review is a component of the Plan’s Utilization Management (UM) program. Medical directors and other clinical staff review services in order to detect and better manage over- and under-utilization and determine whether the services reviewed are consistent with the member’s coverage, medically appropriate, and consistent with evidence-based guidelines. Retrospective Review assesses the appropriateness of services on a case-by-case basis after the service has been provided but prior to payment for services. Retrospective Reviews are based on established review guidelines and may include:

- Review of medical necessity
- Appropriateness of level of care
- Identifying claims issues
- Eligibility determination
- Initiation of appropriate follow-up actions for utilization and quality issues

The Plan conducts medical necessity Retrospective Review of claims/requests for certain outpatient services that have not previously been reviewed as part of the Prior Authorization or Concurrent Review processes. The Plan may conduct Retrospective Review if the service or procedure codes do not match a diagnosis code, if services are experimental, investigational, or unproven (EIU), or if the services are subject to benefit limits/exclusions. The Plan conducts medical necessity Retrospective Review for outpatient services where Prior Authorization was required, but not obtained upon claim submission.

This document includes the following information:

- The Retrospective Review process for M/S and MH/SUD outpatient services
- The description of the NQTL and application (Step 1)
- Factor used to determine which services are subject to the NQTL (Step 2)
- Evidentiary standards and sources used to define, trigger and/or implicate a factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

This comparative analysis refers to the following attachments:

- *Utilization Management Program Description of United HealthCare Services, Inc. and UnitedHealthcare Insurance Company* - Summarizes the philosophy, structure and standards that govern UHC’s medical management, UM and utilization review responsibilities and functions

- *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions* - M/S policy that defines Retrospective Review
- *Optum National Policy Definitions List* – MH/SUD policy that defines Retrospective Review
- *M/S Retrospective Review Codes* - Excel document that lists the M/S codes that may be subject to Retrospective Review
- *Schedule of Benefits - SBN23-Medical-INS-BIND-2021-Choice Plus-LG-GA-UHIC* - Plan document that outlines member responsibilities
- *Core Principles and Practices* - MH/SUD policy that outlines the core principles and practices that should be used by personnel in their interactions with members, authorized member representatives, practitioners and facilities, related to the management of behavioral health benefits, coverage determinations and appeals/grievances of non-coverage determinations
- *Performance Assessment and Incentives* - M/S policy confirming that clinical reviewers are not incented to make denials for financial reasons
- *Medical Necessity NQTL* – Comparative analysis that describes the processes, strategies, evidentiary standards and other factors used to apply medical necessity to M/S and MH/SUD services in accordance with MHPAEA and other regulatory guidance

The Plan concludes that the Retrospective Review requirements for M/S and MH/SUD are comparable and applied no more stringently to MH/SUD out-of-network (OON) outpatient benefits both "as written" and "in operation."

Process

The Plan structures outpatient Retrospective Review processes to be compliant with all applicable federal and state laws. Retrospective Review is governed at both the state and federal level, which includes consumer protections such as external review for adverse benefit determinations after internal appeals options are exhausted.

The Plan delegates management of MH/SUD outpatient services, including Retrospective Review to United Behavioral Health d/b/a Optum Behavioral Health (OBH), its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor.

Retrospective Review of M/S Outpatient Services consists of the following:

Retrospective Review for certain outpatient services begins after the Plan receives claims from OON providers. The Plan conducts medical necessity Retrospective Review of claims/requests for certain outpatient services that have not previously been reviewed as part of the Prior Authorization or Concurrent Review processes. The Plan may conduct Retrospective Review if the service or procedure codes do not match a diagnosis code, if services are EIU, or if the services are subject to benefit limits/exclusion. The Plan also conducts medical necessity Retrospective Review for outpatient services where Prior Authorization was required, but not obtained upon claim submission.

Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. If needed, non-clinical staff request medical records for claims containing services that are subject to Retrospective Review. When medical records are received, the case is referred to clinical reviewers to assess medical necessity.

First Level Clinical Review/Initial Review. The clinical reviewer (physicians or nurses) reviews the claim to determine if the outpatient service billed meets clinical criteria for coverage based on application of objective, evidence-based clinical criteria, nationally recognized guidelines, and the member's benefit plan documents. Clinical reviewers either approve claims for payment or refer claims to peer clinical reviewers (Medical Directors).

Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If a peer clinical reviewer determines that a service was not medically necessary, then an adverse benefit determination will be issued for the claim. The Plan communicates the adverse benefit determination, including applicable

appeal rights, and offers a peer-to-peer conversation consistent with state and federal requirements. Appeal rights are set forth in the member's benefit plan document (*Certificate of Coverage*). The Plan communicates results of Retrospective Review within 30 days of receipt of a claim. The OON provider may bill non-reimbursable charges to the member.

Adverse Benefit Determination. For M/S, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when benefits are exhausted. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials.

Clinical Criteria: Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based medical clinical policies or use clinical criteria from third party sources such as InterQual® or MCG® guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that Retrospective Review determinations are appropriate.

The Plan conducts end-to-end case audits that are designed and approved by clinical leadership each year. The end-to-end audits include all stages of a case review, from intake through appeal. These audits are conducted monthly and approximately 1500 cases are reviewed per month. Results are reported to an oversight team. All deficiencies are remediated. Remediation may include corrective actions and/or additional education, as indicated.

The Plan routinely monitors Retrospective Review performance through its clinical performance oversight functions. Outcomes are monitored against timeliness requirements, performance guarantees, and for potential trends, including overall utilization.

As of April 1, 2023, the Utilization Management Program Committee (UMPC) began overseeing the M/S UM program. The UMPC is responsible for the development and maintenance of the M/S Prior Authorization processes. The UMPC ensures that the UM program considers the factors and evidentiary standards for applying UM. The UMPC is comprised of:

- Chief Medical Officer, Medical Management (Co-Chair)
- Senior Vice President, Clinical Advancement (Co-Chair)
- Chief Medical Officer, UnitedHealthcare
- Senior Vice President, Clinical Appeals & Grievances
- Chief Medical Officer, Clinical Policy
- Chief Medical Officer, UnitedHealthcare Employer & Individual
- Chief Medical Officer, UnitedHealthcare Medicare & Retirement
- Chief Medical Officer, Community & State
- Chief Medical Officer, UnitedHealthcare Individual & Family Plans
- Vice President, Clinical Transformation & Affordability
- Senior Director, Mental Health Parity
- Vice President, Utilization Management Strategy & Implementation

One of the chairs must be an executive leader and a licensed physician. UMPC meets at least six times per year but may meet more frequently if needed.

Per the M/S policy entitled, *Performance Assessment and Incentives*, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons.

M/S generally structures UM processes to comply with federal Employee Retirement Income Security Act of 1974 (ERISA) requirements and state law where applicable.

Retrospective Review of MH/SUD Outpatient Services consists of the following:

The Plan delegates management of MH/SUD outpatient services, including Retrospective Review to United Behavioral Health d/b/a OBH, its delegated MH/SUD MBHO vendor.

MH/SUD claims/requests for outpatient services submitted by OON providers may be subject to Retrospective Review if the service or procedure code required Prior Authorization or Concurrent Review, but that review was not conducted and there is a mitigating circumstance. Additionally, claims may be subject to Retrospective Review if the billed services or procedure codes do not match the authorized codes or if services are EIU.

Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. If needed, non-clinical staff request medical records for claims containing services that are subject to Retrospective Review. When medical records are received, the case is referred to clinical reviewers to assess medical necessity.

First Level Clinical Review/Initial Review. The clinical reviewer (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) reviews the request or claim to determine if the outpatient service meets clinical criteria for coverage based on application of objective, evidence-based clinical criteria, or nationally recognized guidelines. Clinical reviewers either approve claims for payment or refer claims to peer clinical reviewers (Medical Directors or psychologists).

Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If the peer clinical reviewer determines that a service was not medically necessary, then an adverse benefit determination is issued. The Plan communicates the adverse benefit determination, including appeal rights, and offers a peer-to-peer conversation consistent with state and federal requirements. Appeal rights are set forth in the member's benefit plan document (*Certificate of Coverage*). The Plan communicates results of Retrospective Review within 30 days of receipt of a request/claim.

The OON provider may bill non-reimbursable charges to the member.

Adverse Benefit Determination. For MH/SUD, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when benefits are excluded. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials.

Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based behavioral clinical policies, or use clinical criteria from third party sources such as American Society of Addiction Medicine (ASAM) Criteria®, Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System-Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) and Early Childhood Service Intensity Instrument (ECSII) guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that outpatient Retrospective Review determinations are appropriate.

The Plan conducts monthly quality audits of individual non-clinical staff clinical reviewers, and peer clinical reviewers, including staff performing appeal functions. These audits are designed and approved by clinical leadership each year. A minimum of two audits are completed per staff, per month. The results of these real-time audits are shared with supervisors for staff oversight, and all findings are remediated. Remediation may include corrective actions and/or additional education, as indicated.

The Plan routinely monitors Retrospective Review performance through its clinical performance oversight functions. Outcomes are monitored against timeliness requirements, performance guarantees, and for potential trends, including overall utilization.

The Plan's national Clinical Quality & Operations Committee (CQOC) annually reviews overall UM program outcomes, including outpatient Retrospective Review outcomes, to confirm overall utilization is appropriate. The national CQOC is comprised of representatives from sub-committees, and representatives from the clinical quality improvement, UM, care engagement, medical operations, medical policy and standards, clinical operations, appeals, product, legal, compliance, network strategy, provider experience, accreditation, and benefits teams. The Chair of the CQOC must be an executive leader, board certified in psychiatry or psychiatric subspecialty, and a licensed physician.

Per the MH/SUD policy entitled, *Core Principles and Practices*, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse clinical coverage benefit determinations (clinical denials) for financial reasons.

MH/SUD generally structures UM processes to comply with federal ERISA requirements and state law where applicable.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- Retrospective Review

Benefit Classification(s)

- OON, outpatient

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHC)

Plan Terms

The Plan's *Schedule of Benefits* notify members of Retrospective Review requirements.

"The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs."

The *Utilization Management Program Description (UMPD)* discusses Post-Service Reviews and indicates:

"Post-service review assesses the appropriateness of medical services on a case-by-case basis after the service has been provided but prior to payment for services. Post-service reviews are based on established review guidelines and includes:

- Review of medical necessity
- Appropriateness of level of care
- Identifying claims issues
- Eligibility determination
- Initiation of appropriate follow-up actions for utilization and quality issues; and
- Identifying appropriateness and administrative issues such as physician notification, emergency status of admission."

The role of the Plan's delegate, United Behavioral Health d/b/a OBH, is discussed in the *UMPD*:

"United Behavioral Health (UBH) performs the review of requests for coverage of behavioral health services (i.e., substance abuse, and mental health requests for services). UBH provides comprehensive behavioral health care delivery for members through a network of behavioral health practitioners, ancillary care providers, hospitals and other facilities.

For mental health, substance-related disorder services, and wraparound services, UBH uses its Clinical Criteria (see below), behavioral clinical policies, and best practice guidelines to make coverage determinations. UBH adopts externally-developed clinical criteria, and creates internally-developed Clinical Criteria, where appropriate, based on its assessment of relevant guidance. UBH develops clinical criteria that supersedes its standard set or adopts externally-developed clinical criteria when required to do so by contract or regulation.

- Clinical Criteria (Level of Care Utilization System-LOCUS) – Standardized level of care assessment tool developed by the American Association of Community Psychiatrists used to make clinical determinations and placement decisions for mental health disorder benefits for adults ages 19 and older when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (Child and Adolescent Level of Care/Service Intensity Utilization System-CALOCUS-CASII) - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry (AACAP) and the American Association for Community Psychiatry (AAP) used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children and adolescents ages 6-18 when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (Early Childhood Service Intensity Instrument-ECSII) – Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children ages 0-5 when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (State or Contract Specific Level of Care Guidelines) -Criteria used to make medical necessity determinations for mental health disorder benefits when there are explicit mandates or contractual requirements.
- Clinical Criteria (American Society of Addiction Medicine [ASAM]) - Criteria developed by the American Society of Addiction Medicine used to make clinical determinations for substance-related disorder benefits.
- Clinical Criteria (Optum Developed)
 - Optum Behavioral Clinical Policies: Criteria that stem from evaluation of new services or treatments or new applications of existing services or treatments and are used to make clinical determinations regarding proven or unproven services and treatments.

Licensed practitioners conduct all reviews with a focus on measurable outcome goals and objectives for treatment. A senior UBH Medical Director is responsible for directing and implementing behavioral health utilization management programs. A referral is sent to UBH when a member is identified as potentially benefiting from behavioral health services during a “medical event.”

The UBH UM Program is staffed by clinical, non-clinical and administrative personnel. All clinical denials or adverse decisions are made by board certified psychiatrists, or, if the health plans choose, by a panel of other appropriate health care service reviewers. If the health plan chooses to use a panel to make adverse decisions, the panel contains at least one physician who is board certified in psychiatry. When the health care service under review is a mental health or substance abuse service, the adverse decision is made by a licensed physician who is board certified in psychiatry. All potential clinical denials are referred to a physician who is board certified in psychiatry for final determination. An evaluation of the overall effectiveness of the Behavioral Health UM Program is conducted annually to determine how well resources have been deployed to improve UM activities and the clinical care and service provided to members.”

The Plan’s terms require services to be medically necessary for coverage.

List of M/S and MH/SUD Services Subject to NQTL

- Services that have not previously been reviewed in Prior Authorization or Concurrent Review
- Services where the service or procedure codes do not match a diagnosis code
- EIU services
- Services that are subject to benefit limits
- Codes identified by the Plan as subject to Retrospective Review

- Please see the file *M/S Retrospective Review Codes* for the list of M/S codes that may be subject to Retrospective Review
- MH/SUD claims that include the following services are subject to Retrospective Review:
 - Partial Hospitalization Program (PHP)/Day Treatment
 - Applied Behavioral Analysis (ABA)

Step 2 – Factors Used to Determine Retrospective Review Applies

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

The Plan relies on the following factor to determine which OON outpatient services are subject to Retrospective Review. This factor applies to M/S and MH/SUD for the following:

- I. M/S OON outpatient services
 - II. MH/SUD OON outpatient services
- Consistency with Clinical Criteria (Qualitative):
 - Whether the application of Retrospective Review promotes optimal clinical outcomes.

This factor applies to M/S and MH/SUD services. Meeting Consistency with Clinical Criteria is determinative in imposing the limitation.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factor used in designing or applying the Plan's Retrospective Review requirement to OON outpatient services. These evidentiary standards and sources apply to the following:

- I. M/S OON outpatient services
- II. MH/SUD OON outpatient services

Factor - Consistency with Clinical Criteria is defined as whether the application of Retrospective Review promotes optimal clinical outcomes.

- The Plan's evidentiary standards and sources that define and/or trigger the Consistency with Clinical Criteria factor:
 - Clinical criteria from nationally recognized, third-party sources (e.g., InterQual or MCG for M/S services, and ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines for MH/SUD services)
 - Clinical Technology Assessment Committee (CTAC) and Medical Technology and Assessment Committee (MTAC) review
 - Objective, evidence-based medical/behavioral clinical policies and nationally recognized guidelines approved by professional healthcare associations (e.g., clinical guidance from the American Medical Association, American Psychiatric Association, etc.)

The *Medical Necessity NQTL* describes the process for determining how internally developed medical/behavioral clinical policies are created and how externally developed third party guidelines are reviewed and approved.

The Plan's evidentiary standards and sources apply to M/S and MH/SUD services. The Consistency with Clinical Criteria factor, evidentiary standards, and sources are defined in a qualitative manner.

The factor and evidentiary standards used as the basis for subjecting MH/SUD OON outpatient benefits to Retrospective Review are comparable to, and applied no more stringently than, the factor and evidentiary standards used as the basis for subjecting M/S OON outpatient benefits to Retrospective Review "as written" and "in operation."

Step 4 – NQTL "As Written" and "In Operation" Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

As Written

The Plan conducted a comparative analysis of the strategies, processes, factor, evidentiary standards, and source information used to determine which M/S and MH/SUD OON outpatient services are subject to Retrospective Review "as written." The Plan identified the factor and evidentiary standards used as the basis for subjecting M/S and MH/SUD benefits to Retrospective Review for each benefit classification.

Review of Factors and Evidentiary Standards

The Plan reviewed the factor that triggers an OON outpatient services to be subject to Retrospective Review. The factor and evidentiary standards were applied to M/S and MH/SUD services comparably and not more stringently to MH/SUD services than M/S services.

Review of Operational Policies and Procedures

The Plan reviewed M/S and MH/SUD operational policies and procedures, and UM annual oversight to confirm comparability and found MH/SUD policies, procedures, and processes to be comparable and no more stringent than M/S policies, procedures, and processes.

- Medical management operational policies and procedures establish the standards for how the Plan conducts outpatient Retrospective Review. The policies and procedures are consistent with state and federal requirements governing Retrospective Review. Timeframes for decisions, content of adverse benefit determinations, appeal rights, and external review are all governed by state and federal requirements.
- UM oversight monitors and evaluates UM processes by reviewing denial rates, clinical appeals, and under- and over-utilization.

Review of Outpatient Retrospective Review Processes

The strategy for applying Retrospective Review to OON outpatient claims is comparable for M/S and MH/SUD services and applied no more stringently to MH/SUD OON outpatient services. The Plan conducted a review of the M/S and MH/SUD Retrospective Review processes to confirm comparability. The review focused on the following aspects of the process for both M/S and MH/SUD:

- Responsibility. The member is responsible for requesting Retrospective Review for M/S and MH/SUD. OON providers may submit the request or claim on behalf of the member.
- Timeframe to submit. The timeframe for the member to submit a Retrospective Review request was reviewed and it was determined that MH/SUD was no more stringent.
 - For M/S, members must notify the Plan within timely filing requirements
 - For MH/SUD, members have 180 days after the service is rendered to request a Retrospective Review
- Clinical Reviews. For M/S and MH/SUD claims, the Plan may request clinical information and refer the claim to a clinical reviewer for a Retrospective Review. The clinical reviewer reviews applicable member clinical information,

benefit plan documents, and clinical criteria in the case review. The clinical reviewer may approve cases that meet applicable clinical criteria, or refer claims to peer clinical reviewers.

- **Review Timeframes.** M/S and MH/SUD Retrospective Review determination timeframes are defined by state and federal requirements. The same determination timeframes apply to M/S and MH/SUD determinations.
- **Determinations, First Level Clinical Review, and Second Level/Peer Clinical Reviews.** Clinical reviewers determine whether an outpatient service is medically necessary. The clinical reviewer may approve the services based on their review. The clinical reviewer refers cases they cannot approve to a peer clinical reviewer. If the peer clinical reviewer determines that a service was not medically necessary and will not be covered, an adverse benefit determination will be issued. Only qualified peer clinical reviewers may issue adverse benefit determinations.
- **Adverse Benefit Determinations.** An adverse benefit determination is recorded as a clinical denial when it is based on clinical criteria and member clinical information and is recorded as an administrative denial when member benefits are exhausted.
- **Notification of Decisions to Providers and Members.** The Plan notifies M/S and MH/SUD OON providers and members of approvals and adverse benefit determinations, including applicable appeal rights, consistent with state and federal requirements.
- **Review of Staff Qualifications.** For M/S and MH/SUD, clinical staff qualifications align with the type of clinical review and state, and federal requirements.
 - M/S is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are conducted by clinical staff (nurses) and all adverse benefit determinations are made by a physician or other appropriate health care professionals.
 - MH/SUD is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians etc.) and all adverse benefit determinations are made by Medical Directors or psychologists.
- **Clinical Criteria.** For M/S and MH/SUD, clinical reviewers and peer clinical reviewers base determinations on objective, evidence-based medical/behavioral clinical policies or use clinical criteria from third party sources such as InterQual, MCG, ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines.

In Operation

The Plan compared the strategies, processes, factor, evidentiary standards, and source information used to determine which M/S and MH/SUD OON outpatient services are subject to Retrospective Review and how Retrospective Review is applied “in operation.”

The Plan subjected claims/requests for M/S and MH/SUD outpatient services to Retrospective Review that were not reviewed in the Prior Authorization or Concurrent Review process. Additionally, M/S claims for outpatient services submitted by OON providers were subject to Retrospective Review if the services or procedure codes did not match a diagnosis code, if services were EIU, or if the services had benefit limits. MH/SUD claims/requests for outpatient services submitted by OON providers may be subject to Retrospective Review if the service or procedure code required Prior Authorization or Concurrent Review, but that review was not conducted and there is a mitigating circumstance. Additionally, claims may be subject to Retrospective Review if the billed services or procedure codes do not match the authorized codes or if services are EIU.

The Plan may request member clinical information for M/S and MH/SUD outpatient claims and refer claims to a clinical reviewer. The clinical reviewer reviewed applicable member clinical information, benefit plan documents, and clinical criteria in the case review. The clinical reviewer approved cases that met applicable clinical criteria or referred cases to peer clinical reviewers. If an appropriately qualified peer clinical reviewer determined that a service was not medically necessary and would not be covered, an adverse benefit determination was issued for the claim.

The Plan communicated all adverse benefit determinations for M/S and MH/SUD outpatient claims/requests that did not meet applicable clinical criteria, including appeal rights, consistent with state and federal requirements.

The Plan conducts monthly quality audits of individual non-clinical staff, clinical reviewers, including staff performing appeal functions. The Plan routinely monitors Retrospective Review performance through its clinical performance oversight functions. In addition to comparing these “in operation” processes, the Plan reviewed medical necessity approval and denial rates, internal appeals outcomes, and external appeals outcomes related to Retrospective Review determinations for M/S and MH/SUD OON outpatient services.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan's or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The findings of the Plan's comparative analyses confirmed the strategies, processes, factor, evidentiary standards, and source information used to subject certain MH/SUD OON outpatient services to Retrospective Review were comparable to, and applied no more stringently than, the strategies, processes, factor, evidentiary standards, and source information used to subject certain M/S OON outpatient services to Retrospective Review “as written.”

The Plan found the factor used to subject OON MH/SUD outpatient services to Retrospective Review was comparable to and applied no more stringently than the factor used to subject OON M/S outpatient services to Retrospective Review “in operation.”

All M/S outpatient services were subject to Retrospective Review if they were not reviewed via Prior Authorization or Concurrent Review. Additionally, M/S claims for outpatient services submitted by OON providers were subject to Retrospective Review if the services or procedure codes did not match a diagnosis code, if services were EIU, or if the services had benefit limits. MH/SUD claims for outpatient services submitted by OON providers may be subject to Retrospective Review if the service or procedure code required Prior Authorization or Concurrent Review, but that review was not conducted and there is a mitigating circumstance. Additionally, claims may be subject to Retrospective Review if the billed services or procedure codes do not match the authorized codes or if services are EIU.

The Plan used comparable processes to conduct Retrospective Review of claims for M/S and MH/SUD outpatient services. The Plan may request clinical information if necessary. The Plan approved M/S and MH/SUD claims/requests for outpatient services that met applicable clinical criteria or guidelines. The Plan issued an adverse benefit determination for M/S and MH/SUD OON provider claims/requests for outpatient services that did not meet applicable clinical criteria or guidelines.

OON outpatient medical necessity approval and denial rates and appeals outcomes data from 01/01/2022 – 12/31/2022 were evaluated where a minimum threshold of 100 cases were available to ensure a valid data set for analysis. The Plan has established that a minimum of at least 100 M/S and MH/SUD cases are required within each classification for a comparative analysis. Meaningful conclusions cannot be reached when there are fewer than 100 cases within each classification because the data is subject to variability.

Because Georgia Surest Plan became effective on 07/2023 there is minimal membership and as a result an insufficient number of cases from 01/01/2022 – 12/31/2022 to support an in operation analysis. While the Plan notes that the U.S. Department of Labor has indicated generally that outcomes data are not dispositive of parity compliance, the Plan will conduct a comparative analysis of outcomes data, including medical necessity approval and denial rates and appeals outcomes, when there is a minimum of 100 cases available to ensure a valid data set for analysis.

Conclusions

The Plan concluded that how Retrospective Review is applied to MH/SUD OON outpatient services was comparable to, and applied no more stringently than, how Retrospective Review is applied to M/S OON outpatient services “as written.”

Retrospective Review – Out-of-Network Outpatient Non-Quantitative Treatment Limitation (NQTL) Analysis

GA Surest - UnitedHealthcare Insurance Company

12/29/2023

The Plan reviewed the M/S and MH/SUD processes including responsibility for submission, timeframes for submission and review, notification to members and providers, clinical standards for review, and staff qualifications review and concluded how the Plan conducts Retrospective Review for MH/SUD OON outpatient services “in operation” was comparable to, and applied no more stringently than, how the Plan conducts Retrospective Review for M/S OON outpatient services “in operation.”

Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical/surgical (M/S) benefits. This generally means that financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements, such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage.

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Concurrent Review is defined as “a clinical review of an extension of previously approved, ongoing course of treatment over a period of time or number of treatments conducted during an inpatient stay or ongoing ambulatory care. It is sometimes called a “continued stay review.”” The *Optum National Policy Definitions List* defines a Concurrent (Review) Request as “a request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care.” Concurrent Review does not involve onsite reviews.

Concurrent Review is a component of the Plan’s Utilization Management (UM) program that helps ensure members receive appropriate coverage based on their specific clinical status and health care needs. The process is designed to achieve optimal clinical outcomes by applying objective, evidence-based clinical criteria, and nationally recognized guidelines and best practices. Concurrent Review is a UM process that involves applying the benefit plan language and/or clinical criteria to make the most appropriate clinical coverage benefit determination.

This document includes the following information:

- The Concurrent Review process for M/S and MH/SUD inpatient services
- The description of the NQTL and application (Step 1)
- Factors used to determine which services are subject to the NQTL (Step 2)
- Evidentiary standards and sources used to define, trigger, and/or implicate a factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

This analysis refers to the following attachments:

- *Addendum A* - Identifies the M/S and MH/SUD inpatient services that are subject to Concurrent Review
- *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions* - M/S policy that defines Concurrent Review
- *Optum National Policy Definitions List* - MH/SUD policy that defines Concurrent Review
- *Utilization Management Program Description (UMPD) of United HealthCare Services, Inc. and UnitedHealthcare Insurance Company* - Summarizes the philosophy, structure and standards that govern UHC’s medical management, UM and utilization review responsibilities and functions

- *Management of Behavioral Health Benefits Policy*- Describes the mechanisms and processes designed to promote consistency in the management of behavioral health benefits and to ensure that members receive appropriate, high quality behavioral health services in a timely manner
- *Certificates of Coverage* *Certificates of Coverage* for example: *COC23-INS-2018-LG-GA*, *COC23-HMO-2018-LG-GA*, *COC23-INS-2018-SG-GA*, and *COC23-INS-RV-2018-LG-GA*- Plan document that explains covered services, terms, conditions, and limitations of the member's policy
- Plan document that explains covered services, terms, conditions, and limitations of the member's policy
- *Core Principles and Practices*- MH/SUD policy that outlines the Core Principles and Practices that should be used by personnel in their interactions with members, authorized member representatives, practitioners and facilities, related to the management of behavioral health benefits, coverage determinations and appeals/grievances of non-coverage determinations
- *Performance Assessment and Incentives*- M/S policy confirming that clinical reviewers are not incented to make denials for financial reasons
- *2023 UnitedHealthcare Provider Administrative Guide* – Informs M/S providers of the Concurrent Review process. The *UnitedHealthcare Provider Administrative Guide* can be accessed on the website <https://www.uhcprovider.com/en/admin-guides.html>
- *September 2023 Optum National Network Manual* - Informs MH/SUD providers of the Concurrent Review process. <https://public.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/optum-network-manual.html>

The Plan concludes that the Concurrent Review requirements for M/S and MH/SUD are comparable and applied no more stringently for MH/SUD in-network (INN) inpatient benefits both “as written” and “in operation.”

Process

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Concurrent Review is defined as “a clinical review of an extension of previously approved, ongoing course of treatment over a period of time or number of treatments conducted during an inpatient stay or ongoing ambulatory care. It is sometimes called “continued stay review.” The *Optum National Policy Definitions List* defines a Concurrent (Review) Request as “a request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care.”

The Plan structures inpatient Concurrent Review processes to be compliant with all applicable federal and state laws, as well as the National Committee for Quality Assurance (NCQA) accreditation standards. NCQA confirms that the Plan's operations and policies identify appropriate timeframes for decisions, requires decision-making by appropriate personnel, and governs communication of adverse benefit determinations. In addition, Concurrent Review is governed at both the state and federal level, which includes consumer protections such as external review for adverse benefit determinations after internal appeals options are exhausted.

The Plan delegates management of MH/SUD inpatient services, including Concurrent Review for MH/SUD inpatient services, to United Behavioral Health d/b/a Optum Behavioral Health (OBH), its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor.

Addendum A includes a list of all service categories subject to inpatient Concurrent Review.

Concurrent Review of M/S inpatient admissions consists of the following:

Initial Concurrent Review. The Plan requires INN facilities and providers to timely notify the Plan (e.g., within 24 hours) of an unplanned (e.g., urgent/emergent) inpatient admission. Provider notification triggers the inpatient Concurrent Review process. Providers can notify the Plan through the secure provider portal (www.uhcprovider.com), their connected electronic medical

record, by telephone, or by fax (where required).

The Plan confirms receipt of the Concurrent Review request. Non-clinical staff confirm member eligibility and benefit coverage upon receipt of the notification. Non-clinical staff may approve coverage requests in scenarios where the member's plan documents allow and if a clinical review is not required. Non-clinical staff will also approve a coverage request if the facility's contract does not allow for clinical reviews. Non-clinical staff refer coverage requests that they cannot approve to initial clinical reviewers.

First Level Clinical Review/Initial Review. Clinical reviewers (nurses or physicians) consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether the inpatient admission is medically necessary by reviewing the member's clinical information, the applicable clinical criteria or guidelines, and the Plan benefit terms. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs to determine whether the applicable clinical criteria are met or may access clinical information in the provider's electronic medical record (EMR) if the provider has given the Plan access. The clinical reviewer may approve the admission based on their review.

Second Level Clinical Review/Peer Review. The initial clinical reviewer refers cases to a second level/peer clinical reviewer if the case cannot be approved. Peer clinical reviewers (physician or mid-level practitioner) consult clinical criteria when making clinical coverage benefit determinations. Peer clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs. Only qualified peer clinical reviewers (e.g., Medical Director) can issue adverse benefit determinations. The peer clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. If a peer clinical reviewer issues an adverse benefit determination, then the Plan timely communicates the adverse benefit determination, including appeal rights, and offers a peer-to-peer conversation consistent with state, federal, and accreditation requirements.

Adverse Benefit Determination. For M/S, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when benefits are exhausted. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials. Modified coverage requests that are approved are recorded as partial denials.

Ongoing Concurrent Review. INN M/S facilities may request coverage of additional days prior to the expiration of the last day of an approved inpatient admission. The Plan conducts ongoing Concurrent Reviews for additional days for approved inpatient M/S admissions.

The Plan follows the initial Concurrent Review clinical review process when conducting ongoing Concurrent Reviews.

Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based medical clinical policies and clinical criteria from third party sources such as InterQual® or MCG® guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that inpatient Concurrent Review determinations are appropriate.

Per the M/S policy entitled, *Performance Assessment and Incentives*, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons.

M/S generally structures UM processes to comply with federal Employee Retirement Income Security Act of 1974 (ERISA) requirements, NCQA UM standards, and state law where applicable.

Concurrent Review of MH/SUD Inpatient Admissions consists of the following:

The Plan delegates management of MH/SUD inpatient services, including Concurrent Review, to United Behavioral Health d/b/a OBH, its delegated MH/SUD MBHO vendor.

Initial Concurrent Review. All INN inpatient admissions are subject to the Concurrent Review process. The Plan requires INN providers and facilities to timely notify the Plan of MH/SUD inpatient admissions. INN facilities must notify the Plan within one business day after an admission unless a longer period is required by contract or state-specific requirements. Provider notification triggers the inpatient Concurrent Review process. Providers notify the Plan of the need for additional days/services by telephone.

As described in the *Management of Behavioral Health Benefits Policy*, upon receipt of admission notification, non-clinical staff confirm member eligibility and benefit coverage. Non-clinical staff may approve cases that do not require clinical evaluation or interpretation based on the member's diagnosis and the clinical information submitted by providers. Non-clinical staff refer cases that they cannot approve to initial clinical reviewers.

First Level Clinical Review/Initial Review. Clinical decisions are made by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse benefit determinations are made by Medical Directors. Clinical reviewers consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether an inpatient admission is medically necessary by reviewing the member's clinical information, the applicable clinical criteria or guidelines, and the Plan benefit terms. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for certification, related diagnostic results, and history of related treatment and services to determine whether the applicable clinical criteria are met. The clinical reviewer may approve the admission based on their review.

Second Level Clinical Review/Peer Review. The initial clinical reviewer refers cases to a peer clinical reviewer for a peer-to-peer discussion if the case cannot be approved. The requesting provider is offered the opportunity to discuss the case with the peer clinical reviewer, consistent with state, federal, and accreditation requirements before an adverse benefit determination is issued. Only qualified peer clinical reviewers (e.g., Medical Directors) can issue adverse benefit determinations. Peer clinical reviewers apply clinical criteria to member clinical information to determine coverage for an inpatient admission. If the requesting provider fails to complete the peer-to-peer discussion, the peer clinical reviewer makes a determination based on the information available. If a peer clinical reviewer issues an adverse benefit determination, (e.g., the admission is not medically necessary and is not approved), then the Plan timely communicates the adverse benefit determination, including appeal rights, to the member and provider consistent with applicable state, federal, and accreditation requirements.

Adverse Benefit Determination. For MH/SUD, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as a clinical denial when it is based on clinical criteria and member clinical information.

Ongoing Concurrent Review. INN providers may request coverage for additional days by contacting the Plan prior to the expiration of the last covered day of an approved MH/SUD inpatient admission.

Clinical Criteria. Initial clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based behavioral clinical policies or use clinical criteria from third party sources such as American Society of Addiction Medicine (ASAM) Criteria®, Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization

System-Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) and Early Childhood Service Intensity Instrument (ECSII) guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure inpatient Concurrent Review determinations are appropriate.

MH/SUD generally structures UM processes to comply with federal ERISA requirements, NCQA UM standards, and state law, where applicable.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- Concurrent Review

Benefit Classification(s)

- INN, inpatient

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHIC)
- UnitedHealthcare of Georgia, Inc. (UHCGA)
- UnitedHealthcare Insurance Company of the River Valley (UHICRV)

Plan Terms/Source Document(s)

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Concurrent Review is defined as “a clinical review of an extension of previously approved, ongoing course of treatment over a period of time or number of treatments conducted during an inpatient stay or ongoing ambulatory care. It is sometimes called a “continued stay review.” Concurrent Review does not involve onsite reviews.

The *Optum National Policy Definitions List* defines a Concurrent (Review) Request as “a request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care.”

The Plan’s *Certificates of Coverage* notify members of Concurrent Review requirements:

“The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, Concurrent Review, case management, discharge planning, retrospective review or similar programs.”

The *2023 UnitedHealthcare Care Provider Administrative Guide* notifies providers of the Concurrent Review requirements. INN providers are required to comply with UM protocols established by the Plan:

We determine the medical necessity of inpatient admissions through either concurrent or retrospective review. We require you to comply with our requests:

- For information, documents or discussions related to our reviews and discharge planning. This includes primary and secondary diagnosis, clinical information, treatment plan, admission order, patient status, discharge planning needs, barriers to discharge and discharge date. When available, provide access to electronic medical records (EMR).
- From our interdisciplinary care coordination team and/or Medical Director. This includes our requests that you help us engage our members directly face-to-face or by phone.
 - If you receive the request before 1 p.m. local time:

- › Supply all requested information within 4 hours
- If you receive our request after 1 p.m. local time:
 - › Provide the information within the same business day, but no later than 12 p.m. local time the next business day

The *Optum National Network Manual*, September 2023 Edition notifies providers of the Concurrent Review requirements. INN providers are required to comply with UM protocols established by the Plan:

In most cases, inpatient admissions will be directed only to participating hospitals and attending psychiatrists.

All inpatient and sub-acute level of care admissions require notification or pre-authorization by the network provider or facility. Optum requires notification within one business day after an admission for a facility to request a pre-authorization unless a longer period is required by contract or state specific requirements. This includes, but is not limited to, mental health or substance abuse disorder services delivered as inpatient treatment, partial/day hospitalization or residential treatment.

Network providers are solely responsible for completing prior notification or obtaining preauthorization prior to providing inpatient or sub-acute level of care services. This includes timely provision of information necessary for concurrent review of continued stay or ongoing care requests prior to the delivery of services.

Should a provider fail to obtain or otherwise follow the required administrative procedures for notification or pre-authorization, Optum may, in accordance with applicable law, apply a reduction of payment to the network provider up to 100% of provider's reimbursement rate. Network provider payment reductions for failure to complete notification or obtain pre-authorization are solely the network provider's liability (i.e., the member cannot be billed for these reductions in payment).

The role of the Plan's delegate, United Behavioral Health d/b/a OBH, is discussed in the *UMPD*.

“United Behavioral Health (UBH) manages comprehensive behavioral health care delivery for members through a network of behavioral health practitioners, ancillary care providers, hospitals and other facilities. The management includes review of behavioral health care services (e.g., substance abuse and mental health requests for services).

UBH applies objective, evidence-based clinical criteria when making benefit coverage determinations while taking into account individual needs and the local delivery system. The clinical criteria are based on guidance produced by government sources, professional societies, and published research. In addition to making benefit coverage determinations, the clinical criteria inform discussions about evidence-based practices and discharge planning.

UBH selects externally developed clinical criteria and creates internally developed clinical criteria, where appropriate, based on its assessment of relevant guidance. The selection and development of clinical criteria incorporates:

- Annual review of clinical criteria and the procedures for applying them
- Involvement of appropriate stakeholders
- Dissemination of clinical criteria
- Ongoing monitoring and review of Centers for Medicare and Medicaid (CMS) Medicare Coverage Summaries, new or revised guidance in its CMS Local or National Coverage Determinations that are relevant to behavioral health
- Communication of updates to relevant areas

UBH uses the following clinical criteria:

- Clinical Criteria (Level of Care Utilization System-LOCUS) – Standardized level of care assessment tool developed by the American Association of Community Psychiatrists used to make clinical determinations and

placement decisions for mental health disorder benefits for adults ages 19 and older when State or Contract Specific Level of Care Guidelines do not apply.

- Clinical Criteria (Child and Adolescent Level of Care/Service Intensity Utilization System-CALOCUS-CASII) – Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry (AACAP) and the American Association for Community Psychiatry (AACP) used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children and adolescents ages 6-18 when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (Early Childhood Service Intensity Instrument-ECSII) - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children ages 0-5 when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (American Psychological Association Psychological and Neuropsychological Testing Billing and Coding Guide) - Comprehensive billing and coding guide developed by the APA used for making clinical determinations for behavioral health psychological and neuropsychological testing services.
- Clinical Criteria (State or Contract Specific Supplemental Clinical Criteria) - Criteria used to make medical necessity determinations for mental health disorder benefits when there are explicit mandates or contractual requirements.
- Clinical Criteria (American Society of Addiction Medicine [ASAM]) - Criteria developed by the American Society of Addiction Medicine used to make clinical determinations for substance-related disorder benefits.
- Clinical Criteria (UBH Developed)
 - UBH Behavioral Clinical Policies: Criteria that stem from evaluation of new services or treatments or new applications of existing services or treatments and are used to make clinical determinations regarding proven or unproven services and treatments.

The UBH UM Program is staffed by clinical, non-clinical and administrative personnel. A senior UBH Medical Director is responsible for directing and implementing the UM Programs. All clinical denials or adverse decisions are made by board certified psychiatrists, or, if the health plans choose, by a panel of other appropriate clinical peer reviewers. If the health plan chooses to use a panel to make adverse decisions, the panel contains at least one physician who is board certified in psychiatry. When the health care service under review is a mental health or substance abuse service, the adverse decision is made by a licensed physician who is board certified in psychiatry. Potential clinical denials are referred to a physician who is board certified in psychiatry for final determination.

An evaluation of the overall effectiveness of the Behavioral Health UM Program is conducted annually to determine how well resources have been deployed to improve UM activities and the clinical care and service provided to members.”

The Plan’s terms require services to be medically necessary for coverage. INN providers are required to comply with the Plan’s UM protocols including complying with Concurrent Review requirements.

List of M/S and MH/SUD Services Subject to NQTL

Addendum A, attached, lists the M/S and MH/SUD INN inpatient service categories subject to Concurrent Review. Concurrent Review is one component of the UM program that evaluates whether a benefit or service is medically necessary.

- The “Member” tab lists the service categories for which the member is responsible for providing notification for both INN and out-of-network (OON) services. The “Member” tab includes all products in the scope of the analysis.
- The “Provider” tab lists the service categories for which the provider is responsible for providing notification for INN

services. The “Provider” tab applies to all Plans in the scope of the analysis.

Step 2 – Factors Used in the Design and Application of the NQTL

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

The Plan relies on the following factor to determine which INN inpatient services are subject to initial Concurrent Review (design). This factor applies to M/S and MH/SUD for the following:

- I. M/S: General Hospital, SNF, AIR, LTACH
 - II. MH/SUD: Inpatient and residential facilities
- All M/S and MH/SUD Inpatient Admissions – Initial Concurrent Review (Qualitative)
 - All unplanned M/S and MH/SUD inpatient admissions are subject to initial Concurrent Review

The Plan relies on the following factor to determine which INN inpatient services are subject to ongoing Concurrent Review (design). This factor applies to M/S and MH/SUD for the following:

- I. M/S: General Hospital, Specialty Hospital, SNF, AIR, LTACH
 - II. MH/SUD: Inpatient and residential facilities
- All M/S and MH/SUD Inpatient Admission Requests for Additional Days – Ongoing Concurrent Review (Qualitative)
 - All M/S and MH/SUD inpatient admissions are subject to ongoing Concurrent Review if coverage of additional days is requested after initial Concurrent Review approved days expire

The factors apply to M/S and MH/SUD services. The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL. All Concurrent Reviews are subject to Clinical Appropriateness and must have medical necessity criteria.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below is the evidentiary standard and source used to define, trigger, and/or implicate the factor used in designing and applying the Plan’s initial Concurrent Review requirement to INN inpatient services. This evidentiary standard and source apply to the following:

- I. M/S: General Hospital, Specialty Hospital, SNF, AIR, LTACH
- II. MH/SUD: Inpatient and residential facilities

Factor – All M/S and MH/SUD Inpatient Admissions – Initial Concurrent Review includes all inpatient admissions.

- The Plan’s evidentiary standard and source that define and/or trigger the factor is provider notification of an inpatient admission

The Plan's evidentiary standard and source apply to M/S and MH/SUD services and are defined in a qualitative manner.

Below is the evidentiary standard and source used to define, trigger, and/or implicate the factor used in designing and applying the Plan's ongoing Concurrent Review requirement to INN inpatient services. This evidentiary standard and source apply to the following:

- I. M/S: General Hospital, Specialty Hospital, SNF, AIR, LTACH
- II. MH/SUD: Inpatient and residential facilities

Factor – All M/S and MH/SUD Inpatient Admission Requests for Additional Days – Ongoing Concurrent Review includes all inpatient admissions for which a provider requests coverage of additional days.

- The Plan's evidentiary standard and source that define and/or trigger the factor is an inpatient admission for which a provider requests coverage of additional days

The Plan's evidentiary standard and source apply to M/S and MH/SUD services and are defined in a qualitative manner.

The factors and evidentiary standards used as the basis for subjecting MH/SUD INN inpatient services to Concurrent Review are comparable to, and applied no more stringently than, the factors used as the basis for subjecting M/S INN inpatient benefits to Concurrent Review "as written" and "in operation." The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL.

Step 4 – NQTL "As Written" and "In Operation" Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

As Written

The Plan conducted a comparative analysis of the strategies, processes, factors, evidentiary standards, and source information used to determine which M/S and MH/SUD INN inpatient services are subject to Concurrent Review and how Concurrent Review is applied to M/S and MH/SUD INN inpatient services "as written." The Plan identified the factors and evidentiary standards used as the basis for subjecting M/S and MH/SUD benefits to Concurrent Review.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Conclusions

The Plan reviewed the M/S and MH/SUD Concurrent Review operational policies and procedures and concluded the methodology used to determine which MH/SUD INN inpatient services are subject to Concurrent Review "as written" were comparable to, and applied no more stringently than, the methodology used to determine which M/S INN inpatient services

Concurrent Review – Inpatient In-Network Non-Quantitative Treatment Limitation (NQTL) Analysis

GA – UnitedHealthcare Insurance Company, UnitedHealthcare of Georgia,

Inc. and UnitedHealthcare Insurance Company of the River Valley

12/29/2023



are subject to Concurrent Review “as written.” Additionally, the Plan concluded that how Concurrent Review is applied to MH/SUD INN inpatient services was comparable to, and applied no more stringently than, how Concurrent Review is applied to M/S INN inpatient services “as written.”

The Plan reviewed the M/S and MH/SUD processes, including responsibility for submission, timeframes for submission and review, notification to members and providers, clinical standards for review, staff qualifications, outcomes data, and IRR assessment results and concluded how the Plan conducts Concurrent Review for MH/SUD INN inpatient services “in operation” was comparable to, and applied no more stringently than, how the Plan conducts Concurrent Review for M/S INN inpatient services “in operation.”

Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical/surgical (M/S) benefits. This generally means that the financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements, such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage.

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Concurrent Review is defined as “a clinical review of an extension of previously approved, ongoing course of treatment over a period of time or number of treatments conducted during an inpatient stay or ongoing ambulatory care. It is sometimes called a “continued stay review.”” The *Optum National Policy Definitions List* defines a Concurrent (Review) Request as “a request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care. Concurrent Review does not involve onsite reviews.”

Concurrent Review is a component of the Plan’s Utilization Management (UM) program that helps ensure members receive appropriate coverage based on their specific clinical status and health care needs. The process is designed to achieve optimal clinical outcomes by applying objective, evidence-based clinical criteria and nationally recognized guidelines and best practices. Concurrent Review is a UM process that involves applying the benefit plan language and/or clinical criteria to make the most appropriate clinical coverage benefit determination.

This document includes the following information:

- The Concurrent Review process for M/S and MH/SUD outpatient services
- The description of the NQTL and application (Step 1)
- Factors used to determine which services are subject to the NQTL (Step 2)
- Evidentiary standards and sources used to define, trigger, and or implicate a factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

This analysis refers to the following attachments:

- *Addendum A* - Identifies the M/S and MH/SUD outpatient services that are subject to Concurrent Review
- *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions* - M/S policy that defines Concurrent Review
- *Optum National Policy Definitions List* - MH/SUD policy that defines Concurrent Review
- *Utilization Management Program Description (UMPD) of United HealthCare Services, Inc. and UnitedHealthcare Insurance Company* - Summarizes the philosophy, structure and standards that govern UHC’s medical management, UM and utilization review responsibilities and functions

- *Management of Behavioral Health Benefits Policy*- Describes the mechanisms and processes designed to promote consistency in the management of behavioral health benefits and to ensure that members receive appropriate, high quality behavioral health services in a timely manner
- *Concurrent Review Factor Grid(s) (2023 Prior Auth_Concurrent Rev Factor Grid)*- Details the service categories subject to Concurrent Review and the shared factors and evidentiary standards used as the basis for subjecting M/S and MH/SUD outpatient benefits to Concurrent Review
- *Certificates of Coverage* (for example: *COC23-INS-2018-LG-GA*, *COC23-HMO-2018-LG-GA* and *COC23-INS-2018-SG-GA*)- Plan document that explains covered services, terms, conditions, and limitations of the member's policy
- *Schedule of Benefits (SBN23-Medical-HMO-2018-[Choice][Select][Doctors]-LG-GA, SBN23-Medical-HMO-2018-[Choice][Select][Doctors]-SG-GA, SBN23-Medical-INS-2018-[Choice+Plus][Select+Plus][Doctors+Plus]-LG-GA and SBN23-Medical-INS-2018-[Choice+Plus][Select+Plus][Doctors+Plus]-SG-GA)*- Plan document that outlines member responsibilities
- *Core Principles and Practices*- MH/SUD policy that outlines the core principles and practices that should be used by personnel in their interactions with members, authorized member representatives, practitioners and facilities, related to the management of behavioral health benefits, coverage determinations and appeals/grievances of non-coverage determinations
- *Performance Assessment and Incentives*- M/S policy confirming that clinical reviewers are not incented to make denials for financial reasons
- *2023 UnitedHealthcare Provider Administrative Guide* – Informs M/S providers of the Concurrent Review process. The *UnitedHealthcare Provider Administrative Guide* can be accessed on the website <https://www.uhcprovider.com/en/admin-guides.html>
- *September 2023 Optum National Network Manual*- Informs MH/SUD providers of the Concurrent Review process. <https://public.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/optum-network-manual.html>

The Plan concludes that the Concurrent Review requirements for M/S and MH/SUD are comparable and applied no more stringently for MH/SUD in-network (INN) outpatient benefits both “as written” and “in operation.”

Process

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Concurrent Review is defined as: “a clinical review of an extension of previously approved, ongoing course of treatment over a period of time or number of treatments conducted during an inpatient stay or ongoing ambulatory care. It is sometimes called “continued stay review.” The *Optum National Policy Definitions List* defines a Concurrent (Review) Request as: “a request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care.”

The Plan structures outpatient Concurrent Review processes to be compliant with all applicable federal and state requirements, as well as the National Committee for Quality Assurance (NCQA) accreditation standards. NCQA confirms that the Plan's operations and policies identify appropriate timeframes for decisions, requires decision-making by appropriate personnel, and governs communication of adverse benefit determinations. In addition, Concurrent Review is governed at both the state and federal level, which includes consumer protections such as external review for adverse benefit determinations after internal appeals options are exhausted.

The Plan delegates management of MH/SUD outpatient services, including Concurrent Review to United Behavioral Health d/b/a Optum Behavioral Health (OBH), its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor.

The Plan has national committees that approve M/S and MH/SUD outpatient services to be subject to Concurrent Review. Additionally, the Plan has a standard process for assessing the services that are subjected to Concurrent Review and whether they should be retained or removed from the list of services that are subject to Concurrent Review. *Addendum A* includes a list of all service categories subject to outpatient Concurrent Review.

Concurrent Review of M/S outpatient services consists of the following:

The Plan requires INN M/S providers to submit a Concurrent Review request for outpatient services that are described on *Addendum A*. The INN provider's submission of a request (notification) triggers the Concurrent Review process.

The Plan requires INN M/S providers to timely request coverage of additional units of service or extensions of time for services previously approved in Prior Authorization. The Plan reclassifies M/S outpatient Concurrent Review coverage requests as preservice/Prior Authorization requests consistent with NCQA UM standards. The Plan follows the outpatient Prior Authorization process for these requests and uses the outpatient Prior Authorization process to review requests for coverage of additional units of service or extensions of time for previously approved services.

INN providers may submit Prior Authorization requests through the secure provider portal (www.uhcprovider.com), their connected electronic medical record, by telephone, or by fax (where required). Members may submit Prior Authorization requests by phone, fax, or mail, in accordance with Plan requirements. Providers and members communicate basic information to create a case. As outlined in the *UnitedHealthcare Care Provider Administrative Guide*, providers must submit advance notification with supporting documentation as soon as possible, but at least two weeks before the planned service, unless otherwise stated. The provider's submission of a request (notification) triggers the Prior Authorization process.

The Plan confirms receipt of the Prior Authorization request. Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. Non-clinical staff may administratively deny coverage if member benefits are exhausted. Non-clinical staff review cases to ensure availability of accurate and thorough case information. Non-clinical staff may approve coverage requests in scenarios where the member's plan documents allow and if a clinical review is not required. Requests that are submitted through the secure provider portal may also be approved based on the benefit plan coverage criteria, member diagnosis, and the clinical information submitted. Non-clinical staff refer cases that they cannot approve or administratively deny to initial clinical reviewers for medical necessity review.

First Level Clinical Review/Initial Review. Clinical reviewers (nurses) consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs to determine whether the applicable clinical criteria are met. The clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. The clinical reviewer can approve cases that meet applicable clinical criteria.

Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Peer clinical reviewers (physician or mid-level practitioner) consult clinical criteria when making clinical coverage benefit determinations. Peer clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs. The peer clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If a peer clinical reviewer issues an adverse benefit determination, then the Plan communicates the adverse benefit determination, including appeal rights, and offers a peer-to-peer conversation consistent with state, federal, and accreditation requirements.

Adverse Benefit Determination. For M/S, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when member benefits are exhausted. Modified coverage requests that are approved are recorded as partial denials.

Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based medical clinical policies or use clinical criteria from third party sources such as InterQual® or MCG® guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that outpatient Concurrent Review determinations are appropriate.

Per the M/S policy entitled, *Performance Assessment and Incentives*, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons.

M/S generally structures UM processes to comply with federal Employee Retirement Income Security Act of 1974 (ERISA) requirements, NCQA UM standards, and state law, where applicable.

Concurrent Review of MH/SUD outpatient services consists of the following:

The Plan delegates management of MH/SUD outpatient services, including Concurrent Review, to United Behavioral Health d/b/a OBH, its delegated MH/SUD MBHO vendor.

The Plan classifies MH/SUD outpatient requests as either urgent Concurrent Review or preservice depending on whether the MH/SUD request meets the NCQA standard for urgent or standard preservice requests.

The Plan requires INN MH/SUD providers to submit a Concurrent Review request for outpatient services that are described on *Addendum A*. Provider notification triggers the outpatient Concurrent Review process. Outpatient Concurrent Review begins when INN provider requests coverage for additional units of service and/or periods of time beyond those initially authorized by the Plan.

INN providers may submit authorization requests through the secure provider portal (www.providerexpress.com), by telephone, or by fax (where required). Members may submit authorization requests by telephone, fax, or mail, in accordance with Plan requirements. Intensive Outpatient Program (IOP) providers notify the Plan of the need for additional days/services by telephone and Partial Hospitalization Program (PHP) providers notify the Plan of the need for additional days/services by telephone or the secure provider portal.

As described in the *Management of Behavioral Health Benefits Policy*, the Plan confirms receipt of the Concurrent Review request. Non-clinical staff confirm member eligibility and benefit coverage. Non-clinical staff may approve cases that do not require clinical evaluation or interpretation based on the member's diagnosis and the clinical information submitted by providers. Non-clinical staff refer cases that they cannot approve to the initial clinical reviewers.

First Level Clinical Review/Initial Review. Clinical decisions are made by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse benefit determinations are made by Medical Directors or psychologists. Clinical reviewers consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether a service is medically necessary by reviewing the member's clinical information, the applicable clinical criteria or guidelines, and the Plan benefit terms. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for certification, related diagnostic results, and history of related treatment and services. The clinical reviewer may approve cases that meet applicable clinical criteria.

Second Level Clinical Review/Peer Review. The initial clinical reviewer refers cases to a peer clinical reviewer for a peer-to-peer discussion if the case cannot be approved. The requesting provider is offered the opportunity to discuss the case with the peer clinical reviewer, consistent with state, federal, and accreditation requirements before an adverse benefit determination is issued. Only qualified peer clinical reviewers (e.g., Medical Directors or psychologists) can issue adverse benefit determinations. Peer clinical reviewers apply clinical criteria to member clinical information to determine coverage for

additional units of service during an extended period of time. If the requesting provider fails to complete the peer-to-peer discussion, the peer clinical reviewer makes a determination based on the information available. If a peer clinical reviewer issues an adverse benefit determination, (e.g., that numbers of treatments or extensions of time are not authorized), then the Plan timely communicates the adverse benefit determination, including appeal rights, to the member and provider consistent with applicable state, federal, and accreditation requirements.

Adverse Benefit Determination. For MH/SUD, an adverse benefit determination is recorded as a clinical denial when it is based on clinical criteria and member clinical information.

Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity clinical coverage determinations on objective, evidence-based behavioral clinical policies or use clinical criteria from third-party sources such as, American Society of Addiction Medicine (ASAM) Criteria®, Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System-Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) and Early Childhood Service Intensity Instrument (ECSII) guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that outpatient Concurrent Review determinations are appropriate.

MH/SUD generally structures UM processes to comply with federal ERISA requirements, NCQA UM standards, and state law, where applicable.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- Concurrent Review

Benefit Classification(s)

- INN, outpatient

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHIC)
- UnitedHealthcare of Georgia, Inc. (UHCGA)

Plan Terms/Source Document(s)

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Concurrent Review is defined as “A clinical review of an extension of previously approved, ongoing course of treatment over a period of time or number of treatments conducted during an inpatient stay or ongoing ambulatory care. It is sometimes called a “continued stay review.””

The *Optum National Policy Definitions List* defines a Concurrent (Review) Request as:

“A request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care. In addition, the following should be considered when defining Concurrent Reviews:

- If a request to extend a course of treatment beyond the period of time or number of treatments previously approved by the organization does not meet the definition of urgent care, the request may be handled as a new request and decided within the time frame appropriate for the type of decision (e.g., standard pre-service or post-service review).

- In addition, a request made while a member is in the process of receiving care should be considered an urgent Concurrent (Review) Request if the care requested meets the definition of urgent, even if the organization did not previously approve the earlier care.”

The Plan’s Certificates of Coverage notifies members of Concurrent Review requirements:

“The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, Concurrent Review, case management, discharge planning, retrospective review or similar programs.”

The *2023 UnitedHealthcare Care Provider Administrative Guide* notifies providers of the Concurrent Review requirements. INN providers are required to comply with UM protocols established by the Plan:

“We determine the medical necessity of inpatient admissions through either concurrent or retrospective review. We require you to comply with our requests:

- For information, documents or discussions related to our reviews and discharge planning. This includes primary and secondary diagnosis, clinical information, treatment plan, admission order, patient status, discharge planning needs, barriers to discharge and discharge date. When available, provide access to electronic medical records (EMR).
- From our interdisciplinary care coordination team and/or Medical Director. This includes our requests that you help us engage our members directly face-to-face or by phone.
 - If you receive the request before 1 p.m. local time:
 - › Supply all requested information within 4 hours
 - If you receive our request after 1 p.m. local time:
 - › Provide the information within the same business day, but no later than 12 p.m. local time the next business day”

The *Optum National Network Manual*, September 2023 Edition notifies providers of the Concurrent Review requirements. INN providers are required to comply with UM protocols established by the Plan:

“In most cases, inpatient admissions will be directed only to participating hospitals and attending psychiatrists.

All inpatient and sub-acute level of care admissions require notification or pre-authorization by the network provider or facility. Optum requires notification within one business day after an admission for a facility to request a pre-authorization unless a longer period is required by contract or state specific requirements. This includes, but is not limited to, mental health or substance abuse disorder services delivered as inpatient treatment, partial/day hospitalization or residential treatment.

Network providers are solely responsible for completing prior notification or obtaining preauthorization prior to providing inpatient or sub-acute level of care services. This includes timely provision of information necessary for concurrent review of continued stay or ongoing care requests prior to the delivery of services.

Should a provider fail to obtain or otherwise follow the required administrative procedures for notification or pre-authorization, Optum may, in accordance with applicable law, apply a reduction of payment to the network provider up to 100% of provider's reimbursement rate. Network provider payment reductions for failure to complete notification or obtain pre-authorization are solely the network provider's liability (i.e., the member cannot be billed for these reductions in payment).”

The role of the Plan’s delegate, United Behavioral Health d/b/a OBH, is discussed in the *UMPD*:

“United Behavioral Health (UBH) manages comprehensive behavioral health care delivery for members through a network of behavioral health practitioners, ancillary care providers, hospitals and other facilities. The management includes review of behavioral health care services (e.g., substance abuse and mental health requests for services).

UBH applies objective, evidence-based clinical criteria when making benefit coverage determinations while taking into account individual needs and the local delivery system. The clinical criteria are based on guidance produced by government sources, professional societies, and published research. In addition to making benefit coverage determinations, the clinical criteria inform discussions about evidence-based practices and discharge planning.

UBH selects externally developed clinical criteria and creates internally developed clinical criteria, where appropriate, based on its assessment of relevant guidance. The selection and development of clinical criteria incorporates:

- Annual review of clinical criteria and the procedures for applying them
- Involvement of appropriate stakeholders
- Dissemination of clinical criteria
- Ongoing monitoring and review of Centers for Medicare and Medicaid (CMS) Medicare Coverage Summaries, new or revised guidance in its CMS Local or National Coverage Determinations that are relevant to behavioral health
- Communication of updates to relevant areas

UBH uses the following clinical criteria:

- Clinical Criteria (Level of Care Utilization System-LOCUS) – Standardized level of care assessment tool developed by the American Association of Community Psychiatrists used to make clinical determinations and placement decisions for mental health disorder benefits for adults ages 19 and older when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (Child and Adolescent Level of Care/Service Intensity Utilization System-CALOCUS-CASII) – Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry (AACAP) and the American Association for Community Psychiatry (AACP) used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children and adolescents ages 6-18 when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (Early Childhood Service Intensity Instrument-ECSII) - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children ages 0-5 when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (American Psychological Association Psychological and Neuropsychological Testing Billing and Coding Guide) - Comprehensive billing and coding guide developed by the APA used for making clinical determinations for behavioral health psychological and neuropsychological testing services.
- Clinical Criteria (State or Contract Specific Supplemental Clinical Criteria) - Criteria used to make medical necessity determinations for mental health disorder benefits when there are explicit mandates or contractual requirements.
- Clinical Criteria (American Society of Addiction Medicine [ASAM]) - Criteria developed by the American Society of Addiction Medicine used to make clinical determinations for substance-related disorder benefits.
- Clinical Criteria (UBH Developed)
 - UBH Behavioral Clinical Policies: Criteria that stem from evaluation of new services or treatments or new applications of existing services or treatments and are used to make clinical determinations regarding proven or unproven services and treatments.
 - UBH Supplemental Clinical Criteria: Criteria used to make clinical determinations for Applied Behavior Analysis and Electroconvulsive Therapy.
 - UBH's Supplement to the APA Psychological and Neuropsychological Testing Billing and Coding Guide: Additional criteria used regarding provider qualifications, coverage rationale, limitations, and developmental testing.

The UBH UM Program is staffed by clinical, non-clinical and administrative personnel. A senior UBH Medical Director is responsible for directing and implementing the UM Programs. All clinical denials or adverse decisions are made by board

certified psychiatrists, or, if the health plans choose, by a panel of other appropriate clinical peer reviewers. If the health plan chooses to use a panel to make adverse decisions, the panel contains at least one physician who is board certified in psychiatry. When the health care service under review is a mental health or substance abuse service, the adverse decision is made by a licensed physician who is board certified in psychiatry. Potential clinical denials are referred to a physician who is board certified in psychiatry for final determination.

An evaluation of the overall effectiveness of the Behavioral Health UM Program is conducted annually to determine how well resources have been deployed to improve UM activities and the clinical care and service provided to members.”

The Plan’s terms require services to be medically necessary for coverage. INN providers are required to comply with the Plan’s UM protocols including complying with Concurrent Review requirements.

List of M/S and MH/SUD Services Subject to NQTL

Addendum A, attached, lists the M/S and MH/SUD INN outpatient service categories subject to Concurrent Review.

Concurrent Review is one component of the UM program that evaluates whether a benefit or service is medically necessary.

- The “Member” tab lists the service categories for which the member is responsible for providing notification for both INN and out-of-network (OON) services. The “Member” tab includes all products in the scope of the analysis.
- The “Provider” tab lists the service categories for which the provider is responsible for providing notification for INN services. The “Provider” tab applies to all Plans in the scope of the analysis.

Step 2 – Factors Used in the Design and Application of the NQTL

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

The list of services subject to Concurrent Review was originally designed by enterprise clinical leadership. Concurrent Review was applied to new services when they became covered by the Plan and met certain criteria. Examples of Concurrent Review determinants that existed in the business at the time included:

- to monitor and prevent potential overutilization and under-utilization
- manage high-cost and prolonged-duration services
- ensure enrollee safety
- determine the appropriate level of care
- determine whether the service or item is medically necessary

The factors relied upon to determine which INN outpatient benefits were subjected to Concurrent Review were updated and replaced in 2021 with the factors Clinical Appropriateness, Value, and Variation as defined below. After this time, all M/S services subject to Concurrent Review must meet Clinical Appropriateness and all MH/SUD services subject to Concurrent Review must meet Clinical Appropriateness and at least one of the other factors.

Starting in 2022, any additions or deletions to the list of services subject to Concurrent Review were reviewed and approved through committees.

The Plan relies on the following factors to determine which INN outpatient services are added to the list of services subject to Concurrent Review. These factors apply to M/S and MH/SUD for the following:

- I. M/S: INN outpatient Services
 - II. MH/SUD: INN outpatient Services
- Clinical Appropriateness (Qualitative)

Applies to M/S and MH/SUD services.

- Value (Quantitative)

Applies to MH/SUD and M/S services.

- Variation (Quantitative)

Applies to MH/SUD and M/S services

For M/S meeting Clinical Appropriateness is determinative in imposing the limitation. For MH/SUD meeting Clinical Appropriateness plus Value and/or Variation is determinative in imposing the limitation. The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL.

In 2023, to further refine how decisions are made to subject M/S and MH/SUD INN outpatient services to Concurrent Review, the enterprise adopted factors to be assessed when considering whether to remove or retain services on the list of services subject to Concurrent Review. These changes were implemented September 2023. The assessment first considered the factors for removal of the service from the Concurrent Review list. If the service met a removal factor, the Plan then assessed if the service met a retention factor. Services that met a retention factor were retained on the Concurrent Review list. Services that did not meet a removal factor remained on the Concurrent Review list based on the original add factors.

The Plan relies on the following factors to determine which INN outpatient benefits are removed from the list of services subject to Concurrent Review. These factors apply to M/S and MH/SUD benefits for the following:

- I. M/S: INN outpatient services
- II. MH/SUD: INN outpatient services

- Low Value (Quantitative)

Applies to M/S and MH/SUD services.

- Consistency (Quantitative)

Applies to M/S and MH/SUD services.

- Low Volume (Quantitative)

Applies to M/S and MH/SUD services.

Please note that if the primary code within a code family meets the requirements for removal, the family of codes will be addressed in a similar fashion per medical policy and clinical practice patterns.

The Plan then relies on the following factors to determine which INN outpatient benefits are retained on the list of services subject to Concurrent Review. These factors apply to M/S and MH/SUD benefits for the following:

- I. M/S: INN outpatient services
- II. MH/SUD: INN outpatient services

- Services that are experimental, investigational, or unproven (EIU) (Qualitative)

Applies to M/S and MH/SUD services.

- Patient Safety (Qualitative)

Applies to M/S and MH/SUD services.

- Level of Care (Quantitative)

Applies to M/S and MH/SUD services.

- High-Cost Drugs and Services that are greater than \$100,000 (Quantitative)

Applies to M/S and MH/SUD services.

For M/S meeting Clinical Appropriateness is determinative in imposing the limitation. For MH/SUD meeting Clinical Appropriateness plus Value and/or Variation is determinative in imposing the limitation. If the service met a removal factor, the Plan then assessed if the service met a retention factor. Services that met a retention factor were retained on the list of services subject to Concurrent Review. Meeting any one of the factors is determinative in retaining the limitation. The factors are not weighted in that no individual factor carries more value than another in retaining the NQTL.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factors used to add services to the list of services subject to outpatient Concurrent Review. These evidentiary standards and sources apply to benefits for the following:

- I. M/S: INN outpatient services
- II. MH/SUD: INN outpatient services

Factor – Clinical Appropriateness

Factor – Value

Factor – Variation

Factor - Low Value

Factor - Consistency

Factor - Low Volume

The Plan then relies on the following factors to determine which INN outpatient benefits are retained on the list of services that are subject to Concurrent Review. These factors apply to M/S and MH/SUD benefits for the following:

- I. M/S: INN outpatient services
- II. MH/SUD: INN outpatient services

Factor - Services that are EIU

Factor - Patient Safety

Factor - Level of Care

Factor - High-Cost Drugs and Services that are greater than \$100,000

Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

As Written

The Plan conducted a comparative analysis of the strategies, processes, factors, evidentiary standards, and source information used to determine which M/S and MH/SUD INN outpatient services are subject to Concurrent Review and how Concurrent Review is applied to M/S and MH/SUD INN outpatient services “as written.” The Plan identified the factors and evidentiary standards used as the basis for subjecting M/S and MH/SUD INN outpatient benefits to Concurrent Review.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan's or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The findings of the Plan's comparative analyses confirmed the strategies, processes, factors, evidentiary standards, and source information used to determine the MH/SUD INN outpatient services subject to Concurrent Review were comparable to, and applied no more stringently than, the strategies, processes, factors, evidentiary standards, and source information used to determine the M/S INN outpatient services subject to Concurrent Review “as written.” For M/S and MH/SUD INN outpatient benefits, the *Concurrent Review Factor Grid(s)* included with this analysis detail the shared factors used as the basis for adding, removing or retaining M/S and MH/SUD INN outpatient services on the list of services subject to Concurrent Review, as described above.

Conclusions

The Plan reviewed the M/S and MH/SUD Concurrent Review operational policies and procedures and concluded the methodology used to determine which MH/SUD INN outpatient services are subject to Concurrent Review “as written” were comparable to, and applied no more stringently than, the methodology used to determine which M/S INN outpatient services are subject to Concurrent Review “as written.” Additionally, the Plan concluded that how Concurrent Review is applied to MH/SUD INN outpatient services was comparable to, and applied no more stringently than, how Concurrent Review is applied to M/S INN outpatient services “as written.”

The Plan reviewed the M/S and MH/SUD processes, including responsibility for submission, timeframes for submission and review, notification to members and providers, clinical standards for review, staff qualifications, outcomes data, and IRR assessment results and concluded how the Plan conducts Concurrent Review for MH/SUD INN outpatient services “in operation” was comparable to, and applied no more stringently than, how the Plan conducts Concurrent Review for M/S INN outpatient services “in operation.”

Concurrent Review – Inpatient Out-of-Network NQTL Analysis

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical/surgical (M/S) benefits. This generally means that financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements, such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage.

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Concurrent Review is defined as “a clinical review of an extension of previously approved, ongoing course of treatment over a period of time or number of treatments conducted during an inpatient stay or ongoing ambulatory care. It is sometimes called a “continued stay review.” The *Optum National Policy Definitions List* defines a Concurrent (Review) Request as “a request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care.” Concurrent Review does not involve onsite reviews.

Concurrent Review is a component of the Plan’s Utilization Management (UM) program that helps ensure members receive appropriate coverage based on their specific clinical status and health care needs. The process is designed to achieve optimal clinical outcomes by applying objective, evidence-based clinical criteria, and nationally recognized guidelines and best practices. Concurrent Review is a UM process that involves applying the benefit plan language and/or clinical criteria to make the most appropriate clinical coverage benefit determination.

This document includes the following information:

- The Concurrent Review process for both M/S and MH/SUD inpatient services
- The description of the NQTL and application (Step 1)
- Factors used to determine which services are subject to the NQTL (Step 2)
- Evidentiary standards and sources used to define, trigger, and or implicate a factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

This analysis refers to the following attachments:

- *Addendum A* – Identifies the M/S and MH/SUD inpatient services that are subject to Concurrent Review
- *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions* - M/S policy that defines Concurrent Review
- *Optum National Policy Definitions List* - MH/SUD policy that defines Concurrent Review

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- *Utilization Management Program Description (UMPD) of United HealthCare Services, Inc. and UnitedHealthcare Insurance Company* - summarizes the philosophy, structure and standards that govern UHC's medical management, UM and utilization review responsibilities and functions
- *Management of Behavioral Health Benefits Policy* - Describes the mechanisms and processes designed to promote consistency in the management of behavioral health benefits and to ensure that members receive appropriate, high quality behavioral health services in a timely manner.
- *Certificates of Coverage* (for example: *COC23-INS-2018-LG-GA*, *COC23-INS-2018-SG-GA*, and *COC23-INS-RV-2018-LG-GA*) - Plan document that explains covered services, terms, conditions, and limitations of the member's policy
- *Schedule of Benefits* (SBN23-Medical-INS-2018-[Choice+Plus][Select+Plus][Doctors+Plus]-LG-GA, SBN23-Medical-INS-2018-[Choice+Plus][Select+Plus][Doctors+Plus]-SG-GA and SBN23-Medical-INS-RV-2018-HeritagePlus-LG-GA) - Plan document that outlines member responsibilities
- *Core Principles and Practices* - MH/SUD policy that outlines the Core Principles and Practices that should be used by personnel in their interactions with members, authorized member representatives, practitioners and facilities, related to the management of behavioral health benefits, coverage determinations and appeals/grievances of non-coverage determinations
- *Performance Assessment and Incentives* - M/S policy confirming that clinical reviewers are not incented to make denials for financial reasons

The Plan concludes that the Concurrent Review requirements for M/S and MH/SUD are comparable and applied no more stringently for MH/SUD out-of-network (OON) inpatient benefits both "as written" and "in operation."

Process

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Concurrent Review is defined as "a clinical review of an extension of previously approved, ongoing course of treatment over a period of time or number of treatments conducted during an inpatient stay or ongoing ambulatory care. It is sometimes called "continued stay review." The *Optum National Policy Definitions List* defines a Concurrent (Review) Request as "a request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care."

The Plan structures inpatient Concurrent Review processes to be compliant with all applicable federal and state laws, as well as the National Committee for Quality Assurance (NCQA) accreditation standards. NCQA confirms that the Plan's operations and policies identify appropriate timeframes for decisions, requires decision-making by appropriate personnel, and governs communication of adverse benefit determinations. In addition, Concurrent Review is governed at both the state and federal level, which includes consumer protections such as external review for adverse benefit determinations after internal appeals options are exhausted.

The Plan delegates management of MH/SUD inpatient services, including Concurrent Review for MH/SUD inpatient services, to United Behavioral Health d/b/a Optum Behavioral Health (OBH), its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor.

Addendum A includes a list of all service categories subject to inpatient Concurrent Review.

Concurrent Review of M/S Inpatient Admissions consists of the following:

Initial Concurrent Review. Members are required to ensure that OON facilities and providers timely notify the Plan (e.g., within 24 hours) of an unplanned (e.g., urgent/emergent) inpatient admission. Notification triggers the inpatient Concurrent Review process. OON facilities can notify the Plan by telephone or fax (where required).

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The Plan confirms receipt of the Concurrent Review request. Non-clinical staff confirm member eligibility and benefit coverage upon receipt of the notification. Non-clinical staff may approve coverage requests in scenarios where the member's plan documents allow and if a clinical review is not required. Non-clinical staff refer coverage requests that they cannot approve to initial clinical reviewers.

First Level Clinical Review/Initial Review. Clinical reviewers (nurses or physicians) consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether the inpatient admission is medically necessary by reviewing the member's clinical information, the applicable clinical criteria or guidelines, and the Plan benefit terms. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs to determine whether the applicable clinical criteria are met. The clinical reviewer may approve the admission based on their review.

Second Level Clinical Review/Peer Review. The initial clinical reviewer refers cases to a second level/peer clinical reviewer if the case cannot be approved. Peer clinical reviewers (physician or mid-level practitioner) consult clinical criteria when making clinical coverage benefit determinations. Peer clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs. Only qualified peer clinical reviewers (e.g., Medical Director) can issue adverse benefit determinations. The peer clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. If a peer clinical reviewer issues an adverse benefit determination, then the Plan timely communicates the adverse benefit determination, including appeal rights, and offers a peer-to-peer conversation consistent with state, federal, and accreditation requirements.

Adverse Benefit Determination. For M/S, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when benefits are exhausted. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials. Modified coverage requests that are approved are recorded as partial denials.

Ongoing Concurrent Review. OON M/S facilities may request coverage of additional days prior to the expiration of the last day of an approved inpatient admission. The Plan conducts ongoing Concurrent Reviews for additional days for approved inpatient M/S admissions.

The Plan follows the initial Concurrent Review clinical review process when conducting ongoing Concurrent Reviews.

Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based medical clinical policies and clinical criteria from third party sources such as InterQual® or MCG® guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that inpatient Concurrent Review determinations are appropriate.

Per the M/S policy entitled, *Performance Assessment and Incentives*, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons.

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M/S generally structures UM processes to comply with federal Employee Retirement Income Security Act of 1974 (ERISA) requirements, NCQA UM standards, and state law where applicable.

Concurrent Review of MH/SUD Inpatient Admissions consists of the following:

The Plan delegates management of MH/SUD inpatient services, including Concurrent Review, to United Behavioral Health d/b/a OBH, its delegated MH/SUD MBHO vendor.

Initial Concurrent Review. All OON inpatient admissions are subject to the Concurrent Review process. The Plan requires that members ensure that OON providers and facilities timely notify the Plan of inpatient admissions. Notification triggers the inpatient Concurrent Review process. Providers notify the Plan of the need for additional days/services by telephone.

As described in the *Management of Behavioral Health Benefits Policy*, upon receipt of admission notification, non-clinical staff confirm member eligibility and benefit coverage. Non-clinical staff may approve cases that do not require clinical evaluation or interpretation based on the member's diagnosis and the clinical information submitted by providers. Non-clinical staff refer cases that they cannot approve to initial clinical reviewers.

First Level Clinical Review/Initial Review. Clinical decisions are made by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse benefit determinations are made by Medical Directors. Clinical reviewers consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether an inpatient admission is medically necessary by reviewing the member's clinical information, the applicable clinical criteria or guidelines, and the Plan benefit terms. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for certification, related diagnostic results, and history of related treatment and services to determine whether the applicable clinical criteria are met. The clinical reviewer may approve the admission based on their review.

Second Level Clinical Review/Peer Review. The initial clinical reviewer refers cases to a peer clinical reviewer for a peer-to-peer discussion if the case cannot be approved. The requesting provider is offered the opportunity to discuss the case with the peer clinical reviewer, consistent with state, federal, and accreditation requirements before an adverse benefit determination is issued. Only qualified peer clinical reviewers (e.g., Medical Directors) can issue adverse benefit determinations. Peer clinical reviewers apply clinical criteria to member clinical information to determine coverage for an inpatient admission. If the requesting provider fails to complete the peer-to-peer discussion, the peer clinical reviewer makes a determination based on the information available. If a peer clinical reviewer issues an adverse benefit determination, (e.g., the admission is not medically necessary and is not approved), then the Plan timely communicates the adverse benefit determination, including appeal rights, to the member and provider consistent with applicable state, federal, and accreditation requirements.

Adverse Benefit Determination. For MH/SUD, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as a clinical denial when it is based on clinical criteria and member clinical information.

Ongoing Concurrent Review. OON providers may request coverage for additional days by contacting the Plan prior to expiration of the last covered day of an approved MH/SUD inpatient admission.

Clinical Criteria. Initial clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based behavioral clinical policies or use clinical criteria from third party sources such as American Society of Addiction Medicine (ASAM) Criteria®, Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System-Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) and Early Childhood Service Intensity Instrument (ECSII) guidelines.

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Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure inpatient Concurrent Review determinations are appropriate.

MH/SUD generally structures UM processes to comply with federal ERISA requirements, NCQA UM standards, and state law, where applicable.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- Concurrent Review

Benefit Classification(s)

- OON, inpatient

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHIC)
- UnitedHealthcare Insurance Company of the River Valley (UHICRV)

Plan Terms/Source Document(s)

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Concurrent Review is defined as “a clinical review of an extension of previously approved, ongoing course of treatment over a period of time or number of treatments conducted during an inpatient stay or ongoing ambulatory care. It is sometimes called a “continued stay review.”” Concurrent Review does not involve onsite reviews.

The *Optum National Policy Definitions List* defines a Concurrent (Review) Request as “a request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care.”

The Plan’s *Certificates of Coverage* notify members of Concurrent Review requirements:

“The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, Concurrent Review, case management, discharge planning, retrospective review or similar programs.”

The role of the Plan’s delegate, United Behavioral Health d/b/a OBH, is discussed in the *UMPD*:

“United Behavioral Health (UBH) manages comprehensive behavioral health care delivery for members through a network of behavioral health practitioners, ancillary care providers, hospitals and other facilities. The management includes review of behavioral health care services (e.g., substance abuse and mental health requests for services).

UBH applies objective, evidence-based clinical criteria when making benefit coverage determinations while taking into account individual needs and the local delivery system. The clinical criteria are based on guidance produced by government sources, professional societies, and published research. In addition to making benefit coverage determinations, the clinical criteria inform discussions about evidence-based practices and discharge planning.

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UBH selects externally developed clinical criteria and creates internally developed clinical criteria, where appropriate, based on its assessment of relevant guidance. The selection and development of clinical criteria incorporates:

- Annual review of clinical criteria and the procedures for applying them
- Involvement of appropriate stakeholders
- Dissemination of clinical criteria
- Ongoing monitoring and review of Centers for Medicare and Medicaid (CMS) Medicare Coverage Summaries, new or revised guidance in its CMS Local or National Coverage Determinations that are relevant to behavioral health
- Communication of updates to relevant areas

UBH uses the following clinical criteria:

- Clinical Criteria (Level of Care Utilization System-LOCUS) – Standardized level of care assessment tool developed by the American Association of Community Psychiatrists used to make clinical determinations and placement decisions for mental health disorder benefits for adults ages 19 and older when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (Child and Adolescent Level of Care/Service Intensity Utilization System-CALOCUS-CASII) – Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry (AACAP) and the American Association for Community Psychiatry (AACP) used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children and adolescents ages 6-18 when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (Early Childhood Service Intensity Instrument-ECSII) - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children ages 0-5 when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (American Psychological Association Psychological and Neuropsychological Testing Billing and Coding Guide) - Comprehensive billing and coding guide developed by the APA used for making clinical determinations for behavioral health psychological and neuropsychological testing services.
- Clinical Criteria (State or Contract Specific Supplemental Clinical Criteria) - Criteria used to make medical necessity determinations for mental health disorder benefits when there are explicit mandates or contractual requirements.
- Clinical Criteria (American Society of Addiction Medicine [ASAM]) - Criteria developed by the American Society of Addiction Medicine used to make clinical determinations for substance-related disorder benefits.
- Clinical Criteria (UBH Developed)
 - UBH Behavioral Clinical Policies: Criteria that stem from evaluation of new services or treatments or new applications of existing services or treatments and are used to make clinical determinations regarding proven or unproven services and treatments.

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The UBH UM Program is staffed by clinical, non-clinical and administrative personnel. A senior UBH Medical Director is responsible for directing and implementing the UM Programs. All clinical denials or adverse decisions are made by board certified psychiatrists, or, if the health plans choose, by a panel of other appropriate clinical peer reviewers. If the health plan chooses to use a panel to make adverse decisions, the panel contains at least one physician who is board certified in psychiatry. When the health care service under review is a mental health or substance abuse service, the adverse decision is made by a licensed physician who is board certified in psychiatry. Potential clinical denials are referred to a physician who is board certified in psychiatry for final determination.

An evaluation of the overall effectiveness of the Behavioral Health UM Program is conducted annually to determine how well resources have been deployed to improve UM activities and the clinical care and service provided to members.”

The Plan’s terms require services to be medically necessary for coverage.

List of M/S and MH/SUD Services Subject to NQTL

Addendum A, attached, lists the M/S and MH/SUD OON inpatient service categories subject to Concurrent Review.

Concurrent Review is one component of the UM program that evaluates whether a benefit or service is medically necessary.

- The “Member” tab lists the service categories for which the member is responsible for providing notification for both in-network (INN) and OON services. The “Member” tab includes all products in the scope of the analysis.
- The “Provider” tab lists the service categories for which the provider is responsible for providing notification for INN services. The “Provider” tab applies to all Plans in the scope of the analysis.

Step 2 – Factors Used in the Design and Application of the NQTL

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

The Plan relies on the following factor to determine which OON inpatient services are subject to initial Concurrent Review (design). This factor applies to M/S and MH/SUD for the following:

- I. M/S: General Hospital, Specialty Hospital, SNF, AIR, LTACH
 - II. MH/SUD: Inpatient and residential facilities
- **All M/S and MH/SUD Inpatient Admissions – Initial Concurrent Review (Qualitative)**
 - All unplanned M/S and MH/SUD inpatient admissions are subject to initial Concurrent Review

The Plan relies on the following factor to determine which OON inpatient services are subject to ongoing Concurrent Review (design). This factor applies to M/S and MH/SUD for the following:

- I. M/S: General Hospital, Specialty Hospital, SNF, AIR, LTACH
 - II. MH/SUD: Inpatient and residential facilities
- **All M/S and MH/SUD Inpatient Admissions Request for Additional Days – Ongoing Concurrent Review (Qualitative)**
 - All M/S and MH/SUD inpatient admissions are subject to ongoing Concurrent Review if coverage of additional days is requested after initial Concurrent Review approved days expire

Concurrent Review – Inpatient Out-of-Network Non-Quantitative Treatment Limitation (NQTL) Analysis

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The factors apply to M/S and MH/SUD services. The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL. All Concurrent Reviews are subject to Clinical Appropriateness and must have medical necessity criteria.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below is the evidentiary standard and source used to define, trigger, and/or implicate the factor used in designing and applying the Plan's initial Concurrent Review requirement to OON inpatient services. This evidentiary standard and source apply to the following:

- I. M/S: General Hospital, Specialty Hospital, SNF, AIR, LTACH
- II. MH/SUD: Inpatient and residential facilities

Factor – All M/S and MH/SUD Inpatient Admissions – Initial Concurrent Review includes all inpatient admissions.

- The Plan's evidentiary standard and source that define and/or trigger the factor are provider notification of an inpatient admission

The Plan's evidentiary standard and source apply to M/S and MH/SUD services and are defined in a qualitative manner.

Below is the evidentiary standard and source used to define, trigger, and/or implicate the factors used in designing and applying the Plan's ongoing Concurrent Review requirement to OON inpatient services. This evidentiary standard and source apply to the following:

- I. M/S: General Hospital, Specialty Hospital, SNF, AIR, LTACH
- II. MH/SUD: Inpatient and residential facilities

Factor – All M/S and MH/SUD Inpatient Admissions Request for Additional Days – Ongoing Concurrent Review includes all inpatient admissions for which a provider requests coverage of additional days.

- The Plan's evidentiary standard and source that define and/or trigger the factor is an inpatient admission for which a provider requests coverage of additional days

The Plan's evidentiary standard and source apply to M/S and MH/SUD services and is defined in a qualitative manner.

The factors and evidentiary standards used as the basis for subjecting MH/SUD OON inpatient services to Concurrent Review are comparable to, and applied no more stringently than, the factors used as the basis for subjecting M/S OON inpatient benefits to Concurrent Review "as written" and "in operation." The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL.

Concurrent Review – Inpatient Out-of-Network Non-Quantitative Treatment Limitation (NQTL) Analysis

GA – UnitedHealthcare Insurance Company and UnitedHealthcare Insurance

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Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

As Written

The Plan conducted a comparative analysis of the strategies, processes, factors, evidentiary standards, and source information used to determine which M/S and MH/SUD OON inpatient services are subject to Concurrent Review and how Concurrent Review is applied to M/S and MH/SUD OON inpatient services “as written.” The Plan identified the factors and evidentiary standards used as the basis for subjecting M/S and MH/SUD benefits to Concurrent Review.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The findings of the Plan's comparative analyses confirmed the strategies, processes, factors, evidentiary standards, and source information used to determine the MH/SUD OON inpatient services subject to initial and ongoing Concurrent Review were comparable to, and applied no more stringently than, the strategies, processes, factors, evidentiary standards, and source information used to determine the M/S OON inpatient services subject to initial and ongoing Concurrent Review “as written.”

Conclusions

The Plan reviewed the M/S and MH/SUD Concurrent Review operational policies and procedures and concluded the methodology used to determine which MH/SUD OON inpatient services are subject to Concurrent Review “as written” were comparable to, and applied no more stringently than, the methodology used to determine which M/S OON inpatient services are subject to Concurrent Review “as written.” Additionally, the Plan concluded that how Concurrent Review is applied to MH/SUD OON inpatient services was comparable to, and applied no more stringently than, how Concurrent Review is applied to M/S OON inpatient services “as written.”

The Plan reviewed the M/S and MH/SUD processes, including responsibility for submission, timeframes for submission and review, notification to members and providers, clinical standards for review, staff qualifications, outcomes data, and IRR assessment results and concluded how the Plan conducts Concurrent Review for MH/SUD OON inpatient services “in operation” was comparable to, and applied no more stringently than, how the Plan conducts Concurrent Review for M/S OON inpatient services “in operation.”

Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical/surgical (M/S) benefits. This generally means that the financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements, such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage.

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Concurrent Review is defined as “a clinical review of an extension of previously approved, ongoing course of treatment over a period of time or number of treatments conducted during an inpatient stay or ongoing ambulatory care. It is sometimes called a “continued stay review.”” The *Optum National Policy Definitions List* defines a Concurrent (Review) Request as “a request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care. Concurrent Review does not involve onsite reviews.”

Concurrent Review is a component of the Plan’s Utilization Management (UM) program that helps ensure members receive appropriate coverage based on their specific clinical status and health care needs. The process is designed to achieve optimal clinical outcomes by applying objective, evidence-based clinical criteria and nationally recognized guidelines and best practices. Concurrent Review is a UM process that involves applying the benefit plan language and/or clinical criteria to make the most appropriate clinical coverage benefit determination.

This document includes the following information:

- The Concurrent Review process for M/S and MH/SUD outpatient services
- The description of the NQTL and application (Step 1)
- Factors used to determine which services are subject to the NQTL (Step 2)
- Evidentiary standards and sources used to define, trigger and or implicate a factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

This analysis refers to the following attachments:

- *Addendum A* – Identifies the M/S and MH/SUD outpatient services that are subject to Concurrent Review
- *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions* – M/S policy that defines Concurrent Review
- *Optum National Policy Definitions List* – MH/SUD policy that defines Concurrent Review
- *Utilization Management Program Description (UMPD) of United HealthCare Services, Inc. and UnitedHealthcare Insurance Company* - Summarizes the philosophy, structure and standards that govern UHC’s medical management, UM and utilization review responsibilities and functions
- *Management of Behavioral Health Benefits Policy* - Describes the mechanisms and processes designed to promote

consistency in the management of behavioral health benefits and to ensure that members receive appropriate, high quality behavioral health services in a timely manner

- *Concurrent Review Factor Grid(s) (2023 Prior Auth_Concurrent Rev Factor Grid)* - Details the service categories subject to Concurrent Review and the shared factors and evidentiary standards used as the basis for subjecting M/S and MH/SUD outpatient benefits to Concurrent Review
- *Certificates of Coverage* (for example: *COC23-INS-2018-LG-GA* and *COC23-INS-2018-SG-GA*) - Plan document that explains covered services, terms, conditions, and limitations of the member's policy
- *Schedule of Benefits* (SBN23-Medical-INS-2018-[Choice+Plus][Select+Plus][Doctors+Plus]-LG-GA and SBN23-Medical-INS-2018-[Choice+Plus][Select+Plus][Doctors+Plus]-SG-GA) - Plan document that outlines member responsibilities
- *Core Principles and Practices* - MH/SUD policy that outlines the core principles and practices that should be used by personnel in their interactions with members, authorized member representatives, practitioners and facilities, related to the management of behavioral health benefits, coverage determinations and appeals/grievances of non-coverage determinations
- *Performance Assessment and Incentives* - M/S policy confirming that clinical reviewers are not incented to make denials for financial reasons

The Plan concludes that the Concurrent Review requirements for M/S and MH/SUD are comparable and applied no more stringently for MH/SUD out-of-network (OON) outpatient benefits both "as written" and "in operation."

Process

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Concurrent Review is defined as "a clinical review of an extension of previously approved, ongoing course of treatment over a period of time or number of treatments conducted during an inpatient stay or ongoing ambulatory care. It is sometimes called "continued stay review." The *Optum National Policy Definitions List* defines a Concurrent (Review) Request as "a request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care."

The Plan structures outpatient Concurrent Review processes to be compliant with all applicable federal and state requirements, as well as the National Committee for Quality Assurance (NCQA) accreditation standards. NCQA confirms that the Plan's operations and policies identify appropriate timeframes for decisions, requires decision-making by appropriate personnel, and governs communication of adverse benefit determinations. In addition, Concurrent Review is governed at both the state and federal level, which includes consumer protections such as external review for adverse benefit determinations after internal appeals options are exhausted.

The Plan delegates management of MH/SUD outpatient services, including Concurrent Review to United Behavioral Health d/b/a Optum Behavioral Health (OBH), its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor.

The Plan has national committees that approve M/S and MH/SUD outpatient services to be subject to Concurrent Review. Additionally, the Plan has a standard process for assessing the services that are subjected to Concurrent Review and whether they should be retained or removed from the list of services that are subject to Concurrent Review. *Addendum A* includes a list of all service categories subject to outpatient Concurrent Review.

Concurrent Review of M/S outpatient services consists of the following:

Members are required to ensure that OON M/S providers submit clinical information for Concurrent Review for outpatient services that are described on *Addendum A*. The member's benefit plan document (e.g., *Schedule of Benefits*) identifies the services for which the member is responsible for obtaining Prior Authorization and by extension Concurrent Review. The OON provider can request Concurrent Review on behalf of the member.

The Plan requires members, or OON M/S providers on the member's behalf, to timely request coverage of additional units of service or extensions of time for services previously approved in Prior Authorization. The Plan reclassifies M/S outpatient Concurrent Review coverage requests as preservice/Prior Authorization requests consistent with NCQA UM standards. The Plan follows the outpatient Prior Authorization process for these requests and uses the outpatient Prior Authorization process to review requests for coverage of additional units of service or extensions of time for previously approved services.

Members may submit Prior Authorization requests by phone, fax, or mail, in accordance with Plan requirements. OON providers may submit authorization requests on behalf of the member by phone or by fax (where required). Providers and members communicate basic information to create a case. The member or OON provider's submission of a request (notification) triggers the Prior Authorization process.

The Plan confirms receipt of the Prior Authorization request. Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification and non-clinical staff may administratively deny coverage if member benefits are exhausted. Non-clinical staff review cases to ensure availability of accurate and thorough case information. Non-clinical staff may approve coverage requests in scenarios where the member's plan documents allow and if a clinical review is not required. Non-clinical staff refer cases that they cannot approve or administratively deny to the initial clinical reviewers for medical necessity review.

First Level Clinical Review/Initial Review. Clinical reviewers (nurses) consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs to determine whether the applicable clinical criteria are met. The clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. The clinical reviewer can approve cases that meet applicable clinical criteria.

Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Peer clinical reviewers (physician or mid-level practitioner) consult clinical criteria when making clinical coverage benefit determinations. Peer clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs. The peer clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If a peer clinical reviewer issues an adverse benefit determination, then the Plan communicates the adverse benefit determination, including appeal rights, and offers a peer-to-peer conversation consistent with state, federal, and accreditation requirements.

Adverse Benefit Determination. For M/S, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when member benefits are exhausted. Modified coverage requests that are approved are recorded as partial denials.

Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity benefit determinations on objective, evidence-based medical clinical policies or use clinical criteria from third party sources such as InterQual® or MCG® guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that outpatient Concurrent Review determinations are appropriate.

Concurrent Review of MH/SUD outpatient services consists of the following:

The Plan delegates management of MH/SUD outpatient services, including Concurrent Review, to United Behavioral Health d/b/a OBH, its delegated MH/SUD MBHO vendor.

The Plan classifies MH/SUD outpatient requests as either urgent Concurrent Review or preservice depending on whether the MH/SUD request meets the NCQA standard for urgent or standard preservice requests.

Members are required to ensure that the rendering OON provider submits clinical information for Concurrent Review for outpatient services that are described on *Addendum A*. The OON provider must provide clinical information on the member's behalf. The member's benefit plan document (e.g., *Schedule of Benefits*) identifies the services for which the member is responsible for obtaining Concurrent Review. Provider notification triggers the outpatient Concurrent Review process. Concurrent Review begins when OON providers request coverage for additional units of service and/or periods of time beyond those initially authorized by the Plan.

Outpatient OON providers notify the Plan of the need for additional days/services by telephone or by fax (where required).

As described in the *Management of Behavioral Health Benefits Policy*, the Plan confirms receipt of the Concurrent Review request. Non-clinical staff confirm member eligibility and benefit coverage. Non-clinical staff may approve cases that do not require clinical evaluation or interpretation based on the member's diagnosis and the clinical information submitted by providers. Non-clinical staff refer cases that they cannot approve to the initial clinical reviewers.

First Level Clinical Review/Initial Review. Clinical decisions are made by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse benefit determinations are made by Medical Directors or psychologists. Clinical reviewers consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether a service is medically necessary by reviewing the member's clinical information, the applicable clinical criteria or guidelines, and the Plan benefit terms. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for certification, related diagnostic results, and history of related treatment and services. The clinical reviewer may approve cases that meet applicable clinical criteria.

Second Level Clinical Review/Peer Review. The initial clinical reviewer refers cases to a peer clinical reviewer for a peer-to-peer discussion if the case cannot be approved. The requesting provider is offered the opportunity to discuss the case with the peer clinical reviewer, consistent with state, federal, and accreditation requirements before an adverse determination is issued. Only qualified peer clinical reviewers (e.g., Medical Directors or psychologists) can issue adverse benefit determinations. Peer clinical reviewers apply clinical criteria to member clinical information to determine coverage for additional units of service during an extended period of time. If the requesting provider fails to complete the peer-to-peer discussion, the peer clinical reviewer makes a determination based on the information available. If a peer clinical reviewer issues an adverse benefit determination, (e.g., that numbers of treatments or extensions of time are not authorized), then the Plan timely communicates the adverse benefit determination, including appeal rights, to the member and provider consistent with applicable state, federal, and accreditation requirements.

Adverse Benefit Determination. For MH/SUD, an adverse benefit determination is recorded as a clinical denial when it is based on clinical criteria and member clinical information.

Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity clinical coverage determinations on objective, evidence-based behavioral clinical policies or use clinical criteria from third-party sources such as, American Society of Addiction Medicine (ASAM) Criteria®, Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System-Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) and Early Childhood Service Intensity Instrument (ECSII) guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that outpatient Concurrent Review determinations are appropriate.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- Concurrent Review

Benefit Classification(s)

- OON, outpatient

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHIC)

Plan Terms/Source Document(s)

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Concurrent Review is defined as “a clinical review of an extension of previously approved, ongoing course of treatment over a period of time or number of treatments conducted during an inpatient stay or ongoing ambulatory care. It is sometimes called a “continued stay review.”

The *Optum National Policy Definitions List* defines a Concurrent (Review) Request as:

“A request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care. In addition, the following should be considered when defining Concurrent Reviews:

- If a request to extend a course of treatment beyond the period of time or number of treatments previously approved by the organization does not meet the definition of urgent care, the request may be handled as a new request and decided within the time frame appropriate for the type of decision (e.g., standard pre-service or post-service review).
- In addition, a request made while a member is in the process of receiving care should be considered an urgent Concurrent (Review) Request if the care requested meets the definition of urgent, even if the organization did not previously approve the earlier care”

The Plan’s *Certificates of Coverage* notifies members of Concurrent Review requirements:

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, Concurrent Review, case management, discharge planning, retrospective review or similar programs.

The role of the Plan’s delegate, United Behavioral Health d/b/a OBH, is discussed in the *UMPD*:

“United Behavioral Health (UBH) manages comprehensive behavioral health care delivery for members through a network of behavioral health practitioners, ancillary care providers, hospitals and other facilities. The management includes review of behavioral health care services (e.g., substance abuse and mental health requests for services).

UBH applies objective, evidence-based clinical criteria when making benefit coverage determinations while taking into account individual needs and the local delivery system. The clinical criteria are based on guidance produced by government sources, professional societies, and published research. In addition to making benefit coverage determinations, the clinical criteria inform discussions about evidence-based practices and discharge planning.

UBH selects externally developed clinical criteria and creates internally developed clinical criteria, where appropriate, based on its assessment of relevant guidance. The selection and development of clinical criteria incorporates:

- Annual review of clinical criteria and the procedures for applying them
- Involvement of appropriate stakeholders
- Dissemination of clinical criteria
- Ongoing monitoring and review of Centers for Medicare and Medicaid (CMS) Medicare Coverage Summaries, new or revised guidance in its CMS Local or National Coverage Determinations that are relevant to behavioral health
- Communication of updates to relevant areas

UBH uses the following clinical criteria:

- Clinical Criteria (Level of Care Utilization System-LOCUS) – Standardized level of care assessment tool developed by the American Association of Community Psychiatrists used to make clinical determinations and placement decisions for mental health disorder benefits for adults ages 19 and older when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (Child and Adolescent Level of Care/Service Intensity Utilization System-CALOCUS-CASII) – Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry (AACAP) and the American Association for Community Psychiatry (AAPC) used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children and adolescents ages 6-18 when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (Early Childhood Service Intensity Instrument-ECSI) – Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children ages 0-5 when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (American Psychological Association Psychological and Neuropsychological Testing Billing and Coding Guide) – Comprehensive billing and coding guide developed by the APA used for making clinical determinations for behavioral health psychological and neuropsychological testing services.
- Clinical Criteria (State or Contract Specific Supplemental Clinical Criteria) – Criteria used to make medical necessity determinations for mental health disorder benefits when there are explicit mandates or contractual requirements.
- Clinical Criteria (American Society of Addiction Medicine [ASAM]) – Criteria developed by the American Society of Addiction Medicine used to make clinical determinations for substance-related disorder benefits.
- Clinical Criteria (UBH Developed)
 - UBH Behavioral Clinical Policies: Criteria that stem from evaluation of new services or treatments or new applications of existing services or treatments and are used to make clinical determinations regarding proven or unproven services and treatments.
 - UBH Supplemental Clinical Criteria: Criteria used to make clinical determinations for Applied Behavior Analysis and Electroconvulsive Therapy.
 - UBH's Supplement to the APA Psychological and Neuropsychological Testing Billing and Coding Guide: Additional criteria used regarding provider qualifications, coverage rationale, limitations, and developmental testing.

The UBH UM Program is staffed by clinical, non-clinical and administrative personnel. A senior UBH Medical Director is responsible for directing and implementing the UM Programs. All clinical denials or adverse decisions are made by board certified psychiatrists, or, if the health plans choose, by a panel of other appropriate clinical peer reviewers. If the health plan chooses to use a panel to make adverse decisions, the panel contains at least one physician who is board certified in psychiatry. When the health care service under review is a mental health or substance abuse service, the adverse decision is made by a licensed physician who is board certified in psychiatry. Potential clinical denials are referred to a physician who is board certified in psychiatry for final determination.

An evaluation of the overall effectiveness of the Behavioral Health UM Program is conducted annually to determine how well resources have been deployed to improve UM activities and the clinical care and service provided to members.”

The Plan’s terms require services to be medically necessary for coverage.

List of M/S and MH/SUD Services Subject to NQTL

Addendum A, attached, lists the M/S and MH/SUD OON outpatient service categories subject to Concurrent Review.

Concurrent Review is one component of the UM program that evaluates whether a benefit or service is medically necessary.

- The “Member” tab lists the service categories for which the member is responsible for providing notification for both in-network (INN) and OON services. The “Member” tab includes all products in the scope of the analysis.
- The “Provider” tab lists the service categories for which the provider is responsible for providing notification for INN services. The “Provider” tab applies to all Plans in the scope of the analysis.

Step 2 – Factors Used in the Design and Application of the NQTL

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

The list of services subject to Concurrent Review was originally designed by enterprise clinical leadership. Concurrent Review was applied to new services when they became covered by the Plan and met certain criteria. Examples of Concurrent Review determinants that existed in the business at this time included:

- to monitor and prevent potential overutilization and under-utilization
- manage high-cost and prolonged-duration services
- ensure enrollee safety
- determine the appropriate level of care
- determine whether the service or item is medically necessary

The factors relied upon to determine which OON outpatient benefits were subject to Concurrent Review were updated and replaced 2021 with the factors Clinical Appropriateness, Value, and Variation as defined below. After this time, all M/S services subject to Prior Authorization must meet Clinical Appropriateness and all MH/SUD services subject to Prior Authorization must meet Clinical Appropriateness and at least one of the other factors.

Starting in 2022, any additions or deletions to the list of services subject to Concurrent Review were reviewed and approved through committees.

The Plan relies on the following factors to determine which OON outpatient services are added to the list of services subject to Concurrent Review. These factors apply to M/S and MH/SUD for the following:

- I. M/S: OON outpatient services
 - II. MH/SUD: OON outpatient services
- Clinical Appropriateness (Qualitative)

Applies to M/S and MH/SUD services.

- Value (Quantitative)

Applies to MH/SUD and M/S services.

- Variation (Quantitative)

Applies to MH/SUD and M/S services.

The Plan relies on the following factors to determine which OON outpatient benefits are removed from the list of services subject to Concurrent Review. These factors apply to M/S and MH/SUD benefits for the following:

- I. M/S: OON outpatient services
- II. MH/SUD: OON outpatient services

- Low Value (Quantitative)

Applies to M/S and MH/SUD services.

- Consistency (Quantitative)

Applies to M/S and MH/SUD services.

- Low Volume (Quantitative)

Applies to M/S and MH/SUD services.

Please note that if the primary code within a code family meets the requirements for removal, the family of codes will be addressed in a similar fashion per medical policy and clinical practice patterns.

The Plan then relies on the following factors to determine which OON outpatient benefits are retained on the list of services subject to Concurrent Review. These factors apply to M/S and MH/SUD benefits for the following:

- I. M/S: OON outpatient services
- II. MH/SUD: OON outpatient services

- Services that are experimental, investigational, or unproven (EIU) (Qualitative)

Applies to M/S and MH/SUD services.

- Patient Safety (Qualitative)

Applies to M/S and MH/SUD services.

- Level of Care (Quantitative)

Applies to M/S and MH/SUD services.

- High-Cost Drugs and Services that are greater than \$100,000 (Quantitative)

Applies to M/S and MH/SUD services.

For M/S meeting Clinical Appropriateness is determinative in imposing the limitation. For MH/SUD meeting Clinical Appropriateness plus Value and/or Variation is determinative in imposing the limitation. If the service met a removal factor, the Plan then assessed if the service met a retention factor. Services that met a retention factor were retained on the list of services subject to Concurrent Review. Meeting any one of the factors is determinative in retaining the limitation. The factors are not weighted in that no individual factor carries more value than another in retaining the NQTL.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factors used to add services to the list of services subject to outpatient Concurrent Review. These evidentiary standards and sources apply to benefits for the following:

- I. M/S: OON outpatient services
- II. MH/SUD: OON outpatient services

Factor – Clinical Appropriateness

Factor – Value

Factor – Variation

Factor - Low Value

Factor - Consistency

Factor - Low Volume

Factor - Services that are EIU

Factor - Patient Safety

Factor - Level of Care

Factor - High-Cost Drugs and Services that are greater than \$100,000

The factors and evidentiary standards used as the basis for subjecting MH/SUD OON outpatient benefits to Concurrent Review are comparable to, and applied no more stringently than, the factors and evidentiary standards used as the basis for subjecting M/S OON outpatient benefits to Concurrent Review "as written" and "in operation."

Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

As Written

The Plan conducted a comparative analysis of the strategies, processes, factors, evidentiary standards, and source information used to determine which M/S and MH/SUD OON outpatient services are subject to Concurrent Review and how Concurrent Review is applied to M/S and MH/SUD OON outpatient services “as written.” The Plan identified the factors and evidentiary standards used as the basis for subjecting M/S and MH/SUD OON outpatient benefits to Concurrent Review.

National internal committees apply the applicable factors and standards described in Steps 2 and 3 to M/S and MH/SUD services when determining whether the services should be subjected to Concurrent Review.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan's or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The findings of the Plan's comparative analyses confirmed the strategies, processes, factors, evidentiary standards, and source information used to determine the MH/SUD OON outpatient services subject to Concurrent Review were comparable to, and applied no more stringently than, the strategies, processes, factors, evidentiary standards, and source information used to determine the M/S OON outpatient services subject to Concurrent Review “as written.” For M/S and MH/SUD OON outpatient benefits, the *Concurrent Review Factor Grid(s)* included with this analysis detail the shared factors used as the basis for adding, removing or retaining M/S and MH/SUD OON outpatient services on the list of services subject to Concurrent Review, as described above.

Conclusions

The Plan reviewed the M/S and MH/SUD Concurrent Review operational policies and procedures and concluded the methodology used to determine which MH/SUD OON outpatient services are subject to Concurrent Review “as written” were comparable to, and applied no more stringently than, the methodology used to determine which M/S OON outpatient services are subject to Concurrent Review “as written.” Additionally, the Plan concluded that how Concurrent Review is applied to MH/SUD OON outpatient services was comparable to, and applied no more stringently than, how Concurrent Review is applied to M/S OON outpatient services “as written.”

The Plan reviewed the M/S and MH/SUD processes, including responsibility for submission, timeframes for submission and review, notification to members and providers, clinical standards for review, staff qualifications, outcome data, and IRR assessment results and concluded how the Plan conducts Concurrent Review for MH/SUD OON outpatient services “in operation” was comparable to, and applied no more stringently than, how the Plan conducts Concurrent Review for M/S OON outpatient services “in operation.”

Credentialing Program Non-Quantitative Treatment Limitation (NQTL) Analysis

GA – UnitedHealthcare Insurance Company, UnitedHealthcare of Georgia, Inc., UnitedHealthcare Insurance Company of the River Valley, and UnitedHealthcare of Georgia, Inc. Individual Exchange Medical Policy
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Overview

Pursuant to a federal law called the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical and surgical (M/S) benefits. This generally means that financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements, such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage.

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors considered in the design and application of the NQTL (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4). Findings and conclusions both “as written” and “in operation” are presented (Step 5).

Specific NQTL

Credentialing is performed to determine if a provider or facility meets standards to join (credential) or maintain (recredential) its status in the Plan’s network of participating providers. The Plan uses its credentialing and recredentialing processes to validate that its network of contracted providers and facilities providing inpatient, outpatient, and emergency services meet the baseline criteria, as applicable, to the state and practicing specialty. The Plan requires all providers/facilities to be credentialed.

The credentialing process is triggered by a provider or facility seeking to join or continue participation in the Plan’s network. Its purpose is to determine whether the provider or facility has the appropriate level of education/licensure/certification and satisfies additional qualifications (as applicable) to provide covered care to Plan members. The Plan uses credentialing processes and plans based on National Committee for Quality Assurance (NCQA) standards and applicable state or federal regulatory requirements when determining whether to credential M/S and MH/SUD providers or facilities.

This document includes the following information:

- Process for credentialing both M/S and MH/SUD providers and facilities
- Description of the NQTL and application (Step 1)
- Factors used to facilitate credentialing for both M/S and MH/SUD (Step 2)
- Evidentiary standards and sources used to define and/or trigger each of the identified factors (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

The analysis refers to the following attachments:

- *Certificates of Coverage* (COC23-INS-2018-LG-GA, COC23-INS-2018-SG-GA, COC23-HMO-2018-LG-GA, COC23-HMO-2018-SG-GA, COC23-INS-RV-2018-LG-GA, COC23-INS-RV-2018-SG-GA, Policy23-HMO-2022-LEX-GA) Plan document that explains covered services, terms, conditions, and limitations of the member’s policy

The Plan concludes that its methodologies for credentialing for M/S and MH/SUD providers and facilities are comparable and applied no more stringently for MH/SUD providers and facilities than for M/S providers and facilities both “as written” and “in

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operation.”

Process

For both M/S and MH/SUD, the Plan uses comparable credentialing processes.

For M/S, the *UnitedHealthcare (UHC) Credentialing Plan* defines Credential, Credentialing, or Recredentialing as “the process of assessing and validating the applicable criteria and qualifications of Licensed Independent Practitioners and Facilities to become or continue as Participating Licensed Individual Providers (PLIPs) and Participating Facilities, as set forth in the Credentialing Plan and pursuant to Credentialing Authorities.”

For MH/SUD, the *United Behavioral Health (UBH) Credentialing Plan* defines Credentialing or Recredentialing as “the process of assessing and validating the applicable criteria and qualifications of providers to become or continue as Participating Providers, as set forth in the Credentialing Plan.”

Key steps in the credentialing process for both M/S and MH/SUD include:

- The provider/facility submits a completed application to the Plan to be included in the Plan’s provider network
- The Plan confirms the information in the application
- If the provider/facility passes the credentialing requirements as outlined in the respective credentialing plan, the provider/facility is credentialed

Credentialing Plan

The purpose of the applicable credentialing plan is to explain the policy for credentialing. All providers/facilities included in the M/S and MH/SUD network are subject to the applicable credentialing plan. Providers/facilities that provide health care services to Covered Persons under their out-of-network benefits or on an emergency basis are not subject to the credentialing plans.

Credentialing Plan Approval

For M/S, the National Peer Review and Credentialing Policy Committee (NPRCPC) has the authority to approve the *UHC Credentialing Plan*. M/S has the right to change the *UHC Credentialing Plan* to meet regulatory requirements or other organizational or business needs with the Quality Oversight Committee approval. The *UHC Credentialing Plan* can be referenced on the website <https://www.uhcprovider.com/en/resource-library/Join-Our-Network.html> to access the regulatory and accreditation timeframes.

The NPRCPC is comprised of stakeholders from multiple UHC regions and meets regularly. The primary role of the NPRCPC is to ensure that the Regional Peer Review Committees (RPRCs) do not rely on an improper or discriminatory basis for making their decisions. The NPRCPC has the final decision-making authority on all disciplinary actions the RPRC recommends that affect restriction, suspension, or termination of participation status of physicians or health care professionals. In addition, this committee is responsible for review and approval of the *UHC Credentialing Plan* and interpretation of the *UHC Credentialing Plan* as needed. The NPRCPC, when authorized by applicable state or federal law, endeavors to conduct its activities in a manner that constitutes peer review.

For MH/SUD, the Plan delegates credentialing of behavioral health network providers to its affiliate UBH d/b/a Optum Behavioral Health (OBH). The Quality Improvement Committee (QIC) has oversight of the Credentialing Committee and delegates overall responsibility and authority to its standing Credentialing Committee for credentialing. The QIC also delegates to the Credentialing Committee the authority to administer the *UBH Credentialing Plan*. The Credentialing Committee is responsible for administering the *UBH Credentialing Plan* and reviewing and approving policies related to credentialing

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activities on behalf of OBH, subject to oversight by the QIC. The *UBH Credentialing Plan* can be referenced on the website <https://www.providerexpress.com/content/dam/ope-provexpr/us/pdfs/clinResourcesMain/guidelines/credPlans/credPlanUBH.pdf>.

The Credentialing Committee is multidisciplinary and must include at least two OBH Medical Directors. The committee is comprised of at a minimum two external participating clinicians. The committee must have at least seven voting members present to form a quorum. At least one representative of the quorum will be a Medical Director and two must be external clinicians. An OBH Medical Director chairs the Credentialing Committee; other OBH Medical Directors will serve as co-chairs and will chair the meeting in the absence of the chairperson. The Credentialing Committee meets at least monthly.

The OBH Credentialing Committee Chair has responsibility to see that the *UBH Credentialing Plan* and policies are administered fairly to all clinicians and organizational providers, to monitor the ongoing quality of clinician and organizational provider services, and to immediately restrict or terminate a participating clinician's or organizational provider's agreement.

Detailed Process for Credentialing

For M/S and MH/SUD, credentialing is a peer-review process designed to review certain information pertinent to the respective Credentialing Entity's decision whether to contract a provider or facility, either initially or on an ongoing basis. The process described in the credentialing plans will be initiated only after the Credentialing Entity makes a preliminary determination that it wishes to pursue contracting or re-contracting with the applicant.

The credentialing process begins when a provider/facility submits a completed application.

Application Verification

For M/S, staff will collect information to assess whether an applicant meets the minimum credentialing requirements for practice location, specialty, and any other business needs.

A Medical Director may approve initial credentialing or recredentialing applications determined to meet all credentialing criteria. If credentialing criteria are not met, the Medical Director forwards all documentation to the National Credentialing Committee (NCC) for determination. All completed applications are also forwarded to the NCC for determination.

The NCC will make credentialing decisions pursuant to the *UHC Credentialing Plan*. The NCC is comprised of PLIPs from the Credentialing Entities, UHC Medical Directors, and a designated Medical Director Chairperson unless a different committee composition is otherwise required by applicable credentialing authorities. The NCC has discretion to ask for missing information or to deny the application as incomplete. The NCC may request further information not covered by the application if necessary to make a determination. Upon receipt of a complete application, the NCC will render a decision in accordance with the timeframes as specified by the *UHC Credentialing Plan*.

Credentialing decisions are communicated to the applicant and the Plan. If an application is not accepted or participation is terminated, the non-acceptance or termination letter will include the reason(s) for the decision. The Plan permits appeals from adverse credentialing or sanctions monitoring decisions as required by the NCQA, the Center for Medicare and Medicaid Services (CMS), and other applicable state and federal regulatory authorities. Any appeal process related to the termination, suspension, or non-renewal of providers/facilities will be communicated to the affected provider/facility with the notice of termination, suspension, or non-renewal.

For MH/SUD, credentialing decisions and actions of OBH will be guided primarily by (a) consideration of each applicant's potential contribution to the objective of providing effective and efficient health care services to UBH's members, (b) UBH's need for clinicians and organizational providers within its service area, and (c) judging each applicant for credentialing and recredentialing without discrimination due to age, race, gender, color, religion, ethnic/national identity, ancestry, disability,

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marital status, covered veteran status, sexual orientation, status with respect to public assistance, blindness or partial blindness, handicap, physical or mental impairment, victims of domestic violence, types of patients seen, or any other characteristic protected under state, federal, or local law.

The Credentialing Committee is responsible for making credentialing decisions about inclusion of providers and facilities in the network. Applications that meet all the credentialing criteria and require no further review by the Credentialing Committee are sent to the Medical Director for approval. Applications that require additional review are presented to the Credentialing Committee. In this instance the Credentialing Committee has the sole discretion to make a credentialing exception to the required criteria, such as network need. Decisions to make exceptions based on appropriate factors are done in compliance with state and federal regulations. The Credentialing Committee may also at its sole discretion and determination, make the decision to deny the application for network participation.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- Credentialing

Benefit Classification(s)

- Applies to all in-network (INN) M/S and MH/SUD providers and facilities providing covered services in the Inpatient, Outpatient, and Emergency Care classifications as described in the credentialing plans

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHIC)
- UnitedHealthcare of Georgia, Inc. (UHCGA)
- UnitedHealthcare Insurance Company of the River Valley (UHICRV)
- UnitedHealthcare of Georgia, Inc. Individual Exchange Medical Policy (UHC GA)

Plan Terms

The Plan's credentialing process confirms public information about the professionals' and facilities' licenses and other credentials but does not assure the quality of their services. These professionals and facilities are independent practitioners and entities that are solely responsible for the care they deliver.

List of M/S and MH/SUD Benefits Subject to NQTL

Applies to all INN M/S and MH/SUD providers and facilities providing covered services in the Inpatient, Outpatient, and Emergency Care classifications as described in the Credentialing Plan.

Step 2 – Factors Used in the Design and Application of the NQTLs

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

The Plan relies on the following factors to determine if a provider or facility meets standards to join (credential) or maintain (recredential) its status in the Plan's network of participating providers, determine credentialing for M/S and MH/SUD INN inpatient and outpatient services. These factors apply to both M/S and MH/SUD benefits in the following classifications:

- INN M/S providers and facilities providing covered services in the Inpatient, Outpatient, and Emergency classification
- INN MH/SUD providers and facilities providing covered services in the Inpatient, Outpatient, and Emergency

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classification

- The provider or facility completes and attests to the accuracy of the content of the application (Qualitative)
 - Applies to both M/S and MH/SUD
- The Plan verifies certain information (Qualitative)
 - Applies to both M/S and MH/SUD
- The provider or facility continues to meet the applicable requirements (Qualitative)
 - Applies to both M/S and MH/SUD

The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factors used in credentialing. These evidentiary standards and sources apply to the following benefit classifications:

- I. INN M/S providers and facilities providing covered services in the Inpatient, Outpatient, and Emergency classification
- II. INN MH/SUD providers and facilities providing covered services in the Inpatient, Outpatient, and Emergency classification

Factor – Completed Application is defined as the provider or facility completes and attests to the accuracy of the content of the application.

- The Plan’s evidentiary standard and source that triggers and/or defines the identification of the factor:
 - Submission of application

This evidentiary standard and source applies to both M/S and MH/SUD INN providers and facilities providing covered services in the Inpatient, Outpatient, and Emergency Care classifications as described in the credentialing plans. This evidentiary standard and source is defined in a qualitative manner.

Factor – The Plan verifies certain information is defined as primary source verification in the application.

- The Plan’s evidentiary standard and source that triggers and/or defines the identification of the factor:
 - The UHC and UBH Credentialing Plans describe the information, i.e., primary source verification, which is required

This evidentiary standard and source applies to both M/S and MH/SUD INN providers and facilities providing covered services in the Inpatient, Outpatient, and Emergency Care classifications as described in the credentialing plans. This evidentiary standard and source is defined in a qualitative manner.

Factor – The provider or facility continues to meet the applicable requirements is defined as what is set forth in the credentialing plans while they are contracted with the Plan.

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- The Plan's evidentiary standards and sources that trigger and/or define the identification of the factor:
 - State and federal regulatory requirements
 - National accreditation standards, for example NCQA credentialing standards

These evidentiary standards and sources apply to both M/S and MH/SUD INN providers and facilities providing covered services in the Inpatient, Outpatient, and Emergency Care classifications as described in the credentialing plans. These evidentiary standards and sources are defined in a qualitative manner.

The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL.

Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

As Written

The Plan conducted a comparative analysis of the strategies, processes, factors, evidentiary standards, and source information used to determine if a provider or facility meets standards to join (credential) or maintain (recredential) their status in the Plan's network of participating providers for M/S and MH/SUD “as written.”

For M/S, the NCC is responsible for implementing the *UHC Credentialing Plan*. The NCC is comprised of PLIPs, UHC Medical Directors, and a designated Medical Director Chairperson, unless a different committee composition is otherwise required by applicable credentialing authorities. The NCC makes the credentialing decision and informs providers within applicable state or federally mandated timeframes.

For MH/SUD, the Plan delegates credentialing of behavioral health network providers to its affiliate OBH.

The OBH Credentialing Committee is responsible for implementing its *UBH Credentialing Plan*. The OBH Credentialing Committee is multi-disciplinary and must have at least two Optum Medical Directors as members. At least two of the 12 members must be external participating clinicians from each major discipline (i.e., MD, PhD, and MSW). The OBH Credentialing Committee informs providers of credentialing decisions within applicable state or federally mandated timeframes.

The M/S and MH/SUD credentialing committees have similar composition, in that they both include licensed providers with expertise in the relevant disciplines as well as Medical Directors. They also both follow applicable state or federal regulations for response timeframes. In addition, the *UHC* and *UBH Credentialing Plans* are both accredited by NCQA and are reviewed annually.

At times, UHC and OBH may delegate credentialing to third parties. The Plan performs oversight of delegated credentialing as outlined in the *UHC* and *UBH Credentialing Plans*.

The Plan conducted a comparative analysis of the application criteria and required documentation for both M/S and MH/SUD providers.

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Crosswalk of M/S and MH/SUD Credentialing Application and Required Documentation Professional	
M/S credentialing application requirements (<i>UHC Credentialing Plan</i> , uhcprovider.com/content/dam/provider/docs/public/resources/join-network/Credentialing-Plan.pdf, page 22, Attachment A, 11)	MH/SUD credentialing application requirements (<i>UBH Credentialing Plan</i> , providerexpress.com/content/dam/ope-provexpr/us/pdfs/clinResourcesMain/guidelines/credPlans/credPlanUBH.pdf, page 5-6, sections 4.1)
Licensed Individual Providers (LIP) application credentialing criteria: A release granting the Credentialing Entity permission to review the records of and to contact any professional society, hospital, insurance company, present or past employer, professional peer, clinical instructor, or other person, entity, institution, or organization that does or may have records or professional information about the Applicant.	A current and signed attestation/release by the Clinician granting UBH unlimited permission to review records of and to contact any professional society, hospital, insurance carrier, employer, entity, institution or organization that has or may have records/information concerning the Applicant.
A listing of degrees or certifications received from appropriate professional schools, residency training programs, or other specialty training programs appropriate for the type of participation sought, if applicable. May not be required at the time of recredentialing unless it has changed and will impact the LIP's specialty.	A complete list of all professional education/training completed.
Hospital admitting privileges, or coverage arrangements.	For physicians: hospital admitting privileges or a process for providing inpatient care for members in need of a higher level of care, (signed attestation form may be used).
Applicant's current professional liability insurance policy, including the name of insurer, policy number, expiration date, and coverage limits; (Note: M/S standard liability is \$1million/\$3million or an amount or type as otherwise specified by applicable state law)	Professional liability malpractice insurance with liability limits of \$1/\$3 million for physicians and \$1/\$1 million for non-physician Clinicians, or in an amount or type as otherwise specified by applicable state law. This can include evidence of participation in state patient compensation or catastrophic loss funds, if applicable.
Limitations on ability to perform functions of the position with or without accommodation;	Reasons for any inability to perform the essential functions of the position, with or without accommodation.
History of loss or limitation of privileges or disciplinary activity;	Disclosure of any and all loss or limitation of professional privileges or disciplinary activity.
Absence of current, illegal drug use;	Presence of illegal drug use.
History of loss of license and felony convictions;	Disclosure of any and all loss of professional license(s). Disclosure of any and all felony convictions.
Completeness and accuracy of the information provided in the Application. (Page 9, section 4.2)	A signed attestation regarding the correctness and completeness of the application.
Affirmative responses to Disclosure Questions on the Credentialing Application. Applicant is required to provide details on all affirmative responses to Disclosure Questions on the Credentialing Application, which may be reviewed by a Medical Director, and at the discretion of the Medical Director, may be reviewed by Credentialing Committee for a determination of LIP's acceptance into Credentialing	Completed disclosure statements including questions on license disciplinary actions; criminal felony convictions or civil judgments that involved dishonesty, fraud, deceit or misrepresentation; disciplinary actions by any federal programs; any other disciplinary actions or restrictions; and responses to applicable "Yes" answers

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under public records or other applicable laws.

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Entity's Network.	
M/S Required Documentation (Pages 7-9, section 4.2 unless noted otherwise)	MH/SUD Required Documentation (Pages 5-6, sections 4.1)
Insurance or State-approved alternative. The Applicant must maintain errors and omissions (malpractice) insurance through insurers licensed in their State, or show similar financial commitments made through an appropriate State approved alternative, in the minimum amounts required by UnitedHealth Group's Provider Guidelines. The Credentialing Entity may require a copy of the Applicant's current Certificate of Coverage or may allow the Applicant's attestation to current, adequate insurance of State-approved alternative. The pertinent Participation Agreement may require coverage that exceeds the minimum established by this Credentialing Plan.	Professional liability malpractice insurance with liability limits of \$1/\$3 million for physicians and \$1/\$1 million for non-physician Clinicians, or in an amount or type as otherwise specified by applicable state law. This can include evidence of participation in state patient compensation or catastrophic loss funds, if applicable.
Work History. The Credentialing Entity will obtain a five-year work history. Gaps longer than six months must be explained by the LIP and found acceptable by the Credentialing Committee.	List of five-year work history including month and year, on application or copy of resume/CV, complete explanations for gaps in work history of six months or more.
A copy of the Applicant's current Drug Enforcement Agency ("DEA") or Controlled Dangerous Substance ("CDS") Certificate in each state where the Applicant intends to practice, if applicable.	For prescribers: a current copy of the DEA and/or CDS certificate (where required by state), if applicable; in each state where the physician or prescribing Clinician practices.
M/S does not require, MH/SUD only requests "if applicable."	Copy of Educational Commission for Foreign Medical Graduates (ECFMG) certificate, if applicable.
(Page 22, Attachment A) Any other documents or information that the Credentialing Entity determines are necessary for it to effectively and/or efficiently review the Applicants' qualifications.	Any other documents required by state regulations or client requirement.
(Page 8, Section 4.2) Medicare/Medicaid Sanctions Review and Medicare Opt Out Eligibility. Regardless of the contracted line of business, for example, Medicare, Medicaid or Commercial the Applicant must not be ineligible, excluded, debarred or precluded from participation in the Medicare and/or Medicaid and related state and federal programs, or terminated for cause from Medicare or any state's Medicaid or Children's Health Insurance Program (CHIP) program and must be without any sanctions levied by the Office of Inspector General (OIG), the CMS Preclusion List or other disciplinary action by any federal or state entities identified by CMS. Credentialing Entity will, at a minimum,	Proof of participation and meeting CMS Medicare and Medicaid requirements.

Credentialing Program Non-Quantitative Treatment Limitation (NQL) Analysis

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verify reported information from the Office of Inspector General (OIG), the CMS Preclusion list and Medicare Opt Out.	
Crosswalk of M/S and MH/SUD Credentialing Application Facility/ Organizational Providers	
M/S credentialing application requirements (<i>UHC Credentialing Plan</i> , uhcprovider.com/content/dam/provider/docs/public/resources/join-network/Credentialing-Plan.pdf , page 12, Section 7)	MH/ SUD credentialing application requirements (<i>UBH Credentialing Plan</i> , providerexpress.com/content/dam/operovexpr/us/pdfs/clinResourcesMain/guidelines/credPlans/credPlanUBH.pdf , page 12, sections 6.0)
Current required license(s)	Current, applicable and required state license(s) showing the Organizational Provider is in good standing with state and federal regulatory bodies.
Insurance. The Applicant must maintain general/comprehensive liability insurance as well as errors and omissions (malpractice) insurance for at least the “per occurrence” and aggregate limits established by UnitedHealth Group’s Provider Guidelines with an insurer licensed to provide medical malpractice insurance in the Applicant’s State of practice, or show similar financial commitments made through an appropriate State approved alternative, as determined by the Credentialing Entity. The pertinent Participation Agreement may require coverage that exceeds the minimum established by this Credentialing Plan (Note: M/S standard liability is \$1million/\$3million or an amount or type as otherwise specified by applicable state law)	Maintains professional and general liability insurance (malpractice) of \$5 million/occurrence and \$5 million/aggregate for inpatient mental health and/or inpatient rehabilitation substance abuse disorder services and \$1 million/occurrence and \$3 million/aggregate for all other levels of mental health and/or substance use disorder services. UBH does accept umbrellas policy amounts to supplement professional and general liability insurance coverage. All limit requirements listed above are waived, if an Organizational Provider is covered under a Federal, State, County, or Municipal policy/law.
Medicare/Medicaid Sanctions Review. Regardless of the contracted line of business, for example, Medicare, Medicaid or Commercial, the Applicant must not be ineligible, excluded or debarred from participation in the Medicare and/or Medicaid and related State and Federal programs or terminated for cause from Medicare or any state’s Medicaid or CHIP program and must be without any sanctions levied by the Office of Inspector General (OIG), the General Services Administration (GSA) and the CMS Preclusion list or other disciplinary action by any Federal or State entities identified by CMS. Exceptions to this requirement may only be	Medicare/Medicaid Sanctions Review. Regardless of the contracted line of business (Medicare, Medicaid, or Commercial), the Applicant must not be ineligible, excluded, debarred, or precluded from participation in Medicare and/or Medicaid and related state and federal programs, or terminated for cause from Medicare or any state's Medicaid or CHIP program and must be without any sanctions levied by the Office of Inspector General (OIG), the General Services Administration Systems for Awards Management (SAM), and the CMS Preclusion list or other disciplinary action by any federal or state entities identified by CMS.

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Credentialing Program Non-Quantitative Treatment Limitation (NQT) Analysis

GA – UnitedHealthcare Insurance Company, UnitedHealthcare of Georgia, Inc., UnitedHealthcare Insurance Company of the River Valley, and UnitedHealthcare of Georgia, Inc. Individual Exchange Medical Policy
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granted when there are issues of network adequacy, and an OIG waiver has been granted.	
Appropriate Accreditation or Satisfactory Alternative. The Credentialing Entity must obtain a copy of the accreditation report or evidence from the Accrediting Body. If the Applicant is not accredited or does not hold alternative certification by an agency recognized by the Credentialing Entity in Attachment C, a site visit of the organization is required, and results must be found to be satisfactory as defined by the Credentialing Entity in Attachment D. In lieu of a site visit by the Credentialing Entity, a CMS or State quality review may be used if it is not more than three years old. The organization must provide evidence in the form of a final report or letter from CMS or the State, stating that it has been reviewed and passed inspection.	Current, valid accreditation from an agency recognized by UBH in Attachment A. UBH will conduct primary source verification for all accreditations. If an Organizational Provider is not accredited or certified by an agency recognized by UBH, a site review is required, and the Organizational Provider must achieve a site visit score of 80% or higher. If, during the initial credentialing process, the Organizational Provider does not meet the scoring criteria, UBH will notify the Organizational Provider that they do not meet current standards, provide feedback on the deficiencies, and inform the Organizational Provider that they may reapply after six (6) months, at which time a re-audit will be required before the initial credentialing process can commence. In lieu of a site visit by UBH, the Organizational Provider must have been reviewed or received certification by CMS or State Licensing Agency within the past three (3) years. UBH has determined that CMS requirements for Organizational Providers fully meet UBH Organizational Provider site requirements. UBH obtains a copy of the CMS or State Licensing Agency's report from the Organizational Provider

The results of the comparative analysis of the credentialing application and documentation requirements confirms that M/S and MH/SUD have comparable requirements for credentialing providers and facilities.

In Operation

Both M/S and MH/SUD use the credentialing and recredentialing process to ensure their network of contracted providers have the appropriate qualifications to provide care to Plan members according to the *UHC* and *UBH Credentialing Plans*.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The above analysis confirmed the strategies, processes, factors, evidentiary standards, and source information used to determine if an MH/SUD provider or facility meets credentialing or recredentialing standards were comparable to, and applied no more stringently than, the strategies, processes, factors, evidentiary standards, and source information used to determine if an M/S provider or facility meets credentialing or recredentialing standards, both “as written” and “in operation.” The Plan identified the factors and evidentiary standards used to determine if a provider or facility meets credentialing standards apply to both M/S and MH/SUD.

The findings of the parity analysis revealed the *UBH Credentialing Plan* for MH/SUD network providers was comparable to, and applied no more stringently than, the *UHC Credentialing Plan* for M/S network providers. The parity analysis also revealed

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Credentialing Program Non-Quantitative Treatment Limitation (NQTL) Analysis

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that credentialing application requirements for MH/SUD network providers are comparable to, and applied no more stringently than, the application requirements for M/S network providers.

In addition, the findings revealed there were no significant disparate credentialing outcomes for MH/SUD providers as compared to M/S providers.

Lastly, the amount of time it takes to complete initial credentialing for both M/S and MH/SUD providers and facilities was comparable and both M/S and MH/SUD meet applicable state and federal requirements.

Conclusions

In light of the above findings, the Plan concludes that the credentialing requirements for M/S and MH/SUD providers and facilities are comparable and applied no more stringently for MH/SUD than for M/S, both “as written” and “in operation.”

Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical/surgical (M/S) benefits. This generally means that the financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements such as, deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs, which may limit the scope or duration of benefits for treatment under a plan or coverage.

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

The Plan excludes coverage of technologies (e.g., services, interventions, devices, medically administered M/S and MH/SUD drugs, etc.) determined to be experimental, investigational, or unproven (EIU) for specific diagnoses based on medical/behavioral clinical policies and Plan documents. The Plan develops evidence-based medical/behavioral clinical policies for select M/S and MH/SUD technologies. The medical/behavioral clinical policies may identify specific technologies that are categorically considered EIU or that are considered EIU under certain circumstances.

This document includes the following information:

- Process for determining if a technology is EIU for both M/S and MH/SUD technologies
- Description of the NQTL and application (Step 1)
- Factors used to determine which technologies are subject to the NQTL (Step 2)
- Evidentiary standards and sources used to define, trigger and/or implicate a factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

This analysis refers to the following attachments:

- *2023 UnitedHealthcare Provider Administrative Guide* - Informs providers of the EIU limitation. The *UnitedHealthcare Provider Administrative Guide* can be accessed on the website <https://www.uhcprovider.com/en/admin-guides.html>
- September 2023, *Optum National Network Manual* - Informs providers of the EIU limitation. The *Optum National Network Manual* can be accessed on the website <https://public.providerexpress.com/content/open-provexpr/us/en/clinical-resources/guidelines-policies/optum-network-manual.html>
- *Certificates of Coverage* (COC23-INS-2018-LG-GA, COC23-INS-2018-SG-GA, COC23-HMO-2018-LG-GA, COC23-HMO-2018-SG-GA, COC23-INS-RV-2018-LG-GA, COC23-INS-RV-2018-SG-GA, Policy23-HMO-2022-IEX-GA) Plan document that explains covered services, terms, conditions, and limitations of the member’s policy
- *Schedule of Benefits* (for example: *Schedule of Benefits SBN23-Medical-INS-2018-[Choice+Plus][Select+Plus][Doctors+Plus]-LG-GA*, *SBN23-Medical-INS-2018-[Choice+Plus][Select+Plus][Doctors+Plus]-SG-GA*, *SBN23-Medical-INS-RV-2018-HeritagePlus-LG-GA*, *SBN23-Medical-INS-RV-2018-HeritagePlus-SG-GA*, and *SBN23-Medical-HMO-2022-IEX-GA-ADV*) - Plan document that outlines

Experimental, Investigational, and Unproven Non-Quantitative Treatment Limitation (NQTL) Analysis

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member responsibilities

- M/S medical clinical policies are publicly available: [Medical & Drug Policies and Coverage Determination Guidelines for UnitedHealthcare Commercial Plans | UHCprovider.com](#)
- MH/SUD behavioral clinical policies are publicly available: [Guidelines/Policies/Manuals \(providerexpress.com\)](#)
- *UnitedHealthcare (UHC) Hierarchy of Clinical Evidence* – M/S policy that defines the order of clinical evidence to ensure a transparent and consistent approach within UnitedHealthcare
- *Behavioral Health Hierarchy of Clinical Evidence* – MH/SUD policy that defines the order of clinical evidence to ensure a transparent and consistent approach to the review and development of Optum’s Clinical Technology Assessments and Behavioral Clinical Policies
- *Clinical Technology Assessment Committee (CTAC) Charter* – document that outlines the purpose, structure, responsibility, and membership of the committee that develops internal medical criteria and reviews and approves externally developed criteria for MH/SUD
- *Clinical Quality and Operations Committee (CQOC) Charter* – document that outlines the purpose, structure, responsibility, and membership of the committee that oversees CTAC
- *Medical Technology Assessment Committee (MTAC) Charter* – policy that outlines the purpose, responsibility, structure, and membership of the committee that develops internal medical criteria and reviews and approves externally developed criteria for M/S
- *National Medical Care Management Committee (NMCMC) Charter* – document that outlines the purpose, responsibility, membership, and structure of the committee that oversees the MTAC
- *Utilization Management Program Committee Charter* – document that outlines the purpose, responsibility, functions, and composition of the committee that oversees the M/S utilization management program
- *Applying Benefit Plan and Review Criteria* Standard Operating Procedure - outlines the hierarchy of authorities to be reviewed (i.e., state/federal laws and regulations followed by Benefit Plan criteria) when making coverage determinations
- *Utilization Management Program Description (UMPD) of United HealthCare Services, Inc. and UnitedHealthcare Insurance Company* – M/S summarizes the philosophy, structure and standards that govern UHC’s medical management, utilization management (UM) and utilization review responsibilities and functions
- *Clinical Review Criteria Operational Policy* - The purpose of this operational policy is to document that UHC will use evidence-based clinical review criteria to support clinical review decisions for UM programs, and to ensure that the clinical review process is applied consistently
- *Clinical Criteria Development Selection and Application Policy* - addresses Optum’s selection, development, and use of clinical criteria in making benefit determinations
- *UnitedHealthcare Commercial Omnibus Codes* – M/S policy that outlines technologies that are considered EIU
- *UnitedHealthcare Individual Exchange Omnibus Codes* – M/S policy that outlines technologies that are considered EIU

The Plan concludes that the methodologies used to determine whether a M/S or MH/SUD technology is EIU are comparable and applied no more stringently to MH/SUD technologies for all benefit classifications, both “as written” and “in operation.”

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- EIU: The Plan excludes coverage of technologies determined to be EIU for specific diagnoses based on medical/behavioral clinical policies and Plan documents. The Plan develops evidence-based medical/behavioral clinical policies for select M/S and MH/SUD technologies (e.g., services, interventions, devices, medically

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administered M/S and MH/SUD drugs, etc.). The medical/behavioral clinical policies may identify specific technologies that are categorically considered EIU or that are considered unproven under certain circumstances

Benefit Classification(s)

- In-network (INN) inpatient, out-of-network (OON) inpatient, INN outpatient, and OON outpatient

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHIC)
- UnitedHealthcare of Georgia, Inc. (UHCGA)
- UnitedHealthcare Insurance Company of the River Valley (UHICRV)
- UnitedHealthcare of Georgia, Inc. Individual Exchange Medical Policy (IEX)

Plan Terms/Source Document(s)

The Plan's *Certificate of Coverage*, defines EIU as:

UHIC

- *“Experimental or Investigational Service(s) – medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications, or devices that, at the time we make a determination regarding coverage in a particular case, are determined to be any of the following:*
 - *Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified as appropriate for proposed use in any of the following:*
 - *AHFS Drug Information (AHFS DI) under therapeutic uses section;*
 - *Elsevier Gold Standard's Clinical Pharmacology under the indications section;*
 - *DRUGDEX System by Micromedex under the therapeutic uses section and has a strength recommendation rating of class I, class IIa, or class IIb; or*
 - *National Comprehensive Cancer Network (NCCN) drugs and biologics compendium category of evidence 1, 2A, or 2B.*
 - *Subject to review and approval by any institutional review board for the proposed use. (Devices which are FDA approved under the Humanitarian Use Device exemption are not Experimental or Investigational.)*
 - *The subject of an ongoing clinical trial that meets the definition of a Phase I, II or III clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.*
- *Exceptions:*
 - *Clinical trials for which Benefits are available as described under Clinical Trials in Section 1: Covered Health Care Services.*
 - *We may, as we determine, consider an otherwise Experimental or Investigational Service to be a Covered Health Care Service for that Sickness or condition if:*
 - *You are not a participant in a qualifying clinical trial, as described under Clinical Trials in Section 1: Covered Health Care Services, and you have a Sickness or condition that is likely to cause death within one year of the request for treatment.*
 - *Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that Sickness or condition.”*
- *“Unproven Service(s) - services, including medications, that are not determined to be effective for treatment of the*

Experimental, Investigational, and Unproven Non-Quantitative Treatment Limitation (NQTL) Analysis

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medical condition or not determined to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- *Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)*
- *Well-conducted cohort studies from more than one institution. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)*

We have a process by which we compile and review clinical evidence with respect to certain health care services. From time to time, we issue medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at www.myuhc.com. Please note:

- *If you have a Life-Threatening Illness or condition (one that is likely to cause death within one year of the request for treatment) we may, as we determine, consider an otherwise Unproven Service to be a Covered Health Care Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that Sickness or condition."*

UHC GA/UHCGA/UHICRV

- *"Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.*

This exclusion does not apply to Covered Health Care Services provided during a clinical trial for which Benefits are provided as described under Clinical Trials in Section 1: Covered Health Care Services."

- *"Unproven Service(s) - services, including medications, that are not determined to be effective for treatment of the medical condition or not determined to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.*
 - *Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)*
 - *Well-conducted cohort studies from more than one institution. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)*

We have a process by which we compile and review clinical evidence with respect to certain health care services. From time to time, we issue medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at www.myuhc.com. Please note:

- *If you have a Life-Threatening Illness or condition (one that is likely to cause death within one year of the request for treatment) we may, as we determine, consider an otherwise Unproven Service to be a Covered Health Care Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that Sickness or condition."*

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List of M/S and MH/SUD Technologies Subject to NQTL

For M/S and MH/SUD this NQTL applies to all INN inpatient, OON inpatient, INN outpatient, and OON outpatient technologies determined to be EIU

- Plan documents provide that technologies considered EIU are excluded from coverage
- Additionally, for both M/S and MH/SUD, certain medical policies identify technologies that have been determined to be EIU, while other medical policies exclude coverage of technologies for some, but not all, conditions based on EIU status
- M/S maintains a medical clinical policy which identifies the codes that have been determined to be EIU (see *Omnibus Policy*)
- Additionally, other technologies may be determined to be EIU for certain medical conditions. These are identified in the applicable medical clinical policies. M/S medical clinical policies are publicly available: [Medical & Drug Policies and Coverage Determination Guidelines for UnitedHealthcare Commercial Plans | UHCprovider.com](#)
- MH/SUD behavioral clinical policies are publicly available: [Guidelines/Policies/Manuals \(providerexpress.com\)](#)

Step 2 – Factors Used to Determine if a Technology is Experimental, Investigational or Unproven

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

The Plan relies on the following factor to determine whether technologies are EIU for M/S and MH/SUD. This factor applies to M/S and MH/SUD benefits for the following:

- I. All M/S INN inpatient, OON inpatient, INN outpatient, and OON outpatient technologies subject to UM
 - II. All MH/SUD INN inpatient, OON inpatient, INN outpatient, and OON outpatient technologies subject to UM
- M/S and MH/SUD Committee Considerations (Qualitative)

The factor applies to M/S and MH/SUD technologies.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factor used in determining whether a MH/SUD or M/S technology is EIU. These evidentiary standards apply to the following:

- I. All M/S INN inpatient, OON inpatient, INN outpatient, and OON outpatient technologies subject to UM
- II. All MH/SUD INN inpatient, OON inpatient, INN outpatient, and OON outpatient technologies subject to UM

The Plan's evidentiary standards and sources that trigger and/or define the M/S and MH/SUD Committee Considerations factor.

Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

As Written

The Plan conducted an “as written” comparative analysis of the strategies, processes, factors, evidentiary standards, and source information used by M/S and MH/SUD to assess whether a technology is EIU and to develop objective evidence-based medical/behavioral clinical policies.

The Plan uses the following standard process to assess the safety and efficacy of technologies:

The Plan uses committees to assess technologies and conduct a thorough review of the scientifically based clinical evidence and peer-reviewed literature in accordance with the *Hierarchies of Clinical Evidence* to develop medical/behavioral clinical policies that apply to the technologies. The subject matter experts in the committees follow a consistent and comparable process to assess and review technologies and apply comparable *UHC* and *Behavioral Health Hierarchies of Clinical Evidence* (discussed in greater detail below). National internal committees evaluate the applicable factor and standards described in Steps 2 and 3 when determining EIU.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The findings of the Plan's analyses confirmed the strategies, processes, factors, evidentiary standards, and source information used to assess EIU technologies and develop MH/SUD behavioral clinical policies were comparable to, and applied no more stringently than, the strategies, processes, factors, evidentiary standards, and source information used to assess EIU technologies and develop the M/S medical clinical policies “as written” and “in operation.”

The MH/SUD policies, procedures, and processes were found to be comparable and no more stringent than M/S policies, procedures, and processes.

As discussed above, both M/S and MH/SUD committees follow comparable technology assessment processes, including consideration of comparable hierarchies of clinical evidence.

Conclusions

The Plan concluded the methodologies MH/SUD used to assess whether a technology is EIU and develop evidence-based behavioral clinical policies were comparable to, and applied no more stringently than, the methodologies M/S used to assess whether a technology is EIU and develop evidence-based medical clinical policies, both “as written” and “in operation.”

Geographic Restrictions Non-Quantitative Treatment Limitation (NQTL) Analysis

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Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical and surgical (M/S) benefits. This generally means that financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements, such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

The out-of-network (OON), out-of-area, geographic service limitation (geographic restrictions requirement) is intended to encourage members to utilize in-network (INN) providers. The geographic restrictions requirement does not limit coverage for OON benefits within the member’s state of residence, nor does it limit INN services nationally. The goal is to promote access to evidence-based care and improved treatment outcomes.

This document includes the following information:

- Geographic restrictions process for both M/S and MH/SUD services
- The description of the NQTL and application (Step 1)
- Factors used to determine which services are subject to the NQTL (Step 2)
- Evidentiary standards and sources used to define, trigger and/or implicate a factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

This analysis refers to the following attachments:

- *Certificates of Coverage* (COC23-INS-2018-LG-GA, COC23-INS-2018-SG-GA, COC23-HMO-2018-LG-GA, COC23-HMO-2018-SG-GA, COC23-INS-RV-2018-LG-GA, COC23-INS-RV-2018-SG-GA) Plan document that explains covered services, terms, conditions, and limitations of the member’s policy.

The Plan concludes that the geographic restrictions requirements for M/S and MH/SUD are comparable and applied no more stringently for OON benefits both “as written” and “in operation.”

Process

The OON, out-of-area, geographic service limitation (geographic restrictions requirement) is intended to encourage members to utilize INN providers, with the goal being to promote access to evidence-based care and improve treatment outcomes. Health care services from an OON provider for non-emergent, sub-acute inpatient, or outpatient services at any of the following non-hospital facilities: alternate facility, freestanding facility, inpatient rehabilitation facility, or skilled nursing facility received

Geographic Restrictions Non-Quantitative Treatment Limitation (NQTL) Analysis

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outside of the member's State of Residence are not covered. This applies to facility-based services that could be Inpatient or Outpatient.

A member's request for care is assessed to determine whether the servicing provider is an INN or OON provider and within a level of care subject to the restriction. Service requests within these levels of care, rendered by an OON provider at certain non-hospital, sub-acute, non-emergent facilities, and programs that are out of the member's state of residence, as defined in Plan documents, are denied administratively as a non-covered benefit.

The limitation does not apply in the case of an emergency.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- Geographic Restrictions

Benefit Classification(s)

- OON, inpatient and outpatient services as described in the Plan benefit documents
- Under the Plan benefit documents, services received at the following facilities are subject to the OON geographic restriction:
 - Health care services from an OON provider for non-emergent, sub-acute inpatient, or outpatient services at any of the following non-hospital facilities: alternate facility, freestanding facility, residential treatment facility, inpatient rehabilitation facility, or skilled nursing facility received outside of the member's State of Residence

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHIC)
- UnitedHealthcare of Georgia, Inc. (UHCGA)
- UnitedHealthcare Insurance Company of the River Valley (UHICRV)

Plan Terms

The Plan's *Certificate of Coverage* states: "Health care services from an Out-of-Network provider for non-emergent, sub-acute inpatient, or outpatient services at any of the following non-hospital facilities: alternate facility, freestanding facility, residential treatment facility, inpatient rehabilitation facility and skilled nursing facility received outside of the covered person's State of Residence. For the purpose of this exclusion, the 'State of Residence' is the state where the covered person is a legal resident, plus any geographically bordering adjacent state or, for a covered person who is a student, the state where they attend school during the school year. This exclusion does not apply in the case of an Emergency or if authorization through network exception has been obtained in advance."

List of M/S and MH/SUD Services Subject to NQTL

- Health care services from an OON provider for non-emergent, sub-acute inpatient, or outpatient services at any of the following non-hospital facilities: alternate facility, freestanding facility, inpatient rehabilitation facility, or skilled nursing facility received outside of the member's State of Residence.

Geographic Restrictions Non-Quantitative Treatment Limitation (NQTL) Analysis

GA – UnitedHealthcare Insurance Company, UnitedHealthcare of Georgia, Inc., UnitedHealthcare Insurance Company of the River Valley
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Step 2 – Factor Used to Determine Geographic Restriction Applies

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

The Plan relies on the following factor to determine whether OON services are subject to geographic restrictions for both M/S and MH/SUD:

- Whether the OON facility is providing non-emergent, sub-acute inpatient and/or outpatient services located outside of the member's state of residence (Qualitative)

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factor used to determine whether OON services are subject to geographic restrictions for both M/S and MH/SUD services:

Factor – Whether the OON facility is providing non-emergent, sub-acute inpatient, and/or outpatient services located outside of the member's state of residence

- The Plan's evidentiary standards that trigger and/or define the factor:
 - Facility is OON; AND
 - Facility provides non-emergent, sub-acute inpatient and/or outpatient services; AND
 - Facility is located outside of the member's state of residence
 - "State of Residence" is defined as:
 - "The state where the member is a legal resident; plus, any geographically bordering adjacent state;" or
 - "For a member who is a student, the state where the student is attending school, during the school year"

The Plan's sources used to define the factor:

- Provider Directory
- Treatment type requested and/or billed, e.g., revenue codes, Healthcare Common Procedure Coding System (HCPCS), etc.
- Facility service location/address
- Member address
- Plan benefit documents

These evidentiary standards and sources apply to both M/S and MH/SUD services. These standards are defined in a qualitative manner.

Geographic Restrictions Non-Quantitative Treatment Limitation (NQTL) Analysis

GA – UnitedHealthcare Insurance Company, UnitedHealthcare of Georgia, Inc., UnitedHealthcare Insurance Company of the River Valley
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Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

As Written

In Operation

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The findings of the analysis confirmed the strategies, processes, factor, evidentiary standards, and source information used to subject certain MH/SUD OON services to geographic restrictions were comparable to, and applied no more stringently than, the strategies, processes, factor, evidentiary standards, and source information used to subject certain M/S OON services to geographic restrictions “as written.”

Additionally, the same triggering events for the geographic restrictions were applied to both M/S and MH/SUD services and state of residence was defined similarly for all services. The same sources of information were used to define the factor used to determine whether the geographic restriction applies.

Conclusions

The Plan reviewed the M/S and MH/SUD OON triggering events and state of residence definitions and concluded the methodology used to determine which MH/SUD OON services are subject to geographic restrictions “as written” were comparable to, and applied no more stringently than, the methodology used to determine which M/S OON services are subject to geographic restrictions “as written.” Additionally, the Plan concluded the way in which geographic restrictions were applied to MH/SUD OON services were comparable to, and applied no more stringently than, the way in which geographic restrictions were applied to M/S OON services “as written.”

The Plan concluded that MH/SUD processes, triggering events, definitions, and how the Plan applies geographic restrictions for MH/SUD OON services were comparable to, and applied no more stringently than how the Plan applies geographic restrictions for M/S OON services “in operation.”

Overview

Pursuant to a federal law called the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical and surgical (M/S) benefits. This generally means that financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements, such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

In-network (INN) facility reimbursement is the process by which the Plan establishes reimbursement for INN facility-based services.

This document includes the following information:

- Description of process for negotiating reimbursement rates for INN facility-based services for both M/S and MH/SUD facilities
- Description of the NQTL and application (Step 1)
- Factors used to negotiate reimbursement rates for INN facility-based services for both M/S and MH/SUD facilities (Step 2)
- Evidentiary standards and sources used to define and/or trigger each of the identified factors (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

The analysis refers to the following attachments:

- *Certificates of Coverage* (COC23-INS-2018-LG-GA, COC23-INS-2018-SG-GA, COC23-HMO-2018-LG-GA, COC23-HMO-2018-SG-GA, COC23-INS-RV-2018-LG-GA, COC23-INS-RV-2018-SG-GA, Policy23-HMO-2022-LEX-GA) Plan document that explains covered services, terms, conditions, and limitations of the member’s policy.

The Plan concludes that the INN facility reimbursement requirements for M/S and MH/SUD are comparable and applied no more stringently both “as written” and “in operation.”

In-Network Facility Reimbursement Non-Quantitative Treatment Limitation (NQTL) Analysis

GA – UnitedHealthcare Insurance Company, UnitedHealthcare of Georgia, Inc., UnitedHealthcare Insurance Company of the River Valley, and UnitedHealthcare of Georgia, Inc. Individual Exchange Medical Policy
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Process

Negotiation

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- INN Facility Reimbursement

Benefit Classification(s)

- INN, facility-based

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHIC)
- UnitedHealthcare of Georgia, Inc. (UHCGA)
- UnitedHealthcare Insurance Company of the River Valley (UHICRV)
- UnitedHealthcare of Georgia, Inc. Individual Exchange Medical Policy (UHC GA)

Plan Terms/Source Document(s)

In each of the plans *Certificate of Coverage*, the following is referenced:

“What Is Our Relationship with Providers and Groups?

We have agreements in place that govern the relationship between us, our Groups and Network providers, some of which are affiliated providers. Network providers enter into agreements with us to provide Covered Health Care Services to Covered Persons.”

List of M/S and MH/SUD Services Subject to NQTL

- INN acute inpatient
- INN subacute inpatient
- INN facility-based outpatient services

Step 2 – Factors Used in the Design and Application of the NQTL

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/ SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factors used in establishing INN facility reimbursement rates. These evidentiary standards and sources apply to the following:

- I. M/S and MH/SUD inpatient and outpatient facility services

Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

The Plan convenes ongoing working groups that include representatives from both the M/S and MH/SUD network strategy and pricing teams to align business processes and ensure adherence to as-written standards and comparability in operation

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the plan's or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the plan or coverage is or is not in compliance with MHPAEA.

Findings

The findings of that analysis confirmed the strategies, processes, factors, evidentiary standards, and source information used to negotiate and establish reimbursements for MH/SUD INN facility services and/or programs were comparable to, and applied no more stringently than, the strategies, processes, factors, evidentiary standards, and source information used to negotiate and establish facility reimbursement for M/S INN facility services and/or programs “as written.”

The Plan determined that the process to negotiate and establish MH/SUD INN facility reimbursement rates were comparable to, and applied no more stringently than, the process to negotiate and establish M/S INN facility reimbursement rates “in operation.”

Conclusions

Based upon these findings, the Plan concluded the INN facility reimbursement strategy for MH/SUD was comparable to, and applied no more stringently than, the INN facility reimbursement strategy for M/S “as written.”

Additionally, the Plan concluded the factors, evidentiary standards, and source information used to negotiate and establish MH/SUD INN facility reimbursement rates were comparable to, and applied no more stringently than, the factors, evidentiary standards and source information used to negotiate and establish M/S INN facility reimbursement rates “in operation.”

Overview

Pursuant to a federal law called the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical and surgical (M/S) benefits. This generally means that financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

In-network (INN) provider reimbursement is the process by which the Plan establishes reimbursement for INN professional services.

This document includes the following information:

- Process for negotiating and establishing reimbursement rates for INN professional services for both M/S and MH/SUD providers
- Description of the NQTL and application (Step 1)
- Factors used to negotiate reimbursement rates for INN professional services for both M/S and MH/SUD providers (Step 2)
- Evidentiary standards and sources used to define and/or trigger each of the identified factors (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

The analysis refers to the following attachments:

- *Certificates of Coverage* (COC23-INS-2018-LG-GA, COC23-INS-2018-SG-GA, COC23-HMO-2018-LG-GA, COC23-HMO-2018-SG-GA, COC23-INS-RV-2018-LG-GA, COC23-INS-RV-2018-SG-GA, Policy23-HMO-2022-IEG-GA) Plan document that explains covered services, terms, conditions, and limitations of the member’s policy.

The Plan concludes that its methodologies for negotiating and establishing INN reimbursement rates for M/S and MH/SUD professional services are comparable and applied no more stringently for MH/SUD providers than for M/S providers both “as written” and “in operation.”

Process

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- INN Professional Provider Reimbursement

Benefit Classification(s)

- INN, professional services

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHIC)
- UnitedHealthcare of Georgia, Inc. (UHCGA)
- UnitedHealthcare Insurance Company of the River Valley (UHICRV)
- UnitedHealthcare of Georgia, Inc. Individual Exchange Medical Policy (UHC GA)

Plan Terms/Source Document(s)

In each of the Plan's *Certificate of Coverage*, the following is referenced:

"What Is Our Relationship with Providers and Groups?"

We have agreements in place that govern the relationship between us, our Groups and Network providers, some of which are affiliated providers. Network providers enter into agreements with us to provide Covered Health Care Services to Covered Persons."

List of M/S and MH/SUD Services Subject to NQTL

- For M/S, INN professional services rendered by independently licensed health care professionals, e.g., primary care and specialty care
- For MH/SUD, INN professional services rendered by independently licensed behavioral health care professionals, e.g., psychotherapy, medication management, etc.

Step 2 – Factors Used in the Design and Application of the NQTL

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

The Plan convenes ongoing workgroups that include representatives from both the M/S and MH/SUD network strategy and pricing teams to align business processes and ensure adherence to as-written standards and comparability in operation.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

Conclusions

Based upon these findings, the Plan concluded that the methodologies to negotiate and establish INN provider reimbursement for MH/SUD INN professional services was comparable to, and applied no more stringently than, the methodologies to negotiate and establish the INN provider reimbursement for M/S INN professional services “as written.”

Because the reimbursement for MH/SUD physicians and non-physicians compared to M/S physicians and non-physicians was no more stringent, the Plan's methodologies to negotiate and establish reimbursement for MH/SUD INN professional services is comparable to, and applied no more stringently than, its methodologies to negotiate and establish reimbursement for M/S INN professional services “in operation.”

Medical Necessity Non-Quantitative Treatment Limitation (NQTL) Analysis

GA – UnitedHealthcare Insurance Company, UnitedHealthcare of Georgia, Inc., UnitedHealthcare Insurance Company of the River Valley, and UnitedHealthcare of Georgia, Inc. Individual Exchange Medical Policy
12/29/2023



Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical/surgical (M/S) benefits. This generally means that the financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements such as, deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs, which may limit the scope or duration of benefits for treatment under a plan or coverage.

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

The Plan covers M/S and MH/SUD services/technologies (e.g., services, interventions, devices, medically administered M/S and MH/SUD drugs, etc.) that are medically necessary. Medical necessity refers to the principle that healthcare services, technologies and treatments should be in accordance with generally accepted standards of medical practice, appropriate for the member’s disorder, disease, or symptoms, cost-effective, and essential for diagnosing, preventing, or treating a medical condition. The concept of medical necessity takes into account the best interests of the patient and the evidence-based standards of medical practice. It helps ensure that healthcare resources are allocated efficiently and that patients receive appropriate care based on their medical needs. The Plan makes medical necessity clinical coverage determinations using externally developed, evidence-based clinical criteria (also known as medical necessity criteria) such as InterQual®, MCG®, American Society of Addiction Medicine (ASAM) Criteria¹, Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System-Child and Adolescent Service Intensity Instrument (CALOCUS-CASII), and Early Childhood Service Intensity Instrument (ECSII) guidelines as well as internally developed objective, evidence-based, medical/behavioral clinical policies.

Application of medical necessity criteria is integral to the utilization management (UM) processes of a medical necessity clinical coverage benefit determination.

The Plan publishes its medical necessity criteria, which are available through www.uhcprovider.com (M/S) and www.providerexpress.com (MH/SUD), and upon request.

This document includes the following information:

- Process for developing and approving medical necessity criteria for both M/S and MH/SUD services and technologies
- Description of the NQTL and application (Step 1)
- Factors used to determine which services and technologies are subject to the NQTL (Step 2)
- Evidentiary standards and sources used to define, trigger and/or implicate a factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

¹ Only ASAM Criteria are used to make substance use disorder (SUD) medical necessity coverage determinations, unless otherwise mandated by state law or contract.

Medical Necessity Non-Quantitative Treatment Limitation (NQTL) Analysis

GA – UnitedHealthcare Insurance Company, UnitedHealthcare of Georgia, Inc., UnitedHealthcare Insurance Company of the River Valley, and UnitedHealthcare of Georgia, Inc. Individual Exchange Medical Policy
12/29/2023



This analysis refers to the following attachments:

- *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions* - M/S policy that defines Medical Necessity
- *Optum National Policy Definitions List* - MH/SUD policy that defines Medical Necessity
- *UnitedHealthcare (UHC) Hierarchy of Clinical Evidence* – M/S policy that defines the hierarchy of clinical evidence to ensure a transparent and consistent approach within UnitedHealthcare
- *Behavioral Health Hierarchy of Clinical Evidence* – MH/SUD policy that defines the hierarchy of clinical evidence to ensure a transparent and consistent approach to the review and development of Optum's Clinical Technology Assessments and Behavioral Clinical Policies
- *2023 UnitedHealthcare Provider Administrative Guide* - Informs providers of the Prior Authorization process. The *UnitedHealthcare Provider Administrative Guide* can be accessed on the website <https://www.uhcprovider.com/en/admin-guides.html>
- *September 2023 Optum National Network Manual* - Informs providers of the Prior Authorization process. The *Optum National Network Manual* can be accessed on the website <https://public.providerexpress.com/content/optum-network-manual.html>
- *Utilization Management Program Description (UMPD) of United HealthCare Services, Inc. and UnitedHealthcare Insurance Company* - summarizes the philosophy, structure and standards that govern UHC's medical management, UM and utilization review responsibilities and functions
- *Certificates of Coverage* (COC23-INS-2018-LG-GA, COC23-INS-2018-SG-GA, COC23-HMO-2018-LG-GA, COC23-HMO-2018-SG-GA, COC23-INS-RV-2018-LG-GA, COC23-INS-RV-2018-SG-GA, Policy23-HMO-2022-EX-GA) Plan document that explains covered services, terms, conditions, and limitations of the member's policy
- *Schedule of Benefits* (for example: *Schedule of Benefits SBN23-Medical-INS-2018-[Choice+Plus][Select+Plus][Doctors+Plus]-LG-GA*, *SBN23-Medical-INS-2018-[Choice+Plus][Select+Plus][Doctors+Plus]-SG-GA*, *SBN23-Medical-INS-RV-2018-HeritagePlus-LG-GA*, *SBN23-Medical-INS-RV-2018-HeritagePlus-SG-GA*, and *SBN23-Medical-HMO-2022-EX-GA-ADV*) - Plan document that outlines member responsibilities
- *Utilization Management Program Committee Charter* – document that outlines the purpose, responsibility, functions, and composition of the committee that oversees the M/S utilization management program
- *Clinical Technology Assessment Committee (CTAC) Charter* – document that outlines the purpose, structure, responsibility and membership of the committee that develops internal medical criteria and reviews and approves externally developed criteria for MH/SUD
- *Clinical Quality and Operations Committee (CQOC) Charter* – document that outlines the purpose, structure, responsibility, and membership of the committee that oversees CTAC
- *Medical Technology Assessment Committee (MTAC) Charter* – policy that outlines the purpose, responsibility, structure and membership of the committee that develops internal medical criteria and reviews and approves externally developed criteria for M/S
- *National Medical Care Management Committee (NMCMC) Charter* – document that outlines the purpose, responsibility, membership, and structure of the committee that oversees the MTAC
- *Applying Benefit Plan and Review Criteria Standard Operating Procedure* - outlines the hierarchy of authorities to be reviewed (i.e., state/federal laws and regulations followed by Benefit Plan criteria) when making coverage determinations
- *Clinical Review Criteria Operational Policy* - The purpose of this operational policy is to document that UHC will use evidence-based clinical review criteria to support clinical review decisions for UM programs, and to ensure that the clinical review process is applied consistently
- *Clinical Criteria Development Selection and Application Policy* - addresses Optum's selection, development, and use of clinical criteria in making benefit determinations

The Plan concludes that the methodologies used to develop and approve medical necessity criteria and medical/behavioral clinical policies for M/S and MH/SUD services and technologies are comparable and applied no more stringently for MH/SUD both “as written” and “in operation.”

Medical Necessity Non-Quantitative Treatment Limitation (NQTL) Analysis

GA – UnitedHealthcare Insurance Company, UnitedHealthcare of Georgia, Inc., UnitedHealthcare Insurance Company of the River Valley, and UnitedHealthcare of Georgia, Inc. Individual Exchange Medical Policy
12/29/2023



Process

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- Medical Necessity

Benefit Classification(s)

- In-Network (INN) Inpatient, Out-of-Network (OON) Inpatient, INN Outpatient, and OON Outpatient

Please note that the Prior Authorization, Concurrent Review, and Retrospective Review NQTLs describe the services in scope for UM. These NQTLs also describe the factors and evidentiary standards used to determine whether a covered service is subject to a medical necessity review.

The Plan notes that not all covered services are subject to a medical necessity review.

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHC)
- UnitedHealthcare of Georgia, Inc. (UHCGA)
- UnitedHealthcare Insurance Company of the River Valley (UHCVR)
- UnitedHealthcare of Georgia, Inc. Individual Exchange Medical Policy (UHC GA)

Plan Terms/Source Document(s)

In each of the Plan products, Medically Necessary is the Plan term used to guide UM decision-making for both M/S and MH/SUD services and technologies. Medically Necessary is generally defined as follows:

UHC GA

- “Medically Necessary – health care services are all of the following as determined by us or our designee:
 - In accordance with Generally Accepted Standards of Medical **Care**.
 - Clinically appropriate, in terms of type, frequency, extent, service site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms.
 - Not mainly for your convenience or that of your doctor or other health care provider.
 - Not more costly than an alternative drug, service(s), service site or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

*Generally Accepted Standards of Medical **Care** are evidence based independent standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties. Valid, evidence-based sources reflecting **Generally Accepted Standards of Care** include credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.*

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or **nationally recognized clinical practice guidelines** may be considered. We have the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be determined by us.

Medical Necessity Non-Quantitative Treatment Limitation (NQTL) Analysis

GA – UnitedHealthcare Insurance Company, UnitedHealthcare of Georgia, Inc., UnitedHealthcare Insurance Company of the River Valley, and UnitedHealthcare of Georgia, Inc. Individual Exchange Medical Policy
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We develop and maintain clinical policies that describe the *Generally Accepted Standards of Medical Care* scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by us and revised from time to time), are available to Covered Persons through www.myuhc.com/exchange or the telephone number on your ID card. They are also available to Physicians and other health care professionals on UHCprovider.com.”

UHC, UHCGA and UHICRV

- **Medically Necessary - health care services, that are all of the following as determined by us or our designee.**
 - In accordance with *Generally Accepted Standards of Care*.
 - Clinically appropriate, in terms of type, frequency, extent, service site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms.
 - Not mainly for your convenience or that of your doctor or other health care provider.
 - Not more costly than an alternative drug, service(s), service site or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

Generally Accepted Standards of Care are evidence based independent standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties. Valid, evidence-based sources reflecting generally accepted standards of care include credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or nationally recognized clinical practice guidelines may be considered. We have the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be determined by us.

We develop and maintain clinical policies that describe the *Generally Accepted Standards of Care* scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by us and revised from time to time), are available to Covered Persons through www.myuhc.com/exchange or the telephone number on your ID card. They are also available to Physicians and other health care professionals on UHCprovider.com.

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Medical Necessity is defined as follows:

- “Health care services provided for the purpose of preventing, evaluating, diagnosing, or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms, that are all of the following.
- In accordance with Generally Accepted Standards of Medical Practice.
 - Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms.
 - Not mainly for your convenience or that of your doctor or other health care provider.
 - Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.”

Medical Necessity Non-Quantitative Treatment Limitation (NQTL) Analysis

GA – UnitedHealthcare Insurance Company, UnitedHealthcare of Georgia, Inc., UnitedHealthcare Insurance Company of the River Valley, and UnitedHealthcare of Georgia, Inc. Individual Exchange Medical Policy
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The *2023 United Healthcare Provider Administrative Guide* Chapter 7 describes Plan medical necessity processes as follows

“We base coverage decisions, including medical necessity decisions, on:

- Member’s benefits.
- State and federal requirements.
- The contract between us and the plan sponsor.
- Medicare guidelines including NCDs and local coverage determination (LCD) guidelines.
- Medicare Benefit Policy Manual (MA members).
- UnitedHealthcare medical policies, medical benefit drug policies, coverage determination guidelines, utilization review guidelines and MA coverage summaries.

Our employees, contractors and delegates do not receive financial incentives for issuing non-coverage decisions or denials. We and our delegates do not offer incentives for underutilization of care/services or for barriers to care/service. We do not hire, promote, or terminate employees or contractors based on whether they deny benefits.

We use tools such as UnitedHealthcare medical policies and third-party resources (such as InterQual® criteria and other guidelines), to assist us in administering health benefits and determining coverage.

These tools and resources are not equivalent to the practice of medicine or medical advice, and you should use them in addition to independent, qualified medical judgment.”

The *Optum National Policy Definitions List* defers to the definition of Medical Necessity as set forth in member Plan documents: “This term is variable and defined in the member’s applicable Plan or Coverage document.”

The *September 2023, Optum National Network Manual* defines Medical Necessity as:

“Generally, the evaluation of health care services to determine whether the services meet plan criteria for coverage; are medically appropriate and necessary to meet basic health needs; are consistent with the diagnosis or condition; are rendered in a cost-effective manner; and are consistent with national medical practice guidelines regarding type, frequency and duration of treatment. This definition may vary according to Member Benefit Plans or state laws (also referred to as Clinical Necessity).”

List of M/S and MH/SUD Services and Technologies Subject to NQTL

All M/S and MH/SUD INN inpatient, OON inpatient, INN outpatient, and OON outpatient services and technologies subject to UM.

Step 2 – Factor Used to Develop and Approve Medical and Behavioral Clinical Policies

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

The Plan relies on the following factor to develop and approve medical necessity criteria. This factor applies to both M/S and MH/SUD benefits for the following:

- I. All M/S INN inpatient, OON inpatient, INN outpatient, and OON outpatient services and technologies subject to UM
- II. All MH/SUD INN inpatient, OON inpatient, INN outpatient, and OON outpatient services and technologies subject to UM

This factor applies to M/S and MH/SUD services and technologies.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards,

Medical Necessity Non-Quantitative Treatment Limitation (NQTL) Analysis

GA – UnitedHealthcare Insurance Company, UnitedHealthcare of Georgia, Inc., UnitedHealthcare Insurance Company of the River Valley, and UnitedHealthcare of Georgia, Inc. Individual Exchange Medical Policy
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strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factor used in developing or approving medical necessity criteria. These evidentiary standards and sources apply for the following:

- I. All M/S INN inpatient, OON inpatient, INN outpatient, and OON outpatient services and technologies subject to UM
- II. All MH/SUD INN inpatient, OON inpatient, INN outpatient, and OON outpatient services and technologies subject to UM

Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan's or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The findings of the Plan's analyses confirmed the strategies, processes, factor, evidentiary standards, and source information used to develop MH/SUD medical necessity criteria and behavioral clinical policies and review externally developed criteria were comparable to, and applied no more stringently than, the strategies, processes, factor, evidentiary standards, and source information used to develop the M/S medical necessity criteria and medical clinical policies and review externally developed criteria “as written” and “in operation.”

The MH/SUD policies, procedures, and processes were found to be comparable and no more stringent than M/S policies, procedures, and processes.

The Plan used comparable processes and methodologies to assess and develop internal medical/behavioral clinical policies and externally developed medical necessity criteria.

The Plan's Medical Necessity definitions for M/S and MH/SUD are the same, as published in the Plan documents. Additionally, both M/S and MH/SUD clinical reviewers follow the established process of reviewing state/federal laws and regulations, followed by Plan documents and then medical/behavioral clinical policies when making clinical coverage benefit determinations.

Conclusions

The Plan concluded the methodologies used to develop MH/SUD internal evidence-based behavioral clinical policies and approve MH/SUD externally developed medical necessity criteria for use in medical necessity clinical coverage benefit determinations were comparable to, and applied no more stringently than, the methodologies used to develop M/S internal evidence-based medical clinical policies and approve M/S externally developed medical necessity criteria for use in medical necessity clinical coverage benefit determinations both “as written” and “in operation.”

Overview

Pursuant to a federal law called the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical and surgical (M/S) benefits. This generally means that financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA protections include:

- Financial requirements such as, deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs, which may limit the scope or duration of benefits for treatment under a plan or coverage.

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors considered in the design and application of the NQTL (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTLs

The Plan assesses the adequacy of its network based on regulatory requirements.

This document includes the following information:

- Process for both M/S and MH/SUD network management – network adequacy
- Description of the NQTL and application (Step 1)
- Factors used to facilitate network management – network adequacy for both M/S and MH/SUD (Step 2)
- Evidentiary standards and sources used to define and/or trigger each of the identified factors (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

The Plan concludes M/S and MH/SUD network management – network adequacy processes are comparable and applied to MH/SUD no more stringently both “as written” and “in operation.”

Process

The Plan assesses network adequacy based on access standards that are in accordance with the Centers for Medicare & Medicaid Services (CMS) and/or applicable state laws. When determining whether to recruit providers in a given geographic market (such as a county or metropolitan area), the Plan considers network adequacy and access reports.

Key steps in the network management process for both M/S and MH/SUD services include:

- The Plan determines Time, Distance, and Provider Threshold requirements based on state/federal requirements
- The Plan conducts M/S and MH/SUD network adequacy reporting (by state/county) to determine if Time, Distance, and Provider Threshold requirements are met
- If network adequacy requirements are not met, the Plan actively seeks to add providers to the network in that specialty or provider type

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- Network Management – Network Adequacy

Benefit Classification(s)

- Applies to all INN, inpatient and outpatient services

Plan(s) at Issue

- Applies to all Plans

Plan Terms/Source Document(s)

Per the Plan's member portal, "UnitedHealthcare networks consist of a variety of primary care and behavioral professionals, specialists, hospitals, and other facilities. To help provide members with reasonable access to providers who meet their needs, we look at the number of providers and the types of services offered within a geographic area. Additionally, we conduct an assessment of how well the network meets members' cultural needs and preferences, as well as any special healthcare needs. We make outreach to providers, as needed, in order to recruit them to our network. We also accept requests from employers, members, and providers to accommodate needs and preferences." (<https://www.uhc.com/legal/provider/commercial-plans>)

List of M/S and MH/SUD Benefits Subject to NQTL

Applies to all INN M/S and MH/SUD services

Step 2 – Factors Used in the Design and Application of the NQTLs

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

The Plan relies on the following factors to determine network adequacy. These factors apply to both M/S and MH/SUD benefits in the following classifications:

- I. M/S INN inpatient/outpatient services
 - II. MH/SUD INN inpatient/outpatient services
- State-specific standards (Quantitative)
 - When state regulations identify a quantifiable network adequacy measurement for geographic and numeric availability of providers

Applies to both M/S and MH/SUD services.

- Centers for Medicare & Medicaid Services (CMS)/Health Services Delivery (HSD) table (Quantitative)

Applies to both M/S and MH/SUD services.

The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factors used in determining network adequacy. These evidentiary standards and sources apply to the following benefit classifications:

- I. M/S INN inpatient/outpatient services
- II. MH/SUD INN inpatient/outpatient services

Factor – State-specific standards is defined as state regulations identifying a quantifiable network adequacy measurement for geographic and numeric availability of providers.

The Plan's evidentiary standard and source that defines and/or triggers the identification of the factor:

- Applicable state regulatory requirements

These evidentiary standards and sources apply to both M/S and MH/SUD INN inpatient/outpatient services. This evidentiary standard and source is defined in a quantitative manner.

Factor – Centers for Medicare & Medicaid Services (CMS)/Health Services Delivery (HSD) table is defined as CMS guidance for time/distance standards for various types of providers and facilities.

The Plan's evidentiary standard and source that defines and/or triggers the identification of the factor:

- CMS/HSD table (located under downloads in the following website: cms.gov/medicare/medicare-advantage/medicareadvantageapps)

These evidentiary standards and sources apply to both M/S and MH/SUD INN inpatient/outpatient services. This evidentiary standard and source is defined in a quantitative manner.

These evidentiary standards and sources are applicable to both M/S and MH/SUD services. In addition, all of these standards/sources are considered and used to define the factors.

Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Network Management – Network Adequacy Non-Quantitative Treatment Limitation (NQTL) Analysis

GA – UnitedHealthcare Insurance Company, UnitedHealthcare of Georgia, Inc., UnitedHealthcare Insurance Company of the River Valley, and UnitedHealthcare of Georgia, Inc. Individual Exchange Medical Policy
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Findings

The above analysis confirmed the strategies, processes, factors, evidentiary standards, and source information used to determine MH/SUD network adequacy were comparable to, and applied no more stringently than, the strategies, processes, factors, evidentiary standards, and source information used to determine M/S network adequacy “as written.”

Both MH/SUD and M/S run network adequacy reports at least quarterly which are in accordance with CMS and/or state established time and distance thresholds to assess the continued adequacy of the network. Additionally, both M/S and MH/SUD have processes in place to authorize benefit coverage at the INN benefit level for services provided by an OON provider if a network gap is identified. When a network gap is identified, the Plan will work with the member’s network provider to coordinate care through an OON provider.

In addition, the above analysis revealed the process and methodology MH/SUD used to assess network adequacy “in operation” was comparable to, and applied no more stringently than, the process and methodology M/S used to assess network adequacy.

Conclusions

In light of the above findings, the Plan concluded the M/S and MH/SUD network management – network adequacy processes are applied to M/S and MH/SUD networks comparably and are applied no more stringently to MH/SUD both “as written” and “in operation.”

GA – UnitedHealthcare Insurance Company, UnitedHealthcare of Georgia, Inc., UnitedHealthcare Insurance Company of the River Valley, and UnitedHealthcare of Georgia, Inc. Individual Exchange Medical Policy
12/29/2023

Overview

Pursuant to a federal law called the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical and surgical (M/S) benefits. This generally means that financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA protections include:

- Financial requirements, such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

Out-of-network (OON) emergency care reimbursement is the process by which the Plan establishes reimbursement for OON emergency claims as defined in the member’s plan documents. The methodologies applicable to emergency services reimbursement may also be applicable to reimbursement for out of network services provided in network facilities.

This document includes the following information:

- Process for establishing OON emergency care reimbursement rates for both M/S and MH/SUD services
- The description of the NQTL and application (Step 1)
- Factors used to determine which services are subject to the NQTL (Step 2)
- Evidentiary standards and sources used to define, trigger and/or implicate a factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

The analysis refers to the following attachments:

- *Certificates of Coverage* (COC23-INS-2018-LG-GA, COC23-INS-2018-SG-GA, COC23-HMO-2018-LG-GA, COC23-HMO-2018-SG-GA, COC23-INS-RV-2018-LG-GA, COC23-INS-RV-2018-SG-GA, Policy23-HMO-2022-IEG-GA) Plan document that explains covered services, terms, conditions, and limitations of the member’s policy
- *Schedule of Benefits* (for example: *Schedule of Benefits SBN23-Medical-INS-2018-[Choice+Plus][Select+Plus][Doctors+Plus]-LG-GA*, *SBN23-Medical-INS-2018-[Choice+Plus][Select+Plus][Doctors+Plus]-SG-GA*, *SBN23-Medical-INS-RV-2018-HeritagePlus-LG-GA*, *SBN23-Medical-INS-RV-2018-HeritagePlus-SG-GA*, and *SBN23-Medical-HMO-2022-IEG-GA-ADV*) - Plan document that outlines member responsibilities

The Plan concludes that its methodology for establishing M/S and MH/SUD OON emergency care services reimbursement rates is comparable and applied no more stringently for MH/SUD than for M/S both “as written” and “in operation.”

GA – UnitedHealthcare Insurance Company, UnitedHealthcare of Georgia, Inc., UnitedHealthcare Insurance Company of the River Valley, and UnitedHealthcare of Georgia, Inc. Individual Exchange Medical Policy
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Process

For both M/S and MH/SUD emergency care services, the Plan uses a comparable process to establish reimbursement rate(s).

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- OON Emergency Care Reimbursement

Benefit Classification(s)

- OON, emergency care

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHIC)
- UnitedHealthcare of Georgia, Inc. (UHCGA)
- UnitedHealthcare Insurance Company of the River Valley (UHICRV)
- UnitedHealthcare of Georgia, Inc. Individual Exchange Medical Policy (UHC GA)

Plan Terms/Source Documents

The Plan's *Certificate of Coverage* defines emergency health care services.

Step 2 – Factors Used in the Design and Application of the NQTLs

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factor used in determining OON emergency care reimbursement rates. The evidentiary standards and sources apply to the following benefit classifications:

- I. OON emergency services for M/S conditions
- II. OON emergency services for MH/SUD conditions

Step 4 – NQTL “As Written” and “In Operation” Comparability and

GA – UnitedHealthcare Insurance Company, UnitedHealthcare of Georgia, Inc., UnitedHealthcare Insurance Company of the River Valley, and UnitedHealthcare of Georgia, Inc. Individual Exchange Medical Policy
12/29/2023

Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

FAQ 45: A reasoned discussion of the Plan or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The findings of the comparative analysis revealed the process and methodology used for OON emergency care reimbursement for MH/SUD conditions “as written” and “in operation” was comparable to, and applied no more stringently than, the process and methodology used for OON emergency care reimbursement for M/S conditions.

Conclusions

Based upon these findings, the Plan concluded the methodology and processes that the Plan uses for OON emergency care reimbursement for MH/SUD conditions was comparable to the methodology and processes that is used for OON emergency care reimbursement for M/S conditions “as written” and “in operation.”

Overview

Pursuant to a federal law called the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical and surgical (M/S) benefits. This generally means that financial requirements and non-quantitative treatment limitations (NQTLS) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLS applied to M/S benefits. The types of limits covered by MHPAEA protections include:

- Financial requirements such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLS which may limit the scope or duration of benefits for treatment under a plan or coverage.

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

Out-of-network (OON) inpatient and outpatient reimbursement is the process by which the Plan establishes reimbursement for OON inpatient and outpatient claims as defined in the member’s plan documents.

Process

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- OON reimbursement: Inpatient and outpatient services

Benefit Classification(s)

- OON, inpatient and outpatient

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHIC)
- UnitedHealthcare of Georgia, Inc. (UHCGA)
- UnitedHealthcare Insurance Company of the River Valley (UHICRV)

Step 2 – Factors Used in the Design and Application of the NQTL

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The findings of the comparative analysis revealed the process and methodology MH/SUD used to determine OON inpatient and outpatient reimbursement “as written” and “in operation” was comparable to, and applied no more stringently than, the process and methodology M/S used to determine OON inpatient and outpatient reimbursement.

Conclusions

Based upon these findings, the Plan concluded the methodology and processes that M/S and MH/SUD use to determine OON reimbursement was comparable “as written” and “in operation.”

Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical and surgical (M/S) benefits. This generally means that financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits must be comparable to and cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA protections include:

- Financial requirements such as, deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs, which may limit the scope or duration of benefits for treatment under a plan or coverage

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

Prescription Drug List (PDL) a/k/a formulary design is a component of the Plan’s utilization management (UM) program. The goal of PDL/formulary design is to assess the prescription drug’s place in therapy.

This document includes the following information:

- PDL process for both M/S and MH/SUD prescription drugs
- The description of the NQTL and application (Step 1)
- Factors used to determine prescription drugs tier placement and/or benefit coverage (Step 2)
- Evidentiary standards and sources used to define, trigger and/or implicate a factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

This analysis does not refer to any attachments.

The Plan concludes that the PDL/formulary design requirements for M/S and MH/SUD are comparable and applied no more stringently for prescription drug benefits both “as written” and “in operation.”

Process

The Pharmacy & Therapeutics (P&T) Committee assesses a prescription drug’s place in therapy and its relative safety and efficacy in order to provide a clinical recommendation/designation used in determining coverage and tier assignment. The P&T Committee is comprised of individuals from diverse clinical disciplines, including, behavioral health. Additional physician specialists with specific expertise are consulted as part of the clinical evaluation of new and existing drugs.

The Pharmacy & Therapeutics Committee consists of physicians specializing in Obstetrics & Gynecology, Endocrinology/Metabolism, Hematology/Oncology, Rheumatology, Geriatrics, Cardiology, Gastroenterology, Psychiatry, Pediatrics & Internal Medicine, and Internal Medicine. The committee also consists of 4 pharmacists, one of which specializes in Geriatrics & Psychiatry. There is a requirement that the committee consist of at least one physician specializing in psychiatry.

To approve clinical drug policies, the established committee follows a standard process. The P&T Committee evaluates the FDA approved product labeling, peer-reviewed medical literature, published clinical practice guidelines, including randomized clinical trials, drug comparison studies, outcomes research data, pharmacoeconomic studies, comparisons of efficacy, side effects, potential for off-label use and claims data analysis, as relevant, as part of the review and approval process of clinical policies. The P&T Committee assesses external clinical evidence and nationally recognized evidence-based guidelines and benchmarks, as well as a prescription drug's place in therapy, and its relative safety and efficacy to approve clinical drug policies for select M/S and MH/SUD prescription drugs.

The UnitedHealthcare (UHC) Prescription Drug List Management Committee (PDL MC) makes tiering decisions by considering clinical, economic/financial and pharmacoeconomic evidence for populations with an incentive based PDL. The PDL MC makes benefit exclusion decisions using the same types of evidence. This information is provided by UHC Evidence Based Decision Support Committees, including but not limited to, the UHC P&T Committee as outlined above.

PDL a/k/a formulary design is based on the Plan's policy to assign tiers for prescription drugs. Newly launched generic prescription drugs are also reviewed to determine initial tier placement on the PDL and/or benefit coverage. A generic prescription drug includes a prescription drug that is chemically equivalent to a brand drug or that the Plan identifies as a generic based on available data resources including, but not limited to, the daily Medi-Span file load memo that classifies drugs as either brand or generic based on several factors. Generics will be considered for initial tier placement and/or benefit coverage equal to that of the current placement of the brand prescription drug.

The Plan reviews the number of M/S and MH/SUD prescription drugs by tier on a tri-annual basis. The results are reviewed with the UM Committee to determine if any changes should be made in the PDL/formulary design.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- PDL a/k/a Formulary Design

Benefit Classification(s)

- Prescription Drugs

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHIC)
- UnitedHealthcare of Georgia, Inc. (UHCGA)
- UnitedHealthcare Insurance Company of the River Valley (UHICRV)

Plan Terms

- "Benefits are available for Prescription Drug Products at a Network Pharmacy and are subject to Copayments and/or Co-insurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is placed."

List of M/S and MH/SUD Services Subject to NQTL

- All prescription drugs are part of the Plan's PDL a/k/a formulary design
- The PDLs generally contain brand and generics that provide the highest overall value on Tiers 1 and 2, with brand and generics that provide the lowest overall value on Tiers 3 and 4

Step 2 – Factors Used to Determine Formulary Design Applies

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

The Plan relies on the following factors to determine the PDL for both M/S and MH/SUD prescription drugs:

- Assessment of the prescription drug's place in therapy (Qualitative)
 - Goal is to promote optimal drug use based on review of FDA approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off-label use and claims data analysis

Applies to M/S and MH/SUD prescription drugs

- Relative safety and efficacy (Qualitative)
 - Goal is to promote optimal drug use by performing a comprehensive efficacy comparison as well as reviewing the type and frequency of side effects and potential drug interactions among alternative drug products

Applies to M/S and MH/SUD prescription drugs

- Available therapeutic equivalent prescription drugs (Quantitative)
 - Goal is to promote optimal drug use in therapeutic classes with several alternative drug products. A trial of clinically appropriate, lower cost alternative(s) may be appropriate prior to coverage of a more expensive alternative

Applies to M/S and MH/SUD prescription drugs

The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL. The factors apply to both M/S and MH/SUD prescription drugs.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factors used in determining the PDL. These evidentiary standards and sources apply to both M/S and MH/SUD prescription drugs.

Factor – Assessment of the prescription drug's place in therapy

- The Plan's evidentiary standard and source that defines and/or triggers the assessment of the prescription drug's place in therapy factor:
 - FDA-approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off-label use, and claims data analysis as relevant

This evidentiary standard and source applies to both M/S and MH/SUD prescription drugs and is defined in a qualitative manner.

Factor – Relative safety and efficacy

- The Plan’s evidentiary standard and source that defines and/or triggers the relative safety and efficacy factor:
 - FDA approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off label use and claims data analysis as relevant

This evidentiary standard and source applies to both M/S and MH/SUD prescription drugs and is defined in a qualitative manner.

Factor – Available therapeutic equivalent prescription drugs

- The Plan’s evidentiary standard and source that defines and/or triggers the available therapeutic equivalent prescription drugs factor:
 - FDA-approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off-label use, and claims data analysis as relevant

This evidentiary standard and source applies to both M/S and MH/SUD prescription drugs and is defined in a quantitative manner.

The factors and evidentiary standards used as the basis for determining the PDL for MH/SUD prescription drugs are comparable to, and applied no more stringently than, the factors used as the basis for determining the PDL for M/S prescription drugs “as written” and “in operation.” The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL.

Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer’s analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert’s qualifications and the extent to which the Plan or issuer ultimately relied upon each expert’s evaluations in setting recommendations regarding both.

As Written

The Plan compared the strategies, processes, factors, evidentiary standards, and source information used to determine which M/S and MH/SUD prescription drugs are subject to PDL a/k/a formulary design “as written.”

The Plan identified the shared factors and evidentiary standards used as the basis for subjecting M/S and MH/SUD benefits to formulary design for prescription drugs. The factors and evidentiary standards are applied to both M/S and MH/SUD prescription drugs comparably and not more stringently to MH/SUD prescription drugs.

Review of Operational Policies and Procedures

The P&T Committee assesses the prescription drug’s place in therapy and its relative safety and efficacy in order to provide a clinical recommendation/designation used in determining coverage and tier assignment. The UHC PDL MC makes tiering and benefit exclusion decisions by considering clinical, economic/financial and pharmacoeconomic evidence for populations with an incentive based PDL. The PDL MC makes benefit exclusion decisions using the same types of evidence.

The P&T Committee is comprised of individuals from diverse clinical disciplines including, behavioral health. Additional physician specialists with specific expertise are consulted as part of the clinical evaluation of new and existing drugs.

The P&T Committee consists of physicians specializing in Obstetrics & Gynecology, Endocrinology/Metabolism, Hematology/Oncology, Rheumatology, Geriatrics, Cardiology, Gastroenterology, Psychiatry, Pediatrics & Internal Medicine, and Internal Medicine. The committee also consists of 4 pharmacists, one of which specializes in Geriatrics & Psychiatry.

Physician specialists with specific expertise are consulted for clinical evaluation of a drug using P&T committee members if the specific specialty is represented and outside consultants are used if the specialty is not represented in the P&T committee. As part of the clinical evaluation of new drugs or for some existing drugs with new evidence, these consults are routinely done.

In Operation

The Plan compared the strategies, processes, factors, evidentiary standards, and source information used to determine which M/S and MH/SUD prescription drugs are subject to formulary design “in operation.”

The Plan reviewed the number of M/S and MH/SUD prescription drugs by tier on a tri-annual basis. The results are reviewed by the UHC UM Committee to determine if any changes should be made in the PDL/formulary design.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The findings of the analysis revealed the strategies, processes, factors, evidentiary standards, and source information the Plan used to administer the PDL a/k/a formulary design for MH/SUD prescription drugs were comparable to, and applied no more stringently than, the strategies, processes, factors, evidentiary standards, and source information used to administer the PDL a/k/a formulary design for M/S prescription drugs “as written.”

Further, both M/S and MH/SUD utilize generally accepted types of data, evidentiary sources, and trend analyses to create and maintain the PDL/formulary design.

The Plan evaluates the number of M/S and MH/SUD prescription drugs by tier on a tri-annual basis.

The findings of the analysis revealed for all prescription drugs covered under the pharmacy benefit, the Plan uses the same PDL MC to determine tier placement and/or benefit coverage. The Committee does not distinguish between M/S and MH/SUD prescription drugs, and the processes are administered in the same fashion and not applied more stringently to MH/SUD prescription drugs. The tiering for M/S and MH/SUD prescription drugs shows the majority are placed on Tiers 1 and 2 allowing for easier access and is in compliance with MHPAEA.

The findings of the Prescription Drug Tier Analysis (see data below) indicated the percent of prescription drugs by tiers for MH/SUD prescription drugs were comparable to the percent of prescription drugs by tiers for M/S prescription drugs. Data is for (January, May, and September 2022). The Plan also notes that the U.S. Department of Labor has indicated generally that outcomes data are not dispositive of parity compliance.

The following are results of each analysis in 2022:

- January 2022 –
 - 59.0% of MH/SUD drugs are on Tiers 1 and 2
 - 53.3% of M/S drugs are on Tiers 1 and 2
- May 2022 –
 - 57.9% of MH/SUD drugs are on Tiers 1 and 2

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- 52.9% of M/S drugs are on Tiers 1 and 2
- September 2022 –
 - 56.9% of MH/SUD drugs are on Tiers 1 and 2
 - 52.8% of M/S drugs are on Tiers 1 and 2

These evaluations were based on the Advantage PDL, which is the most commonly used PDL.

Conclusions

Based upon these findings, the Plan concluded that the methodologies to administer the PDL a/k/a formulary design for MH/SUD prescription drugs were comparable to, and applied no more stringently than, the methodologies to administer the PDL a/k/a formulary design for M/S prescription drugs “as written.”

Based on the above review and data, the Plan concluded the methodologies to administer the PDL a/k/a formulary design for MH/SUD prescription drugs were comparable to, and applied no more stringently than, the methodologies to administer the PDL a/k/a formulary design for M/S prescription drugs “in operation.”

Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical and surgical (M/S) benefits. This generally means that financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits are comparable to and no more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA protections include:

- Financial requirements such as, deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs, which may limit the scope or duration of benefits for treatment under a plan or coverage

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

Per the Outpatient Prescription Drug *Schedule of Benefits*, “Before certain Prescription Drug Products are dispensed to you, your Physician, your pharmacist or you are required to [\[notify\]](#) [\[obtain prior authorization from\]](#) us or our designee. The reason for [\[notifying\]](#) [\[obtaining prior authorization from\]](#) us is to determine whether the Prescription Drug Product, in accordance with our approved guidelines, is each of the following:

- It meets the definition of a Covered Health Care Service.
- It is not an Experimental or Investigational or Unproven Service.

We may also require you to [\[notify\]](#) [\[obtain prior authorization from\]](#) us or our designee so we can determine whether the Prescription Drug Product, in accordance with our approved guidelines, was prescribed by a Specialist.”

[“\[Certain Prescription Drug Products for which Benefits are described under this Prescription Drug Rider are subject to step therapy requirements. In order to receive Benefits for such Prescription Drug Products you must use a different Prescription Drug Product\(s\) first.](#)

[You may find out whether a Prescription Drug Product is subject to step therapy requirements by contacting us at \[\\[www.myuhc.com\\]\]\(#\) or the telephone number on your ID card.\]”](#)

“Benefits for Prescription Drug Products are subject to the supply limits that are stated in the “Description and Supply Limits” column of the Benefit Information table. For a single Co-payment and/or Co-insurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed. Supply limits are subject, from time to time, to our review and change. This may limit the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may find out whether a Prescription Drug Product has a supply limit for dispensing by contacting us at [\[www.myuhc.com\]](#) or the telephone number on your ID card.”

The *Certificate of Coverage* defines Covered Health Care Service as “health care services, including supplies or Pharmaceutical Products, which we determine to be all of the following:

- Provided for the purpose of preventing, evaluating, diagnosing, or treating a sickness, injury, mental illness, substance-related and addictive disorders, condition, disease or its symptoms.

Prescription Drug Prior Auth/Step Therapy Non-Quantitative Treatment Limitation (NQTL) Analysis

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- Medically Necessary
- Described as a Covered Health Care Service in the Certificate under Section 1: Covered Health Care Services and in the Schedule of Benefits
- Not excluded in the Certificate under Section 2: Exclusions and Limitations”

Prior Authorization is a component of the Plan’s utilization management (UM) program that helps members receive appropriate coverage based on their specific clinical status and health care needs. The process is designed to achieve optimal clinical outcomes by applying objective, evidence-based clinical criteria and nationally recognized guidelines and best practices.

Prior Authorization for prescription drugs commences prior to a drug being covered. Prior Authorization is a UM process that involves applying clinical criteria to member clinical information in order to render a clinical coverage benefit determination.

The goal of Prior Authorization, Step Therapy, and Quantity Limits is to ensure cost-effective and clinically effective prescription drugs are covered to achieve a positive clinical outcome. Prior Authorization, Step Therapy, and Quantity Limits apply to prescription drugs provided to a member at the point-of-sale. Drug products are selected for Quantity Limits to encourage Food and Drug Administration (FDA) labeling, prevent abuse, address safety concerns, prevent pharmacy billing errors and encourage dose optimization.

Prior Authorization, Step Therapy, and Quantity Limits for prescription drugs begin after a provider or member requests coverage for a prescription drug and receipt of clinical information. The provider or member’s submission of a request (notification) triggers the Prior Authorization, Step Therapy, and Quantity Limits process. Quantity Limits trigger a Prior Authorization if the member is seeking more than the quantity limit set.

Note: The comparative analysis “as written” and “in operation” are the same for Prior Authorization, Step Therapy and Quantity Limits; therefore, the analysis has been combined.

This document includes the following information:

- Prior Authorization, Step Therapy, and Quantity Limits process for both M/S and MH/SUD prescription drugs
- The description of the NQTL and application (Step 1)
- Factors used to determine which prescription drugs are subject to the NQTL (Step 2)
- Evidentiary standards and sources used to define, trigger, and/or implicate a factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

This analysis refers to the following attachments:

- *UnitedHealthcare Provider Administrative Guide* - [2023 UnitedHealthcare Care Provider Administrative Guide \(uhcprovider.com\)](https://uhcprovider.com)- Informs providers of the Prior Authorization process
- *Certificates of Coverage* (for example: *COC23-INS-2018-LG-GA*, *COC23-HMO-2018-LG-GA*, *COC23-INS-2018-SG-GA*, and *COC23-INS-RV-2018-LG-GA*)- Plan document that explains covered services, terms, conditions, and limitations of the member’s policy
- *Schedule of Benefits* (for example: *SBN23-Pharmacy-INS-2018-Pharmacy+Network+and+Out-of-Network-LG-GA*, *SBN23-Pharmacy-INS-2018-Pharmacy+Network+and+Out-of-Network-SG-GA*, *SBN23-Pharmacy-HMO-2018-Pharmacy+Network-LG-GA*, *SBN23-Pharmacy-HMO-2018-Pharmacy+Network+and+Out-of-Network-SG-GA*, *SBN23-Pharmacy-HMO-2018-Pharmacy+Network-SG-GA*, *SBN23-Pharmacy-INS-RV-2018-NET-OON-Hybrid-LG-GA* and *SBN23-Pharmacy-INS-RV-2018-NET-OON-SG-GA*) Plan document that outlines member responsibilities.
- Drugs with Clinical Programs dated 12/01/2023.

The Plan concludes that the Prior Authorization, Step Therapy, and Quantity Limit requirements for M/S and MH/SUD are comparable and applied no more stringently for M/S or MH/SUD prescription drug benefits both "as written" and "in operation.”

Process

For all prescription drugs covered under the pharmacy benefit, the Plan uses the same policies and procedures to create clinical criteria and develop clinical drug policies through a single Pharmacy & Therapeutics (P&T) Committee.

Per the Outpatient Prescription Drug *Schedule of Benefits*, “Before certain Prescription Drug Products are dispensed to you, your Physician, your pharmacist or you are required to [\[notify\]](#) [\[obtain prior authorization from\]](#) us or our designee. The reason for [\[notifying\]](#) [\[obtaining prior authorization from\]](#) us is to determine whether the Prescription Drug Product, in accordance with our approved guidelines, is each of the following:

- It meets the definition of a Covered Health Care Service.
- It is not an Experimental or Investigational or Unproven Service.

We may also require you to [\[notify\]](#) [\[obtain prior authorization from\]](#) us or our designee so we can determine whether the Prescription Drug Product, in accordance with our approved guidelines, was prescribed by a Specialist.”

“[\[Certain Prescription Drug Products for which Benefits are described under this Prescription Drug Rider are subject to step therapy requirements. In order to receive Benefits for such Prescription Drug Products you must use a different Prescription Drug Product\(s\) first.](#)

[You may find out whether a Prescription Drug Product is subject to step therapy requirements by contacting us at \[\\[www.myuhc.com\\]\]\(#\) or the telephone number on your ID card.\]”](#)

“Benefits for Prescription Drug Products are subject to the supply limits that are stated in the “Description and Supply Limits” column of the Benefit Information table. For a single Co-payment and/or Co-insurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed. Supply limits are subject, from time to time, to our review and change. This may limit the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may find out whether a Prescription Drug Product has a supply limit for dispensing by contacting us at [\[www.myuhc.com\]](#) or the telephone number on your ID card.”

The *Certificate of Coverage* defines Covered Health Care Service as “health care services, including supplies or Pharmaceutical Products, which we determine to be all of the following:

- Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms.
- Medically Necessary
- Described as a Covered Health Care Service in the Certificate under Section 1: Covered Health Care Services and in the Schedule of Benefits
- Not excluded in the Certificate under Section 2: Exclusions and Limitations”

The Plan structures prescription drug Prior Authorization processes to be compliant with all applicable federal and state laws, as well as the National Committee for Quality Assurance (NCQA) accreditation standards. NCQA confirms that Plan operations and policies identify appropriate time frames for decisions, requires decision-making by appropriate personnel, and governs communication of adverse benefit determinations. In addition, Prior Authorization is governed at both the state and federal level, which includes consumer protections such as external review for adverse benefit determinations after internal appeals options are exhausted, as applicable.

Prior Authorization, Step Therapy and Quantity Limits review of M/S and MH/SUD prescription drugs consists of the following:

Prior Authorization, Step Therapy, and Quantity Limits for prescription drugs begin after a provider or member requests

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coverage for a prescription drug and receipt of clinical information. The provider or member's submission of a request (notification) triggers the Prior Authorization, Step Therapy, and Quantity Limits process. Quantity Limits trigger a Prior Authorization if the member is seeking more than the quantity limit set. A Prior Authorization (including Quantity Limits) or Step Therapy request may be submitted by telephone or electronically. The Plan confirms receipt of the Prior Authorization, Step Therapy or Quantity Limit request. Non-clinical staff confirm member eligibility and benefit plan coverage. The Plan can administratively deny cases for lack of eligibility or benefit coverage.

Determinations. Clinical reviewers (Medical Director or healthcare professional) consult clinical drug policies when making clinical coverage benefit determinations. The clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical drug policies in the case review to assess whether a prescription drug should be covered. The Prior Authorization, Step Therapy, or Quantity Limit request is approved based on whether the member's clinical condition meets criteria for coverage as determined by the application of clinical drug policies. Only qualified clinical reviewers (e.g., physicians or pharmacists) can issue adverse benefit determinations. If an adverse benefit determination is issued, then the adverse benefit determination and appeal rights are communicated to the member and provider.

Adverse Benefit Determinations. For prescription drugs, an adverse benefit determination is an administrative or clinical review decision resulting in a reduction or termination, non-coverage or non-certification of a prescription drug. Adverse benefit determinations are recorded as administrative denials when member eligibility and benefit coverage cannot be confirmed, or benefits are exhausted. Adverse benefit determinations are recorded as clinical denials when they are based on clinical drug policies and member clinical information

Clinical Criteria. Clinical reviewers base Prior Authorization clinical coverage benefit determinations on objective, evidence-based clinical drug policies.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- Prescription Drug Prior Authorization, Step Therapy, and/or Quantity Limits

Benefit Classification(s)

- Prescription Drugs

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHIC)
- UnitedHealthcare of Georgia, Inc. (UHCGA)
- UnitedHealthcare Insurance Company of the River Valley (UHICRV)

Plan Terms/Source Document(s)

The Plan's *Certificates of Coverage* notify members of the Prior Authorization requirements. Members or providers are required to comply with UM protocols established by the Plan.

Per the Outpatient Prescription Drug *Schedule of Benefits*, "Before certain Prescription Drug Products are dispensed to you, your Physician, your pharmacist or you are required to [\[notify\]](#) [\[obtain prior authorization from\]](#) us or our designee. The reason for [\[notifying\]](#) [\[obtaining prior authorization from\]](#) us is to determine whether the Prescription Drug Product, in accordance with our approved guidelines, is each of the following:

- It meets the definition of a Covered Health Care Service.
- It is not an Experimental or Investigational or Unproven Service.

We may also require you to [\[notify\]](#) [\[obtain prior authorization from\]](#) us or our designee so we can determine whether the Prescription Drug Product, in accordance with our approved guidelines, was prescribed by a Specialist."

Prescription Drug Prior Auth/Step Therapy Non-Quantitative Treatment Limitation (NQTL) Analysis

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“[Certain Prescription Drug Products for which Benefits are described under this Prescription Drug Rider are subject to step therapy requirements. In order to receive Benefits for such Prescription Drug Products you must use a different Prescription Drug Product(s) first.

You may find out whether a Prescription Drug Product is subject to step therapy requirements by contacting us at [\[www.myuhc.com\]](http://www.myuhc.com) or the telephone number on your ID card.]”

“Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Co-payment and/or Co-insurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed. Supply limits are subject, from time to time, to our review and change. This may limit the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may find out whether a Prescription Drug Product has a supply limit for dispensing by contacting us at [\[www.myuhc.com\]](http://www.myuhc.com) or the telephone number on your ID card.”

The *Certificate of Coverage* defines Covered Health Care Service as “health care services, including supplies or Pharmaceutical Products, which we determine to be all of the following:

- Provided for the purpose of preventing, evaluating, diagnosing, or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms.
- Medically Necessary
- Described as a Covered Health Care Service in the Certificate under Section 1: Covered Health Care Services and in the Schedule of Benefits
- Not excluded in the Certificate under Section 2: Exclusions and Limitations”

The *2023 UnitedHealthcare Care Provider Administrative Guide* notifies providers of the Prior Authorization requirements. In-network providers are required to comply with UM protocols established by the Plan.

“We develop medical policies, medical benefit drug policies, coverage determination guidelines, and utilization review guidelines to support the administration of medical benefits. You may request a copy of our medical policies and guidelines by calling our care management team at 1-877-842-3210 or 1-888-478-4760 (Individual Exchange Plans). They are only for informational purposes; they are not medical advice. You are responsible for deciding what care to give our members. Members should talk to their health care providers before making medical decisions. Drug policies for commercial members covered under the pharmacy benefit are on uhcprovider.com/pharmacy.

Benefit coverage is determined by the following:

- Laws that may require coverage
- The member's benefit plan document
 - Summary Plan Description
 - Schedule of Benefits
 - Certificate of Coverage

The member's benefit plan document identifies which services are covered, which are excluded, and which are subject to limitations. If there is a conflict, the member's benefit plan document supersedes our policies and guidelines.

We develop our policies and guidelines as needed. We regularly review and update them. They are subject to change. We believe the information in these policies and guidelines is accurate and current as of the publication date. We also use tools developed by third parties, such as InterQual criteria, to help us manage health benefits. If you believe we should consider new or additional clinical evidence pertaining to a specific medical policy, complete this form for UnitedHealthcare medical policy review. Do not submit protected health information using this form. If you have questions

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or concerns about a specific service for a member, refer to the appropriate benefits, claims or prior authorization/notification process.”

List of M/S and MH/SUD Services Subject to NQTL

See list of Drugs with Clinical Programs dated 12/01/2023:

Step 2 – Factors Used to in the Design and Application of the NQTL

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

The Plan relies on the following factors to determine whether prescription drugs are subject to Prior Authorization, Step Therapy, or Quantity Limits for both M/S and MH/SUD:

- Assessment of the prescription drug’s place in therapy (Qualitative)
 - Goal is to promote optimal drug use based on review of FDA approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off-label use and claims data analysis

Applies to M/S and MH/SUD prescription drugs.

- Availability of clinically similar lower cost medications to treat the condition (Quantitative)
 - Goal is to promote optimal drug use in therapeutic classes with several alternative drug products. A trial of clinically appropriate, lower cost alternative(s) may be appropriate prior to coverage of a more expensive alternative

Applies to M/S and MH/SUD prescription drugs.

- Value to implement Prior Authorization/ Step Therapy (Qualitative)
 - Goal is to evaluate whether inclusion of contingency edits or inclusion in Diagnosis to Prescription match (Dx2Rx) or Silent Authorization is appropriate or whether a coverage review is required to determine whether conditions of coverage are met. Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class

Applies to M/S and MH/SUD prescription drugs.

- Relative safety and efficacy (Qualitative)
 - Goal is to promote optimal drug use by performing a comprehensive efficacy comparison as well as reviewing the type and frequency of side effects and potential drug interactions among alternative drug products

Applies to M/S and MH/SUD prescription drugs.

- Prevention of off-label use or unproven uses (Qualitative)
 - Goal is to promote optimal drug use by evaluating the potential for the drug to be used for indications other than what is included on FDA approved product labeling

Applies to M/S and MH/SUD prescription drugs.

The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL. The factors apply to both M/S and MH/SUD prescription drugs.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below are the sources and evidentiary standards used to define, trigger, and/or implicate the factor used in designing or applying the Plan's Prior Authorization, Step Therapy, or Quantity Limits requirement to prescription drugs.

Factor – Assessment of the prescription drug's place in therapy - Goal is to promote optimal drug use based on review of FDA approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off-label use and claims data analysis.

- The Plan's evidentiary standards and sources that define and/or trigger the assessment of the prescription drug's place in therapy factor:
 - State and/or Federal regulations and guidelines
 - FDA-approved product labeling
 - Review of external clinical evidence
 - FDA-approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off-label use, and claims data analysis as relevant
 - Nationally recognized evidence-based guidelines and benchmarks
 - FDA-approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off-label use, and claims data analysis as relevant

These evidentiary standards and sources apply to both M/S and MH/SUD prescription drugs. These evidentiary standards and sources are defined in a qualitative manner.

Factor – Availability of clinically similar lower cost medications to treat the condition - Goal is to promote optimal drug use in therapeutic classes with several alternative drug products. A trial of clinically appropriate, lower cost alternative(s) may be appropriate prior to coverage of a more expensive alternative.

- The Plan's evidentiary standards and sources that define and/or trigger the availability of clinically similar lower cost medications to treat the condition factor:
 - State and/or Federal regulations and guidelines
 - FDA-approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off-label use, and claims data analysis as relevant
 - Review of external clinical evidence
 - FDA-approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off-label use, and claims data analysis as relevant
 - Nationally recognized evidence-based guidelines and benchmarks

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- FDA-approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off-label use, and claims data analysis as relevant

These evidentiary standards and sources apply to both M/S and MH/SUD prescription drugs. These evidentiary standards and sources are defined in a quantitative manner.

Factor – Value to implement Prior Authorization/Step Therapy - Goal is to evaluate whether inclusion of contingency edits or inclusion in Diagnosis to Prescription match (Dx2Rx) or Silent Authorization is appropriate or whether a coverage review is required to determine whether conditions of coverage are met. Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.

- The Plan's evidentiary standards and sources that define and/or trigger the value to implement Prior Authorization/Step Therapy factor:
 - State and/or Federal regulations and guidelines
 - FDA-approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off-label use, and claims data analysis as relevant
 - Review of external clinical evidence
 - FDA-approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off-label use, and claims data analysis as relevant
 - Nationally recognized evidence-based guidelines and benchmarks
 - FDA-approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off-label use, and claims data analysis as relevant

These evidentiary standards and sources apply to both M/S and MH/SUD prescription drugs. These evidentiary standards and sources are defined in a qualitative manner.

Factor – Relative safety and efficacy - Goal is to promote optimal drug use by performing a comprehensive efficacy comparison as well as reviewing the type and frequency of side effects and potential drug interactions among alternative drug products.

- The Plan's evidentiary standards and sources that define and/or trigger the Relative safety and efficacy factor:
 - State and/or Federal regulations and guidelines
 - FDA-approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off-label use, and claims data analysis as relevant
 - Review of external clinical evidence
 - FDA-approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off-label use, and claims data analysis as relevant
 - Nationally recognized evidence-based guidelines and benchmarks

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- FDA-approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off-label use, and claims data analysis as relevant

These evidentiary standards and sources apply to both M/S and MH/SUD prescription drugs. These evidentiary standards and sources are defined in a qualitative manner.

Factor – Prevention of off-label use or unproven uses - Goal is to promote optimal drug use by evaluating the potential for the drug to be used for indications other than what is included on FDA approved product labeling.

- The Plan's evidentiary standards and sources that define and/or trigger the Prevention of off-label use or unproven uses factor:
 - State and/or Federal regulations and guidelines
 - FDA-approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off-label use, and claims data analysis as relevant
 - Review of external clinical evidence
 - FDA-approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off-label use, and claims data analysis as relevant
 - Nationally recognized evidence-based guidelines and benchmarks
 - FDA-approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off-label use, and claims data analysis as relevant

These evidentiary standards and sources apply to both M/S and MH/SUD prescription drugs. These evidentiary standards and sources are defined in a qualitative manner.

These are the factors and evidentiary standards used in designing or applying the Plan's Prior Authorization, Step Therapy, or Quantity Limits requirement to prescription drugs. The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL.

Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

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The findings of the analyses confirmed the strategies, processes, factors, evidentiary standards, and source information used to subject certain MH/SUD prescription drugs to Prior Authorization, Step Therapy, or Quantity Limits were comparable to, and applied no more stringently than, the strategies, processes, factors, evidentiary standards, and source information used to subject certain M/S prescription drugs to Prior Authorization, Step Therapy, or Quantity Limits “as written.”

In addition, both M/S and MH/SUD utilize the same generally accepted types of data, evidentiary sources, and trend analysis in order to create and maintain a Prior Authorization, Step Therapy, or Quantity Limit requirement.

The findings of the prescription drug Prior Authorization, Step Therapy, or Quantity Limits outcomes analysis for each Plan (see data below) indicated the percentage of prescription drugs subject to Prior Authorization, Step Therapy, and/or Quantity Limits for MH/SUD prescription drugs were comparable to the percentage of prescription drugs subject to Prior Authorization, Step Therapy, and/or Quantity Limits for M/S prescription drugs. Data is for (January, May, and September 2022). The Plan notes that the U.S. Department of Labor has indicated generally that outcomes data are not dispositive of parity compliance.

Conclusions

The Plan reviewed the M/S and MH/SUD processes and noted the Plan uses a single P&T committee which follows a standard process to create clinical criteria and develop clinical drug policies for M/S and MH/SUD prescription drugs. From review of the Prior Authorization Step Therapy, or Quantity Limit policies and procedures, the Plan concluded the methodology used to determine which MH/SUD prescription drugs are subject to Prior Authorization Step Therapy, or Quantity Limits “as written” were comparable to, and applied no more stringently than, the methodology used to determine which M/S prescription drugs are subject to Prior Authorization, Step Therapy, or Quantity Limits “as written.” Additionally, the Plan concluded how Prior Authorization, Step Therapy, or Quantity Limits is applied to MH/SUD prescription drugs was comparable to, and applied no more stringently than, how Prior Authorization, Step Therapy, or Quantity Limits was applied to M/S prescription drugs “as written.”

The Plan notes that the percentage of MH/SUD drugs subject to Prior Authorization, Step Therapy, and/or Quantity Limits is higher than the percentage of M/S drugs subject to Prior Authorization, Step Therapy, and/or Quantity Limits. The Plan concluded this was due to the following contributing factors: a smaller pool of MH/SUD products to evaluate, a broader range of strengths for MH/SUD products, and an increased risk of abuse and diversion of MH/SUD products explain the variance. The Plan concluded this does not indicate a parity concern, but rather is an indicator of patient safety in disbursing MH/SUD drugs.

The Plan reviewed the M/S and MH/SUD processes and noted the Plan uses the same policies and procedures to create clinical criteria and develop clinical drug policies for both M/S and MH/SUD prescription drugs. The Plan also reviewed the percentage of M/S and MH/SUD prescription drugs which are subject to Prior Authorization, Step Therapy, or Quantity Limits and concluded the methodology used to determine which MH/SUD prescription drugs are subject to Prior Authorization, Step Therapy, or Quantity Limits and how Prior Authorization, Step Therapy, or Quantity Limits were applied were comparable to, and applied no more stringent than, the methodology used to determine which M/S prescription drugs were subject to Prior Authorization, Step Therapy, or Quantity Limits “in operation.”

Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical/surgical (M/S) benefits. This generally means that financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements, such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage.

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Prior Authorization is defined as: “A required or mandatory clinical assessment for proposed service(s) based on clinical information provided and the terms of the health plan benefits before the service(s) are performed or delivered. Clinical and medical necessity requirements, level of care appropriateness, and the terms of the health plan benefits must be met in order for services to be covered by the member's plan.” The *Optum National Policy Definitions List* defines pre-authorization (aka Prior Authorization) as “a form of prospective utilization review of health care services proposed to be provided to a member.”

Prior Authorization is a component of the Plan’s Utilization Management (UM) program that helps ensure members receive appropriate coverage based on their specific clinical status and health care needs. The process is designed to achieve optimal clinical outcomes by applying objective, evidence-based clinical criteria, and nationally recognized guidelines and best practices.

Prior Authorization for inpatient services commences prior to a service being delivered. Prior Authorization is a UM process that involves applying the benefit plan language and/or clinical criteria to make the most appropriate clinical coverage benefit determination.

This document includes the following information:

- Prior Authorization process for M/S and MH/SUD inpatient services
- Description of the NQTL and application (Step 1)
- Factors used to determine which services are subject to the NQTL (Step 2)
- Evidentiary standards and sources used to define, trigger and/or implicate a factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

This analysis refers to the following attachments:

- *Addendum A* - Identifies the M/S and MH/SUD inpatient services that are subject to Prior Authorization
- *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions* - M/S policy that defines Prior Authorization

- *Optum National Policy Definitions List* - MH/SUD policy that defines Prior Authorization
- *Utilization Management Program Description (UMPD) of United HealthCare Services, Inc. and UnitedHealthcare Insurance Company* - Summarizes the philosophy, structure and standards that govern UHC's medical management, UM and utilization review responsibilities and functions
- *Management of Behavioral Health Benefits Policy* - Describes the mechanisms and processes designed to promote consistency in the management of behavioral health benefits and to ensure that members receive appropriate, high quality behavioral health services in a timely manner
- *Prior Authorization Factor Grid(s) provided for (2023 Prior Auth_Concurrent Rev Factor Grid)* - Details the service categories subject to Prior Authorization and the shared factors and evidentiary standards used as the basis for subjecting M/S and MH/SUD inpatient benefits to Prior Authorization
- *Core Principles and Practices* - MH/SUD policy that outlines the core principles and practices that should be used by personnel in their interactions with members, authorized member representatives, practitioners and facilities, related to the management of behavioral health benefits, coverage determinations and appeals/grievances of non-coverage determinations.
- *Performance Assessment and Incentives* - M/S policy confirming that clinical reviewers are not incented to make denials for financial reasons
- *2023 UnitedHealthcare Provider Administrative Guide* – Informs M/S providers of the Prior Authorization process. The *UnitedHealthcare Provider Administrative Guide* can be accessed on the website <https://www.uhcprovider.com/en/admin-guides.html>
- *September 2023 Optum National Network Manual* - Informs MH/SUD providers of the Prior Authorization process. <https://public.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/optum-network-manual.html>
- *Certificates of Coverage (COC23-INS-2018-LG-GA, COC23-HMO-2018-LG-GA, COC23-INS-2018-SG-GA and COC23-HMO-2018-SG-GA)* - Plan documents that explains covered services, terms, conditions, and limitations of the member's policy
- *Schedule of Benefits (SBN23-Medical-INS-2018-[Charter][Navigate][Nexus+[N]R]-LG-GA, SBN23-Medical-INS-2018-[Choice+Plus][Select+Plus][Doctors+Plus]-LG-GA, SBN23-Medical-INS-2018-[Core][Nexus+OAP]-LG-GA, SBN23-Medical-INS-2018-[Core+Essential][Nexus+OA]-LG-GA, SBN23-Medical-HMO-2018-[Charter][Navigate][Nexus+[N]R]-LG-GA, SBN23-Medical-INS-2018-[Choice+Plus][Select+Plus][Doctors+Plus]-SG-GA, SBN23-Medical-HMO-2018-[CharterBal][NavigateBal][Nexus+[N]RB]-LG-GA, SBN23-Medical-HMO-2018-[CharterPls][NavigatePls][Nexus+[N]RP]-LG-GA, SBN23-Medical-HMO-2018-[Choice][Select][Doctors]-LG-GA, SBN23-Medical-HMO-2018-[Core][Nexus+OAP]-LG-GA, SBN23-Medical-HMO-2018-[Core+Essential][Nexus+OA]-LG-GA, SBN23-Medical-INS-2018-NonDifferential-LG-GA, and SBN23-Medical-HMO-2018-[Choice][Select][Doctors]-SG-GA)* - Plan documents that outlines member responsibilities

The Plan concludes that the Prior Authorization requirements for M/S and MH/SUD are comparable and applied no more stringently for MH/SUD in-network (INN) inpatient benefits, both “as written” and “in operation.”

Process

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Prior Authorization is defined as: “A required or mandatory clinical assessment for proposed service(s) based on clinical information provided and the terms of the health plan benefits before the service(s) are performed or delivered. Clinical and medical necessity requirements, level of care appropriateness, and the terms of the health plan benefits must be met in order for services to be covered by the member's plan.” The *Optum National Policy Definitions List* defines pre-authorization (aka Prior Authorization) as “a form of prospective utilization review of health care services proposed to be provided to a member.”

The Plan structures inpatient Prior Authorization processes to be compliant with all applicable federal and state requirements, as well as the National Committee for Quality Assurance (NCQA) accreditation standards. NCQA confirms that Plan operations and policies identify appropriate timeframes for decisions, requires decision-making by appropriate personnel, and governs

communication of adverse benefit determinations. In addition, Prior Authorization is governed at both the state and federal level, which includes consumer protections such as external review for adverse benefit determinations after internal appeal options are exhausted.

The Plan delegates management of MH/SUD inpatient services, including Prior Authorization, to United Behavioral Health d/b/a Optum Behavioral Health (OBH), its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor.

The Plan has national committees that approve M/S and MH/SUD services to be subject to Prior Authorization. *Addendum A* includes a list of service categories subject to inpatient Prior Authorization. The Plan publishes the services subject to Prior Authorization on the provider portal(s) ([Advance Notification and Clinical Submission Requirements | UHCprovider.com](#) for M/S and [Optum - Provider Express Home](#) for MH/SUD). Members can learn what services are subject to Prior Authorization in their benefit plan document, through [myuhc.com](#), or by contacting customer service.

Prior Authorization Review of M/S inpatient admissions consists of the following:

The Plan requires INN facilities and providers to submit a Prior Authorization request for services on the Prior Authorization list prior to rendering the service. There may be some INN benefits for which the member is responsible for obtaining Prior Authorization. These are identified in the member's benefit plan document (i.e., *Schedule of Benefits*). The INN provider's submission of a request (notification) triggers the Prior Authorization process.

INN providers can submit Prior Authorization requests through the secure provider portal ([www.uhcprovider.com](#)), their connected electronic medical record, by telephone, or by fax (where required). Members may submit Prior Authorization requests by telephone, fax, or mail, in accordance with Plan requirements. Providers and members communicate basic information to create a case. As outlined in the *UnitedHealthcare Care Provider Administrative Guide*, providers must submit advance notification with supporting documentation as soon as possible, but at least two weeks before the planned service, unless otherwise stated.

The Plan confirms receipt of the Prior Authorization request. Non-clinical staff confirm member eligibility and benefit coverage upon receipt of the notification. Non-clinical staff review cases to ensure availability of accurate and thorough case information. Non-clinical staff may approve coverage requests in scenarios where the member's plan documents allow and if a clinical review is not required. Non-clinical staff will also approve a coverage request if the facility's contract does not allow for clinical reviews. Requests that are submitted through the secure provider portal may also be approved based on the benefit plan coverage criteria, member diagnosis, and the clinical information submitted. Non-clinical staff may administratively deny coverage when a member's benefits are exhausted. Non-clinical staff refer coverage requests that they cannot approve or administratively deny to initial clinical reviewers.

First Level Clinical Review/Initial Review. Clinical reviewers (nurses or physicians) consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether the inpatient admission is medically necessary by reviewing the member's clinical information, the applicable clinical criteria or guidelines, and the Plan benefit terms. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs to determine whether the applicable clinical criteria are met or may access clinical information in the provider's electronic medical record (EMR) if the provider has given the Plan access. The clinical reviewer may approve cases that meet applicable clinical criteria.

Second Level Clinical Review/Peer Review. The initial clinical reviewer refers cases to a second level/peer clinical reviewer if the case cannot be approved. Peer clinical reviewers (physician or mid-level practitioner) consult clinical criteria when making clinical coverage benefit determinations. Peer clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history

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of related treatment and services, and photographs. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. The peer clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. If a peer clinical reviewer issues an adverse benefit determination, then the Plan communicates the adverse benefit determination and appeal rights and offers a peer-to-peer conversation consistent with state, federal, and accreditation requirements.

Adverse Benefit Determination. For M/S, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when member benefits are exhausted. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials. Modified coverage requests that are approved are recorded as partial denials.

Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based medical clinical policies and use clinical criteria from third-party sources such as InterQual® or MCG® guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that inpatient Prior Authorization determinations are appropriate.

Per the M/S policy entitled *Performance Assessment and Incentives*, at no time are initial clinical reviewers or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons.

M/S generally structures UM processes to comply with federal Employee Retirement Income Security Act of 1974 (ERISA) requirements, NCQA UM standards, and state law where applicable.

Prior Authorization review of MH/SUD inpatient admissions consists of the following:

The Plan delegates management of MH/SUD inpatient services, including Prior Authorization, to United Behavioral Health d/b/a OBH, its delegated MH/SUD MBHO vendor.

The Plan requires INN providers and facilities to submit a Prior Authorization request for services on the Prior Authorization list prior to rendering the service. There may be some INN benefits for which the member is responsible for obtaining Prior Authorization. These are identified in the member's benefit plan document (i.e., *Schedule of Benefits*). The INN provider's submission of a request (notification) triggers the inpatient Prior Authorization process.

INN providers may submit Prior Authorization requests through the secure provider portal (www.providerexpress.com), by telephone, or by fax (where required). Providers communicate basic information to create a case. As outlined in the *Optum National Network Manual*, inpatient behavioral health services require an initial Prior Authorization or notification in advance of the service.

As described in the *Management of Behavioral Health Benefits Policy*, the Plan confirms receipt of the Prior Authorization request. Non-clinical staff confirm member eligibility and benefit coverage. Non-clinical staff may approve coverage requests that do not require clinical evaluation or interpretation based on the member's diagnosis and the clinical information submitted by providers. Non-clinical staff may administratively deny coverage when member benefits are exhausted. Non-clinical staff refer cases that they cannot approve or administratively deny to initial clinical reviewers.

First Level Clinical Review/Initial Review. Clinical decisions are made by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse benefit determinations are made by Medical Directors. Clinical reviewers consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether an inpatient admission is medically necessary by reviewing the member's clinical information, the applicable clinical criteria or guidelines, and the Plan benefit terms. Clinical reviewers may request more clinical information including, but not

limited to, office or facility medical records, consultations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for certification, related diagnostic results, and history of related treatment and services to determine whether the applicable clinical criteria are met. The clinical reviewer may approve the admission based on their review.

Second Level Clinical Review/Peer Review. The initial clinical reviewer refers cases to a peer clinical reviewer for a peer-to-peer discussion if the case cannot be approved. The requesting provider is offered the opportunity to discuss the case with the peer clinical reviewer, consistent with state, federal, and accreditation requirements before an adverse benefit determination is issued. Only qualified peer clinical reviewers (e.g., Medical Directors) can issue adverse benefit determinations. Peer clinical reviewers apply clinical criteria to member clinical information to determine coverage for an inpatient admission. If the requesting provider fails to complete the peer-to-peer discussion, the peer clinical reviewer makes a determination based on the information available. If a peer clinical reviewer issues an adverse benefit determination (e.g., the admission is not medically necessary and is not approved), then the Plan timely communicates the adverse benefit determination, including appeal rights, to the member and provider consistent with applicable state, federal, and accreditation requirements.

Adverse Benefit Determination. For MH/SUD, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as a clinical denial when it is based on clinical criteria and member clinical information and is recorded as an administrative denial when member benefits are excluded.

Platinum Designation. The Plan offers a Platinum Designation program to MH/SUD facilities based on facilities' quantitative practice patterns (effectiveness and efficiency benchmarks). The Platinum Designation program's effectiveness and efficiency benchmarks include targeted 30- and 90-day readmission rates, 7- and 30-day follow up after hospitalization, outlier length of stay, and outlier behavioral health episode spend. INN MH/SUD facilities that meet the Platinum Designation are required to notify the Plan of admissions and provide member information. The Plan covers the first 8 to 21 days of a stay depending on the specific level of care without review. The Plan evaluates INN MH/SUD facilities performance annually as described in the *Optum National Network Manual*.

Clinical Criteria. Initial clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based behavioral clinical policies or use clinical criteria from third-party sources such as American Society of Addiction Medicine (ASAM) Criteria®, Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System-Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) and Early Childhood Service Intensity Instrument (ECSII) guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that inpatient Prior Authorization determinations are appropriate.

Per the MH/SUD policy entitled, *Core Principles and Practices*, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons.

MH/SUD generally structures UM processes to comply with federal ERISA requirements, NCQA UM standards, and state law where applicable.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- Prior Authorization

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Benefit Classification(s)

- INN, inpatient

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHC)
- UnitedHealthcare of Georgia, Inc. (UHCGA)

Plan Terms/Source Document(s)

In each of the Plan products, “Medically Necessary” is the Plan term used to guide Prior Authorization decision-making for both M/S and MH/SUD services. “Medically Necessary” is generally defined as follows:

- “Medically Necessary – health care services are all of the following as determined by us or our designee:
 - In accordance with Generally Accepted Standards of Care.
 - Clinically appropriate, in terms of type, frequency, extent, service site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms.
 - Not mainly for your convenience or that of your doctor or other health care provider.
 - Not more costly than an alternative drug, service(s), service site or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.
- Generally Accepted Standards of Care are evidence based independent standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties. Valid, evidence based sources reflecting generally accepted standards of care include credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.
- If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We have the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be determined by us.
- We develop and maintain clinical policies that describe the Generally Accepted Standards of Care scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by us and revised from time to time), are available to Covered Persons through www.myuhc.com or the telephone number on your ID card. They are also available to Physicians and other health care professionals on www.UHCprovider.com”

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Prior Authorization is defined as:

“A required or mandatory clinical assessment for proposed service(s) based on clinical information provided and the terms of the health plan benefits before the service(s) are performed or delivered. Clinical and medical necessity requirements, level of care appropriateness, and the terms of the health plan benefits must be met in order for services to be covered by the member's plan.”

The *Optum National Policy Definitions List* defines pre-authorization (aka Prior Authorization) as “a form of prospective utilization review of health care services proposed to be provided to a member.”

The Plan’s *Schedule of Benefits* notify members of the Prior Authorization requirements:

“We require prior authorization for certain Covered Health Care Services. Network providers are responsible for obtaining prior authorization before they provide these services to you.

We recommend that you confirm with us that all Covered Health Care Services have been prior authorized as required. Before receiving these services from a Network provider, you may want to call us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they do not prior authorize as required. You can call us at the telephone number on your ID card.

When you choose to receive certain Covered Health Care Services from out-of-Network providers, you are responsible for obtaining prior authorization before you receive these services. Note that your obligation to obtain prior authorization is also applicable when an out-of-Network provider intends to admit you to a Network facility or to an out-of-Network facility or refers you to other Network or out-of-Network providers. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization. Services for which you are required to obtain prior authorization are shown in the Schedule of Benefits table within each Covered Health Care Service category.

To obtain prior authorization, call the telephone number on your ID card. This call starts the utilization review process.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the Schedule of Benefits table to find out how far in advance you must obtain prior authorization.

For Covered Health Care Services that do not require you to obtain prior authorization, when you choose to receive services from out-of-Network providers, we urge you to confirm with us that the services you plan to receive are Covered Health Care Services. That is because in some instances, certain procedures may not be Medically Necessary or may not otherwise meet the definition of a Covered Health Care Service, and therefore are excluded. In other instances, the same procedure may meet the definition of Covered Health Care Services. By calling before you receive treatment, you can check to see if the service is subject to limitations or exclusions.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those received, our final coverage determination will be changed to account for those differences, and we will only pay Benefits based on the services delivered to you. If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Care Service, you will be responsible for paying all charges and no Benefits will be paid.”

The *2023 UnitedHealthcare Care Provider Administrative Guide* notifies providers of the Prior Authorization requirements. INN providers are required to comply with UM protocols established by the Plan:

“We require prior authorization for all MA benefit plans and some commercial benefit plans. Prior authorization requests allow us to verify if services are medically necessary and covered. After you notify us of a planned service listed on the Advance Notification/Prior Authorization List, we tell you if a clinical coverage review is required, as part of our prior authorization process, and what additional information we need to proceed. We notify you of our coverage decision within the time required by law. Just because we require notification for a service, does not mean it is covered. We determine coverage by the member’s benefit plan.

If there is a conflict or inconsistency between applicable regulations and the notification requirements in this guide, the applicable regulations govern.

Physicians, health care professionals and ancillary care providers are responsible for:

- Providing advance notification or requesting prior authorization for services on the Advance Notification/Prior Authorization List, including for non-emergent air transport services.
- Directing members to use care providers within their network. Members may be required to obtain prior authorization for out-of-network services.

If you perform multiple procedures for a member in one day, and at least one service requires prior authorization, you must obtain Prior authorization for any of the services to be paid.

If you do not follow these requirements, we may deny claims. In that case, you cannot bill the member. Advance notification or prior authorization is valid only for the date of service or date range listed on it. If that specified date of service or date range has passed, you must submit a new request.

Giving us advance notification, or receiving prior authorization from us, is not a guarantee of payment, unless required by law or Medicare guidelines. This includes regulations about care providers on either a sanctions and excluded list, the Medicare preclusion list and/or care providers not included in the Medicare Provider Enrollment Chain and Ownership System (PECOS)* list. Payment of covered services is based on:

- The member's benefit plan,
- If you are eligible for payment,
- Claim processing requirements, and Your Agreement.

The list of services that require advance notification and prior authorization is the same. The process for providing notification and submitting a prior authorization request is the same. Services that require Prior authorization require a clinical coverage review based on medical necessity.

Advance notification/prior authorization lists are available online. They are subject to change. We will post inform you of changes on UHCprovider.com/networknews > Network Bulletin. Sign up to receive the Network Bulletin by email at UHCprovider.com/subscribe.

If you need a paper copy of the requirements, contact your UnitedHealthcare Network Management representative or provider advocate. We recommend that you submit advance notification with supporting documentation as soon as possible, but at least 2 weeks before the planned service (unless the Advance Notification Requirements states otherwise). Following a facility discharge, advance notification for home health services and durable medical equipment is required within 48 hours after the start of service."

The *Optum National Network Manual*, September 2023 Edition notifies providers of the Prior Authorization requirements. INN providers are required to comply with UM protocols established by the Plan:

"In most cases, inpatient admissions will be directed only to participating hospitals and attending psychiatrists.

All inpatient and sub-acute level of care admissions require notification or pre-authorization by the network provider or facility. Optum requires notification within one business day after an admission for a facility to request a pre-authorization unless a longer period is required by contract or state specific requirements. This includes, but is not limited to, mental health or substance abuse disorder services delivered as inpatient treatment, partial/day hospitalization or residential treatment.

Network providers are solely responsible for completing prior notification or obtaining preauthorization prior to providing inpatient or sub-acute level of care services. This includes timely provision of information necessary for concurrent review of continued stay or ongoing care requests prior to the delivery of services."

The role of the Plan's delegate, United Behavioral Health d/b/a OBH, is discussed in the *UMPD*:

“United Behavioral Health (UBH) performs the review of requests for coverage of behavioral health services (i.e., substance abuse, and mental health requests for services). UBH provides comprehensive behavioral health care delivery for members through a network of behavioral health practitioners, ancillary care providers, hospitals and other facilities.

For mental health, substance-related disorder services, and wraparound services, UBH uses its Clinical Criteria (see below), behavioral clinical policies and best practice guidelines to make coverage determinations. UBH adopts externally-developed clinical criteria, and creates internally-developed Clinical Criteria, where appropriate, based on its assessment of relevant guidance. UBH develops clinical criteria that supersedes its standard set or adopts externally-developed clinical criteria when required to do so by contract or regulation.

- Clinical Criteria (Level of Care Utilization System-LOCUS) – Standardized level of care assessment tool developed by the American Association of Community Psychiatrists used to make clinical determinations and placement decisions for mental health disorder benefits for adults ages 19 and older when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (Child and Adolescent Level of Care/Service Intensity Utilization System-CALOCUS-CASII) - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry (AACAP) and the American Association for Community Psychiatry (AACP) used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children and adolescents ages 6-18 when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (Early Childhood Service Intensity Instrument-ECSII) - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children ages 0-5 when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (State or Contract Specific Level of Care Guidelines) – Criteria used to make medical necessity determinations for mental health disorder benefits when there are explicit mandates or contractual requirements.
- Clinical Criteria (American Society of Addiction Medicine [ASAM]) - Criteria developed by the American Society of Addiction Medicine used to make clinical determinations for substance-related disorder benefits.
- Clinical Criteria (Optum Developed)
 - Optum Behavioral Clinical Policies: Criteria that stem from evaluation of new services or treatments or new applications of existing services or treatments and are used to make clinical determinations regarding proven or unproven services and treatments.

Licensed practitioners conduct all reviews with a focus on measurable outcome goals and objectives for treatment. A senior UBH Medical Director is responsible for directing and implementing behavioral health utilization management programs. A referral is sent to UBH when a member is identified as potentially benefiting from behavioral health services during a “medical event.”

The UBH UM Program is staffed by clinical, non-clinical and administrative personnel. All clinical denials or adverse decisions are made by board certified psychiatrists, or, if the health plans choose, by a panel of other appropriate health care service reviewers. If the health plan chooses to use a panel to make adverse decisions, the panel contains at least one physician who is board certified in psychiatry. When the health care service under review is a mental health or substance abuse service, the adverse decision is made by a licensed physician who is board certified in psychiatry. All potential clinical denials are referred to a physician who is board certified in psychiatry for final determination. An evaluation of the overall effectiveness of the Behavioral Health UM Program is conducted annually to determine how well resources have been deployed to improve UM activities and the clinical care and service provided to members.”

The Plan’s terms require services to be medically necessary for coverage. INN providers are required to comply with the Plan’s UM protocols including complying with Prior Authorization requirements.

List of M/S and MH/SUD Services Subject to NQTL

Addendum A, attached, lists the M/S and MH/SUD INN inpatient service categories subject to Prior Authorization. Prior Authorization is one component of the UM program that evaluates whether a benefit or service is medically necessary.

- The “Member” tab lists the service categories for which the member is responsible for obtaining authorization for INN

services. The “Member” tab includes all products in the scope of the analysis.

- The “Provider” tab lists the service categories for which the provider is responsible for obtaining authorization for INN services. The “Provider” tab applies to all products in the scope of the analysis.

Step 2 – Factors Used to Determine Prior Authorization

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

The Prior Authorization list was originally designed by enterprise clinical leadership. Prior Authorization was applied to new services when they became covered by the Plan and met certain criteria. Examples of Prior Authorization determinants that existed in the business at this time included:

- to monitor and prevent potential overutilization and under-utilization
- manage high-cost and prolonged-duration services
- ensure enrollee safety
- determine the appropriate level of care
- determine whether the service or item is medically necessary

The factors relied upon to determine which INN inpatient services were subjected to Prior Authorization were updated and replaced 2021 with the factors Clinical Appropriateness and Value, as defined below. After this time, all M/S services subject to Prior Authorization must meet Clinical Appropriateness and all MH/SUD services must meet Clinical Appropriateness and Value.

Starting in 2022, any additions or deletions to the Prior Authorization list were reviewed and approved through committees.

The Plan relies on the following factors to determine which INN inpatient benefits will be subject to Prior Authorization. These factors apply to M/S and MH/SUD benefits for the following:

- I. M/S: INN inpatient services
- II. MH/SUD: INN inpatient services

- Clinical Appropriateness (Qualitative)

Applies to M/S and MH/SUD services.

- Value (Quantitative)

Applies to M/S and MH/SUD services.

For M/S meeting Clinical Appropriateness is determinative in imposing the limitation. For MH/SUD meeting Clinical Appropriateness and Value is determinative in imposing the limitation. The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL. All Prior Authorization reviews are subject to Clinical Appropriateness and must have medical necessity criteria.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factors used to add services to the Plan's Prior Authorization requirement for INN inpatient services. These evidentiary standards and sources apply benefits for the following:

- I. M/S: INN inpatient services
- II. MH/SUD: INN inpatient services

Factor – Clinical Appropriateness

Factor – Value

Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The findings of the Plan's comparative analyses confirmed the strategies, processes, factors, evidentiary standards, and source information used to determine the MH/SUD INN inpatient services subject to Prior Authorization were comparable to, and applied no more stringently than, the strategies, processes, factors, evidentiary standards, and source information used to determine the M/S INN inpatient services subject to Prior Authorization “as written.” For M/S and MH/SUD INN inpatient benefits, the *Prior Authorization Factor Grid* included with this analysis detail the shared factors used as the basis for subjecting M/S and MH/SUD INN inpatient benefits to Prior Authorization, as described above.

The Plan found the factors used to determine the MH/SUD INN inpatient services subject to Prior Authorization were comparable to, and applied no more stringently than, the factors used to determine the M/S INN inpatient services subject to Prior Authorization. Beginning in 2022, INN M/S and MH/SUD inpatient services that met the Clinical Appropriateness plus the Value factor were subject to Prior Authorization review “in operation.” Certain MH/SUD facilities that attained Platinum Designation were exempt from inpatient Prior Authorization.

Conclusions

The Plan reviewed the M/S and MH/SUD Prior Authorization operational policies and procedures and concluded the methodology used to determine which MH/SUD INN inpatient services are subject to Prior Authorization “as written” were comparable to, and applied no more stringently than, the methodology used to determine which M/S INN inpatient services are subject to Prior Authorization “as written.” Additionally, the Plan concluded that how Prior Authorization is applied to MH/SUD INN inpatient services was comparable to, and applied no more stringently than, how Prior Authorization is applied to M/S INN inpatient services “as written.”

The Plan reviewed the M/S and MH/SUD processes including responsibility for submission, timeframes for submission and

Prior Authorization – Inpatient In-Network Non-Quantitative Treatment Limitation (NQTL) Analysis

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review, notification to members and providers, clinical standards for review, staff qualifications, outcomes data, and IRR assessment results and concluded how the Plan conducts Prior Authorization for MH/SUD INN inpatient services “in operation” was comparable to, and applied no more stringently than, how the Plan conducts Prior Authorization for M/S INN inpatient services “in operation.”

Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical/surgical (M/S) benefits. This generally means that financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements, such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage.

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth the findings and conclusions both “as written” and “in operation” (Step 5).

Specific NQTL

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Prior Authorization is defined as: “A required or mandatory clinical assessment for proposed service(s) based on clinical information provided and the terms of the health plan benefits before the service(s) are performed or delivered. Clinical and medical necessity requirements, level of care appropriateness, and the terms of the health plan benefits must be met in order for services to be covered by the member’s plan.” The *Optum National Policy Definitions List* defines pre-authorization (aka Prior Authorization) as “a form of prospective utilization review of health care services proposed to be provided to a member.”

Prior Authorization is a component of the Plan’s Utilization Management (UM) program that helps ensure members receive appropriate coverage based on their specific clinical status and health care needs. The process is designed to achieve optimal clinical outcomes by applying objective, evidence-based clinical criteria and nationally recognized guidelines and best practices.

Prior Authorization for outpatient services commences prior to a service being delivered. Prior Authorization is a UM process that involves applying the benefit plan language and/or clinical criteria to make the most appropriate clinical coverage benefit determination.

This document includes the following information:

- Prior Authorization process for M/S and MH/SUD outpatient services
- Description of the NQTL and application (Step 1)
- Factors used to determine which services are subject to the NQTL (Step 2)
- Evidentiary standards and sources used to define, trigger and/or implicate a factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

This analysis refers to the following attachments:

- *Addendum A* - Identifies the M/S and MH/SUD outpatient services that are subject to Prior Authorization
- *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions* - M/S policy that defines Prior Authorization
- *Optum National Policy Definitions List* - MH/SUD policy that defines Prior Authorization

- *Utilization Management Program Description (UMPD) of United HealthCare Services, Inc. and UnitedHealthcare Insurance Company* - Summarizes the philosophy, structure and standards that govern UHC's medical management, UM and utilization review responsibilities and functions
- *Management of Behavioral Health Benefits Policy* - Describes the mechanisms and processes designed to promote consistency in the management of behavioral health benefits and to ensure that members receive appropriate, high quality behavioral health services in a timely manner
- *Prior Authorization Factor Grid(s) provided for (2023 Prior Auth_Concurrent Rev Factor Grid)* - Details the service categories subject to Prior Authorization and the shared factors and evidentiary standards used as the basis for subjecting M/S and MH/SUD outpatient benefits to Prior Authorization
- *Core Principles and Practices* - MH/SUD policy that outlines the core principles and practices that should be used by personnel in their interactions with members, authorized member representatives, practitioners and facilities, related to the management of behavioral health benefits, coverage determinations and appeals/grievances of non-coverage determinations.
- *Performance Assessment and Incentives* - M/S policy confirming that clinical reviewers are not incented to make denials for financial reasons
- *2023 UnitedHealthcare Provider Administrative Guide* – Informs M/S providers of the Prior Authorization process. The *UnitedHealthcare Provider Administrative Guide* can be accessed on the website <https://www.uhcprovider.com/en/admin-guides.html>
- *September 2023 Optum National Network Manual* - Informs MH/SUD providers of the Prior Authorization process. <https://public.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/optum-network-manual.html>
- *Certificates of Coverage (COC23-INS-2018-LG-GA, COC23-HMO-2018-LG-GA, COC23-INS-2018-SG-GA and COC23-HMO-2018-SG-GA)* - Plan documents that explains covered services, terms, conditions, and limitations of the member's policy
- *Schedule of Benefits (SBN23-Medical-INS-2018-[Charter][Navigate][Nexus+[N]R]-LG-GA, SBN23-Medical-INS-2018-[Choice+Plus][Select+Plus][Doctors+Plus]-LG-GA, SBN23-Medical-INS-2018-[Core][Nexus+OAP]-LG-GA, SBN23-Medical-INS-2018-[Core+Essential][Nexus+OA]-LG-GA, SBN23-Medical-HMO-2018-[Charter][Navigate][Nexus+[N]R]-LG-GA, SBN23-Medical-INS-2018-[Choice+Plus][Select+Plus][Doctors+Plus]-SG-GA, SBN23-Medical-HMO-2018-[CharterBal][NavigateBal][Nexus+[N]RB]-LG-GA, SBN23-Medical-HMO-2018-[CharterPls][NavigatePls][Nexus+[N]RP]-LG-GA, SBN23-Medical-HMO-2018-[Choice][Select][Doctors]-LG-GA, SBN23-Medical-HMO-2018-[Core][Nexus+OAP]-LG-GA, SBN23-Medical-HMO-2018-[Core+Essential][Nexus+OA]-LG-GA, SBN23-Medical-INS-2018-NonDifferential-LG-GA, and SBN23-Medical-HMO-2018-[Choice][Select][Doctors]-SG-GA)* - Plan documents that outlines member responsibilities

The Plan concludes that the Prior Authorization requirements for M/S and MH/SUD are comparable and applied no more stringently for MH/SUD in-network (INN) outpatient benefits both "as written" and "in operation."

Process

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Prior Authorization is defined as: "A required or mandatory clinical assessment for proposed service(s) based on clinical information provided and the terms of the health plan benefits before the service(s) are performed or delivered. Clinical and medical necessity requirements, level of care appropriateness, and the terms of the health plan benefits must be met in order for services to be covered by the member's plan." The *Optum National Policy Definitions List* defines pre-authorization (aka Prior Authorization) as "a form of prospective utilization review of health care services proposed to be provided to a member."

The Plan structures outpatient Prior Authorization processes to be compliant with all applicable federal and state requirements, as well as the National Committee for Quality Assurance (NCQA) accreditation standards. NCQA confirms that Plan operations and policies identify appropriate timeframes for decisions, requires decision-making by appropriate personnel, and governs communication of adverse benefit determinations. In addition, Prior Authorization is governed at both the state and federal level, which includes consumer protections such as external review for adverse benefit determinations after

internal appeals options are exhausted.

The Plan delegates management of MH/SUD outpatient services, including Prior Authorization, to United Behavioral Health d/b/a Optum Behavioral Health (OBH), its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor.

The Plan has national committees that approve M/S and MH/SUD outpatient services to be subject to Prior Authorization. Additionally, the Plan has a standard process for assessing the services that are subjected to Prior Authorization and whether they should be retained or removed from the Prior Authorization list. *Addendum A* includes the list of service categories subject to Prior Authorization. The Plan publishes the services subject to Prior Authorization on the provider portal(s) ([Advance Notification and Clinical Submission Requirements | UHCprovider.com](#) for M/S and [Optum - Provider Express Home](#) for MH/SUD). Members can learn what services are subject to Prior Authorization in their benefit plan document, through <https://member.uhc.com/myuhc>, myuhc.com, or by contacting customer service.

Prior Authorization review of M/S outpatient services consists of the following:

The Plan requires INN providers to submit a Prior Authorization request for services on the Prior Authorization list prior to rendering the service. There may be some INN benefits for which the member is responsible for obtaining Prior Authorization. These are identified in the member's benefit plan document (i.e., *Schedule of Benefits*). The INN provider's submission of a request (notification) triggers the Prior Authorization process.

INN providers may submit Prior Authorization requests through the secure provider portal (www.uhcprovider.com), their connected electronic medical record, by telephone, or by fax (where required). Members may submit Prior Authorization requests by phone, fax, or mail, in accordance with Plan requirements. Providers and members communicate basic information to create a case. As outlined in the *UnitedHealthcare Care Provider Administrative Guide*, providers must submit advance notification with supporting documentation as soon as possible, but at least two weeks before the planned service, unless otherwise stated.

The Plan confirms receipt of the Prior Authorization request. Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. Non-clinical staff review cases to ensure availability of accurate and thorough case information. Non-clinical staff may approve coverage requests in scenarios where the member's plan documents allow and if a clinical review is not required. Requests that are submitted through the secure provider portal may also be approved based on the benefit plan coverage criteria, member diagnosis, and the clinical information submitted. Non-clinical staff may administratively deny coverage when a member's benefits are exhausted. Non-clinical staff refer cases that they cannot approve or administratively deny to the initial clinical reviewers for medical necessity review.

First Level Clinical Review/Initial Review. Clinical reviewers (nurses) consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs to determine whether the applicable clinical criteria are met. The clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. The clinical reviewer can approve cases that meet applicable clinical criteria.

Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Peer clinical reviewers (physician or mid-level practitioner) consult clinical criteria when making clinical coverage benefit determinations. Peer clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs. The peer clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If a peer clinical reviewer issues an adverse benefit determination, then

the Plan communicates the adverse benefit determination, including appeal rights, and offers a peer-to-peer conversation consistent with state, federal, and accreditation requirements.

Adverse Benefit Determination. For M/S an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when member benefits are exhausted. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials. Modified coverage requests that are approved are recorded as partial denials.

Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based, medical clinical policies or use clinical criteria from third-party sources such as InterQual® or MCG® guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that outpatient Prior Authorization determinations are appropriate.

Per the M/S policy entitled, *Performance Assessment and Incentives*, at no time are initial or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons.

M/S generally structures UM processes to comply with federal Employee Retirement Income Security Act of 1974 (ERISA) requirements, NCQA UM standards, and state law where applicable.

Prior Authorization review of MH/SUD outpatient services consists of the following:

The Plan delegates management of MH/SUD outpatient services, including Prior Authorization, to United Behavioral Health d/b/a OBH, its delegated MH/SUD MBHO vendor.

The Plan requires INN providers to submit a Prior Authorization request for services on the Prior Authorization list prior to rendering the service. There may be some INN benefits for which the member is responsible for obtaining Prior Authorization. These are identified in the member's benefit plan document (i.e., *Schedule of Benefits*).

INN providers may submit Prior Authorization requests through the secure provider portal (www.providerexpress.com), by telephone, or by fax (where required). Providers and members communicate basic information to create a case. As outlined in the *Optum National Network Manual*, most routine outpatient behavioral health services do not require an initial pre-authorization or notification in advance of the service. The INN provider's submission of a request (notification) triggers the Prior Authorization process.

As described in the *Management of Behavioral Health Benefits Policy*, the Plan confirms receipt of the Prior Authorization request. Non-clinical staff confirm member eligibility and benefit plan coverage. Non-clinical staff may approve cases that do not require clinical evaluation or interpretation based on the member's diagnosis and the clinical information submitted by providers. Non-clinical staff may administratively deny coverage when member benefits are exhausted. Non-clinical staff refer cases that they cannot approve or administratively deny to the initial clinical reviewers.

First Level Clinical Review/Initial Review. Clinical decisions are made by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse benefit determinations are made by Medical Directors or psychologists. Clinical reviewers consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether a service is medically necessary by reviewing the member's clinical information, the applicable clinical criteria or guidelines, and the Plan benefit terms. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for certification, related diagnostic results, and history of related treatment and services. The clinical reviewer may approve cases that meet applicable clinical criteria.

Second Level Clinical Review/Peer Review. The initial clinical reviewer refers cases to a peer clinical reviewer for a peer-to-peer discussion if the case cannot be approved. The requesting provider is offered the opportunity to discuss the case with the peer clinical reviewer, consistent with state, federal, and accreditation requirements, before an adverse benefit determination is issued. Only qualified peer clinical reviewers (e.g., Medical Directors or psychologists) can issue adverse benefit determinations. Peer clinical reviewers apply clinical criteria to member clinical information to determine coverage. If the requesting provider fails to complete the peer-to-peer discussion, the peer clinical reviewer makes a determination based on the information available. If a peer clinical reviewer issues an adverse benefit determination (e.g., the number of treatments are not authorized), then the Plan timely communicates the adverse benefit determination including appeal rights, to the member and provider consistent with applicable state, federal, and accreditation requirements.

Adverse Benefit Determination. For MH/SUD, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as a clinical denial when it is based on clinical criteria and member clinical information and is recorded as an administrative denial when member benefits are excluded.

Intensive Outpatient Program (IOP) Practice Management. The Plan identifies INN MH/SUD IOP facilities and clinics that demonstrate effective performance based on readmission rates, lengths of stay, and post-discharge outcomes for inclusion in Practice Management. INN MH/SUD facilities or clinics that meet these performance criteria do not have to obtain Prior Authorization for IOP services. Instead, the facilities submit claims post-service, which the Plan pays.

Platinum Designation. The Plan offers a Platinum Designation program to MH/SUD providers based on facilities' quantitative practice patterns (effectiveness and efficiency benchmarks). The Platinum Designation program's effectiveness and efficiency benchmarks include targeted 30- and 90-day readmission rates, 7- and 30-day follow up after hospitalization, outlier length of stay, and outlier behavioral health episode spend. INN MH/SUD facilities that meet the Platinum Designation are required to notify the Plan of admissions to Partial Hospitalization Program (PHP) and provide member information. The Plan covers the first 17 days of admission to PHP without review. Facilities notify the Plan if additional days are needed. The Plan evaluates INN MH/SUD facilities' performance annually as described in the *Optum National Network Manual*.

Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity clinical coverage determinations on objective, evidence-based behavioral clinical policies or use clinical criteria from third-party sources such as American Society of Addiction Medicine (ASAM) Criteria®, Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System-Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) and Early Childhood Service Intensity Instrument (ECSII) guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that outpatient Prior Authorization determinations are appropriate.

Per the MH/SUD policy entitled, *Core Principles and Practices*, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse clinical coverage benefit determinations (clinical denials) for financial reasons.

MH/SUD generally structures UM processes to comply with federal ERISA requirements, NCQA UM standards, and state law where applicable.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- Prior Authorization

Benefit Classification(s)

- INN, outpatient

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHC)
- UnitedHealthcare of Georgia, Inc. (UHCGA)

Plan Terms/Source Document(s)

In each of the Plan products, “Medically Necessary” is the Plan term used to guide Prior Authorization decision-making for both M/S and MH/SUD services. “Medically Necessary” is generally defined as follows:

- “Medically Necessary – health care services are all of the following as determined by us or our designee:
 - In accordance with Generally Accepted Standards of Care.
 - Clinically appropriate, in terms of type, frequency, extent, service site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms.
 - Not mainly for your convenience or that of your doctor or other health care provider.
 - Not more costly than an alternative drug, service(s), service site or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

Generally Accepted Standards of Care are evidence based independent standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties. Valid, evidence based sources reflecting generally accepted standards of care include credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We have the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be determined by us.

We develop and maintain clinical policies that describe the Generally Accepted Standards of Care scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by us and revised from time to time), are available to Covered Persons through www.myuhc.com or the telephone number on your ID card. They are also available to Physicians and other health care professionals on www.UHCprovider.com.

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Prior Authorization is defined as:

“A required or mandatory clinical assessment for proposed service(s) based on clinical information provided and the terms of the health plan benefits before the service(s) are performed or delivered. Clinical and medical necessity requirements, level of care appropriateness, and the terms of the health plan benefits must be met in order for services to be covered by the member's plan.”

The *Optum National Policy Definitions List* defines pre-authorization (aka Prior Authorization) as “a form of prospective utilization review of health care services proposed to be provided to a member.”

The Plan's *Schedule of Benefits* notify members of the Prior Authorization requirements:

“We require prior authorization for certain Covered Health Care Services. Network providers are responsible for obtaining prior authorization before they provide these services to you.

We recommend that you confirm with us that all Covered Health Care Services have been prior authorized as required. Before receiving these services from a Network provider, you may want to call us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they do not prior authorize as required. You can call us at the telephone number on your ID card.

When you choose to receive certain Covered Health Care Services from out-of-Network providers, you are responsible for obtaining prior authorization before you receive these services. Note that your obligation to obtain prior authorization is also applicable when an out-of-Network provider intends to admit you to a Network facility or to an out-of-Network facility or refers you to other Network or out-of-Network providers. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization. Services for which you are required to obtain prior authorization are shown in the Schedule of Benefits table within each Covered Health Care Service category.

To obtain prior authorization, call the telephone number on your ID card. This call starts the utilization review process.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the Schedule of Benefits table to find out how far in advance you must obtain prior authorization.

For Covered Health Care Services that do not require you to obtain prior authorization, when you choose to receive services from out-of-Network providers, we urge you to confirm with us that the services you plan to receive are Covered Health Care Services. That is because in some instances, certain procedures may not be Medically Necessary or may not otherwise meet the definition of a Covered Health Care Service, and therefore are excluded. In other instances, the same procedure may meet the definition of Covered Health Care Services. By calling before you receive treatment, you can check to see if the service is subject to limitations or exclusions.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those received, our final coverage determination will be changed to account for those differences, and we will only pay Benefits based on the services delivered to you. If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Care Service, you will be responsible for paying all charges and no Benefits will be paid.”

The *2023 UnitedHealthcare Care Provider Administrative Guide* notifies providers of the Prior Authorization requirements. INN providers are required to comply with UM protocols established by the Plan:

“We require prior authorization for all MA benefit plans and some commercial benefit plans. Prior authorization requests allow us to verify if services are medically necessary and covered. After you notify us of a planned service listed on the Advance Notification/Prior Authorization List, we tell you if a clinical coverage review is required, as part of our prior authorization process, and what additional information we need to proceed. We notify you of our coverage decision within the time required by law. Just because we require notification for a service, does not mean it is covered. We determine coverage by the member’s benefit plan.

If there is a conflict or inconsistency between applicable regulations and the notification requirements in this guide, the applicable regulations govern.

Physicians, health care professionals and ancillary care providers are responsible for:

- Providing advance notification or requesting prior authorization for services on the Advance Notification/Prior Authorization List, including
- for non-emergent air transport services.
- Directing members to use care providers within their network. Members may be required to obtain prior authorization for out-of-network services.

If you perform multiple procedures for a member in one day, and at least one service requires prior authorization, you must obtain Prior authorization for any of the services to be paid.

If you do not follow these requirements, we may deny claims. In that case, you cannot bill the member. Advance notification or prior authorization is valid only for the date of service or date range listed on it. If that specified date of service or date range has passed, you must submit a new request.

Giving us advance notification, or receiving prior authorization from us, is not a guarantee of payment, unless required by law or Medicare guidelines. This includes regulations about care providers on either a sanctions and excluded list, the Medicare preclusion list and/or care providers not included in the Medicare Provider Enrollment Chain and Ownership System (PECOS)* list. Payment of covered services is based on:

- The member's benefit plan,
- If you are eligible for payment,
- Claim processing requirements, and Your Agreement.

The list of services that require advance notification and prior authorization is the same. The process for providing notification and submitting a prior authorization request is the same. Services that require Prior authorization require a clinical coverage review based on medical necessity.

Advance notification/prior authorization lists are available online. They are subject to change. We will post inform you of changes on UHCprovider.com/networknews > Network Bulletin. Sign up to receive the Network Bulletin by email at UHCprovider.com/subscribe.

If you need a paper copy of the requirements, contact your UnitedHealthcare Network Management representative or provider advocate. We recommend that you submit advance notification with supporting documentation as soon as possible, but at least 2 weeks before the planned service (unless the Advance Notification Requirements states otherwise). Following a facility discharge, advance notification for home health services and durable medical equipment is required within 48 hours after the start of service."

The *Optum National Network Manual*, September 2023 Edition notifies providers of the Prior Authorization requirements. INN providers are required to comply with UM protocols established by the Plan:

"In accordance with the Agreement and many Benefit Plans, most routine outpatient behavioral health services do not require an initial pre-authorization or notification. Some non-routine outpatient services require ongoing authorization prior to providing services. These may include, but are not limited to, the following:

- Outpatient Electro-Convulsive Treatment
- Applied Behavioral Analysis (ABA) for the treatment of Autism
- Transcranial Magnetic Stimulation (TMS) (for MDs only)
- Psychological Testing

Authorization for some non-routine services may be requested online:

- ABA services: Provider Express > Autism Corner: Autism/ABA Information
 - ABA Assessment Portal (electronic authorization request submissions)
 - ABA Treatment Request Documents (please review webpage for specific forms)
- Psychological/Neuropsychological Testing: Provider Express > Clinical Resources > Forms > Psychological Testing Request Forms:
 - Optum Psychological and Neuropsychological Testing Request Form
- Transcranial Magnetic Stimulation (TMS) & Electroconvulsive Therapy (ECT) (electronic submission)

- TMS & ECT Authorization Request Form (electronic submission)

For authorization of other non-routine outpatient services, call the number on the Member's ID Card. For more information refer to the "Psychological Testing" section below.

Authorizations for non-routine outpatient services are specific to the requesting Clinician. The Clinician will receive a copy of this authorization. When a written authorization lists a range of CPT and/or HCPCS codes, payment for any specific code is subject to ongoing medical necessity review.

Psychological testing must be pre-authorized separately for both outpatient and inpatient services. Psychological testing is considered after a standard evaluation (including clinical interview, direct observation and collateral input, as indicated) has been completed and one of the following circumstances exists:

- There are significant diagnostic questions remaining that can only be clarified through testing
- There are questions about the appropriate treatment course for a patient, or a patient has not responded to standard treatment with no clear explanation, and testing would have a timely effect on the treatment plan
- There is reason to suspect, based on the initial assessment, the presence of cognitive, intellectual and/or neurological deficits or impairment that may affect functioning or interfere with the patient's ability to participate in or benefit from treatment, and testing will verify the presence or absence of such deficits or dysfunction

In some cases where a member in need of testing has already received sufficient evaluation to conclude testing is necessary, it is permissible to conduct the initial interview intake on the same day of service as testing.

Generally, psychological testing solely for purposes of education or school evaluations, learning disorders, legal and/or administrative requirements is not covered. Also not covered are tests performed routinely as part of an assessment. We recommend that you contact Optum pre-service to determine authorization requirements and procedures."

The role of the Plan's delegate, United Behavioral Health d/b/a OBH, is discussed in the UMPD:

"United Behavioral Health (UBH) manages comprehensive behavioral health care delivery for members through a network of behavioral health practitioners, ancillary care providers, hospitals and other facilities. The management includes review of behavioral health care services (e.g., substance abuse and mental health requests for services).

UBH applies objective, evidence-based clinical criteria when making benefit coverage determinations while taking into account individual needs and the local delivery system. The clinical criteria are based on guidance produced by government sources, professional societies, and published research. In addition to making benefit coverage determinations, the clinical criteria inform discussions about evidence-based practices and discharge planning.

UBH selects externally developed clinical criteria and creates internally developed clinical criteria, where appropriate, based on its assessment of relevant guidance. The selection and development of clinical criteria incorporates:

- Annual review of clinical criteria and the procedures for applying them
- Involvement of appropriate stakeholders
- Dissemination of clinical criteria
- Ongoing monitoring and review of Centers for Medicare and Medicaid (CMS) Medicare Coverage Summaries, new or revised guidance in its CMS Local or National Coverage Determinations that are relevant to behavioral health
- Communication of updates to relevant areas

UBH uses the following clinical criteria:

- Clinical Criteria (Level of Care Utilization System-LOCUS) – Standardized level of care assessment tool developed by the American Association of Community Psychiatrists used to make clinical determinations and placement decisions for mental health disorder benefits for adults ages 19 and older when State or Contract Specific Level of Care Guidelines do not apply.

- Clinical Criteria (Child and Adolescent Level of Care/Service Intensity Utilization System-CALOCUS-CASII) – Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry (AACAP) and the American Association for Community Psychiatry (AAP) used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children and adolescents ages 6-18 when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (Early Childhood Service Intensity Instrument-ECSII) - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children ages 0-5 when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (American Psychological Association Psychological and Neuropsychological Testing Billing and Coding Guide) - Comprehensive billing and coding guide developed by the APA used for making clinical determinations for behavioral health psychological and neuropsychological testing services.
- Clinical Criteria (State or Contract Specific Supplemental Clinical Criteria) - Criteria used to make medical necessity determinations for mental health disorder benefits when there are explicit mandates or contractual requirements.
- Clinical Criteria (American Society of Addiction Medicine [ASAM]) - Criteria developed by the American Society of Addiction Medicine used to make clinical determinations for substance-related disorder benefits.
- Clinical Criteria (UBH Developed)
 - UBH Behavioral Clinical Policies: Criteria that stem from evaluation of new services or treatments or new applications of existing services or treatments and are used to make clinical determinations regarding proven or unproven services and treatments.
 - UBH Supplemental Clinical Criteria: Criteria used to make clinical determinations for Applied Behavior Analysis and Electroconvulsive Therapy.
 - UBH's Supplement to the APA Psychological and Neuropsychological Testing Billing and Coding Guide: Additional criteria used regarding provider qualifications, coverage rationale, limitations, and developmental testing.

The UBH UM Program is staffed by clinical, non-clinical and administrative personnel. A senior UBH Medical Director is responsible for directing and implementing the UM Programs. All clinical denials or adverse decisions are made by board certified psychiatrists, or, if the health plans choose, by a panel of other appropriate clinical peer reviewers. If the health plan chooses to use a panel to make adverse decisions, the panel contains at least one physician who is board certified in psychiatry. When the health care service under review is a mental health or substance abuse service, the adverse decision is made by a licensed physician who is board certified in psychiatry. Potential clinical denials are referred to a physician who is board certified in psychiatry for final determination.

An evaluation of the overall effectiveness of the Behavioral Health UM Program is conducted annually to determine how well resources have been deployed to improve UM activities and the clinical care and service provided to members.”

The Plan's terms require services to be medically necessary for coverage.

List of M/S and MH/SUD Services Subject to NQTL

Addendum A, attached, lists the M/S and MH/SUD INN outpatient service categories subject to Prior Authorization requirements. Prior Authorization is one component of the UM program that evaluates whether a benefit or service is medically necessary.

- The “Member”- tab lists the service categories for which the member is responsible for obtaining authorization for INN services. The “Member” tab includes all products in the scope of the analysis.
- The “Provider” tab lists the service categories for which the provider is responsible for obtaining authorization for INN services. The “Provider” tab applies to all products in the scope of the analysis.

Step 2 – Factors Used in the Design and Application of the NQTL

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

The Prior Authorization list was originally designed by enterprise clinical leadership. Prior Authorization was applied to new services when they became covered by the Plan and met certain criteria. Examples of Prior Authorization determinants that existed in the business at the time included:

- to monitor and prevent potential overutilization and under-utilization
- manage high-cost and prolonged-duration services
- ensure enrollee safety
- determine the appropriate level of care
- determine whether the service or item is medically necessary

The factors relied upon to determine which INN outpatient services by category were subjected to Prior Authorization were updated and replaced in 2021 with the factors Clinical Appropriateness, Value, and Variation as defined below. After this time, all M/S services subject to Prior Authorization must meet Clinical Appropriateness and all MH/SUD services subject to Prior Authorization must meet Clinical Appropriateness and at least one of the other factors.

Starting in 2022, any additions or deletions to the Prior Authorization list were reviewed and approved through committees.

The Plan relies on the following factors to determine which INN outpatient services are added to the Prior Authorization list. These factors apply to M/S and MH/SUD benefits for the following:

- I. M/S INN outpatient services
- II. MH/SUD INN outpatient services

- Clinical Appropriateness (Qualitative)

Applies to M/S and MH/SUD services.

- Value (Quantitative)

Applies to M/S and MH/SUD services.

- Variation (Quantitative)

Applies to M/S and MH/SUD services.

For M/S meeting Clinical Appropriateness is determinative in imposing the limitation. For MH/SUD meeting Clinical Appropriateness plus Value and/or Variation is determinative in imposing the limitation. The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL.

In 2023, to further refine how decisions are made to subject INN outpatient services to Prior Authorization, the enterprise adopted factors to be assessed when considering whether to remove or retain services on the enterprise Prior Authorization list. These changes were implemented September 2023. The assessment first considered the factors for removal of the service from the Prior Authorization list. If the service met a removal factor, the Plan then assessed if the service met a retention factor. Services that met a retention factor were retained on the Prior Authorization list. Services that did not meet a removal factor remained on the Prior Authorization list based on the original add factors.

The Plan relies on the following factors to determine which INN outpatient benefits are removed from the Prior Authorization list. These factors apply to M/S and MH/SUD benefits for the following:

- I. M/S: INN outpatient services
- II. MH/SUD: INN outpatient services

- Low Value (Quantitative)

Applies to M/S and MH/SUD services.

- Consistency (Quantitative)

Applies to M/S and MH/SUD services.

- Low Volume (Quantitative)

Applies to M/S and MH/SUD services.

Please note that if the primary code within a code family meets the requirements for removal, the family of codes will be addressed in a similar fashion per medical policy and clinical practice patterns.

The Plan then relies on the following factors to determine which INN outpatient benefits are retained on the Prior Authorization list. These factors apply to M/S and MH/SUD benefits for the following:

- I. M/S: INN outpatient services
- II. MH/SUD: INN outpatient services

- Services that are experimental, investigational, or unproven (EIU) (Qualitative)

Applies to M/S and MH/SUD services.

- Patient Safety (Qualitative)

Applies to M/S and MH/SUD services.

- Level of Care (Quantitative)

Applies to M/S and MH/SUD services.

- High-Cost Drugs and Services that are greater than \$100,000 (Quantitative)

Applies to M/S and MH/SUD services.

For M/S meeting Clinical Appropriateness is determinative in imposing the limitation. For MH/SUD meeting Clinical Appropriateness plus Value and/or Variation is determinative in imposing the limitation. If the service met a removal factor, the Plan then assessed if the service met a retention factor. Services that met a retention factor were retained on the Prior Authorization list. Meeting any one of the factors is determinative in retaining the limitation. The factors are not weighted in that no individual factor carries more value than another in retaining the NQTL.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factors used to add services to the Plan's Prior Authorization list for INN outpatient services. These evidentiary standards and sources apply to benefits for the following:

- I. M/S INN outpatient services
- II. MH/SUD INN outpatient services

Factor – Clinical Appropriateness

Factor – Value

Factor – Variation

For M/S meeting Clinical Appropriateness is determinative in imposing the limitation. For MH/SUD meeting Clinical Appropriateness plus Value and/or Variation is determinative in imposing the limitation. The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL.

In 2023, to further refine how decisions are made to subject INN outpatient services to Prior Authorization, the enterprise adopted factors to be assessed when considering whether to remove or retain services on the enterprise Prior Authorization list. These changes were implemented September 2023. The assessment first considered the factors for removal of the service from the Prior Authorization list. If the service met a removal factor, the Plan then assessed if the service met a retention factor. Services that met a retention factor were retained on the Prior Authorization list. Services that did not meet a removal factor remained on the Prior Authorization list based on the original add factors.

The Plan relies on the following factors to determine which INN outpatient benefits are removed from the Prior Authorization list. These factors apply to M/S and MH/SUD and M/S benefits for the following:

- I. M/S: INN outpatient services
- II. MH/SUD: INN outpatient services

Factor - Low Value

Factor - Consistency

Factor - Low Volume

The Plan then relies on the following factors to determine which INN outpatient benefits are retained on the Prior Authorization list. These factors apply to M/S and MH/SUD and M/S benefits for the following:

- I. M/S: INN outpatient services
- II. MH/SUD: INN outpatient services

Factor - Services that are EIU

Factor - Patient

Factor - Level of Care

Factor - High-Cost Drugs and Services that are greater than \$100,000

If the service met a removal factor, the Plan then assessed if the service met a retention factor. Services that met a retention factor were retained on the Prior Authorization list. Meeting any one of the factors is determinative in retaining the limitation. The factors are not weighted in that no individual factor carries more value than another in retaining the NQTL.

The factors and evidentiary standards used as the basis for subjecting MH/SUD INN outpatient benefits to Prior Authorization are comparable to, and applied no more stringently than, the factors and evidentiary standards used as the basis for subjecting M/S INN outpatient benefits to Prior Authorization “as written” and “in operation.”

Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan's or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The findings of the Plan's comparative analyses confirmed the strategies, processes, factors, evidentiary standards, and source information used to determine the MH/SUD INN outpatient services subject to Prior Authorization were comparable to, and applied no more stringently than, the strategies, processes, factors, evidentiary standards, and source information used to determine the M/S INN outpatient services subject to Prior Authorization “as written.” For M/S and MH/SUD INN outpatient benefits, the *Prior Authorization Factor Grid(s)* included with this analysis detail the shared factors used as the basis for adding, removing, or retaining M/S and MH/SUD INN outpatient services on the Prior Authorization list, as described above.

The Plan found the factors used to add, remove, or retain MH/SUD INN outpatient services on the Prior Authorization list were comparable to, and applied no more stringently than, the factors used to add, remove, or retain M/S INN outpatient services on the Prior Authorization list. INN M/S and MH/SUD outpatient services that met the applicable factor(s) were subject to Prior Authorization “in operation.”

Conclusions

The Plan reviewed the M/S and MH/SUD Prior Authorization policies and procedures and concluded the methodology used to determine which MH/SUD INN outpatient services are subject to Prior Authorization “as written” were comparable to, and applied no more stringently than, the methodology used to determine which M/S INN outpatient services are subject to Prior Authorization “as written.” Additionally, the Plan concluded that how Prior Authorization is applied to MH/SUD INN outpatient services was comparable to, and applied no more stringently than, how Prior Authorization is applied to M/S INN outpatient services “as written.”

The Plan reviewed the M/S and MH/SUD processes including responsibility for submission, timeframes for submission and review, notification to members and providers, clinical standards for review, staff qualifications, outcomes data, and IRR assessment results and concluded how the Plan conducts Prior Authorization for MH/SUD INN outpatient services “in operation” was comparable to, and applied no more stringently than, how the Plan conducts Prior Authorization for M/S INN outpatient services “in operation.”

Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical/surgical (M/S) benefits. This generally means that the financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements, such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage.

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Prior Authorization is defined as: “A required or mandatory clinical assessment for proposed service(s) based on clinical information provided and the terms of the health plan benefits before the service(s) are performed or delivered. Clinical and medical necessity requirements, level of care appropriateness, and the terms of the health plan benefits must be met in order for services to be covered by the member’s plan.” The *Optum National Policy Definitions List* defines pre-authorization (aka Prior Authorization) as “a form of prospective utilization review of health care services proposed to be provided to a member.”

Prior Authorization is a component of the Plan’s Utilization Management (UM) program that helps ensure members receive appropriate coverage based on their specific clinical status and health care needs. The process is designed to achieve optimal clinical outcomes by applying objective, evidence-based clinical criteria, and nationally recognized guidelines and best practices.

Prior Authorization for inpatient services commences prior to a service being delivered. Prior Authorization is a UM process that involves applying the benefit plan language and/or clinical criteria to make the most appropriate clinical coverage benefit determination.

This document includes the following information:

- Prior Authorization process for M/S and MH/SUD inpatient services
- Description of the NQTL and application (Step 1)
- Factors used to determine which services are subject to the NQTL (Step 2)
- Evidentiary standards and sources used to define, trigger and/or implicate a factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

This analysis refers to the following attachments:

- *Addendum A* - Identifies the M/S and MH/SUD inpatient services that are subject to Prior Authorization
- *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions* - M/S policy that

defines Prior Authorization

- *Optum National Policy Definitions List* - MH/SUD policy that defines Prior Authorization
- *Utilization Management Program Description (UMPD) of United HealthCare Services, Inc. and UnitedHealthcare Insurance Company* - Summarizes the philosophy, structure and standards that govern UHC's medical management, UM and utilization review responsibilities and functions
- *Management of Behavioral Health Benefits Policy* - Describes the mechanisms and processes designed to promote consistency in the management of behavioral health benefits and to ensure that members receive appropriate, high quality behavioral health services in a timely manner
- *Prior Authorization Factor Grid(s)* provided for (*2023 Prior Auth_Concurrent Rev Factor Grid*) - Details the service categories subject to Prior Authorization and the shared factors and evidentiary standards used as the basis for subjecting M/S and MH/SUD inpatient benefits to Prior Authorization
- *Core Principles and Practices* - MH/SUD policy that outlines the core principles and practices that should be used by personnel in their interactions with members, authorized member representatives, practitioners and facilities, related to the management of behavioral health benefits, coverage determinations and appeals/grievances of non-coverage determinations.
- *Performance Assessment and Incentives* - M/S policy confirming that clinical reviewers are not incented to make denials for financial reasons
- *Certificates of Coverage (COC23-INS-2018-LG-GA, COC23-HMO-2018-LG-GA, COC23-INS-2018-SG-GA and COC23-HMO-2018-SG-GA)* - Plan documents that explains covered services, terms, conditions, and limitations of the member's policy
- *Schedule of Benefits (SBN23-Medical-INS-2018-[Charter][Navigate][Nexus+[N]R]-LG-GA, SBN23-Medical-INS-2018-[Choice+Plus][Select+Plus][Doctors+Plus]-LG-GA, SBN23-Medical-INS-2018-[Core][Nexus+OAP]-LG-GA, SBN23-Medical-INS-2018-[Core+Essential][Nexus+OA]-LG-GA, SBN23-Medical-HMO-2018-[Charter][Navigate][Nexus+[N]R]-LG-GA, SBN23-Medical-INS-2018-[Choice+Plus][Select+Plus][Doctors+Plus]-SG-GA, SBN23-Medical-HMO-2018-[CharterBal][NavigateBal][Nexus+[N]RB]-LG-GA, SBN23-Medical-HMO-2018-[CharterPls][NavigatePls][Nexus+[N]RP]-LG-GA, SBN23-Medical-HMO-2018-[Choice][Select][Doctors]-LG-GA, SBN23-Medical-HMO-2018-[Core][Nexus+OAP]-LG-GA, SBN23-Medical-HMO-2018-[Core+Essential][Nexus+OA]-LG-GA, SBN23-Medical-INS-2018-NonDifferential-LG-GA, and SBN23-Medical-HMO-2018-[Choice][Select][Doctors]-SG-GA)* - Plan documents that outlines member responsibilities

The Plan concludes that the Prior Authorization requirements for M/S and MH/SUD are comparable and applied no more stringently for MH/SUD for out-of-network (OON) inpatient benefits, both “as written” and “in operation.”

Process

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Prior Authorization is defined as: “A required or mandatory clinical assessment for proposed service(s) based on clinical information provided and the terms of the health plan benefits before the service(s) are performed or delivered. Clinical and medical necessity requirements, level of care appropriateness, and the terms of the health plan benefits must be met in order for services to be covered by the member's plan.” The *Optum National Policy Definitions List* defines pre-authorization (aka Prior Authorization) as “a form of prospective utilization review of health care services proposed to be provided to a member.”

The Plan structures inpatient Prior Authorization processes to be compliant with all applicable federal and state requirements, as well as the National Committee for Quality Assurance (NCQA) accreditation standards. NCQA confirms that Plan operations and policies identify appropriate timeframes for decisions, requires decision-making by appropriate personnel, and governs communication of adverse benefit determinations. Prior Authorization is governed at both the state and federal level, which includes consumer protections such as external review for adverse benefit determinations after internal appeals options are exhausted.

The Plan delegates management of MH/SUD inpatient services, including Prior Authorization, to United Behavioral Health d/b/a Optum Behavioral Health (OBH), its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor.

The Plan has national committees that approve M/S and MH/SUD services to be subject to Prior Authorization. *Addendum A* includes a list of service categories subject to inpatient Prior Authorization. Members can learn what services are subject to Prior Authorization in their benefit plan document, through myuhc.com, or by contacting customer service.

Prior Authorization review of M/S inpatient admissions consists of the following:

Members are responsible for obtaining Prior Authorization for services rendered by OON facilities and providers. The member's benefit plan document (i.e., *Schedule of Benefits*) identify the services for which the member is responsible for obtaining Prior Authorization and the required timeframe(s). The member or OON provider's submission of a request (notification) triggers the Prior Authorization process.

Members may submit Prior Authorization requests by phone, fax, or mail, in accordance with Plan requirements. OON providers may submit Prior Authorization requests on behalf of the member by phone or by fax (where required). Members or providers communicate basic information to create a case.

The Plan confirms receipt of the Prior Authorization request. Non-clinical staff confirm member eligibility and benefit coverage upon receipt of the notification. Non-clinical staff review cases to ensure availability of accurate and thorough case information. Non-clinical staff may approve coverage requests in scenarios where the member's plan documents allow and if a clinical review is not required. Non-clinical staff may administratively deny coverage when a member's benefits are exhausted. Non-clinical staff refer coverage requests that they cannot approve or administratively deny to the initial clinical reviewers.

First Level Clinical Review/Initial Review. Clinical reviewers (nurses or physicians) consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether the inpatient admission is medically necessary by reviewing the member's clinical information, the applicable clinical criteria or guidelines, and the Plan benefit terms. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs to determine whether the applicable clinical criteria are met. The clinical reviewer may approve cases that meet applicable clinical criteria.

Second Level Clinical Review/Peer Review. The initial clinical reviewer refers cases to a second level/peer clinical reviewer if the case cannot be approved. Peer clinical reviewers (physician or mid-level practitioner) consult clinical criteria when making clinical coverage benefit determinations. Peer clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. The peer clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. If a peer clinical reviewer issues an adverse benefit determination, then the Plan communicates the adverse benefit determination, including appeal rights, and offers a peer-to-peer conversation consistent with state, federal, and accreditation requirements.

Adverse Benefit Determination. For M/S, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when member benefits are exhausted. Based on individual state requirements, cases may be cancelled if the member is not eligible for

benefits. Cancelled cases are not considered administrative or clinical denials. Modified coverage requests that are approved are recorded as partial denials.

Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based medical clinical policies and use clinical criteria from third-party sources such as InterQual® or MCG® guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that inpatient Prior Authorization determinations are appropriate.

Per the M/S policy entitled, *Performance Assessment and Incentives*, at no time are initial or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons.

M/S generally structures UM processes to comply with federal Employee Retirement Income Security Act of 1974 (ERISA) requirements, NCQA UM standards, and state law where applicable.

Prior Authorization review of MH/SUD inpatient admissions consists of the following:

The Plan delegates management of MH/SUD inpatient services, including Prior Authorization, to United Behavioral Health d/b/a OBH, its delegated MH/SUD MBHO vendor.

Members are responsible for ensuring Prior Authorization is obtained by the OON provider administering the service. The OON provider must provide clinical information on the member's behalf. The member's benefit plan document (i.e., *Schedule of Benefits*) identifies the services for which the member is responsible for ensuring Prior Authorization is obtained. As outlined in the Plan document, OON providers must submit the Prior Authorization request before inpatient MH/SUD services are received. OON provider's submission of a request (notification) triggers the Prior Authorization process.

OON providers may submit Prior Authorization requests on behalf of the member by telephone, or by fax (where required). Providers communicate basic information to create a case.

As described in the *Management of Behavioral Health Benefits Policy*, the Plan confirms receipt of the Prior Authorization request. Non-clinical staff confirm member eligibility and benefit coverage. Non-clinical staff may approve coverage requests that do not require clinical evaluation or interpretation based on the member's diagnosis and the clinical information submitted by providers. Non-clinical staff may administratively deny coverage when member benefits are exhausted. Non-clinical staff refer cases that they cannot approve or administratively deny to the initial clinical reviewers.

First Level Clinical Review/Initial Review. Clinical decisions are made by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse benefit determinations are made by Medical Directors. Clinical reviewers consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether an inpatient admission is medically necessary by reviewing the member's clinical information, the applicable clinical criteria or guidelines, and the Plan benefit terms. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for certification, related diagnostic results, and history of related treatment and services to determine whether the applicable clinical criteria are met. The clinical reviewer may approve the admission based on their review.

Second Level Clinical Review/Peer Review. The initial clinical reviewer refers cases to a peer clinical reviewer for a peer-to-peer discussion if the case cannot be approved. The requesting provider is offered the opportunity to discuss the case with the peer clinical reviewer, consistent with state, federal, and accreditation requirements before an adverse benefit determination is issued. Only qualified peer clinical reviewers (e.g., Medical Directors) can issue adverse benefit determinations. Peer clinical

reviewers apply clinical criteria to member clinical information to determine coverage for an inpatient admission. If the requesting provider fails to complete the peer-to-peer discussion, the peer clinical reviewer makes a determination based on the information available. If a peer clinical reviewer issues an adverse benefit determination (e.g., the admission is not medically necessary and is not approved), then the Plan timely communicates the adverse benefit determination, including appeal rights, to the member and provider consistent with applicable state, federal, and accreditation requirements.

Adverse Benefit Determination. For MH/SUD, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as a clinical denial when it is based on clinical criteria and member clinical information and is recorded as an administrative denial when member benefits are excluded.

Clinical Criteria. Initial clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based behavioral clinical policies or use clinical criteria from third-party sources such as American Society of Addiction Medicine (ASAM) Criteria®, Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System-Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) and Early Childhood Service Intensity Instrument (ECSII) guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that inpatient Prior Authorization determinations are appropriate.

MH/SUD generally structures UM processes to comply with federal ERISA requirements, NCQA UM standards, and state law where applicable.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- Prior Authorization

Benefit Classification(s)

- OON, inpatient

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHIC)
- UnitedHealthcare of Georgia, Inc. (UHCGA)

Plan Terms/Source Document(s)

In each of the Plan products, “Medically Necessary” is the Plan term used to guide Prior Authorization decision-making for both M/S and MH/SUD services. “Medically Necessary” is generally defined as follows:

- “Medically Necessary – health care services are all of the following as determined by us or our designee:
 - In accordance with Generally Accepted Standards of Care.
 - Clinically appropriate, in terms of type, frequency, extent, service site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms.
 - Not mainly for your convenience or that of your doctor or other health care provider.
 - Not more costly than an alternative drug, service(s), service site or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

- Generally Accepted Standards of Care are evidence based independent standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties. Valid, evidence based sources reflecting generally accepted standards of care include credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.
- If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We have the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be determined by us.
- We develop and maintain clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by us and revised from time to time), are available to Covered Persons through www.myuhc.com or the telephone number on your ID card. They are also available to Physicians and other health care professionals on www.UHCprovider.com”

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Prior Authorization is defined as:

“A required or mandatory clinical assessment for proposed service(s) based on clinical information provided and the terms of the health plan benefits before the service(s) are performed or delivered. Clinical and medical necessity requirements, level of care appropriateness, and the terms of the health plan benefits must be met in order for services to be covered by the member's plan.”

The *Optum National Policy Definitions List* defines pre-authorization (aka Prior Authorization) as “a form of prospective utilization review of health care services proposed to be provided to a member.”

The Plan's *Schedule of Benefits* notify members of the Prior Authorization requirements:

“We require prior authorization for certain Covered Health Care Services. Network providers are responsible for obtaining prior authorization before they provide these services to you.

We recommend that you confirm with us that all Covered Health Care Services have been prior authorized as required. Before receiving these services from a Network provider, you may want to call us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they do not prior authorize as required. You can call us at the telephone number on your ID card.

When you choose to receive certain Covered Health Care Services from out-of-Network providers, you are responsible for obtaining prior authorization before you receive these services. Note that your obligation to obtain prior authorization is also applicable when an out-of-Network provider intends to admit you to a Network facility or to an out-of-Network facility or refers you to other Network or out-of-Network providers. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization. Services for which you are required to obtain prior authorization are shown in the Schedule of Benefits table within each Covered Health Care Service category.

To obtain prior authorization, call the telephone number on your ID card. This call starts the utilization review process.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may

include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the Schedule of Benefits table to find out how far in advance you must obtain prior authorization.

For Covered Health Care Services that do not require you to obtain prior authorization, when you choose to receive services from out-of-Network providers, we urge you to confirm with us that the services you plan to receive are Covered Health Care Services. That is because in some instances, certain procedures may not be Medically Necessary or may not otherwise meet the definition of a Covered Health Care Service, and therefore are excluded. In other instances, the same procedure may meet the definition of Covered Health Care Services. By calling before you receive treatment, you can check to see if the service is subject to limitations or exclusions.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those received, our final coverage determination will be changed to account for those differences, and we will only pay Benefits based on the services delivered to you. If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Care Service, you will be responsible for paying all charges and no Benefits will be paid.”

The role of the Plan’s delegate, United Behavioral Health d/b/a OBH, is discussed in the *UMPD*:

“United Behavioral Health (UBH) manages comprehensive behavioral health care delivery for members through a network of behavioral health practitioners, ancillary care providers, hospitals and other facilities. The management includes review of behavioral health care services (e.g., substance abuse and mental health requests for services).

UBH applies objective, evidence-based clinical criteria when making benefit coverage determinations while taking into account individual needs and the local delivery system. The clinical criteria are based on guidance produced by government sources, professional societies, and published research. In addition to making benefit coverage determinations, the clinical criteria inform discussions about evidence-based practices and discharge planning.

UBH selects externally developed clinical criteria and creates internally developed clinical criteria, where appropriate, based on its assessment of relevant guidance. The selection and development of clinical criteria incorporates:

- Annual review of clinical criteria and the procedures for applying them
- Involvement of appropriate stakeholders
- Dissemination of clinical criteria
- Ongoing monitoring and review of Centers for Medicare and Medicaid (CMS) Medicare Coverage Summaries, new or revised guidance in its CMS Local or National Coverage Determinations that are relevant to behavioral health
- Communication of updates to relevant areas

UBH uses the following clinical criteria:

- Clinical Criteria (Level of Care Utilization System-LOCUS) – Standardized level of care assessment tool developed by the American Association of Community Psychiatrists used to make clinical determinations and placement decisions for mental health disorder benefits for adults ages 19 and older when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (Child and Adolescent Level of Care/Service Intensity Utilization System-CALOCUS-CASII) –

Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry (AACAP) and the American Association for Community Psychiatry (AAPC) used to make clinical determinations and to

provide level of service intensity recommendations for mental health disorder benefits for children and adolescents ages 6-18 when State or Contract Specific Level of Care Guidelines do not apply.

- Clinical Criteria (Early Childhood Service Intensity Instrument-ECSII) - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children ages 0-5 when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (American Psychological Association Psychological and Neuropsychological Testing Billing and Coding Guide) - Comprehensive billing and coding guide developed by the APA used for making clinical determinations for behavioral health psychological and neuropsychological testing services.
- Clinical Criteria (State or Contract Specific Supplemental Clinical Criteria) - Criteria used to make medical necessity determinations for mental health disorder benefits when there are explicit mandates or contractual requirements.
- Clinical Criteria (American Society of Addiction Medicine [ASAM]) - Criteria developed by the American Society of Addiction Medicine used to make clinical determinations for substance-related disorder benefits. Clinical Criteria (UBH Developed)
 - UBH Behavioral Clinical Policies: Criteria that stem from evaluation of new services or treatments or new applications of existing services or treatments and are used to make clinical determinations regarding proven or unproven services and treatments.

The UBH UM Program is staffed by clinical, non-clinical and administrative personnel. A senior UBH Medical Director is responsible for directing and implementing the UM Programs. All clinical denials or adverse decisions are made by board certified psychiatrists, or, if the health plans choose, by a panel of other appropriate clinical peer reviewers. If the health plan chooses to use a panel to make adverse decisions, the panel contains at least one physician who is board certified in psychiatry. When the health care service under review is a mental health or substance abuse service, the adverse decision is made by a licensed physician who is board certified in psychiatry. Potential clinical denials are referred to a physician who is board certified in psychiatry for final determination.

An evaluation of the overall effectiveness of the Behavioral Health UM Program is conducted annually to determine how well resources have been deployed to improve UM activities and the clinical care and service provided to members.”

The Plan’s terms require services to be medically necessary for coverage.

List of M/S and MH/SUD Services Subject to NQTL

Addendum A, attached, lists the M/S and MH/SUD OON inpatient service categories subject to Prior Authorization. Prior Authorization is one component of the UM program that evaluates whether a benefit or service is medically necessary.

- The “Member” tab lists the service categories for which the member is responsible for obtaining authorization for OON services. The “Member” tab includes all products in the scope of the analysis.
- The “Provider” tab lists the service categories for which the provider is responsible for obtaining authorization for in-network services. The “Provider” tab applies to all products in the scope of the analysis.

Step 2 – Factors Used to Determine the Listed Services are Subject to Prior Authorization

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

The Prior Authorization list was originally designed by enterprise clinical leadership. Prior Authorization was applied to new

services when they became covered by the Plan and met certain criteria. Examples of Prior Authorization determinants that existed in the business at this time included:

- to monitor and prevent potential overutilization and under-utilization
- manage high-cost and prolonged-duration services
- ensure enrollee safety
- determine the appropriate level of care
- determine whether the service or item is medically necessary

The factors relied upon to determine which OON inpatient services were subjected to Prior Authorization were updated and replaced 2021 with the factors Clinical Appropriateness and Value, as defined below. After this time, all M/S services subject to Prior Authorization must meet Clinical Appropriateness and all MH/SUD services subject to Prior Authorization must meet Clinical Appropriateness and Value.

Starting in 2022, any additions or deletions to the Prior Authorization list were reviewed and approved through committees.

The Plan relies on the following factors to determine which OON inpatient benefits will be subject to Prior Authorization. These factors apply to M/S and MH/SUD benefits for the following:

- I. M/S: OON inpatient services
 - II. MH/SUD: OON inpatient services
- Clinical Appropriateness (Qualitative)

Applies to M/S and MH/SUD services.

- Value (Quantitative)

Applies to M/S and MH/SUD services.

For M/S meeting Clinical Appropriateness is determinative in imposing the limitation. For MH/SUD meeting Clinical Appropriateness and Value is determinative in imposing the limitation. The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL. All Prior Authorization reviews are subject to Clinical Appropriateness and must have medical necessity criteria.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below are the evidentiary standards and sources and used to define, trigger, and/or implicate the factors used to add services to the Plan's Prior Authorization requirement for OON inpatient services. These evidentiary standards and sources apply to benefits for the following:

- I. M/S: OON inpatient services
- II. MH/SUD: OON inpatient services

Factor – Clinical Appropriateness

These evidentiary standards and sources apply to M/S and MH/SUD services and are defined in a qualitative manner.

Factor – Value

This evidentiary standard and the sources apply to M/S and MH/SUD OON inpatient services and are defined in a quantitative manner.

For M/S meeting Clinical Appropriateness is determinative in imposing the limitation. For MH/SUD meeting Clinical Appropriateness and Value is determinative in imposing the limitation. The factors are not weighted in that no individual factor carries more importance than another in retaining the NQTL.

The factors and evidentiary standards used as the basis for subjecting MH/SUD OON inpatient benefits to Prior Authorization are comparable to, and applied no more stringently than, the factors and evidentiary standards used as the basis for subjecting M/S OON inpatient benefits to Prior Authorization “as written” and “in operation.”

Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The findings of the Plan's comparative analysis confirmed the strategies, processes, factors, evidentiary standards, and source information used to determine the MH/SUD OON inpatient services subject to Prior Authorization were comparable to, and applied no more stringently than, the strategies, processes, factors, evidentiary standards, and source information used to determine the M/S OON inpatient services subject to Prior Authorization “as written.” For M/S and MH/SUD OON inpatient benefits, the *Prior Authorization Factor Grid(s)* included with this analysis detail the shared factors used as the basis for subjecting M/S and MH/SUD OON inpatient benefits to Prior Authorization, as described above.

The Plan found the factors used to determine the MH/SUD OON inpatient services subject to Prior Authorization were comparable to, and applied no more stringently than, the factors used to determine the M/S OON inpatient services subject to Prior Authorization. Beginning in 2022, OON M/S and MH/SUD inpatient services that met the Clinical Appropriateness plus the Value factor were subject to Prior Authorization review “in operation.”

Conclusions

The Plan reviewed the M/S and MH/SUD Prior Authorization operational policies and procedures and concluded the methodology used to determine which MH/SUD OON inpatient services are subject to Prior Authorization “as written” were

comparable to, and applied no more stringently than, the methodology used to determine which M/S OON inpatient services are subject to Prior Authorization “as written.” Additionally, the Plan concluded that how Prior Authorization is applied to MH/SUD OON inpatient services was comparable to, and applied no more stringently than, how Prior Authorization is applied to M/S OON inpatient services “as written.”

The Plan reviewed the M/S and MH/SUD processes including responsibility for submission, timeframes for submission and review, notification to members and providers, clinical standards for review, staff qualifications, outcomes data, and IRR assessment results and concluded how the Plan conducts Prior Authorization for MH/SUD OON inpatient services “in operation” was comparable to, and applied no more stringently than, how the Plan conducts Prior Authorization for M/S OON inpatient services “in operation.”

Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical/surgical (M/S) benefits. This generally means that the financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements, such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage.

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth the findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Prior Authorization is defined as: “A required or mandatory clinical assessment for proposed service(s) based on clinical information provided and the terms of the health plan benefits before the service(s) are performed or delivered. Clinical and medical necessity requirements, level of care appropriateness, and the terms of the health plan benefits must be met in order for services to be covered by the member's plan.” The *Optum National Policy Definitions List* defines pre-authorization (aka Prior Authorization) as “a form of prospective utilization review of health care services proposed to be provided to a member.”

Prior Authorization is a component of the Plan’s Utilization Management (UM) program that helps ensure members receive appropriate coverage based on their specific clinical status and health care needs. The process is designed to achieve optimal clinical outcomes by applying objective, evidence-based clinical criteria and nationally recognized guidelines and best practices.

Prior Authorization for outpatient services commences prior to a service being delivered. Prior Authorization is a UM process that involves applying the benefit plan language and/or clinical criteria to make the most appropriate clinical coverage benefit determination.

This document includes the following information:

- Prior Authorization process for M/S and MH/SUD outpatient services
- Description of the NQTL and application (Step 1)
- Factors used to determine which services are subject to the NQTL (Step 2)
- Evidentiary standards and sources used to define, trigger and/or implicate a factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

This analysis refers to the following attachments:

- *Addendum A* – Identifies the M/S and MH/SUD outpatient services that are subject to Prior Authorization
- *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions* - M/S policy that defines Prior Authorization
- *Optum National Policy Definitions List* - MH/SUD policy that defines Prior Authorization
- *Utilization Management Program Description (UMPD) of United HealthCare Services, Inc. and UnitedHealthcare*

Insurance Company - Summarizes the philosophy, structure and standards that govern UHC's medical management, UM and utilization review responsibilities and functions

- *Management of Behavioral Health Benefits Policy* - Describes the mechanisms and processes designed to promote consistency in the management of behavioral health benefits and to ensure that members receive appropriate, high quality behavioral health services in a timely manner
- *Prior Authorization Factor Grid(s)* (provided for (2023 Prior Auth_Concurrent Rev Factor Grid)- Details the service categories subject to Prior Authorization and the shared factors and evidentiary standards used as the basis for subjecting M/S and MH/SUD outpatient benefits to Prior Authorization
- *Core Principles and Practices* - MH/SUD policy that outlines the core principles and practices that should be used by personnel in their interactions with members, authorized member representatives, practitioners and facilities, related to the management of behavioral health benefits, coverage determinations and appeals/grievances of non-coverage determinations.
- *Performance Assessment and Incentives* - M/S policy confirming that clinical reviewers are not incented to make denials for financial reasons
- *2023 UnitedHealthcare Provider Administrative Guide* – Informs M/S providers of the Prior Authorization process
- *Certificates of Coverage (COC23-INS-2018-LG-GA, COC23-INS-2018-SG-GA)* - Plan documents that explains covered services, terms, conditions, and limitations of the member's policy
- *Schedule of Benefits (SBN23-Medical-INS-2018-[Charter][Navigate][Nexus+[N]R]-LG-GA, SBN23-Medical-INS-2018-[Choice+Plus][Select+Plus][Doctors+Plus]-LG-GA, SBN23-Medical-INS-2018-[Core][Nexus+OAP]-LG-GA, SBN23-Medical-INS-2018-[Core+Essential][Nexus+OA]-LG-GA, SBN23-Medical-INS-2018-[Choice+Plus][Select+Plus][Doctors+Plus]-SG-GA)*. Plan documents that outlines member responsibilities

The Plan concludes that the Prior Authorization requirements for M/S and MH/SUD are comparable and applied no more stringently for MH/SUD out-of-network (OON) outpatient benefits both "as written" and "in operation."

Process

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Prior Authorization is defined as: "A required or mandatory clinical assessment for proposed service(s) based on clinical information provided and the terms of the health plan benefits before the service(s) are performed or delivered. Clinical and medical necessity requirements, level of care appropriateness, and the terms of the health plan benefits must be met in order for services to be covered by the member's plan." The *Optum National Policy Definitions List* defines pre-authorization (aka Prior Authorization) as "a form of prospective utilization review of health care services proposed to be provided to a member."

The Plan structures outpatient Prior Authorization processes to be compliant with all applicable federal and state requirements, as well as the National Committee for Quality Assurance (NCQA) accreditation standards. NCQA confirms that Plan operations and policies identify appropriate timeframes for decisions, requires decision-making by appropriate personnel, and governs communication of adverse benefit determinations. In addition, Prior Authorization is governed at both the state and federal level, which includes consumer protections such as external review for adverse benefit determinations after internal appeals options are exhausted.

The Plan delegates management of MH/SUD outpatient services, including Prior Authorization, to United Behavioral Health d/b/a Optum Behavioral Health (OBH), its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor.

The Plan has national committees that approve M/S and MH/SUD outpatient services to be subject to Prior Authorization. Additionally, the Plan has a standard process for assessing the services that are subjected to Prior Authorization and whether they should be retained or removed from the Prior Authorization list. *Addendum A* includes the list of services categories subject to Prior Authorization. The Plan publishes the services subject to Prior Authorization on the provider portal(s) ([Advance Notification and Clinical Submission Requirements | UHCprovider.com](#) for M/S and [Optum - Provider Express Home](#) for MH/SUD). Members can learn what services are subject to Prior Authorization in their benefit plan document, through

<https://member.uhc.com/myuhc>, myuhc.com, or by contacting customer service.

Prior Authorization review of M/S outpatient services consists of the following:

Members are responsible for obtaining Prior Authorization for services rendered by OON providers. The member's benefit plan document (i.e., *Schedule of Benefits*) identifies the services for which the member is responsible for obtaining Prior Authorization and the required timeframe(s). The member or OON provider's submission of a request (notification) triggers the Prior Authorization process.

Members may submit Prior Authorization requests by phone, fax, or mail, in accordance with Plan requirements. OON providers may submit Prior Authorization requests on behalf of the member by phone, online or by fax (where required). Members or providers communicate basic information to create a case.

The Plan confirms receipt of the Prior Authorization request. Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. Non-clinical staff review cases to ensure availability of accurate and thorough case information. Non-clinical staff may approve coverage requests in scenarios where the member's plan documents allow and if a clinical review is not required. Non-clinical staff may administratively deny coverage when a member's benefits are exhausted. Non-clinical staff refer cases that they cannot approve or administratively deny to clinical reviewers.

First Level Clinical Review/Initial Review. Clinical reviewers (nurses) consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs. The clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. The clinical reviewer can approve cases that meet applicable clinical criteria.

Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Peer clinical reviewers (physician or mid-level practitioner) consult clinical criteria when making clinical coverage benefit determinations. Peer clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs. The peer clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If a peer clinical reviewer issues an adverse benefit determination, then the Plan communicates the adverse benefit determination, including appeal rights, and offers a peer-to-peer conversation consistent with state, federal, and accreditation requirements.

Adverse Benefit Determination. For M/S an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when member benefits are exhausted. Modified coverage requests that are approved are recorded as partial denials.

Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based medical clinical policies and use clinical criteria from third-party sources such as InterQual® or MCG® guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that outpatient Prior Authorization determinations are appropriate.

Per the M/S policy entitled, *Performance Assessment and Incentives*, at no time are initial or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons.

M/S generally structures UM processes to comply with federal Employee Retirement Income Security Act of 1974 (ERISA) requirements, NCQA UM standards, and state law where applicable.

Prior Authorization review of MH/SUD outpatient services consists of the following:

The Plan delegates management of MH/SUD outpatient services, including Prior Authorization, to United Behavioral Health d/b/a OBH, its delegated MH/SUD MBHO vendor.

Members are responsible for ensuring Prior Authorization is obtained by the OON provider administering the service. The OON provider must provide clinical information on the member's behalf. The member's benefit plan document (i.e., *Schedule of Benefits*) identifies the services for which the member is responsible for ensuring Prior Authorization is obtained. As outlined in the Plan document, OON providers must submit the Prior Authorization request before outpatient MH/SUD services are received.

OON providers may submit Prior Authorization requests on behalf of the member by telephone, online (for certain services) or by fax (where required). Providers communicate basic information to create a case. OON provider's submission of a request (notification) triggers the Prior Authorization process.

As described in the *Management of Behavioral Health Benefits Policy*, the Plan confirms receipt of the Prior Authorization request. Non-clinical staff confirm member eligibility and benefit coverage. Non-clinical staff may administratively deny coverage when member benefits are exhausted. Non-clinical staff may approve coverage requests that do not require clinical evaluation or interpretation based on the member's diagnosis and the clinical information submitted by providers. Non-clinical staff refer cases that they cannot approve or administratively deny to the initial clinical reviewers.

First Level Clinical Review/Initial Review. Clinical decisions are made by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse benefit determinations are made by Medical Directors or psychologists. Clinical reviewers consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether a service is medically necessary by reviewing the member's clinical information, the applicable clinical criteria or guidelines, and the Plan benefit terms. Clinical reviewers may request additional clinical information including, but not limited to, office or facility medical records, consultations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for certification, related diagnostic results, and history of related treatment and services. The clinical reviewer may approve cases that meet applicable clinical criteria.

Second Level Clinical Review/Peer Review. The initial clinical reviewer refers cases to a peer clinical reviewer for a peer-to-peer discussion if the case cannot be approved. The requesting provider is offered the opportunity to discuss the case with the peer clinical reviewer, consistent with state, federal, and accreditation requirements before an adverse benefit determination is issued. Only qualified peer clinical reviewers (e.g., Medical Directors or psychologists) can issue adverse benefit determinations. Peer clinical reviewers apply clinical criteria to member clinical information to determine coverage. If the requesting provider fails to complete the peer-to-peer discussion, the peer clinical reviewer makes a determination based on the information available. If a peer clinical reviewer issues an adverse benefit determination (e.g., number of treatments are not authorized), then the Plan timely communicates the adverse benefit determination, including appeal rights, to the member and provider consistent with applicable state, federal, and accreditation requirements.

Adverse Benefit Determination. For MH/SUD, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as a clinical denial when it is based on clinical criteria and member clinical information and is recorded as an administrative denial when member benefits are excluded.

Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity clinical coverage determinations on objective, evidence-based behavioral clinical policies or use clinical criteria from third-party sources such as American Society

of Addiction Medicine (ASAM) Criteria®, Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System-Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) and Early Childhood Service Intensity Instrument (ECSII) guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that outpatient Prior Authorization determinations are appropriate.

Per the MH/SUD policy entitled, *Core Principles and Practices*, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse clinical coverage benefit determinations (clinical denials) for financial reasons.

MH/SUD generally structures UM processes to comply with federal ERISA requirements, NCQA UM standards, and state law where applicable.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- Prior Authorization

Benefit Classification(s)

- OON, outpatient

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHC)

Plan Terms/Source Document(s)

In each of the Plan products, “Medically Necessary” is the Plan term used to guide Prior Authorization decision-making for both M/S and MH/SUD services. “Medically Necessary” is generally defined as follows:

- Medically Necessary – health care services are all of the following as determined by us or our designee:
 - In accordance with Generally Accepted Standards of Care.
 - Clinically appropriate, in terms of type, frequency, extent, service site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms.
 - Not mainly for your convenience or that of your doctor or other health care provider.
 - Not more costly than an alternative drug, service(s), service site or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.
- Generally Accepted Standards of Care are evidence based independent standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties. Valid, evidence based sources reflecting generally accepted standards of care include credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.
- If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We have the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be determined by us.
- We develop and maintain clinical policies that describe the Generally Accepted Standards of Care scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These

clinical policies (as developed by us and revised from time to time), are available to Covered Persons through www.myuhc.com or the telephone number on your ID card. They are also available to Physicians and other health care professionals on www.UHCprovider.com.”

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Prior Authorization is defined as:

“A required or mandatory clinical assessment for proposed service(s) based on clinical information provided and the terms of the health plan benefits before the service(s) are performed or delivered. Clinical and medical necessity requirements, level of care appropriateness, and the terms of the health plan benefits must be met in order for services to be covered by the member's plan.”

The *Optum National Policy Definitions List* defines pre-authorization (aka Prior Authorization) as “a form of prospective utilization review of health care services proposed to be provided to a member.”

The Plan's *Schedule of Benefits* notify members of the Prior Authorization requirements:

“We require prior authorization for certain Covered Health Care Services. Network providers are responsible for obtaining prior authorization before they provide these services to you.

We recommend that you confirm with us that all Covered Health Care Services have been prior authorized as required. Before receiving these services from a Network provider, you may want to call us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they do not prior authorize as required. You can call us at the telephone number on your ID card.

When you choose to receive certain Covered Health Care Services from out-of-Network providers, you are responsible for obtaining prior authorization before you receive these services. Note that your obligation to obtain prior authorization is also applicable when an out-of-Network provider intends to admit you to a Network facility or to an out-of-Network facility or refers you to other Network or out-of-Network providers. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization. Services for which you are required to obtain prior authorization are shown in the Schedule of Benefits table within each Covered Health Care Service category.

To obtain prior authorization, call the telephone number on your ID card. This call starts the utilization review process.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the Schedule of Benefits table to find out how far in advance you must obtain prior authorization.

For Covered Health Care Services that do not require you to obtain prior authorization, when you choose to receive services from out-of-Network providers, we urge you to confirm with us that the services you plan to receive are Covered Health Care Services. That is because in some instances, certain procedures may not be Medically Necessary or may not otherwise meet the definition of a Covered Health Care Service, and therefore are excluded. In other instances, the same procedure may meet the definition of Covered Health Care Services. By calling before you receive treatment, you can check to see if the service is subject to limitations or exclusions.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those received, our final coverage

determination will be changed to account for those differences, and we will only pay Benefits based on the services delivered to you. If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Care Service, you will be responsible for paying all charges and no Benefits will be paid.”

The role of the Plan’s delegate, United Behavioral Health d/b/a OBH, is discussed in the UMPD:

“United Behavioral Health (UBH) manages comprehensive behavioral health care delivery for members through a network of behavioral health practitioners, ancillary care providers, hospitals and other facilities. The management includes review of behavioral health care services (e.g., substance abuse and mental health requests for services).

UBH applies objective, evidence-based clinical criteria when making benefit coverage determinations while taking into account individual needs and the local delivery system. The clinical criteria are based on guidance produced by government sources, professional societies, and published research. In addition to making benefit coverage determinations, the clinical criteria inform discussions about evidence-based practices and discharge planning.

UBH selects externally developed clinical criteria and creates internally developed clinical criteria, where appropriate, based on its assessment of relevant guidance. The selection and development of clinical criteria incorporates:

- Annual review of clinical criteria and the procedures for applying them
- Involvement of appropriate stakeholders
- Dissemination of clinical criteria
- Ongoing monitoring and review of Centers for Medicare and Medicaid (CMS) Medicare Coverage Summaries, new or revised guidance in its CMS Local or National Coverage Determinations that are relevant to behavioral health
- Communication of updates to relevant areas

UBH uses the following clinical criteria:

- Clinical Criteria (Level of Care Utilization System-LOCUS) – Standardized level of care assessment tool developed by the American Association of Community Psychiatrists used to make clinical determinations and placement decisions for mental health disorder benefits for adults ages 19 and older when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (Child and Adolescent Level of Care/Service Intensity Utilization System-CALOCUS-CASII) – Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry (AACAP) and the American Association for Community Psychiatry (AAP) used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children and adolescents ages 6-18 when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (Early Childhood Service Intensity Instrument-ECSII) - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children ages 0-5 when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (American Psychological Association Psychological and Neuropsychological Testing Billing and Coding Guide) - Comprehensive billing and coding guide developed by the APA used for making clinical determinations for behavioral health psychological and neuropsychological testing services.
- Clinical Criteria (State or Contract Specific Supplemental Clinical Criteria) - Criteria used to make medical necessity determinations for mental health disorder benefits when there are explicit mandates or contractual requirements.
- Clinical Criteria (American Society of Addiction Medicine [ASAM]) - Criteria developed by the American Society of Addiction Medicine used to make clinical determinations for substance-related disorder benefits.
- Clinical Criteria (UBH Developed)
 - UBH Behavioral Clinical Policies: Criteria that stem from evaluation of new services or treatments or new applications of existing services or treatments and are used to make clinical determinations regarding proven or unproven services and treatments.

- UBH Supplemental Clinical Criteria: Criteria used to make clinical determinations for Applied Behavior Analysis and Electroconvulsive Therapy.
- UBH's Supplement to the APA Psychological and Neuropsychological Testing Billing and Coding Guide: Additional criteria used regarding provider qualifications, coverage rationale, limitations, and developmental testing.

The UBH UM Program is staffed by clinical, non-clinical and administrative personnel. A senior UBH Medical Director is responsible for directing and implementing the UM Programs. All clinical denials or adverse decisions are made by board certified psychiatrists, or, if the health plans choose, by a panel of other appropriate clinical peer reviewers. If the health plan chooses to use a panel to make adverse decisions, the panel contains at least one physician who is board certified in psychiatry. When the health care service under review is a mental health or substance abuse service, the adverse decision is made by a licensed physician who is board certified in psychiatry. Potential clinical denials are referred to a physician who is board certified in psychiatry for final determination.

An evaluation of the overall effectiveness of the Behavioral Health UM Program is conducted annually to determine how well resources have been deployed to improve UM activities and the clinical care and service provided to members.”

The Plan's terms require services to be medically necessary for coverage.

List of M/S and MH/SUD Services Subject to NQTL

Addendum A, attached, lists the M/S and MH/SUD OON outpatient service categories subject to Prior Authorization requirements. Prior Authorization is one component of the UM program that evaluates whether a benefit or service is medically necessary.

- The “Member” tab lists the service categories for which the member is responsible for obtaining authorization for OON services. The “Member” tab includes all products in the scope of the analysis
- The “Provider” tab lists the service categories for which the provider is responsible for obtaining authorization for in-network (INN) services. The “Provider” tab applies to all products in the scope of the analysis

Step 2 – Factors Used in the Design and Application of the NQTL

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

The Prior Authorization list was originally designed by enterprise clinical leadership. Prior Authorization was applied to new services when they became covered by the Plan and met certain criteria. Examples of Prior Authorization determinants that existed in the business at this time included:

- to monitor and prevent potential overutilization and under-utilization
- manage high-cost and prolonged-duration services
- ensure enrollee safety
- determine the appropriate level of care
- determine whether the service or item is medically necessary

The factors relied upon to determine which OON outpatient services by category were subjected to Prior Authorization were updated and replaced 2021 with the factors Clinical Appropriateness, Value, and Variation as defined below. After this time, all M/S services subject to Prior Authorization must meet Clinical Appropriateness and all MH/SUD services subject to Prior Authorization must meet Clinical Appropriateness and at least one of the other factors.

Starting in 2022, any additions or deletions to the Prior Authorization list were reviewed and approved through committees.

The Plan relies on the following factors to determine which OON outpatient services are added to the Prior Authorization list.

These factors apply to M/S and MH/SUD benefits for the following:

- I. M/S OON outpatient services
- II. MH/SUD OON outpatient services

- Clinical Appropriateness (Qualitative)

Applies to M/S and MH/SUD services

- Value (Quantitative)

Applies to M/S and MH/SUD services

- Variation (Quantitative)

Applies to M/S and MH/SUD services

For M/S meeting Clinical Appropriateness is determinative in imposing the limitation for MH/SUD meeting Clinical Appropriateness plus Value and/or Variation is determinative in imposing the limitation. The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL.

In 2023, to further refine how decisions are made to subject M/S and MH/SUD OON outpatient services to Prior Authorization, the enterprise adopted factors to be assessed when considering whether to remove or retain services on the enterprise Prior Authorization list. These changes were implemented September 2023. The assessment first considered the factors for removal of the service from the Prior Authorization list. If the service met a removal factor, the Plan then assessed if the service met a retention factor. Services that met a retention factor were retained on the Prior Authorization list. Services that did not meet a removal factor remained on the Prior Authorization list based on the original add factors.

The Plan relies on the following factors to determine which OON outpatient benefits are removed from the Prior Authorization list. These factors apply to M/S and MH/SUD and M/S benefits for the following:

- I. M/S: OON outpatient services
- II. MH/SUD: OON outpatient services

- Low Value (Quantitative)

- Consistency (Quantitative)

Applies to M/S and MH/SUD OON outpatient services.

- Low Volume (Quantitative)

Applies to M/S and MH/SUD OON outpatient services.

Please note that if the primary code within a code family meets the requirements for removal, the family of codes will be addressed in a similar fashion per medical policy and clinical practice patterns.

The Plan then relies on the following factors to determine which OON outpatient benefits are retained on the Prior Authorization list. These factors apply to M/S and MH/SUD and M/S benefits for the following:

- I. M/S: OON outpatient services
- II. MH/SUD: OON outpatient services

- Services that are experimental, investigational, or unproven (EIU) (Qualitative)

Applies to M/S and MH/SUD OON outpatient services.

- Patient Safety (Qualitative)

Applies to M/S and MH/SUD OON outpatient services.

- Level of Care (Quantitative)

-

Applies to M/S and MH/SUD OON outpatient services.

- High-Cost Drugs and Services that are greater than \$100,000 (Quantitative)

For M/S meeting Clinical Appropriateness is determinative in imposing the limitation. For MH/SUD meeting Clinical Appropriateness plus Value and/or Variation is determinative in imposing the limitation. If the service met a removal factor, the Plan then assessed if the service met a retention factor. Services that met a retention factor were retained on the Prior Authorization list. Meeting any one of the factors is determinative in retaining the limitation. The factors are not weighted in that no individual factor carries more value than another in retaining the NQTL.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factors used to add services to the Plan's Prior Authorization requirement for OON outpatient services. These evidentiary standards and sources apply to benefits for the following:

- I. M/S OON outpatient services
- II. MH/SUD OON outpatient services

Factor – Clinical Appropriateness

These evidentiary standards and sources apply to M/S and MH/SUD OON outpatient services and are defined in a qualitative manner.

Factor – Value

This evidentiary standard and sources apply to M/S and MH/SUD OON outpatient services and are defined in a quantitative manner.

Factor – Variation

The evidentiary standard and source applies to M/S and MH/SUD OON outpatient services and are defined in a quantitative manner.

For M/S meeting Clinical Appropriateness is determinative in imposing the limitation. For MH/SUD meeting Clinical Appropriateness plus Value and/or Variation is determinative in imposing the limitation. The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL.

In 2023, to further refine how decisions are made to subject M/S and MH/SUD OON outpatient services to Prior Authorization, the enterprise adopted factors to be assessed when considering whether to remove or retain services on the enterprise Prior Authorization list. These changes were implemented September 2023. The assessment first considered the factors for removal of the service from the Prior Authorization list. If the service met a removal factor, the Plan then assessed if the service met a retention factor. Services that met a retention factor were retained on the Prior Authorization list. Services that did not meet a removal factor remained on the Prior Authorization list based on the original add factors.

The Plan relies on the following factors to determine which OON outpatient benefits are removed from the Prior Authorization list. These factors apply to M/S and MH/SUD and M/S benefits for the following:

- I. M/S: OON outpatient services
- II. MH/SUD: OON outpatient services

Factor - Low Value

The evidentiary standard and the sources apply to M/S and MH/SUD OON outpatient services and are defined in a quantitative manner.

Factor -

The evidentiary standard and the source apply to M/S and MH/SUD OON outpatient services and are defined in a quantitative manner.

Factor - Low Volume

The evidentiary standard and the source apply to M/S and MH/SUD OON outpatient services and are defined in a quantitative manner.

The Plan then relies on the following factors to determine which OON outpatient benefits are retained on the Prior Authorization list. These factors apply to M/S and MH/SUD and M/S benefits for the following:

- I. M/S: OON outpatient services
- II. MH/SUD: OON outpatient services

Factor - Services that are EIU

The evidentiary standard and the source apply to M/S and MH/SUD OON outpatient services and are defined in a qualitative manner.

Factor - Patient Safety

These evidentiary standards and the sources apply to M/S and MH/SUD OON outpatient services and are defined in a qualitative manner.

Factor - Level of Care

These evidentiary standards and the sources apply to M/S and MH/SUD OON outpatient services and are defined in a quantitative manner.

Factor - High-Cost Drugs and Services that are greater than \$100,000

The evidentiary standard and the source applies to M/S and MH/SUD OON outpatient services and are defined in a quantitative manner.

If the service met a removal factor, the Plan then assessed if the service met a retention factor. Services that met a retention factor were retained on the Prior Authorization list. Meeting any one of the factors is determinative in retaining the limitation. The factors are not weighted in that no individual factor carries more value than another in retaining the NQTL.

The factors and evidentiary standards used as the basis for subjecting MH/SUD OON outpatient benefits to Prior Authorization are comparable to, and applied no more stringently than, the factors and evidentiary standards used as the basis for subjecting M/S OON outpatient benefits to Prior Authorization “as written” and “in operation.”

Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan's or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The findings of the Plan's comparative analyses confirmed the strategies, processes, factors, evidentiary standards, and source information used to determine the MH/SUD OON outpatient services subject to Prior Authorization were comparable to, and applied no more stringently than, the strategies, processes, factors, evidentiary standards, and source information used to determine the M/S OON outpatient services subject to Prior Authorization “as written.” For M/S and MH/SUD OON outpatient benefits, the *Prior Authorization Factor Grid(s)* included with this analysis detail the shared factors used as the basis for adding, removing, or retaining M/S and MH/SUD OON outpatient services on the Prior Authorization list, as described above.

The Plan found the factors used to add to, remove, or retain MH/SUD OON outpatient services on the Prior Authorization list were comparable to, and applied no more stringently than, the factors used to add to, remove, or retain M/S OON outpatient services on the Prior Authorization list. OON M/S and MH/SUD outpatient services that met the applicable factor(s) were subject to Prior Authorization review “in operation.”

Conclusions

The Plan reviewed the M/S and MH/SUD Prior Authorization policies and procedures and concluded the methodology used to determine which MH/SUD OON outpatient services are subject to Prior Authorization “as written” were comparable to, and applied no more stringently than, the methodology used to determine which M/S OON outpatient services are subject to Prior Authorization “as written.” Additionally, the Plan concluded that how Prior Authorization is applied to MH/SUD OON outpatient services was comparable to, and applied no more stringently than, how Prior Authorization is applied to M/S OON outpatient services “as written.”

The Plan reviewed the M/S and MH/SUD processes including responsibility for submission, timeframes for submission and review, notification to members and providers, clinical standards for review, staff qualifications, outcomes data, and IRR assessment results and concluded how the Plan conducts Prior Authorization for MH/SUD OON outpatient services “in operation” was comparable to, and applied no more stringently than, how the Plan conducts Prior Authorization for M/S OON outpatient services “in operation.”

Reimbursement Policy-Coding Edits Non-Quantitative Treatment Limitation (NQTL) Analysis

GA – UnitedHealthcare Insurance Company, UnitedHealthcare of Georgia, Inc., UnitedHealthcare Insurance Company of the River Valley
12/29/2023

Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical/surgical (M/S) benefits. This generally means that the financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements, such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage.

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

Per the Plan’s *Certificate of Coverage*, the Plan reviews and determines benefits in accordance with reimbursement policies.

Process

Per the M/S *UHC Provider Administrative Guide* and the MH/SUD *Optum National Network Manual*, providers are required to timely submit complete claims with accurate coding. For example, coding must comply with nationally recognized CMS’ Correct Coding Initiative (CCI) standards. UHC Plan documents reflect M/S and MH/SUD coverage determinations are made in accordance with the Plan’s reimbursement policies.

Both M/S *UnitedHealthcare Commercial Reimbursement Policies* and MH/SUD *Optum Reimbursement Policies* are publicly available to providers through the respective provider portals (M/S: <https://www.uhcprovider.com/en/policies-protocols/commercial-policies/commercial-reimbursement-policies.html> and MH/SUD: <https://www.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/reimbursement-policies.html>). Providers are made aware of changes to these policies on [UHCprovider.com/networknews](https://www.uhcprovider.com/networknews) > Network Bulletin.

Reimbursement Policy Development

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, plan terms, and policies at issue. Identification of the specific MH/SUD and medical/surgical benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as medical/surgical.

Specific NQTL

- Development and application of reimbursement policies

Benefit Classification(s)

Reimbursement Policy-Coding Edits Non-Quantitative Treatment Limitation (NQTL) Analysis

GA – UnitedHealthcare Insurance Company, UnitedHealthcare of Georgia, Inc., UnitedHealthcare Insurance Company of the River Valley
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- Applies to all benefit classifications

Plan(s) at Issue

- Applies to all plans

Plan Terms/Source Document(s)

The following language is reflected in the Plan's Certificate of Coverage documents:

Review and Determine Benefits in Accordance with our Reimbursement Policies

"We develop our reimbursement policy guidelines, as we determine, in accordance with one or more of the following methodologies:

- As shown in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS).
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that we accept.

Following evaluation and validation of certain provider billings (e.g., error, abuse, and fraud reviews), reimbursement policies are applied to provider billings. We share our reimbursement policies with Physicians and other providers in our Network through our provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by our reimbursement policies) and the billed charge. However, out-of-Network providers may bill you for any amounts we do not pay, including amounts that are denied because one of our reimbursement policies does not reimburse (in whole or in part) for the service billed. You may get copies of our reimbursement policies for yourself or to share with your out-of-Network Physician or provider by contacting us at www.myuhc.com or the telephone number on your ID card.

We may apply a reimbursement methodology established by OptumInsight and/or a third-party vendor, which is based on CMS coding principles, to determine appropriate reimbursement levels for Emergency Health Care Services. The methodology is usually based on elements reflecting the patient complexity, direct costs, and indirect costs of an Emergency Health Care Service. If the methodology(ies) currently in use become no longer available, we will use a comparable methodology(ies). We and OptumInsight are related companies through common ownership by UnitedHealth Group. Refer to our website at www.myuhc.com for information regarding the vendor that provides the applicable methodology."

INN providers adhere to the Plan's *UHC Provider Administrative Guide (M/S)* and the *Optum National Network Manual (MH/SUD)*, while OON providers are guided by the member's Plan documents. The *UHC Provider Administrative Guide (M/S)* states:

Reimbursement policies:

"We apply reimbursement policies. Our reimbursement policies are available online at:

- uhcprovider.com/policies > For Commercial Plans > Reimbursement Policies for UnitedHealthcare Commercial Plans.
- uhcprovider.com/policies > For Medicare Advantage Plans > Reimbursement Policies for Medicare Advantage Plans.
- uhcprovider.com/policies > For Exchange Plans > Reimbursement Policies for UnitedHealthcare Individual Exchange Plans.

River Valley

- Claim payment is subject to reimbursement policies on uhcprovider.com/policies > Commercial Policies >

Reimbursement Policy-Coding Edits Non-Quantitative Treatment Limitation (NQTL) Analysis

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Reimbursement Policies for Commercial. Claims Estimator tools are not available for River Valley members.

- We will inform you of changes to these policies on uhcprovider.com/news.
- Coding edits may also affect reimbursements. We apply coding edits based primarily on the NCCI edits developed by the Centers for Medicare and Medicaid Services (CMS), as well as the CMS' Outpatient Code Editor (OCE). You may find NCCI and OCE edits on cms.gov > Medicare > Coding > National Correct Coding Initiative Edits
- uhcprovider.com/policies > For River Valley > Reimbursement Policies for UnitedHealthcare Commercial Plans

We use the terms “reimbursement policies” and “payment policies” interchangeably.”

The *Optum Reimbursement Policies*:

Our reimbursement policies are available online at: [Reimbursement Policies \(providerexpress.com\)](https://uhcprovider.com/policies)

List of M/S and MH/SUD Services Subject to NQTL

All covered M/S and MH/SUD services are subject to reimbursement policies as described in the Plan documents and reimbursement policies.

Step 2 – Factors Used in the Design and Application of the NQTL

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH or SUD benefits and medical or surgical benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and medical/surgical benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factors used in designing the Plan's M/S and MH/SUD reimbursement policies.

Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the plan's or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources

Reimbursement Policy-Coding Edits Non-Quantitative Treatment Limitation (NQTL) Analysis

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identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the plan or coverage is or is not in compliance with MHPAEA.

Findings

The findings of the Plan's analysis confirmed the strategies, processes, factors, evidentiary standards, and source information used to develop the MH/SUD reimbursement policies were comparable to, and applied no more stringently than, the strategies, processes, factors, evidentiary standards, and source information used to develop the M/S reimbursement policies.

Conclusions

The Plan reviewed the M/S and MH/SUD reimbursement policies and procedures and concluded the methodology used to develop the MH/SUD reimbursement policies "as written" was comparable to, and applied no more stringently than, the methodology used to develop the M/S reimbursement policies "as written." Additionally, the Plan concluded that the MH/SUD reimbursement policies were applied no more stringently than, the M/S reimbursement policies were applied "as written."

The Plan reviewed the M/S and MH/SUD processes for applying the reimbursement policies and found they were comparable and no more stringently applied for MH/SUD. Additionally, from review of the M/S and MH/SUD processes for applying the reimbursement policies, including notification, timeframes for processing, determinations, and determination communications, the Plan concluded the methodology used to apply the MH/SUD reimbursement policies "in operation" was comparable to, and applied no more stringently than, the methodology used to apply the M/S reimbursement policies "in operation."

Retrospective Review In-Network Inpatient Non-Quantitative Treatment Limitations (NQTL) Analysis

GA – UnitedHealthcare Insurance Company, UnitedHealthcare of Georgia,
Inc. and UnitedHealthcare Insurance Company of the River Valley
12/29/2023

Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical/surgical (M/S) benefits. This generally means that the financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements, such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage.

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

Retrospective Review is a component of the Plan’s Utilization Management (UM) program. Medical directors and other clinical staff review services in order to detect and better manage over- and under-utilization and determine whether the services reviewed are consistent with the member’s coverage, medically appropriate, and consistent with evidence-based guidelines. Retrospective Review assesses the appropriateness of services on a case-by-case basis after the service has been provided but prior to payment for services. Retrospective Reviews are based on established review guidelines and may include:

- Review of medical necessity
- Appropriateness of level of care
- Identifying claims issues
- Eligibility determination
- Initiation of appropriate follow-up actions for utilization and quality issues

The Plan conducts medical necessity Retrospective Review of claims/requests for certain inpatient services that have not previously been reviewed as part of the Prior Authorization or Concurrent Review processes. The Plan may conduct Retrospective Review if the service or procedure codes do not match a diagnosis code, if services are experimental, investigational, or unproven (EIU), or if the services are subject to benefit limits/exclusions. The Plan conducts medical necessity Retrospective Review for inpatient services where Prior Authorization was required, but not obtained upon claim submission. INN M/S providers may also request Retrospective Review of inpatient claims that are denied.

This document includes the following information:

- The Retrospective Review process for M/S and MH/SUD inpatient services
- The description of the NQTL and application (Step 1)
- Factor used to determine which services are subject to the NQTL (Step 2)
- Evidentiary standards and sources used to define, trigger and/or implicate the factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

This comparative analysis refers to the following attachments:

Retrospective Review In-Network Inpatient Non-Quantitative Treatment Limitations (NQTL) Analysis

GA – UnitedHealthcare Insurance Company, UnitedHealthcare of Georgia,
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- *Utilization Management Program Description (UMPD) of United HealthCare Services, Inc. and UnitedHealthcare Insurance Company* - Summarizes the philosophy, structure and standards that govern UHC's medical management, UM and utilization review responsibilities and functions
- *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions* - M/S policy that defines Retrospective Review
- *Optum National Policy Definitions List* - MH/SUD policy that defines Retrospective Review
- *M/S Retrospective Review Codes* – Excel document that lists M/S codes that may be subject to Retrospective Review
- *Certificates of Coverage* (for example: *COC23-INS-2018-LG-GA*, *COC23-HMO-2018-LG-GA*, *COC23-INS-2018-SG-GA*, and *COC23-INS-RV-2018-LG-GA*) - Plan document that explains covered services, terms, conditions, and limitations of the member's policy
- *Core Principles and Practices* - MH/SUD policy that outlines the core principles and practices that should be used by personnel in their interactions with members, authorized member representatives, practitioners, and facilities, related to the management of behavioral health benefits, coverage determinations and appeals/grievances of non-coverage determinations
- *Performance Assessment and Incentives* - M/S policy confirming that clinical reviewers are not incented to make denials for financial reasons
- *2023 UnitedHealthcare Provider Administrative Guide* – Informs M/S providers of the Prior Authorization process. The *UnitedHealthcare Provider Administrative Guide* can be accessed on the website <https://www.uhcprovider.com/en/admin-guides.html>
- *September 2023 Optum National Network Manual* - Informs MH/SUD providers of the Prior Authorization process. <https://public.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/optum-network-manual.html>
- *Medical Necessity NQTL* – Comparative analysis that describes the processes, strategies, evidentiary standards and other factors used to apply medical necessity to M/S and MH/SUD services in accordance with MHPAEA and other regulatory guidance

The Plan concludes that the Retrospective Review requirements for M/S and MH/SUD are comparable and applied no more stringently to MH/SUD in-network (INN) inpatient benefits both “as written” and “in operation.”

Process

The Plan structures inpatient Retrospective Review processes to be compliant with all applicable federal and state laws. Retrospective Review is governed at both the state and federal level, which includes consumer protections such as external review for adverse benefit determinations after internal appeals options are exhausted.

The Plan delegates management of MH/SUD inpatient services, including Retrospective Review to United Behavioral Health d/b/a Optum Behavioral Health (OBH), its delegated MH/SUD Managed Behavioral Healthcare Organization (MBHO) vendor.

Retrospective Review of M/S Inpatient Admissions consists of the following:

Retrospective Review for certain inpatient services begins after the Plan receives claims or notification of inpatient admission post discharge from an INN facility. The Plan conducts medical necessity Retrospective Review of claims/requests for certain inpatient services that have not previously been reviewed as part of the Prior Authorization or Concurrent Review processes. The Plan may conduct Retrospective Review if the service or procedure codes do not match a diagnosis code, if services EIU, or if the services are subject to benefit limits/exclusions. The Plan conducts medical necessity Retrospective Review for inpatient services where Prior Authorization was required but not obtained upon claim submission.

Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. If needed, non-clinical staff request medical records for claims containing services that are subject to Retrospective Review. When medical records are received, the case is referred to clinical reviewers to assess medical necessity.

Retrospective Review In-Network Inpatient Non-Quantitative Treatment Limitations (NQTL) Analysis

GA – UnitedHealthcare Insurance Company, UnitedHealthcare of Georgia, Inc. and UnitedHealthcare Insurance Company of the River Valley
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First Level Clinical Review/Initial Review. The clinical reviewer (physicians or nurses) reviews the claim to determine if the inpatient service billed meets clinical criteria for coverage based on application of objective, evidence-based clinical criteria, nationally recognized guidelines, and the member's benefit plan documents. Clinical reviewers either approve claims for payment or refer claims to peer clinical reviewers (e.g., Medical Directors).

Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If a peer clinical reviewer determines that a service was not medically necessary, then an adverse benefit determination will be issued for the claim. The Plan communicates the adverse benefit determination, including applicable appeal rights, and offers a peer-to-peer conversation consistent with state, federal, and accreditation requirements. Appeal rights are set forth in the member's benefit plan document (*Certificate of Coverage*). The Plan communicates results of Retrospective Review within 30 days of receipt of a claim.

Adverse Benefit Determination. For M/S, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when benefits are exhausted. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials.

Clinical Criteria: Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based medical clinical policies or use clinical criteria from third party sources such as InterQual® or MCG® guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that Retrospective Review determinations are appropriate.

Per the M/S policy entitled, *Performance Assessment and Incentives*, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons.

M/S generally structures UM processes to comply with federal Employee Retirement Income Security Act of 1974 (ERISA) requirements, and state law where applicable.

Retrospective Review of MH/SUD Inpatient Admissions consist of the following:

The Plan delegates management of MH/SUD inpatient services, including Retrospective Review to United Behavioral Health d/b/a OBH, its delegated MH/SUD MBHO vendor.

MH/SUD claims/requests for inpatient services submitted by INN providers may be subject to Retrospective Review if the service or procedure code required Prior Authorization or Concurrent Review, but that review was not conducted and there is a mitigating circumstance. Additionally, claims may be subject to Retrospective Review if the billed services or procedure codes do not match the authorized codes or if services are EIU.

Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. If needed, non-clinical staff request medical records for requests or claims containing services that are subject to Retrospective Review. When medical records are received, the case is referred to clinical reviewers to assess medical necessity.

First Level Clinical Review/Initial Review. The clinical reviewer (e.g., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) review the claim to determine if the inpatient admission billed meets clinical criteria for coverage based on application of objective, evidence-based, clinical criteria, or nationally recognized guidelines. Clinical reviewers either approve requests for payment or refer requests to peer clinical reviewers (Medical Directors).

Retrospective Review In-Network Inpatient Non-Quantitative Treatment Limitations (NQTL) Analysis

GA – UnitedHealthcare Insurance Company, UnitedHealthcare of Georgia, Inc. and UnitedHealthcare Insurance Company of the River Valley
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Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If the peer clinical reviewer determines that an admission was not medically necessary, then an adverse benefit determination will be issued for the claim. The Plan communicates the adverse benefit determination, including applicable appeal rights. Appeal rights are set forth in the member's benefit plan document (*Certificate of Coverage*). The Plan communicates results of Retrospective Review within 30 days of receipt of a request/claim.

Adverse Benefit Determination. For MH/SUD, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when benefits are exhausted. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials.

Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based behavioral clinical policies or use clinical criteria from third party sources such as American Society of Addiction Medicine (ASAM) Criteria®, Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System-Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) and Early Childhood Service Intensity Instrument (ECSII) guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that inpatient Retrospective Review determinations are appropriate.

Per the MH/SUD policy entitled, *Core Principles and Practices*, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse clinical coverage benefit determinations (clinical denials) for financial reasons.

MH/SUD generally structures UM processes to comply with federal ERISA requirements, and state law where applicable.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- Retrospective Review

Benefit Classification(s)

- INN, inpatient

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHIC)
- UnitedHealthcare of Georgia, Inc. (UHCGA)
- UnitedHealthcare Insurance Company of the River Valley (UHICRV)

Plan Terms

The Plan's *Schedule of Benefits* notify members of Retrospective Review requirements.

"The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, Concurrent Review, case management, discharge planning, retrospective review or similar programs."

The *Utilization Management Program Description (UMPD)* discusses Post-Service Reviews and indicates:

"Post-service review assesses the appropriateness of medical services on a case-by-case basis after the service has been

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provided but prior to payment for services. Post-service reviews are based on established review guidelines and includes:

- Review of medical necessity;
- Appropriateness of level of care;
- Identifying claims issues;
- Eligibility determination;
- Initiation of appropriate follow-up actions for utilization and quality issues; and
- Identifying appropriateness and administrative issues such as physician notification, emergency status of admission.”

The Plan’s delegate, United Behavioral Health d/b/a OBH, is discussed in the *UMPD*:

“United Behavioral Health (UBH) manages comprehensive behavioral health care delivery for members through a network of behavioral health practitioners, ancillary care providers, hospitals and other facilities. The management includes review of behavioral health care services (e.g., substance abuse and mental health requests for services).

UBH applies objective, evidence-based clinical criteria when making benefit coverage determinations while taking into account individual needs and the local delivery system. The clinical criteria are based on guidance produced by government sources, professional societies, and published research. In addition to making benefit coverage determinations, the clinical criteria inform discussions about evidence-based practices and discharge planning.

UBH selects externally developed clinical criteria and creates internally developed clinical criteria, where appropriate, based on its assessment of relevant guidance. The selection and development of clinical criteria incorporates:

- Annual review of clinical criteria and the procedures for applying them
- Involvement of appropriate stakeholders
- Dissemination of clinical criteria
- Ongoing monitoring and review of Centers for Medicare and Medicaid (CMS) Medicare Coverage Summaries, new or revised guidance in its CMS Local or National Coverage Determinations that are relevant to behavioral health
- Communication of updates to relevant areas

UBH uses the following clinical criteria:

- Clinical Criteria (Level of Care Utilization System-LOCUS) – Standardized level of care assessment tool developed by the American Association of Community Psychiatrists used to make clinical determinations and placement decisions for mental health disorder benefits for adults ages 19 and older when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (Child and Adolescent Level of Care/Service Intensity Utilization System-CALOCUS-CASII) – Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry (AACAP) and the American Association for Community Psychiatry (AACP) used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children and adolescents ages 6-18 when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (Early Childhood Service Intensity Instrument-ECSII) - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children ages 0-5 when State or Contract Specific Level of Care Guidelines do not apply.

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- Clinical Criteria (American Psychological Association Psychological and Neuropsychological Testing Billing and Coding Guide) - Comprehensive billing and coding guide developed by the APA used for making clinical determinations for behavioral health psychological and neuropsychological testing services.
- Clinical Criteria (State or Contract Specific Supplemental Clinical Criteria) - Criteria used to make medical necessity determinations for mental health disorder benefits when there are explicit mandates or contractual requirements.
- Clinical Criteria (American Society of Addiction Medicine [ASAM]) - Criteria developed by the American Society of Addiction Medicine used to make clinical determinations for substance-related disorder benefits.
- Clinical Criteria (UBH Developed)
 - UBH Behavioral Clinical Policies: Criteria that stem from evaluation of new services or treatments or new applications of existing services or treatments and are used to make clinical determinations regarding proven or unproven services and treatments.

The UBH UM Program is staffed by clinical, non-clinical and administrative personnel. A senior UBH Medical Director is responsible for directing and implementing the UM Programs. All clinical denials or adverse decisions are made by board certified psychiatrists, or, if the health plans choose, by a panel of other appropriate clinical peer reviewers. If the health plan chooses to use a panel to make adverse decisions, the panel contains at least one physician who is board certified in psychiatry. When the health care service under review is a mental health or substance abuse service, the adverse decision is made by a licensed physician who is board certified in psychiatry. Potential clinical denials are referred to a physician who is board certified in psychiatry for final determination.

An evaluation of the overall effectiveness of the Behavioral Health UM Program is conducted annually to determine how well resources have been deployed to improve UM activities and the clinical care and service provided to members.”

The Plan’s terms require services to be medically necessary for coverage. INN providers are required to comply with the Plan’s UM protocols including complying with Retrospective Review requirements.

Step 2 – Factors Used to Determine Retrospective Review Applies

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

The Plan relies on the following factor to determine which INN inpatient admissions are subject to Retrospective Review. This factor applies to M/S and MH/SUD for the following:

- I. M/S INN inpatient admissions
 - II. MH/SUD INN inpatient admissions
- Consistency with Clinical Criteria (Qualitative):

This factor applies to M/S and MH/SUD services. Meeting Consistency with Clinical Criteria is determinative in imposing the limitation.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or

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Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factor used in designing or applying the Plan's Retrospective Review requirement to INN inpatient services. These evidentiary standards and sources apply to the following:

- I. M/S INN inpatient admissions
- II. MH/SUD INN inpatient admissions

Factor: Consistency with Clinical Criteria

The Plan's evidentiary standards and sources apply to M/S and MH/SUD services. The Consistency with Clinical Criteria factor, evidentiary standards, and sources are defined in a qualitative manner.

The factor and evidentiary standards used as the basis for subjecting MH/SUD INN inpatient benefits to Retrospective Review are comparable to, and applied no more stringently than, the factor and evidentiary standards used as the basis for subjecting M/S INN inpatient benefits to Retrospective Review "as written" and "in operation."

Step 4 – NQTL "As Written" and "In Operation" Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The findings of the Plan's comparative analyses confirmed the strategies, processes, factor, evidentiary standards, and source information used to subject certain MH/SUD INN inpatient services to Retrospective Review were comparable to, and applied no more stringently than, the strategies, processes, factor, evidentiary standards, and source information used to subject certain M/S INN inpatient services to Retrospective Review "as written."

The Plan found the factor used to subject INN MH/SUD inpatient services to Retrospective Review was comparable to and applied no more stringently than the factor used to subject INN M/S inpatient services to Retrospective Review "in operation." All M/S and MH/SUD inpatient admissions were subject to Retrospective Review if they were not reviewed via Prior Authorization or Concurrent Review. Additionally, M/S and MH/SUD claims for inpatient services submitted by INN providers were subject to Retrospective Review if the services or procedure codes did not match a diagnosis code, if services were EIU, or if the services had benefit limits/exclusions. Claims/requests for inpatient services submitted by INN providers may be subject to Retrospective Review if the service or procedure code required Prior Authorization or Concurrent Review, but that review was not conducted and there is a mitigating circumstance.

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Conclusions

The Plan concluded that how Retrospective Review is applied to MH/SUD INN inpatient services was comparable to, and applied no more stringently than, how Retrospective Review is applied to M/S INN inpatient services “as written.”

The Plan reviewed the M/S and MH/SUD processes including responsibility for submission, timeframes for submission and review, notification to members and providers, clinical standards for review, staff qualifications, and outcome data and concluded how the Plan conducts Retrospective Review for MH/SUD INN inpatient services “in operation” was comparable to, and applied no more stringently than, how the Plan conducts Retrospective Review for M/S INN inpatient services “in operation.”

Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical/surgical (M/S) benefits. This generally means that financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements, such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage.

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

Retrospective Review is a component of the Plan’s Utilization Management (UM) program. Medical directors and other clinical staff review services in order to detect and better manage over- and under-utilization and determine whether the services reviewed are consistent with the member’s coverage, medically appropriate, and consistent with evidence-based guidelines. Retrospective Review assesses the appropriateness of services on a case-by-case basis after the service has been provided, but prior to payment for services. Retrospective Reviews are based on established review guidelines and may include:

- Review of medical necessity
- Appropriateness of level of care
- Identifying claims issues
- Eligibility determination
- Initiation of appropriate follow-up actions for utilization and quality issues

The Plan conducts medical necessity Retrospective Review of claims/requests for certain outpatient services that have not previously been reviewed as part of the Prior Authorization or Concurrent Review processes. The Plan may conduct Retrospective Review if the service or procedure codes do not match a diagnosis code, if services are experimental, investigational, or unproven (EIU), or if the services are subject to benefit limits/exclusion. The Plan conducts medical necessity Retrospective Review for outpatient services where Prior Authorization was required, but not obtained upon claim submission. INN M/S providers may also request Retrospective Review of outpatient claims that are denied.

This document includes the following information:

- The Retrospective Review process for M/S and MH/SUD outpatient services
- The description of the NQTL and application (Step 1)
- Factor used to determine which services are subject to the NQTL (Step 2)
- Evidentiary standards and sources used to define, trigger and/or implicate a factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

This comparative analysis refers to the following attachments:

- *Utilization Management Program Description (UMPD) of United HealthCare Services, Inc. and UnitedHealthcare Insurance Company* - Summarizes the philosophy, structure and standards that govern UHC's medical management, UM and utilization review responsibilities and functions
- *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions* - M/S policy that defines Retrospective Review
- *Optum National Policy Definitions List* - MH/SUD policy that defines Retrospective Review
- *M/S Retrospective Review Codes* - Excel document that lists M/S codes that may be subject to Retrospective Review
- *Certificates of Coverage* (for example: *COC23-INS-2018-LG-GA*, *COC23-HMO-2018-LG-GA*, and *COC23-INS-2018-SG-GA*) - Plan document that explains covered services, terms, conditions, and limitations of the member's policy
- *Core Principles and Practices* - MH/SUD policy that outlines the core principles and practices that should be used by personnel in their interactions with members, authorized member representatives, practitioners, and facilities, related to the management of behavioral health benefits, coverage determinations and appeals/grievances of non-coverage determinations
- *Performance Assessment and Incentives* - M/S policy confirming that clinical reviewers are not incented to make denials for financial reasons
- *2023 UnitedHealthcare Provider Administrative Guide* - Informs M/S providers of the Prior Authorization process. The *UnitedHealthcare Provider Administrative Guide* can be accessed on the website <https://www.uhcprovider.com/en/admin-guides.html>
- *September 2023 Optum National Network Manual* - Informs MH/SUD providers of the Prior Authorization process. <https://public.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/optum-network-manual.html>
- *Medical Necessity NQTL* - Comparative analysis that describes the processes, strategies, evidentiary standards and other factors used to apply medical necessity to M/S and MH/SUD services in accordance with MHPAEA and other regulatory guidance

The Plan concludes that the Retrospective Review requirements for M/S and MH/SUD are comparable and applied no more stringently to MH/SUD in-network (INN) outpatient benefits both “as written” and “in operation.”

Process

The Plan structures outpatient Retrospective Review processes to be compliant with all applicable federal and state laws. Retrospective Review is governed at both the state and federal level, which includes consumer protections such as external review for adverse benefit determinations after internal appeals options are exhausted.

The Plan delegates management of MH/SUD outpatient services, including Retrospective Review to United Behavioral Health d/b/a Optum Behavioral Health (OBH), its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor.

Retrospective Review of M/S Outpatient Services consists of the following:

Retrospective Review for certain outpatient services begins after the Plan receives claims from INN providers. The Plan conducts medical necessity Retrospective Review of claims/requests for certain outpatient services that have not previously been reviewed as part of the Prior Authorization or Concurrent Review processes. The Plan may conduct Retrospective Review if the service or procedure codes do not match a diagnosis code, if services are EIU, or if the services are subject to benefit limits/exclusion. The Plan also conducts medical necessity Retrospective Review for outpatient services where Prior Authorization was required, but not obtained upon claim submission. INN providers may also request Retrospective Review of outpatient claims that are denied.

Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. If needed, non-clinical staff request medical records for claims containing services that are subject to Retrospective Review. When medical records are received, the case is referred to clinical reviewers to assess medical necessity.

First Level Clinical Review/Initial Review. The clinical reviewer (physician or nurse) reviews the claim to determine if the outpatient service billed meets clinical criteria for coverage based on application of objective, evidence-based clinical criteria, nationally recognized guidelines, and the member's benefit plan documents. Clinical reviewers either approve claims for payment or refer claims to peer clinical reviewers (Medical Directors).

Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If a peer clinical reviewer determines that a service was not medically necessary, then an adverse benefit determination will be issued for the claim. The Plan communicates the adverse benefit determination, including applicable appeal rights, and offers a peer-to-peer conversation consistent with state and federal requirements. Appeal rights are set forth in the member's benefit plan document (*Certificate of Coverage*). The Plan communicates results of Retrospective Review within 30 days of receipt of a claim.

Adverse Benefit Determination. For M/S, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when benefits are exhausted. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials.

Clinical Criteria: Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based medical clinical policies or use clinical criteria from third party sources such as InterQual® or MCG® guidelines.

Monitoring/Quality Oversight: The Plan conducts a variety of activities that ensure that Retrospective Review determinations are appropriate.

M/S generally structures UM processes to comply with federal Employee Retirement Income Security Act of 1974 (ERISA) requirements and state law where applicable.

Retrospective Review of MH/SUD Outpatient Services consists of the following:

The Plan delegates management of MH/SUD outpatient services, including Retrospective Review to United Behavioral Health d/b/a OBH, its delegated MH/SUD MBHO vendor.

MH/SUD claims/requests for outpatient services submitted by INN providers may be subject to Retrospective Review if the service or procedure code required Prior Authorization or Concurrent Review, but that review was not conducted and there is a mitigating circumstance. Additionally, claims may be subject to Retrospective Review if the billed services or procedure codes do not match the authorized codes or if services are EIU.

Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. If needed, non-clinical staff request medical records for claims containing services that are subject to Retrospective Review. When medical records are received, the case is referred to clinical reviewers to assess medical necessity.

First Level Clinical Review/Initial Review. The clinical reviewer (e.g., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) reviews the request or claim to determine if the outpatient service meets clinical criteria for coverage based on application of objective, evidence-based clinical criteria, or nationally recognized guidelines. Clinical reviewers either approve claims for payment or refer claims to peer clinical reviewers (Medical Directors or psychologists).

Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If the peer clinical reviewer determines that a service was not medically necessary, then an adverse benefit determination is issued. The Plan communicates the adverse benefit determination, including appeal rights, and offers a peer-to-peer conversation consistent with state and federal requirements. Appeal rights are set forth in the member's benefit plan

document (*Certificate of Coverage*). The Plan communicates results of Retrospective Review within 30 days of receipt of a request/claim.

Adverse Benefit Determination. For MH/SUD, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when benefits are excluded. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials.

Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based behavioral clinical policies, or use clinical criteria from third party sources such as American Society of Addiction Medicine (ASAM) Criteria®, Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System-Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) and Early Childhood Service Intensity Instrument (ECSII) guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that outpatient Retrospective Review determinations are appropriate.

Per the MH/SUD policy entitled, *Core Principles and Practices*, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse clinical coverage benefit determinations (clinical denials) for financial reasons.

MH/SUD generally structures UM processes to comply with federal ERISA requirements, and state law where applicable.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- Retrospective Review

Benefit Classification(s)

- INN, outpatient

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHIC)
- UnitedHealthcare of Georgia, Inc. (UHCGA)

Plan Terms

The Plan's *Certificates of Coverage* notify members of Retrospective Review requirements:

"The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, Concurrent Review, case management, discharge planning, Retrospective Review or similar programs."

The *Utilization Management Program Description (UMPD)* discusses Post-Service Reviews and indicates:

"Post-service review assesses the appropriateness of medical services on a case by-case basis after the service has been provided but prior to payment for services. Post- service reviews are based on established review guidelines and includes:

- Review of medical necessity
- Appropriateness of level of care
- Identifying claims issues
- Eligibility determination
- Initiation of appropriate follow-up actions for utilization and quality issues

- Identifying appropriateness and administrative issues such as physician notification, emergency status of admission”

The role of the Plan’s delegate, United Behavioral Health d/b/a OBH, is discussed in the *UMPD*:

“United Behavioral Health (UBH) manages comprehensive behavioral health care delivery for members through a network of behavioral health practitioners, ancillary care providers, hospitals and other facilities. The management includes review of behavioral health care services (e.g., substance abuse and mental health requests for services).

UBH applies objective, evidence-based clinical criteria when making benefit coverage determinations while taking into account individual needs and the local delivery system. The clinical criteria are based on guidance produced by government sources, professional societies, and published research. In addition to making benefit coverage determinations, the clinical criteria inform discussions about evidence-based practices and discharge planning.

UBH selects externally developed clinical criteria and creates internally developed clinical criteria, where appropriate, based on its assessment of relevant guidance. The selection and development of clinical criteria incorporates:

- Annual review of clinical criteria and the procedures for applying them
- Involvement of appropriate stakeholders
- Dissemination of clinical criteria
- Ongoing monitoring and review of Centers for Medicare and Medicaid (CMS) Medicare Coverage Summaries, new or revised guidance in its CMS Local or National Coverage Determinations that are relevant to behavioral health
- Communication of updates to relevant areas

UBH uses the following clinical criteria:

- Clinical Criteria (Level of Care Utilization System-LOCUS) – Standardized level of care assessment tool developed by the American Association of Community Psychiatrists used to make clinical determinations and placement decisions for mental health disorder benefits for adults ages 19 and older when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (Child and Adolescent Level of Care/Service Intensity Utilization System-CALOCUS-CASII) – Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry (AACAP) and the American Association for Community Psychiatry (AAPC) used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children and adolescents ages 6-18 when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (Early Childhood Service Intensity Instrument-ECSI) – Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children ages 0-5 when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (American Psychological Association Psychological and Neuropsychological Testing Billing and Coding Guide) – Comprehensive billing and coding guide developed by the APA used for making clinical determinations for behavioral health psychological and neuropsychological testing services.
- Clinical Criteria (State or Contract Specific Supplemental Clinical Criteria) – Criteria used to make medical necessity determinations for mental health disorder benefits when there are explicit mandates or contractual requirements.
- Clinical Criteria (American Society of Addiction Medicine [ASAM]) – Criteria developed by the American Society of Addiction Medicine used to make clinical determinations for substance-related disorder benefits.
- Clinical Criteria (UBH Developed)
 - UBH Behavioral Clinical Policies: Criteria that stem from evaluation of new services or treatments or new applications of existing services or treatments and are used to make clinical determinations regarding proven or unproven services and treatments.

- UBH Supplemental Clinical Criteria: Criteria used to make clinical determinations for Applied Behavior Analysis and Electroconvulsive Therapy.
- UBH's Supplement to the APA Psychological and Neuropsychological Testing Billing and Coding Guide: Additional criteria used regarding provider qualifications, coverage rationale, limitations, and developmental testing.

The UBH UM Program is staffed by clinical, non-clinical and administrative personnel. A senior UBH Medical Director is responsible for directing and implementing the UM Programs. All clinical denials or adverse decisions are made by board certified psychiatrists, or, if the health plans choose, by a panel of other appropriate clinical peer reviewers. If the health plan chooses to use a panel to make adverse decisions, the panel contains at least one physician who is board certified in psychiatry. When the health care service under review is a mental health or substance abuse service, the adverse decision is made by a licensed physician who is board certified in psychiatry. Potential clinical denials are referred to a physician who is board certified in psychiatry for final determination.

An evaluation of the overall effectiveness of the Behavioral Health UM Program is conducted annually to determine how well resources have been deployed to improve UM activities and the clinical care and service provided to members.”

The Plan's terms require services to be medically necessary for coverage. INN providers are required to comply with UM protocols established by the Plan including complying with Retrospective Review requirements.

Step 2 – Factors Used to Determine Retrospective Review Applies

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

The Plan relies on the following factor to determine which INN outpatient services are subject to Retrospective Review. This factor applies to M/S and MH/SUD for the following:

- I. M/S INN outpatient services
 - II. MH/SUD INN outpatient services
- Consistency with Clinical Criteria (Qualitative):

This factor applies to M/S and MH/SUD services. Meeting Consistency with Clinical Criteria is determinative in imposing the limitation.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factor used in designing or applying the Plan's Retrospective Review requirement to INN outpatient services. These evidentiary standards and sources apply to the following:

- I. M/S INN outpatient services
- II. MH/SUD INN outpatient services

Factor - Consistency with Clinical Criteria

The factor and evidentiary standards used as the basis for subjecting MH/SUD INN outpatient benefits to Retrospective Review are comparable to, and applied no more stringently than, the factor and evidentiary standards used as the basis for subjecting M/S INN outpatient benefits to Retrospective Review “as written” and “in operation.”

Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The findings of the Plan's comparative analyses confirmed the strategies, processes, factor, evidentiary standards, and source information used to subject certain MH/SUD INN outpatient services to Retrospective Review were comparable to, and applied no more stringently than, the strategies, processes, factor, evidentiary standards, and source information used to subject certain M/S INN outpatient services to Retrospective Review “as written.”

The Plan found the factor used to subject INN MH/SUD outpatient services to Retrospective Review was comparable to and applied no more stringently than the factor used to subject INN M/S outpatient services to Retrospective Review “in operation.”

Conclusions

The Plan concluded that how Retrospective Review is applied to MH/SUD INN outpatient services was comparable to, and applied no more stringently than, how Retrospective Review is applied to M/S INN outpatient services “as written.”

The Plan reviewed the M/S and MH/SUD processes including responsibility for submission, timeframes for submission and review, notification to members and providers, clinical standards for review, staff qualifications, and outcome data and concluded how the Plan conducts Retrospective Review for MH/SUD INN outpatient services “in operation” was comparable to, and applied no more stringently than, how the Plan conducts Retrospective Review for M/S INN outpatient services “in operation.”

Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical/surgical (M/S) benefits. This generally means that the financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements, such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage.

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

Retrospective Review is a component of the Plan’s Utilization Management (UM) program. Medical directors and other clinical staff review services in order to detect and better manage over- and under-utilization and determine whether the services reviewed are consistent with the member’s coverage, medically appropriate, and consistent with evidence-based guidelines. Retrospective Review assesses the appropriateness of services on a case-by-case basis after the service has been provided but prior to payment for services. Retrospective Reviews are based on established review guidelines and may include:

- Review of medical necessity
- Appropriateness of level of care
- Identifying claims issues
- Eligibility determination
- Initiation of appropriate follow-up actions for utilization and quality issues

The Plan conducts medical necessity Retrospective Review of claims/requests for certain inpatient services that have not previously been reviewed as part of the Prior Authorization or Concurrent Review processes. The Plan may conduct Retrospective Review if the service or procedure codes do not match a diagnosis code, if services are experimental, investigational, or unproven (EIU), or if the services are subject to benefit limits/exclusions. The Plan conducts medical necessity Retrospective Review for inpatient services where Prior Authorization was required but not obtained upon claim submission.

This document includes the following information:

- The Retrospective Review process for M/S and MH/SUD inpatient services
- The description of the NQTL and application (Step 1)
- Factor used to determine which services are subject to the NQTL (Step 2)
- Evidentiary standards and sources used to define, trigger and/or implicate the factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

This comparative analysis refers to the following attachments:

- *Utilization Management Program Description (UMPD) of United HealthCare Services, Inc. and UnitedHealthcare Insurance Company* - summarizes the philosophy, structure and standards that govern UHC’s medical management, UM and utilization review responsibilities and functions
- *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions* - M/S policy that

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defines Retrospective Review

- *Optum National Policy Definitions List* - MH/SUD policy that defines Retrospective Review
- *M/S Retrospective Review Codes* – Excel document that lists M/S codes that may be subject to Retrospective Review
- *Certificates of Coverage* (for example: *COC23-INS-2018-LG-GA*, *COC23-HMO-2018-LG-GA*, and *COC23-INS-2018-SG-GA*) - Plan document that explains covered services, terms, conditions, and limitations of the member's policy
- *Core Principles and Practices* - MH/SUD policy that outlines the core principles and practices that should be used by personnel in their interactions with members, authorized member representatives, practitioners, and facilities, related to the management of behavioral health benefits, coverage determinations and appeals/grievances of non-coverage determinations
- *Performance Assessment and Incentives* - M/S policy confirming that clinical reviewers are not incented to make denials for financial reasons
- *Medical Necessity NQTL* – Comparative analysis that describes the processes, strategies, evidentiary standards and other factors used to apply medical necessity to M/S and MH/SUD services in accordance with MHPAEA and other regulatory guidance

The Plan concludes that the Retrospective Review requirements for M/S and MH/SUD are comparable and applied no more stringently to MH/SUD out-of-network (OON) inpatient benefits both “as written” and “in operation.”

Process

The Plan structures inpatient Retrospective Review processes to be compliant with all applicable federal and state laws. Retrospective Review is governed at both the state and federal level, which includes consumer protections such as external review for adverse benefit determinations after internal appeals options are exhausted.

The Plan delegates management of MH/SUD Inpatient services, including Retrospective Review to United Behavioral Health d/b/a Optum Behavioral Health (OBH), its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor.

Retrospective Review of M/S Inpatient Admissions consist of the following:

Retrospective Review for certain inpatient services begins after the Plan receives claims or notification of an inpatient admission post discharge from an OON facility. The Plan conducts medical necessity Retrospective Review of claims/requests for certain inpatient services that have not previously been reviewed as part of the Prior Authorization or Concurrent Review processes. The Plan may conduct Retrospective Review if the service or procedure codes do not match a diagnosis code, if services EIU, or if the services are subject to benefit limits/exclusions. The Plan conducts medical necessity Retrospective Review for inpatient services where Prior Authorization was required but not obtained upon claim submission.

Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. If needed, non-clinical staff request medical records for claims containing services that are subject to Retrospective Review. When medical records are received, cases are referred to clinical reviewers to assess medical necessity.

First Level Clinical Review/Initial Review. The clinical reviewer (physicians or nurses) reviews the claim to determine if the inpatient service billed meets clinical criteria for coverage based on application of objective, evidence-based clinical criteria, nationally recognized guidelines, and the member's benefit plan documents. Clinical reviewers either approve claims for payment or refer claims to peer clinical reviewers (Medical Directors).

Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If a peer clinical reviewer determines that a service was not medically necessary, then an adverse benefit determination will be issued for the claim. The Plan communicates the adverse benefit determination, including applicable appeal rights, and offers a peer-to-peer conversation consistent with state, federal, and accreditation requirements. Appeal rights are set forth in the member's benefit plan document (*Certificate of Coverage*). The Plan communicates results of

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Retrospective Review within 30 days of receipt of a claim.

Adverse Benefit Determination. For M/S, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when benefits are exhausted. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials.

Clinical Criteria: Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based medical clinical policies or use clinical criteria from third party sources such as InterQual® or MCG® Guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that Retrospective Review determinations are appropriate.

Per the M/S policy entitled, *Performance Assessment and Incentives*, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons.

M/S generally structures UM processes to comply with federal Employee Retirement Income Security Act of 1974 (ERISA) requirements, and state law where applicable.

Retrospective Review of MH/SUD Inpatient Admissions consist of the following:

The Plan delegates management of MH/SUD inpatient services, including Retrospective Review to United Behavioral Health d/b/a OBH, its delegated MH/SUD MBHO vendor.

MH/SUD claims/requests for inpatient services submitted by OON providers may be subject to Retrospective Review if the service or procedure code required Prior Authorization or Concurrent Review, but that review was not conducted and there is a mitigating circumstance. Additionally, claims may be subject to Retrospective Review if the billed services or procedure codes do not match the authorized codes, or if services are EIU.

Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. If needed, non-clinical staff request medical records for requests or claims containing services that are subject to Retrospective Review. When medical records are received, the case is referred to clinical reviewers to assess medical necessity.

First Level Clinical Review/Initial Review. The clinical reviewer (e.g., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) review the claim to determine if the inpatient admission billed meets clinical criteria for coverage based on application of objective, evidence-based, clinical criteria, or nationally recognized guidelines. Clinical reviewers either approve claims for payment or refer claims to peer clinical reviewers (Medical Directors).

Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If the peer clinical reviewer determines that an admission was not medically necessary, then an adverse benefit determination will be issued for the claim. The Plan communicates the adverse benefit determination, including applicable appeal rights. Appeal rights are set forth in the member's benefit plan document (*Certificate of Coverage*). The Plan communicates results of Retrospective Review within 30 days of receipt of a request/claim.

The OON provider may bill non-reimbursable charges to the member.

Adverse Benefit Determination. For MH/SUD, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when benefits are exhausted. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits.

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Cancelled cases are not considered administrative or clinical denials.

Clinical Criteria: Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based behavioral clinical policies or use clinical criteria from third party sources such as American Society of Addiction Medicine (ASAM) Criteria®, Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System-Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) and Early Childhood Service Intensity Instrument (ECSII) guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that inpatient Retrospective Review determinations are appropriate.

MH/SUD generally structures UM processes to comply with federal ERISA requirements, and state law where applicable.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- Retrospective Review

Benefit Classification(s)

- OON, inpatient

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHIC)
- UnitedHealthcare of Georgia (UHCGA)

Plan Terms

The Plan's *Certificates of Coverage* notify members of Retrospective Review requirements.

"The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, Concurrent Review, case management, discharge planning, retrospective review or similar programs"

The *Utilization Management Program Description (UMPD)* discusses Post-Service Reviews and indicates:

"Post-service review assesses the appropriateness of medical services on a case-by-case basis after the service has been provided but prior to payment for services. Post- service reviews are based on established review guidelines and includes:

- Review of medical necessity;
- Appropriateness of level of care;
- Identifying claims issues;
- Eligibility determination;
- Initiation of appropriate follow-up actions for utilization and quality issues; and
- Identifying appropriateness and administrative issues such as physician notification, emergency status of admission."

The Plan's delegate, United Behavioral Health d/b/a OBH, is discussed in the *UMPD*:

"United Behavioral Health (UBH) manages comprehensive behavioral health care delivery for members through a network of behavioral health practitioners, ancillary care providers, hospitals and other facilities. The management includes review of behavioral health care services (e.g., substance abuse and mental health requests for services).

UBH applies objective, evidence-based clinical criteria when making benefit coverage determinations while taking into account individual needs and the local delivery system. The clinical criteria are based on guidance produced by government sources, professional societies, and published research. In addition to making benefit coverage determinations, the clinical

criteria inform discussions about evidence-based practices and discharge planning.

UBH selects externally developed clinical criteria and creates internally developed clinical criteria, where appropriate, based on its assessment of relevant guidance. The selection and development of clinical criteria incorporates:

- Annual review of clinical criteria and the procedures for applying them
- Involvement of appropriate stakeholders
- Dissemination of clinical criteria
- Ongoing monitoring and review of Centers for Medicare and Medicaid (CMS) Medicare Coverage Summaries, new or revised guidance in its CMS Local or National Coverage Determinations that are relevant to behavioral health
- Communication of updates to relevant areas

UBH uses the following clinical criteria:

- Clinical Criteria (Level of Care Utilization System-LOCUS) – Standardized level of care assessment tool developed by the American Association of Community Psychiatrists used to make clinical determinations and placement decisions for mental health disorder benefits for adults ages 19 and older when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (Child and Adolescent Level of Care/Service Intensity Utilization System-CALOCUS-CASII) – Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry (AACAP) and the American Association for Community Psychiatry (AACP) used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children and adolescents ages 6-18 when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (Early Childhood Service Intensity Instrument-ECSII) - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children ages 0-5 when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (American Psychological Association Psychological and Neuropsychological Testing Billing and Coding Guide) - Comprehensive billing and coding guide developed by the APA used for making clinical determinations for behavioral health psychological and neuropsychological testing services.
- Clinical Criteria (State or Contract Specific Supplemental Clinical Criteria) - Criteria used to make medical necessity determinations for mental health disorder benefits when there are explicit mandates or contractual requirements.
- Clinical Criteria (American Society of Addiction Medicine [ASAM]) - Criteria developed by the American Society of Addiction Medicine used to make clinical determinations for substance-related disorder benefits.
- Clinical Criteria (UBH Developed)
 - UBH Behavioral Clinical Policies: Criteria that stem from evaluation of new services or treatments or new applications of existing services or treatments and are used to make clinical determinations regarding proven or unproven services and treatments.

The UBH UM Program is staffed by clinical, non-clinical and administrative personnel. A senior UBH Medical Director is responsible for directing and implementing the UM Programs. All clinical denials or adverse decisions are made by board certified psychiatrists, or, if the health plans choose, by a panel of other appropriate clinical peer reviewers. If the health plan chooses to use a panel to make adverse decisions, the panel contains at least one physician who is board certified in

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psychiatry. When the health care service under review is a mental health or substance abuse service, the adverse decision is made by a licensed physician who is board certified in psychiatry. Potential clinical denials are referred to a physician who is board certified in psychiatry for final determination.

An evaluation of the overall effectiveness of the Behavioral Health UM Program is conducted annually to determine how well resources have been deployed to improve UM activities and the clinical care and service provided to members.”

The Plan’s terms require services to be medically necessary for coverage.

Step 2 – Factors Used to Determine Retrospective Review Applies

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

The Plan relies on the following factor to determine which OON inpatient admissions are subject to Retrospective Review. This factor applies to M/S and MH/SUD for the following:

- I. M/S OON inpatient admissions
 - II. MH/SUD OON inpatient admissions
- Consistency with Clinical Criteria (Qualitative):

This factor applies to M/S and MH/SUD services. Meeting Consistency with Clinical Criteria is determinative in imposing the limitation.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factor used in designing or applying the Plan’s Retrospective Review requirements to OON inpatient services. These evidentiary standards and sources apply to the following:

- I. M/S OON inpatient admissions
- II. MH/SUD OON inpatient admissions

Factor: Consistency with Clinical Criteria

The factor and evidentiary standards used as the basis for subjecting MH/SUD OON inpatient benefits to Retrospective Review are comparable to, and applied no more stringently than, the factor and evidentiary standards used as the basis for subjecting M/S OON inpatient benefits to Retrospective Review “as written” and “in operation.”

Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer’s analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert’s qualifications and the extent to which the Plan or issuer ultimately relied upon each expert’s evaluations in setting recommendations regarding both.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The findings of the Plan's comparative analyses confirmed the strategies, processes, factor, evidentiary standards, and source information used to subject certain MH/SUD OON inpatient services to Retrospective Review were comparable to, and applied no more stringently than, the strategies, processes, factor, evidentiary standards, and source information used to subject certain M/S OON inpatient services to Retrospective Review "as written."

The Plan found the factor used to subject OON MH/SUD inpatient services to Retrospective Review was comparable to and applied no more stringently than the factor used to subject ONN M/S inpatient services to Retrospective Review "in operation." All

Conclusions

The Plan concluded that how Retrospective Review is applied to MH/SUD OON inpatient services was comparable to, and applied no more stringently than, how Retrospective Review is applied to M/S OON inpatient services "as written."

The Plan reviewed the M/S and MH/SUD processes including responsibility for submission, timeframes for submission and review, notification to members and providers, clinical standards for review, staff qualifications, and outcome data and concluded how the Plan conducts Retrospective Review for MH/SUD OON inpatient services "in operation" was comparable to, and applied no more stringently than, how the Plan conducts Retrospective Review for M/S OON inpatient services "in operation."

Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical/surgical (M/S) benefits. This generally means that financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements, such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage.

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

Retrospective Review is a component of the Plan’s Utilization Management (UM) program. Medical directors and other clinical staff review services in order to detect and better manage over- and under-utilization and determine whether the services reviewed are consistent with the member’s coverage, medically appropriate, and consistent with evidence-based guidelines. Retrospective Review assesses the appropriateness of services on a case-by-case basis after the service has been provided but prior to payment for services. Retrospective Reviews are based on established review guidelines and may include:

- Review of medical necessity
- Appropriateness of level of care
- Identifying claims issues
- Eligibility determination
- Initiation of appropriate follow-up actions for utilization and quality issues

The Plan conducts medical necessity Retrospective Review of claims/requests for certain outpatient services that have not previously been reviewed as part of the Prior Authorization or Concurrent Review processes. The Plan may conduct Retrospective Review if the service or procedure codes do not match a diagnosis code, if services are experimental, investigational, or unproven (EIU), or if the services are subject to benefit limits/exclusions. The Plan conducts medical necessity Retrospective Review for outpatient services where Prior Authorization was required, but not obtained upon claim submission.

This document includes the following information:

- The Retrospective Review process for M/S and MH/SUD outpatient services
- The description of the NQTL and application (Step 1)
- Factor used to determine which services are subject to the NQTL (Step 2)
- Evidentiary standards and sources used to define, trigger and/or implicate a factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

This comparative analysis refers to the following attachments:

- *Utilization Management Program Description (UMPD) of United HealthCare Services, Inc. and UnitedHealthcare Insurance Company* - Summarizes the philosophy, structure and standards that govern UHC’s medical management, UM and utilization review responsibilities and functions
- *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions* - M/S policy that defines Retrospective Review

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- *Optum National Policy Definitions List* – MH/SUD policy that defines Retrospective Review
- *M/S Retrospective Review Codes* - Excel document that lists the M/S codes that may be subject to Retrospective Review
- *Certificates of Coverage* (for example: *COC23-INS-2018-LG-GA* and *COC23-INS-2018-SG-GA*) - Plan document that explains covered services, terms, conditions, and limitations of the member's policy
- *Core Principles and Practices* - MH/SUD policy that outlines the core principles and practices that should be used by personnel in their interactions with members, authorized member representatives, practitioners and facilities, related to the management of behavioral health benefits, coverage determinations and appeals/grievances of non-coverage determinations
- *Performance Assessment and Incentives* - M/S policy confirming that clinical reviewers are not incented to make denials for financial reasons
- *Medical Necessity NQTL* – Comparative analysis that describes the processes, strategies, evidentiary standards and other factors used to apply medical necessity to M/S and MH/SUD services in accordance with MHPAEA and other regulatory guidance

The Plan concludes that the Retrospective Review requirements for M/S and MH/SUD are comparable and applied no more stringently to MH/SUD out-of-network (OON) outpatient benefits both "as written" and "in operation."

Process

The Plan structures outpatient Retrospective Review processes to be compliant with all applicable federal and state laws. Retrospective Review is governed at both the state and federal level, which includes consumer protections such as external review for adverse benefit determinations after internal appeals options are exhausted.

The Plan delegates management of MH/SUD outpatient services, including Retrospective Review to United Behavioral Health d/b/a Optum Behavioral Health (OBH), its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor.

Retrospective Review of M/S Outpatient Services consists of the following:

Retrospective Review for certain outpatient services begins after the Plan receives claims from OON providers. The Plan conducts medical necessity Retrospective Review of claims/requests for certain outpatient services that have not previously been reviewed as part of the Prior Authorization or Concurrent Review processes. The Plan may conduct Retrospective Review if the service or procedure codes do not match a diagnosis code, if services are EIU, or if the services are subject to benefit limits/exclusion. The Plan also conducts medical necessity Retrospective Review for outpatient services where Prior Authorization was required, but not obtained upon claim submission.

Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. If needed, non-clinical staff request medical records for claims containing services that are subject to Retrospective Review. When medical records are received, the case is referred to clinical reviewers to assess medical necessity.

First Level Clinical Review/Initial Review. The clinical reviewer (physicians or nurses) reviews the claim to determine if the outpatient service billed meets clinical criteria for coverage based on application of objective, evidence-based clinical criteria, nationally recognized guidelines, and the member's benefit plan documents. Clinical reviewers either approve claims for payment or refer claims to peer clinical reviewers (Medical Directors).

Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If a peer clinical reviewer determines that a service was not medically necessary, then an adverse benefit determination will be issued for the claim. The Plan communicates the adverse benefit determination, including applicable appeal rights, and offers a peer-to-peer conversation consistent with state and federal requirements. Appeal rights are set forth in the member's benefit plan document (*Certificate of Coverage*). The Plan communicates results of Retrospective Review within 30 days of receipt of a claim. The OON provider may bill non-reimbursable charges to the member.

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Adverse Benefit Determination. For M/S, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when benefits are exhausted. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials.

Clinical Criteria: Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based medical clinical policies or use clinical criteria from third party sources such as InterQual® or MCG® guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that Retrospective Review determinations are appropriate.

Per the M/S policy entitled, *Performance Assessment and Incentives*, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons.

M/S generally structures UM processes to comply with federal Employee Retirement Income Security Act of 1974 (ERISA) requirements and state law where applicable.

Retrospective Review of MH/SUD Outpatient Services consists of the following:

The Plan delegates management of MH/SUD outpatient services, including Retrospective Review to United Behavioral Health d/b/a OBH, its delegated MH/SUD MBHO vendor.

MH/SUD claims/requests for outpatient services submitted by OON providers may be subject to Retrospective Review if the service or procedure code required Prior Authorization or Concurrent Review, but that review was not conducted and there is a mitigating circumstance. Additionally, claims may be subject to Retrospective Review if the billed services or procedure codes do not match the authorized codes or if services are EIU.

Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. If needed, non-clinical staff request medical records for claims containing services that are subject to Retrospective Review. When medical records are received, the case is referred to clinical reviewers to assess medical necessity.

First Level Clinical Review/Initial Review. The clinical reviewer (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) reviews the request or claim to determine if the outpatient service meets clinical criteria for coverage based on application of objective, evidence-based clinical criteria, or nationally recognized guidelines. Clinical reviewers either approve claims for payment or refer claims to peer clinical reviewers (Medical Directors or psychologists).

Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If the peer clinical reviewer determines that a service was not medically necessary, then an adverse benefit determination is issued. The Plan communicates the adverse benefit determination, including appeal rights, and offers a peer-to-peer conversation consistent with state and federal requirements. Appeal rights are set forth in the member's benefit plan document (*Certificate of Coverage*). The Plan communicates results of Retrospective Review within 30 days of receipt of a request/claim.

The OON provider may bill non-reimbursable charges to the member.

Adverse Benefit Determination. For MH/SUD, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when benefits are excluded. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials.

Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based behavioral clinical policies, or use clinical criteria from third party sources such as American Society of Addiction Medicine (ASAM) Criteria®, Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System-Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) and Early Childhood Service Intensity Instrument (ECSII) guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that outpatient Retrospective Review determinations are appropriate.

Per the MH/SUD policy entitled, *Core Principles and Practices*, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse clinical coverage benefit determinations (clinical denials) for financial reasons.

MH/SUD generally structures UM processes to comply with federal ERISA requirements, and state law where applicable.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- Retrospective Review

Benefit Classification(s)

- OON, outpatient

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHIC)

Plan Terms

The Plan's *Certificates of Coverage* notify members of Retrospective Review requirements.

"The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, Concurrent Review, case management, discharge planning, Retrospective Review or similar programs."

The *Utilization Management Program Description (UMPD)* discusses Post-Service Reviews and indicates:

"Post-service review assesses the appropriateness of medical services on a case-by-case basis after the service has been provided but prior to payment for services. Post-service reviews are based on established review guidelines and includes:

- Review of medical necessity
- Appropriateness of level of care
- Identifying claims issues
- Eligibility determination
- Initiation of appropriate follow-up actions for utilization and quality issues; and
- Identifying appropriateness and administrative issues such as physician notification, emergency status of admission.

The role of the Plan's delegate, United Behavioral Health d/b/a OBH, is discussed in the *UMPD*:

"United Behavioral Health (UBH) manages comprehensive behavioral health care delivery for members through a network of behavioral health practitioners, ancillary care providers, hospitals and other facilities. The management includes review of behavioral health care services (e.g., substance abuse and mental health requests for services).

UBH applies objective, evidence-based clinical criteria when making benefit coverage determinations while taking into account individual needs and the local delivery system. The clinical criteria are based on guidance produced by government

sources, professional societies, and published research. In addition to making benefit coverage determinations, the clinical criteria inform discussions about evidence-based practices and discharge planning.

UBH selects externally developed clinical criteria and creates internally developed clinical criteria, where appropriate, based on its assessment of relevant guidance. The selection and development of clinical criteria incorporates:

- Annual review of clinical criteria and the procedures for applying them
- Involvement of appropriate stakeholders
- Dissemination of clinical criteria
- Ongoing monitoring and review of Centers for Medicare and Medicaid (CMS) Medicare Coverage Summaries, new or revised guidance in its CMS Local or National Coverage Determinations that are relevant to behavioral health
- Communication of updates to relevant areas

UBH uses the following clinical criteria:

- Clinical Criteria (Level of Care Utilization System-LOCUS) – Standardized level of care assessment tool developed by the American Association of Community Psychiatrists used to make clinical determinations and placement decisions for mental health disorder benefits for adults ages 19 and older when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (Child and Adolescent Level of Care/Service Intensity Utilization System-CALOCUS-CASII) – Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry (AACAP) and the American Association for Community Psychiatry (AACP) used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children and adolescents ages 6-18 when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (Early Childhood Service Intensity Instrument-ECSII) - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children ages 0-5 when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (American Psychological Association Psychological and Neuropsychological Testing Billing and Coding Guide) - Comprehensive billing and coding guide developed by the APA used for making clinical determinations for behavioral health psychological and neuropsychological testing services.
- Clinical Criteria (State or Contract Specific Supplemental Clinical Criteria) - Criteria used to make medical necessity determinations for mental health disorder benefits when there are explicit mandates or contractual requirements.
- Clinical Criteria (American Society of Addiction Medicine [ASAM]) - Criteria developed by the American Society of Addiction Medicine used to make clinical determinations for substance-related disorder benefits.
- Clinical Criteria (UBH Developed)
 - UBH Behavioral Clinical Policies: Criteria that stem from evaluation of new services or treatments or new applications of existing services or treatments and are used to make clinical determinations regarding proven or unproven services and treatments.
 - UBH Supplemental Clinical Criteria: Criteria used to make clinical determinations for Applied Behavior Analysis and Electroconvulsive Therapy.
 - UBH's Supplement to the APA Psychological and Neuropsychological Testing Billing and Coding Guide: Additional criteria used regarding provider qualifications, coverage rationale, limitations, and developmental testing.

The UBH UM Program is staffed by clinical, non-clinical and administrative personnel. A senior UBH Medical Director is responsible for directing and implementing the UM Programs. All clinical denials or adverse decisions are made by board certified psychiatrists, or, if the health plans choose, by a panel of other appropriate clinical peer reviewers. If the health plan chooses to use a panel to make adverse decisions, the panel contains at least one physician who is board certified in psychiatry. When the health care service under review is a mental health or substance abuse service, the adverse decision is made by a licensed physician who is board certified in psychiatry. Potential clinical denials are referred to a physician who is

board certified in psychiatry for final determination.

An evaluation of the overall effectiveness of the Behavioral Health UM Program is conducted annually to determine how well resources have been deployed to improve UM activities and the clinical care and service provided to members.”

The Plan’s terms require services to be medically necessary for coverage.

Step 2 – Factors Used to Determine Retrospective Review Applies

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

The Plan relies on the following factor to determine which OON outpatient services are subject to Retrospective Review. This factor applies to M/S and MH/SUD for the following:

- I. M/S OON outpatient services
 - II. MH/SUD OON outpatient services
- Consistency with Clinical Criteria (Qualitative):

This factor applies to M/S and MH/SUD services. Meeting Consistency with Clinical Criteria is determinative in imposing the limitation.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factor used in designing or applying the Plan’s Retrospective Review requirement to OON outpatient services. These evidentiary standards and sources apply to the following:

- I. M/S OON outpatient services
- II. MH/SUD OON outpatient services

Factor - Consistency with Clinical Criteria

The factor and evidentiary standards used as the basis for subjecting MH/SUD OON outpatient benefits to Retrospective Review are comparable to, and applied no more stringently than, the factor and evidentiary standards used as the basis for subjecting M/S OON outpatient benefits to Retrospective Review “as written” and “in operation.”

Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan's or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The findings of the Plan's comparative analyses confirmed the strategies, processes, factor, evidentiary standards, and source information used to subject certain MH/SUD OON outpatient services to Retrospective Review were comparable to, and applied no more stringently than, the strategies, processes, factor, evidentiary standards, and source information used to subject certain M/S OON outpatient services to Retrospective Review “as written.”

The Plan found the factor used to subject OON MH/SUD outpatient services to Retrospective Review was comparable to and applied no more stringently than the factor used to subject OON M/S outpatient services to Retrospective Review “in operation.”

Conclusions

The Plan concluded that how Retrospective Review is applied to MH/SUD OON outpatient services was comparable to, and applied no more stringently than, how Retrospective Review is applied to M/S OON outpatient services “as written.”

The Plan reviewed the M/S and MH/SUD processes including responsibility for submission, timeframes for submission and review, notification to members and providers, clinical standards for review, staff qualifications, and outcome data for review and concluded how the Plan conducts Retrospective Review for MH/SUD OON outpatient services “in operation” was comparable to, and applied no more stringently than, how the Plan conducts Retrospective Review for M/S OON outpatient services “in operation.”

Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical/surgical (M/S) benefits. This generally means that financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements, such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage.

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Concurrent Review is defined as “a clinical review of an extension of previously approved, ongoing course of treatment over a period of time or number of treatments conducted during an inpatient stay or ongoing ambulatory care. It is sometimes called a “continued stay review.”” The *Optum National Policy Definitions List* defines a Concurrent (Review) Request as “a request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care.” Concurrent Review does not involve onsite reviews.

Concurrent Review is a component of the Plan’s Utilization Management (UM) program that helps ensure members receive appropriate coverage based on their specific clinical status and health care needs. The process is designed to achieve optimal clinical outcomes by applying objective, evidence-based clinical criteria, and nationally recognized guidelines and best practices. Concurrent Review is a UM process that involves applying the benefit plan language and/or clinical criteria to make the most appropriate clinical coverage benefit determination.

This document includes the following information:

- The Concurrent Review process for M/S and MH/SUD inpatient services
- The description of the NQTL and application (Step 1)
- Factors used to determine which services are subject to the NQTL (Step 2)
- Evidentiary standards and sources used to define, trigger, and/or implicate a factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

This analysis refers to the following attachments:

- *Addendum A* - Identifies the M/S and MH/SUD inpatient services that are subject to Concurrent Review
- *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions* - M/S policy that defines Concurrent Review
- *Optum National Policy Definitions List* - MH/SUD policy that defines Concurrent Review
- *Utilization Management Program Description (UMPD) of United HealthCare Services, Inc. and UnitedHealthcare Insurance Company* - Summarizes the philosophy, structure and standards that govern UHC’s medical management, UM and utilization review responsibilities and functions

- *Management of Behavioral Health Benefits Policy*- Describes the mechanisms and processes designed to promote consistency in the management of behavioral health benefits and to ensure that members receive appropriate, high quality behavioral health services in a timely manner
- *Certificates of Coverage* *Certificates of Coverage* for example: *COC23-INS-2018-LG-GA*, *COC23-HMO-2018-LG-GA*, *COC23-INS-2018-SG-GA*, and *COC23-INS-RV-2018-LG-GA*)- Plan document that explains covered services, terms, conditions, and limitations of the member's policy
- Plan document that explains covered services, terms, conditions, and limitations of the member's policy
- *Core Principles and Practices*- MH/SUD policy that outlines the Core Principles and Practices that should be used by personnel in their interactions with members, authorized member representatives, practitioners and facilities, related to the management of behavioral health benefits, coverage determinations and appeals/grievances of non-coverage determinations
- *Performance Assessment and Incentives* - M/S policy confirming that clinical reviewers are not incented to make denials for financial reasons
- *2023 UnitedHealthcare Provider Administrative Guide* – Informs M/S providers of the Concurrent Review process. The *UnitedHealthcare Provider Administrative Guide* can be accessed on the website <https://www.uhcprovider.com/en/admin-guides.html>
- *September 2023 Optum National Network Manual* - Informs MH/SUD providers of the Concurrent Review process. <https://public.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/optum-network-manual.html>

The Plan concludes that the Concurrent Review requirements for M/S and MH/SUD are comparable and applied no more stringently for MH/SUD in-network (INN) inpatient benefits both “as written” and “in operation.”

Process

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Concurrent Review is defined as “a clinical review of an extension of previously approved, ongoing course of treatment over a period of time or number of treatments conducted during an inpatient stay or ongoing ambulatory care. It is sometimes called “continued stay review.” The *Optum National Policy Definitions List* defines a Concurrent (Review) Request as “a request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care.”

The Plan structures inpatient Concurrent Review processes to be compliant with all applicable federal and state laws, as well as the National Committee for Quality Assurance (NCQA) accreditation standards. NCQA confirms that the Plan's operations and policies identify appropriate timeframes for decisions, requires decision-making by appropriate personnel, and governs communication of adverse benefit determinations. In addition, Concurrent Review is governed at both the state and federal level, which includes consumer protections such as external review for adverse benefit determinations after internal appeals options are exhausted.

The Plan delegates management of MH/SUD inpatient services, including Concurrent Review for MH/SUD inpatient services, to United Behavioral Health d/b/a Optum Behavioral Health (OBH), its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor.

Addendum A includes a list of all service categories subject to inpatient Concurrent Review.

Concurrent Review of M/S inpatient admissions consists of the following:

Initial Concurrent Review. The Plan requires INN facilities and providers to timely notify the Plan (e.g., within 24 hours) of an unplanned (e.g., urgent/emergent) inpatient admission. Provider notification triggers the inpatient Concurrent Review process.

Providers can notify the Plan through the secure provider portal (www.uhcprovider.com), their connected electronic medical record, by telephone, or by fax (where required).

The Plan confirms receipt of the Concurrent Review request. Non-clinical staff confirm member eligibility and benefit coverage upon receipt of the notification. Non-clinical staff may approve coverage requests in scenarios where the member's plan documents allow and if a clinical review is not required. Non-clinical staff will also approve a coverage request if the facility's contract does not allow for clinical reviews. Non-clinical staff refer coverage requests that they cannot approve to initial clinical reviewers.

First Level Clinical Review/Initial Review. Clinical reviewers (nurses or physicians) consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether the inpatient admission is medically necessary by reviewing the member's clinical information, the applicable clinical criteria or guidelines, and the Plan benefit terms. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs to determine whether the applicable clinical criteria are met or may access clinical information in the provider's electronic medical record (EMR) if the provider has given the Plan access. The clinical reviewer may approve the admission based on their review.

Second Level Clinical Review/Peer Review. The initial clinical reviewer refers cases to a second level/peer clinical reviewer if the case cannot be approved. Peer clinical reviewers (physician or mid-level practitioner) consult clinical criteria when making clinical coverage benefit determinations. Peer clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs. Only qualified peer clinical reviewers (e.g., Medical Director) can issue adverse benefit determinations. The peer clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. If a peer clinical reviewer issues an adverse benefit determination, then the Plan timely communicates the adverse benefit determination, including appeal rights, and offers a peer-to-peer conversation consistent with state, federal, and accreditation requirements.

Adverse Benefit Determination. For M/S, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when benefits are exhausted. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials. Modified coverage requests that are approved are recorded as partial denials.

Ongoing Concurrent Review. INN M/S facilities may request coverage of additional days prior to the expiration of the last day of an approved inpatient admission. The Plan conducts ongoing Concurrent Reviews for additional days for approved inpatient M/S admissions as follows:

- General acute care facilities reimbursed on a per diem basis: every two days
- General acute care facilities reimbursed on a diagnosis related group (DRG) basis: when the inpatient admission meets the number of days stated in the provider participation agreement
- Skilled Nursing Facility (SNF) admissions: initial Concurrent Review at day three and then weekly. Subsequent reviews may be sooner if clinically appropriate
- Acute Inpatient Rehab (AIR) admissions: initial Concurrent Review at day five and then weekly. Subsequent reviews may be sooner if clinically appropriate
- Long Term Acute Care Hospital (LTACH) admissions: initial Concurrent Review at day 14 and then weekly

The Plan follows the initial Concurrent Review clinical review process when conducting ongoing Concurrent Reviews.

Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based medical clinical policies and clinical criteria from third party sources such as InterQual® or MCG® guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that inpatient Concurrent Review determinations are appropriate.

M/S monitors clinical reviewer and peer clinical reviewer application of clinical criteria through an annual inter-rater reliability (IRR) assessment that is provided by InterQual. Clinical reviewers and peer clinical reviewers are required to pass the IRR assessment with a score of 90% or better through three attempts. After a second failed IRR assessment, staff enter a remediation period and are required to review all cases with a supervisor for 30 days, or until 90% is achieved on the assessment. If the clinical reviewer achieves a passing score within the 30-day period, supervisors review a minimum of one case per week for the remainder of the 30-day period.

The Plan also conducts end-to-end case audits that are designed and approved by clinical leadership each year. The end-to-end audits include all stages of a case review, from intake through appeal. These audits are conducted monthly and approximately 1500 cases are reviewed per month. Results are reported to an oversight team. All deficiencies are remediated. Remediation may include corrective actions and/or additional education, as indicated.

The Plan routinely monitors Concurrent Review performance through its clinical performance oversight functions. Outcomes are monitored against timeliness requirements, performance guarantees, and for potential trends, including overall utilization.

The Plan's National Medical Care Management Committee (NMCMC) annually reviews overall UM program outcomes, including inpatient Concurrent Review outcomes, to confirm overall utilization is appropriate. The NMCMC is comprised of the Chief Medical Officer, and representatives from clinical policy, clinical advocacy and grievances, business standardization and advancement, regional chief medical officers, inpatient care management, lines of business, medical policy, clinical operations, and OBH. The Chair of the NMCMC must be an executive leader and licensed physician.

As of April 1, 2023, the Utilization Management Program Committee (UMPC) began overseeing the M/S UM program. The UMPC is responsible for the development and maintenance of the M/S Prior Authorization processes. The UMPC ensures that the UM program considers the factors and evidentiary standards for applying UM. The UMPC is comprised of:

- Chief Medical Officer, Medical Management (Co-Chair)
- Senior Vice President, Clinical Advancement (Co-Chair)
- Chief Medical Officer, UnitedHealthcare
- Senior Vice President, Clinical Appeals & Grievances
- Chief Medical Officer, Clinical Policy
- Chief Medical Officer, UnitedHealthcare Employer & Individual
- Chief Medical Officer, UnitedHealthcare Medicare & Retirement
- Chief Medical Officer, Community & State
- Chief Medical Officer, UnitedHealthcare Individual & Family Plans
- Vice President, Clinical Transformation & Affordability
- Senior Director, Mental Health Parity
- Vice President, Utilization Management Strategy & Implementation

One of the chairs must be an executive leader and a licensed physician. UMPC meets at least six times per year but may meet more frequently if needed.

Per the M/S policy entitled, *Performance Assessment and Incentives*, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons.

M/S generally structures UM processes to comply with federal Employee Retirement Income Security Act of 1974 (ERISA) requirements, NCQA UM standards, and state law where applicable.

Concurrent Review of MH/SUD Inpatient Admissions consists of the following:

The Plan delegates management of MH/SUD inpatient services, including Concurrent Review, to United Behavioral Health d/b/a OBH, its delegated MH/SUD MBHO vendor.

Initial Concurrent Review. All INN inpatient admissions are subject to the Concurrent Review process. The Plan requires INN providers and facilities to timely notify the Plan of MH/SUD inpatient admissions. INN facilities must notify the Plan within one business day after an admission unless a longer period is required by contract or state-specific requirements. Provider notification triggers the inpatient Concurrent Review process. Providers notify the Plan of the need for additional days/services by telephone.

As described in the *Management of Behavioral Health Benefits Policy*, upon receipt of admission notification, non-clinical staff confirm member eligibility and benefit coverage. Non-clinical staff may approve cases that do not require clinical evaluation or interpretation based on the member's diagnosis and the clinical information submitted by providers. Non-clinical staff refer cases that they cannot approve to initial clinical reviewers.

First Level Clinical Review/Initial Review. Clinical decisions are made by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse benefit determinations are made by Medical Directors. Clinical reviewers consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether an inpatient admission is medically necessary by reviewing the member's clinical information, the applicable clinical criteria or guidelines, and the Plan benefit terms. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for certification, related diagnostic results, and history of related treatment and services to determine whether the applicable clinical criteria are met. The clinical reviewer may approve the admission based on their review.

Second Level Clinical Review/Peer Review. The initial clinical reviewer refers cases to a peer clinical reviewer for a peer-to-peer discussion if the case cannot be approved. The requesting provider is offered the opportunity to discuss the case with the peer clinical reviewer, consistent with state, federal, and accreditation requirements before an adverse benefit determination is issued. Only qualified peer clinical reviewers (e.g., Medical Directors) can issue adverse benefit determinations. Peer clinical reviewers apply clinical criteria to member clinical information to determine coverage for an inpatient admission. If the requesting provider fails to complete the peer-to-peer discussion, the peer clinical reviewer makes a determination based on the information available. If a peer clinical reviewer issues an adverse benefit determination, (e.g., the admission is not medically necessary and is not approved), then the Plan timely communicates the adverse benefit determination, including appeal rights, to the member and provider consistent with applicable state, federal, and accreditation requirements.

Adverse Benefit Determination. For MH/SUD, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as a clinical denial when it is based on clinical criteria and member clinical information.

Ongoing Concurrent Review. INN providers may request coverage for additional days by contacting the Plan prior to the expiration of the last covered day of an approved MH/SUD inpatient admission. The Plan's INN MH/SUD general acute care facilities are reimbursed on a per diem basis. The Plan conducts ongoing Concurrent Review for INN MH/SUD admissions depending on the applicable clinical criteria and the member's clinical presentation. Upon receipt of a request for coverage of additional days, the Plan reviews the medical necessity of inpatient admissions. Clinical reviewers and peer clinical reviewers follow the initial Concurrent Review process.

Clinical Criteria. Initial clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based behavioral clinical policies or use clinical criteria from third party sources such as American Society of Addiction Medicine (ASAM) Criteria®, Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System-Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) and Early Childhood Service Intensity Instrument (ECSII) guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure inpatient Concurrent Review determinations are appropriate.

MH/SUD monitors clinical reviewer and peer clinical reviewer application of clinical criteria through an annual IRR assessment. Clinical reviewers and peer clinical reviewers are required to pass the IRR assessment with a score of 90% or better through three attempts. After a second failed IRR assessment, the reviewer enters a remediation period and is required to review all cases with a supervisor for 30 days, or until 90% is achieved on the assessment. If the clinical reviewer achieves a passing score within the 30-day period, supervisors review a minimum of one case per week for the remainder of the 30-day period.

The Plan also conducts monthly quality audits of individual non-clinical staff, clinical reviewers, and peer clinical reviewers, including staff performing appeal functions. These audits are designed and approved by clinical leadership. A minimum of two audits are completed per staff, per month. The results of these real-time audits are shared with supervisors for staff oversight, and all findings are remediated. Remediation may include corrective actions and/or additional education, as warranted.

The Plan routinely monitors Concurrent Review program performance through its clinical performance oversight functions. Outcomes are monitored against timeliness requirements, performance guarantees, and for potential trends, including overall utilization.

The Plan's national Clinical Quality & Operations Committee (CQOC) annually reviews UM program outcomes, including inpatient Concurrent Review outcomes, to confirm overall utilization is appropriate. The CQOC is comprised of representatives from sub-committees, and representatives from the clinical quality improvement, UM, care engagement, medical operations, medical policy and standards, clinical operations, appeals, product, legal, compliance, network strategy, provider experience, accreditation, and benefits teams. The Chair of the Clinical Quality & Operations Committee must be an executive leader, board certified in psychiatry or psychiatric subspecialty and a licensed physician.

Per the MH/SUD policy entitled, *Core Principles and Practices*, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons.

MH/SUD generally structures UM processes to comply with federal ERISA requirements, NCQA UM standards, and state law, where applicable.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- Concurrent Review

Benefit Classification(s)

- INN, inpatient

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHIC)

- UnitedHealthcare of Georgia, Inc. (UHCGA)
- UnitedHealthcare Insurance Company of the River Valley (UHICRV)

Plan Terms/Source Document(s)

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Concurrent Review is defined as “a clinical review of an extension of previously approved, ongoing course of treatment over a period of time or number of treatments conducted during an inpatient stay or ongoing ambulatory care. It is sometimes called a “continued stay review.” Concurrent Review does not involve onsite reviews.

The *Optum National Policy Definitions List* defines a Concurrent (Review) Request as “a request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care.”

The Plan’s *Certificates of Coverage* notify members of Concurrent Review requirements:

“The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, Concurrent Review, case management, discharge planning, retrospective review or similar programs.”

The *2023 UnitedHealthcare Care Provider Administrative Guide* notifies providers of the Concurrent Review requirements. INN providers are required to comply with UM protocols established by the Plan:

We determine the medical necessity of inpatient admissions through either concurrent or retrospective review. We require you to comply with our requests:

- For information, documents or discussions related to our reviews and discharge planning. This includes primary and secondary diagnosis, clinical information, treatment plan, admission order, patient status, discharge planning needs, barriers to discharge and discharge date. When available, provide access to electronic medical records (EMR).
- From our interdisciplinary care coordination team and/or Medical Director. This includes our requests that you help us engage our members directly face-to-face or by phone.
 - If you receive the request before 1 p.m. local time:
 - › Supply all requested information within 4 hours
 - If you receive our request after 1 p.m. local time:
 - › Provide the information within the same business day, but no later than 12 p.m. local time the next business day

The *Optum National Network Manual*, September 2023 Edition notifies providers of the Concurrent Review requirements. INN providers are required to comply with UM protocols established by the Plan:

In most cases, inpatient admissions will be directed only to participating hospitals and attending psychiatrists.

All inpatient and sub-acute level of care admissions require notification or pre-authorization by the network provider or facility. Optum requires notification within one business day after an admission for a facility to request a pre-authorization unless a longer period is required by contract or state specific requirements. This includes, but is not limited to, mental health or substance abuse disorder services delivered as inpatient treatment, partial/day hospitalization or residential treatment.

Network providers are solely responsible for completing prior notification or obtaining preauthorization prior to providing inpatient or sub-acute level of care services. This includes timely provision of information necessary for concurrent review of continued stay or ongoing care requests prior to the delivery of services.

Should a provider fail to obtain or otherwise follow the required administrative procedures for notification or pre-authorization, Optum may, in accordance with applicable law, apply a reduction of payment to the network provider up to

100% of provider's reimbursement rate. Network provider payment reductions for failure to complete notification or obtain pre-authorization are solely the network provider's liability (i.e., the member cannot be billed for these reductions in payment).

The role of the Plan's delegate, United Behavioral Health d/b/a OBH, is discussed in the *UMPD*:

"United Behavioral Health (UBH) performs the review of requests for coverage of behavioral health services (i.e., substance abuse, and mental health requests for services). UBH provides comprehensive behavioral health care delivery for members through a network of behavioral health practitioners, ancillary care providers, hospitals and other facilities.

For mental health, substance-related disorder services, and wraparound services, UBH uses its Clinical Criteria (see below), behavioral clinical policies and best practice guidelines to make coverage determinations. UBH adopts externally-developed clinical criteria, and creates internally-developed Clinical Criteria, where appropriate, based on its assessment of relevant guidance. UBH develops clinical criteria that supersedes its standard set or adopts externally-developed clinical criteria when required to do so by contract or regulation.

- Clinical Criteria (Level of Care Utilization System-LOCUS) – Standardized level of care assessment tool developed by the American Association of Community Psychiatrists used to make clinical determinations and placement decisions for mental health disorder benefits for adults ages 19 and older when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (Child and Adolescent Level of Care/Service Intensity Utilization System-CALOCUS-CASII) - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry (AACAP) and the American Association for Community Psychiatry (AACP) used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children and adolescents ages 6-18 when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (Early Childhood Service Intensity Instrument-ECSII) - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children ages 0-5 when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (State or Contract Specific Level of Care Guidelines) - Criteria used to make medical necessity determinations for mental health disorder benefits when there are explicit mandates or contractual requirements.
- Clinical Criteria (American Society of Addiction Medicine [ASAM]) - Criteria developed by the American Society of Addiction Medicine used to make clinical determinations for substance-related disorder benefits.
- Clinical Criteria (Optum Developed)
 - Optum Behavioral Clinical Policies: Criteria that stem from evaluation of new services or treatments or new applications of existing services or treatments and are used to make clinical determinations regarding proven or unproven services and treatments.

Licensed practitioners conduct all reviews with a focus on measurable outcome goals and objectives for treatment. A senior UBH Medical Director is responsible for directing and implementing behavioral health utilization management programs. A referral is sent to UBH when a member is identified as potentially benefiting from behavioral health services during a "medical event."

The UBH UM Program is staffed by clinical, non-clinical and administrative personnel. All clinical denials or adverse decisions are made by board certified psychiatrists, or, if the health plans choose, by a panel of other appropriate health care service reviewers. If the health plan chooses to use a panel to make adverse decisions, the panel contains at least one physician who is board certified in psychiatry. When the health care service under review is a mental health or substance abuse service, the adverse decision is made by a licensed physician who is board certified in psychiatry. All potential clinical denials are referred to a physician who is board certified in psychiatry for final determination. An evaluation of the overall effectiveness of the Behavioral Health UM Program is conducted annually to determine how well resources have been deployed to improve UM activities and the clinical care and service provided to members."

The Plan's terms require services to be medically necessary for coverage. INN providers are required to comply with the Plan's UM protocols including complying with Concurrent Review requirements.

List of M/S and MH/SUD Services Subject to NQTL

Addendum A, attached, lists the M/S and MH/SUD INN inpatient service categories subject to Concurrent Review. Concurrent Review is one component of the UM program that evaluates whether a benefit or service is medically necessary.

- The “Member” tab lists the service categories for which the member is responsible for providing notification for both INN and out-of-network (OON) services. The “Member” tab includes all products in the scope of the analysis.
- The “Provider” tab lists the service categories for which the provider is responsible for providing notification for INN services. The “Provider” tab applies to all Plans in the scope of the analysis.

Step 2 – Factors Used in the Design and Application of the NQTL

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

The Plan relies on the following factor to determine which INN inpatient services are subject to initial Concurrent Review (design). This factor applies to M/S and MH/SUD for the following:

- I. M/S: General Hospital, SNF, AIR, LTACH
 - II. MH/SUD: Inpatient and residential facilities
- All M/S and MH/SUD Inpatient Admissions – Initial Concurrent Review (Qualitative)
 - All unplanned M/S and MH/SUD inpatient admissions are subject to initial Concurrent Review

The Plan relies on the following factor to determine which INN inpatient services are subject to ongoing Concurrent Review (design). This factor applies to M/S and MH/SUD for the following:

- I. M/S: General Hospital, Specialty Hospital, SNF, AIR, LTACH
 - II. MH/SUD: Inpatient and residential facilities
- All M/S and MH/SUD Inpatient Admission Requests for Additional Days – Ongoing Concurrent Review (Qualitative)
 - All M/S and MH/SUD inpatient admissions are subject to ongoing Concurrent Review if coverage of additional days is requested after initial Concurrent Review approved days expire

The factors apply to M/S and MH/SUD services. The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL. All Concurrent Reviews are subject to Clinical Appropriateness and must have medical necessity criteria.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below is the evidentiary standard and source used to define, trigger, and/or implicate the factor used in designing and applying the Plan's initial Concurrent Review requirement to INN inpatient services. This evidentiary standard and source apply to the following:

- I. M/S: General Hospital, Specialty Hospital, SNF, AIR, LTACH
- II. MH/SUD: Inpatient and residential facilities

Factor – All M/S and MH/SUD Inpatient Admissions – Initial Concurrent Review includes all inpatient admissions.

- The Plan's evidentiary standard and source that define and/or trigger the factor is provider notification of an inpatient admission

The Plan's evidentiary standard and source apply to M/S and MH/SUD services and are defined in a qualitative manner.

Below is the evidentiary standard and source used to define, trigger, and/or implicate the factor used in designing and applying the Plan's ongoing Concurrent Review requirement to INN inpatient services. This evidentiary standard and source apply to the following:

- I. M/S: General Hospital, Specialty Hospital, SNF, AIR, LTACH
- II. MH/SUD: Inpatient and residential facilities

Factor – All M/S and MH/SUD Inpatient Admission Requests for Additional Days – Ongoing Concurrent Review includes all inpatient admissions for which a provider requests coverage of additional days.

- The Plan's evidentiary standard and source that define and/or trigger the factor is an inpatient admission for which a provider requests coverage of additional days

The Plan's evidentiary standard and source apply to M/S and MH/SUD services and are defined in a qualitative manner.

The factors and evidentiary standards used as the basis for subjecting MH/SUD INN inpatient services to Concurrent Review are comparable to, and applied no more stringently than, the factors used as the basis for subjecting M/S INN inpatient benefits to Concurrent Review "as written" and "in operation." The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL.

Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

As Written

The Plan conducted a comparative analysis of the strategies, processes, factors, evidentiary standards, and source information used to determine which M/S and MH/SUD INN inpatient services are subject to Concurrent Review and how Concurrent Review is applied to M/S and MH/SUD INN inpatient services “as written.” The Plan identified the factors and evidentiary standards used as the basis for subjecting M/S and MH/SUD benefits to Concurrent Review.

National internal committees apply the applicable factors and standards described in Steps 2 and 3 to M/S and MH/SUD services when determining which services to subject to Concurrent Review.

Review of Factors and Evidentiary Standards

The Plan reviewed the factors that trigger an INN inpatient service to be subject to Concurrent Review. The factors and evidentiary standards were applied to M/S and MH/SUD services comparably and not more stringently to MH/SUD services than to M/S services as evidenced by the attached *Concurrent Review Factor Grid(s)*.

Review of Operational Policies and Procedures

The Plan reviewed M/S and MH/SUD operational policies and procedures, IRR assessment processes, and UM annual oversight to confirm comparability and found MH/SUD policies, procedures, and processes to be comparable and no more stringent than M/S policies, procedures, and processes.

- Medical management operational policies and procedures establish the standards for how the Plan conducts inpatient Concurrent Review. The policies and procedures are consistent with state and federal law and accreditation requirements governing Concurrent Review. Timeframes for decisions, content of adverse benefit determinations, appeal rights and external review are all governed by state and federal law and accreditation requirements.
- The IRR assessment measures the consistency with which clinical reviewers and peer clinical reviewers apply the Plan's clinical criteria. IRR assessment processes apply to M/S and MH/SUD inpatient services.
- UM oversight monitors and evaluates UM processes by reviewing program outcomes, clinical appeals, IRR assessments, and under- and over-utilization.

Review of Inpatient Concurrent Review Processes

The strategy for applying both initial and ongoing Concurrent Review to INN inpatient services is comparable for M/S and MH/SUD services and is applied no more stringently to MH/SUD INN inpatient services. The Plan conducted a review of the M/S and MH/SUD Concurrent Review processes to confirm comparability. The review focused on the following aspects of the process for both M/S and MH/SUD:

- Notification. INN M/S and MH/SUD facilities and providers are contractually responsible for notifying the Plan of M/S and MH/SUD inpatient admissions.
- Timeframe to Submit. The *UnitedHealthcare Administrative Guide* (for M/S) and *Optum National Network Manual* (for MH/SUD) were reviewed for notification timeframes. The timeframe for the provider or member to notify of an admission was reviewed and determined that MH/SUD was comparable and no more stringent.
 - INN M/S facilities must notify the Plan within 24-hours for week-day admissions, unless otherwise indicated.
 - INN MH/SUD facilities must notify the Plan within one business day after an admission unless a longer period is required by contract or state-specific requirements.
- Clinical Reviews. For M/S and MH/SUD inpatient Concurrent Reviews, clinical reviewers may gather more clinical

information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for certification, related diagnostic results, and history of related treatment and services, and photographs. The clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. The clinical reviewer may approve cases that meet applicable clinical criteria.

- **Review Timeframes.** M/S and MH/SUD inpatient Concurrent Review determination timeframes are defined by state, federal, and accreditation requirements. The same determination timeframes apply to M/S and MH/SUD determinations.
- **Determinations and Non-clinical Reviews, First Level Clinical Reviews, and Second Level Peer Clinical Reviews.**
 - For M/S, non-clinical staff may approve requests for coverage of cases in scenarios where the Plan identified applicable clinical criteria always indicate that an inpatient level of care is medically necessary. Non-clinical staff refer coverage requests that they cannot approve to clinical reviewers. Clinical reviewers determine whether the inpatient admission is medically necessary. The clinical reviewer may approve the admission based on their review. If the case cannot be approved by the clinical reviewer, it is referred to a peer (physician) clinical reviewer. Only qualified peer clinical reviewers (e.g., Medical Directors) may issue adverse benefit determinations. Peer-to-peer discussions are offered as required.
 - For MH/SUD, non-clinical staff refer coverage requests that they cannot approve to clinical reviewers. Clinical reviewers (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether an inpatient admission is medically necessary. The clinical reviewer may approve the admission based on their review. The clinical reviewer refers cases to a peer clinical reviewer for a peer-to-peer discussion if the case cannot be approved. Only qualified peer clinical reviewers (e.g., Medical Directors) may issue adverse benefit determinations. Peer-to-peer discussions are offered as required.
- **Adverse Benefit Determinations and Peer-to-Peer Conversations.**
 - **INN inpatient M/S services**
 - The Plan offers INN M/S facilities and providers the opportunity to discuss adverse benefit determinations after the adverse benefit determination is issued. Only M/S peer clinical reviewers (e.g., Medical Directors) may issue adverse benefit determinations for coverage of M/S inpatient services.
 - For M/S, adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information. Modified coverage requests that are approved are recorded as partial denials.
 - **INN inpatient MH/SUD services**
 - The Plan offers INN inpatient MH/SUD facilities and providers the opportunity to discuss a potential adverse benefit determination before the Plan issues such determination. This process allows INN inpatient MH/SUD facilities and providers the opportunity to provide additional information and/or modify their request prior to an adverse benefit determination being issued.
 - For MH/SUD, an adverse benefit determination is recorded as a clinical denial when it is based on clinical criteria and member clinical information. If during the course of the peer-to-peer conversation the provider withdraws their original request and submits a new request, the case is approved.
- **Notification of Decisions to Providers and Members.** The Plan notifies M/S and MH/SUD INN facilities, providers, and members of approvals and adverse benefit determinations, including applicable appeal rights consistent with state, federal, and accreditation requirements.
- **Review of Staff Qualifications.** For M/S and MH/SUD, clinical staff qualifications align with the type of clinical review and state, federal, and accreditation requirements (NCQA).
 - M/S is staffed by clinical, non-clinical, and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., nurses, physicians, etc.) and all adverse benefit determinations are made by Medical Directors.
 - MH/SUD is staffed by clinical, non-clinical, and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse benefit determinations are made by Medical Directors.
- **Clinical Criteria.** For M/S and MH/SUD, clinical reviewers and peer clinical reviewers base determinations on objective, evidence-based medical/behavioral clinical policies and use clinical criteria from third party sources such as InterQual,

MCG, ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines.

- Ongoing Concurrent Review. All M/S and MH/SUD requests for coverage of additional days trigger ongoing Concurrent Review.

In Operation

The Plan compared the strategies, processes, factors, evidentiary standards, and source information used to determine which M/S and MH/SUD INN inpatient services are subject to Concurrent Review and how Concurrent Review is applied “in operation.”

Initial Concurrent Review

All INN M/S and MH/SUD inpatient services are subject to the Concurrent Review process. The Plan required INN M/S and MH/SUD facilities and providers to notify the Plan timely of inpatient admissions. Notification triggered the initial Concurrent Review process for INN M/S and MH/SUD inpatient admissions.

M/S and MH/SUD initial Concurrent Reviews included confirmation of member eligibility and benefit availability for the requested services. During the initial reviews for M/S and MH/SUD INN inpatient services, non-clinical staff approved coverage for inpatient admissions that did not require clinical review or interpretation and where member’s plan documents allowed. Non-clinical staff also approved coverage requests if the facility’s contract did not allow for clinical reviews. All INN M/S inpatient admissions and MH/SUD inpatient admissions were subject to initial Concurrent Review.

M/S and MH/SUD inpatient cases that were not administratively approved in initial administrative review were referred to a clinical reviewer for further research and evaluation. The M/S and MH/SUD clinical reviewers applied benefit plan documents and medical necessity criteria to member clinical information. M/S and MH/SUD clinical reviewers requested additional clinical information if they were unable to approve cases based on the available member clinical information. The clinical reviewers approved the admission based on their review when clinical criteria were met.

If the requested clinical information was not received or if the case could not be approved, M/S and MH/SUD clinical reviewers referred cases to a peer clinical reviewer. For INN MH/SUD inpatient cases, the Plan offered peer-to-peer conversations so the INN MH/SUD provider could provide additional clinical information prior to the issuance of an adverse benefit determination. For INN M/S inpatient admissions, the Plan offered peer-to-peer conversations at the time of issuing an adverse benefit determination. Only qualified peer clinical reviewers issued M/S and MH/SUD adverse benefit determinations.

The Plan communicated all adverse benefit determinations for M/S and MH/SUD inpatient cases that did not meet applicable clinical criteria consistent with state, federal, and accreditation requirements, including appeal rights, as applicable.

Ongoing Concurrent Review

All INN M/S and MH/SUD inpatient admissions were subject to ongoing Concurrent Review if an INN M/S or MH/SUD facility sought coverage of additional days for an approved admission. INN M/S and MH/SUD facilities were required to request coverage of additional days prior to expiration of the last day of an approved admission.

For all INN M/S and MH/SUD inpatient admissions, the Plan followed the initial Concurrent Review clinical review process when conducting ongoing Concurrent Reviews.

The Plan offered INN MH/SUD facilities the opportunity to discuss a potential adverse benefit determination with a peer clinical reviewer prior to issuing the adverse benefit determination. The Plan offered INN M/S facilities the opportunity to discuss an adverse benefit determination with a peer clinical reviewer when it issued the adverse benefit determination.

The Plan communicated all adverse benefit determinations issued for M/S and MH/SUD inpatient cases that did not meet clinical criteria consistent with state, federal and accreditation requirements, including appeal rights, as applicable. Only

qualified peer clinical reviewers issued adverse benefit determinations for M/S and MH/SUD inpatient admissions.

The Plan monitors M/S and MH/SUD clinical and peer clinical reviewers' application of clinical criteria through annual IRR assessments. The Plan also conducts quality audits of cases. The Plan routinely monitors Concurrent Review performance through its clinical performance oversight functions. In addition to comparing these "in operation" processes, the Plan reviewed medical necessity approval and denial rates, internal appeals outcomes, and external appeals outcomes related to Concurrent Review determinations for M/S and MH/SUD INN inpatient services. The results of these analyses are discussed in greater detail in Step 5.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The findings of the Plan's comparative analyses confirmed the strategies, processes, factors, evidentiary standards, and source information used to determine the MH/SUD INN inpatient services subject to initial and ongoing Concurrent Review were comparable to, and applied no more stringently than, the strategies, processes, factors, evidentiary standards, and source information used to determine the M/S INN inpatient services subject to initial and ongoing Concurrent Review "as written."

The Plan found the factors used to subject INN MH/SUD inpatient services to initial and ongoing Concurrent Review were comparable to and applied no more stringently than the factors used to subject INN M/S inpatient services to initial and ongoing Concurrent Review "in operation." All M/S and MH/SUD inpatient admissions were subject to initial Concurrent Review. All M/S and MH/SUD inpatient admissions were subject to ongoing Concurrent Review if coverage of additional days was requested after initial Concurrent Review approved days expire.

The Plan used comparable processes to conduct initial and ongoing Concurrent Review of INN M/S and MH/SUD inpatient admissions. The Plan required INN M/S and MH/SUD facilities to timely notify the Plan of inpatient admissions. The Plan used qualified staff to confirm member eligibility and benefit availability, and to request additional clinical information if necessary. The Plan issued approvals for M/S and MH/SUD inpatient admissions that met applicable clinical criteria or guidelines. Only qualified M/S and MH/SUD peer clinical reviewers issued adverse benefit determinations. The Plan gave INN MH/SUD facilities the opportunity to discuss potential adverse benefit determinations with qualified peer clinical reviewers prior to issuing adverse benefit determinations. This afforded INN MH/SUD facilities the opportunity to convert potential denials to approvals and avoid adverse benefit determinations. The Plan did not offer the opportunity to avoid potential adverse benefit determinations to INN M/S facilities and only offered the peer-to-peer review at the time the adverse benefit determination was issued.

The Plan operated monitoring and oversight programs to ensure that clinical reviewers and peer clinical reviewers rendered appropriate determinations. Both M/S and MH/SUD required clinical reviewers, including peer clinical reviewers, to successfully complete the annual IRR assessment. Clinical reviewers were required to pass the IRR assessment with a score of 90% or better to render UM decisions independently. The 2022 IRR M/S results were 97% and MH/SUD results were 96%, demonstrating that M/S and MH/SUD clinical reviewers comparably applied medical necessity criteria when making utilization review determinations.

INN inpatient medical necessity approval and denial rates and appeals outcomes data from 01/01/2022-12/31/2022 were evaluated where a minimum threshold of 100 cases were available to ensure a valid data set for analysis.

The findings of a comparative analysis for each Plan product (see data below) indicated the Concurrent Review process for

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MH/SUD INN inpatient services was comparable to the Concurrent Review process for M/S INN inpatient services.

For UnitedHealthcare Insurance Company (UHC) M/S had a clinical denial rate of 29.52% and MH/SUD had a clinical denial rate of 0.00%. The denial rates did not reflect any material differences in Prior Authorization processes .

The Plan notes the UM outcomes data do not reflect material differences in Concurrent Review processes for M/S or MH/SUD benefit coverage determinations. Similarly, the appeals data do not reflect that members face a materially different or more stringent review process.

There is an insufficient number of MH/SUD INN inpatient cases from 01/01/2022-12/31/2022 to support an analysis of clinical outcomes data for UnitedHealthcare of Georgia (UHCGA)

There is an insufficient number of MH/SUD INN inpatient cases from 01/01/2022-12/31/2022 to support an analysis of clinical outcomes data for UnitedHealthcare Insurance Company of the River Valley (UHCVR).

The following definitions are applicable to the charts below:

- Total # of Requests Received: the aggregate number of INN inpatient Concurrent Review requests received
- Total # of Requests Approved: the aggregate number of INN inpatient Concurrent Review requests approved
- Total # of Requests Clinically Denied: the aggregate number of INN inpatient Concurrent Review requests that were denied for clinical reasons (request did not meet medical necessity)
- Approval Rate %: (Requests Approved / Requests Received)
- Clinical Denial Rate %: (Total number of Requests Clinically Denied / Total number of Requests Received) (not administrative)
- Total # of Clinical Denials reviewed upon appeal: Total (internal & external): the aggregate number of INN inpatient Concurrent Review clinical internal and external appeals received
- Total # of Clinical Denials Overturned upon appeal: Total (internal & external): the aggregate number of INN inpatient Concurrent Review clinical internal and external appeals overturned
- Clinical Denial Overturn Rate %: Total (Internal & External): percent of INN inpatient Concurrent Review clinical internal and external appeals overturned (Total # of Clinical Denials Overturned upon internal and external appeal/Total # of Clinical Denials reviewed upon internal and external appeal)
- Total # of Clinical Denials Upheld: Total (Internal & External): the aggregate number of INN inpatient Concurrent Review clinical internal and external appeals upheld
- Clinical Denial Uphold Rate %: Total (Internal & External): percent of INN inpatient Concurrent Review clinical internal and external appeals upheld (Total # of Clinical Denials Upheld upon internal and external appeal/Total # of Clinical Denials reviewed upon internal and external appeal)
- Total # of Clinical Denials reviewed upon internal appeal only: the aggregate number of INN inpatient Concurrent Review clinical internal appeals received
- Total # of Clinical Denials Overturned upon internal appeal only: the aggregate number of INN inpatient Concurrent Review clinical internal appeals overturned
- Clinical Denial Overturn Rate %, internal appeal only: percent of INN inpatient Concurrent Review clinical internal appeals overturned (Total # of Clinical Denials Overturned upon internal appeal/Total # of Clinical Denials reviewed upon internal appeal)
- Total # of Clinical Denials Upheld upon internal appeal: the aggregate number of INN inpatient Concurrent Review clinical internal appeals upheld
- Clinical Denial Uphold Rate %, internal appeal only: percent of INN inpatient Concurrent Review clinical internal appeals upheld (Total # of Clinical Denials Upheld upon internal appeal/Total # of Clinical Denials reviewed upon internal appeal)
- Total # of Clinical Denials reviewed upon external appeal only: the aggregate number of INN inpatient Concurrent Review clinical external appeals received
- Total # of Clinical Denials Overturned upon external appeal only: the aggregate number of INN inpatient Concurrent Review clinical external appeals overturned

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Review clinical external appeals overturned

- Clinical Overturn Rate %, external appeal only: percent of INN inpatient Concurrent Review clinical external appeals overturned (Total # of Clinical Denials Overturned upon external appeal/Total # of Clinical Denials reviewed upon external appeal)
- Total # of Clinical Denials Upheld upon external appeal: the aggregate number of INN inpatient Concurrent Review clinical external appeals upheld
- Clinical Uphold Denial Rate %, external appeal only: percent of INN inpatient Concurrent Review clinical external appeals upheld (Total # of Clinical Denials Upheld upon external appeal/Total # of Clinical Denials reviewed upon external appeal)

UHC

	In-Network Inpatient	
	M/S	MH/SUD
Total # of Requests Received	2,480	504
Total # of Requests Approved	1,748	504
Total # of Requests Clinically Denied	732	0
Approval Rate %	70.48%	100.00%
Clinical Denial Rate %	29.52%	0.00%
Total # of Clinical Denials reviewed upon appeal--Total (Internal & External)	0	2
Total # of Clinical Denials Overturned upon appeal--Total (Internal & External)	0	1
Clinical Denial Overturn Rate %- Total (Internal & External)	-	50.00%
Total # of Clinical Denials Upheld--Total (Internal & External)	0	1
Clinical Denial Uphold Rate %--Total (Internal & External)	-	50.00%
Total # of Clinical Denials reviewed upon internal appeal only	0	2
Total # of Clinical Denials Overturned upon internal appeal only	0	1
Clinical Denial Overturn Rate %, internal appeal only	-	50.00%
Total # of Clinical Denials Upheld upon internal appeal only	0	1
Clinical Denial Uphold Rate %, internal appeal only	-	50.00%
Total # of Clinical Denials reviewed upon external appeal only	0	0
Total # of Clinical Denials Overturned upon external appeal only	0	0
Clinical Overturn Rate %, external appeal only	-	-
Total # of Clinical Denials Upheld upon external appeal only	0	0
Clinical Uphold Denial Rate %, external appeal only	-	-

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UHC GA

Outcomes Data Concurrent Review Analysis:	In-Network Inpatient	
	M/S	MH/SUD
Total # of Requests Received	354	95
Total # of Requests Approved	243	95
Total # of Requests Clinically Denied	111	0
Approval Rate %	68.64%	100.00%
Clinical Denial Rate %	31.36%	0.00%
Total # of Clinical Denials reviewed upon appeal--Total (Internal & External)	0	0
Total # of Clinical Denials Overturned upon appeal--Total (Internal & External)	0	0
Clinical Denial Overturn Rate %- Total (Internal & External)	-	-
Total # of Clinical Denials Upheld--Total (Internal & External)	0	0
Clinical Denial Uphold Rate %--Total (Internal & External)	-	-
Total # of Clinical Denials reviewed upon internal appeal only	0	0
Total # of Clinical Denials Overturned upon internal appeal only	0	0
Clinical Denial Overturn Rate %, internal appeal only	-	-
Total # of Clinical Denials Upheld upon internal appeal only	0	0
Clinical Denial Uphold Rate %, internal appeal only	-	-
Total # of Clinical Denials reviewed upon external appeal only	0	0
Total # of Clinical Denials Overturned upon external appeal only	0	0
Clinical Overturn Rate %, external appeal only	-	-
Total # of Clinical Denials Upheld upon external appeal only	0	0
Clinical Uphold Denial Rate %, external appeal only	-	-

UHC RV

Outcomes Data Concurrent Review Analysis:	In-Network Inpatient	
	M/S	MH/SUD
Total # of Requests Received	196	62
Total # of Requests Approved	131	62
Total # of Requests Clinically Denied	65	0
Approval Rate %	66.84%	100.00%
Clinical Denial Rate %	33.16%	0.00%
Total # of Clinical Denials reviewed upon appeal--Total (Internal & External)	0	0
Total # of Clinical Denials Overturned upon appeal--Total (Internal & External)	0	0
Clinical Denial Overturn Rate %- Total (Internal & External)	-	-
Total # of Clinical Denials Upheld--Total (Internal & External)	0	0
Clinical Denial Uphold Rate %--Total (Internal & External)	-	-
Total # of Clinical Denials reviewed upon internal appeal only	0	0
Total # of Clinical Denials Overturned upon internal appeal only	0	0
Clinical Denial Overturn Rate %, internal appeal only	-	-
Total # of Clinical Denials Upheld upon internal appeal only	0	0
Clinical Denial Uphold Rate %, internal appeal only	-	-
Total # of Clinical Denials reviewed upon external appeal only	0	0
Total # of Clinical Denials Overturned upon external appeal only	0	0
Clinical Overturn Rate %, external appeal only	-	-
Total # of Clinical Denials Upheld upon external appeal only	0	0
Clinical Uphold Denial Rate %, external appeal only	-	-

Conclusions

The Plan reviewed the M/S and MH/SUD Concurrent Review operational policies and procedures and concluded the methodology used to determine which MH/SUD INN inpatient services are subject to Concurrent Review “as written” were comparable to, and applied no more stringently than, the methodology used to determine which M/S INN inpatient services are subject to Concurrent Review “as written.” Additionally, the Plan concluded that how Concurrent Review is applied to

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12/29/2023



MH/SUD INN inpatient services was comparable to, and applied no more stringently than, how Concurrent Review is applied to M/S INN inpatient services “as written.”

The Plan reviewed the M/S and MH/SUD processes, including responsibility for submission, timeframes for submission and review, notification to members and providers, clinical standards for review, staff qualifications, outcomes data, and IRR assessment results and concluded how the Plan conducts Concurrent Review for MH/SUD INN inpatient services “in operation” was comparable to, and applied no more stringently than, how the Plan conducts Concurrent Review for M/S INN inpatient services “in operation.”

Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical/surgical (M/S) benefits. This generally means that the financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements, such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage.

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Concurrent Review is defined as “a clinical review of an extension of previously approved, ongoing course of treatment over a period of time or number of treatments conducted during an inpatient stay or ongoing ambulatory care. It is sometimes called a “continued stay review.”” The *Optum National Policy Definitions List* defines a Concurrent (Review) Request as “a request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care. Concurrent Review does not involve onsite reviews.”

Concurrent Review is a component of the Plan’s Utilization Management (UM) program that helps ensure members receive appropriate coverage based on their specific clinical status and health care needs. The process is designed to achieve optimal clinical outcomes by applying objective, evidence-based clinical criteria and nationally recognized guidelines and best practices. Concurrent Review is a UM process that involves applying the benefit plan language and/or clinical criteria to make the most appropriate clinical coverage benefit determination.

This document includes the following information:

- The Concurrent Review process for M/S and MH/SUD outpatient services
- The description of the NQTL and application (Step 1)
- Factors used to determine which services are subject to the NQTL (Step 2)
- Evidentiary standards and sources used to define, trigger, and or implicate a factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

This analysis refers to the following attachments:

- *Addendum A* - Identifies the M/S and MH/SUD outpatient services that are subject to Concurrent Review
- *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions* - M/S policy that defines Concurrent Review
- *Optum National Policy Definitions List* - MH/SUD policy that defines Concurrent Review
- *Utilization Management Program Description (UMPD) of United HealthCare Services, Inc. and UnitedHealthcare Insurance Company* - Summarizes the philosophy, structure and standards that govern UHC’s medical management, UM and utilization review responsibilities and functions

- *Management of Behavioral Health Benefits Policy*- Describes the mechanisms and processes designed to promote consistency in the management of behavioral health benefits and to ensure that members receive appropriate, high quality behavioral health services in a timely manner
- *Concurrent Review Factor Grid(s) (2023 Prior Auth_Concurrent Rev Factor Grid)*- Details the service categories subject to Concurrent Review and the shared factors and evidentiary standards used as the basis for subjecting M/S and MH/SUD outpatient benefits to Concurrent Review
- *Certificates of Coverage* (for example: *COC23-INS-2018-LG-GA*, *COC23-HMO-2018-LG-GA* and *COC23-INS-2018-SG-GA*)- Plan document that explains covered services, terms, conditions, and limitations of the member's policy
- *Schedule of Benefits (SBN23-Medical-HMO-2018-[Choice][Select][Doctors]-LG-GA, SBN23-Medical-HMO-2018-[Choice][Select][Doctors]-SG-GA, SBN23-Medical-INS-2018-[Choice+Plus][Select+Plus][Doctors+Plus]-LG-GA and SBN23-Medical-INS-2018-[Choice+Plus][Select+Plus][Doctors+Plus]-SG-GA)*- Plan document that outlines member responsibilities
- *Core Principles and Practices*- MH/SUD policy that outlines the core principles and practices that should be used by personnel in their interactions with members, authorized member representatives, practitioners and facilities, related to the management of behavioral health benefits, coverage determinations and appeals/grievances of non-coverage determinations
- *Performance Assessment and Incentives*- M/S policy confirming that clinical reviewers are not incented to make denials for financial reasons
- *2023 UnitedHealthcare Provider Administrative Guide* – Informs M/S providers of the Concurrent Review process. The *UnitedHealthcare Provider Administrative Guide* can be accessed on the website <https://www.uhcprovider.com/en/admin-guides.html>
- *September 2023 Optum National Network Manual*- Informs MH/SUD providers of the Concurrent Review process. <https://public.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/optum-network-manual.html>

The Plan concludes that the Concurrent Review requirements for M/S and MH/SUD are comparable and applied no more stringently for MH/SUD in-network (INN) outpatient benefits both “as written” and “in operation.”

Process

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Concurrent Review is defined as: “a clinical review of an extension of previously approved, ongoing course of treatment over a period of time or number of treatments conducted during an inpatient stay or ongoing ambulatory care. It is sometimes called “continued stay review.” The *Optum National Policy Definitions List* defines a Concurrent (Review) Request as: “a request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care.”

The Plan structures outpatient Concurrent Review processes to be compliant with all applicable federal and state requirements, as well as the National Committee for Quality Assurance (NCQA) accreditation standards. NCQA confirms that the Plan's operations and policies identify appropriate timeframes for decisions, requires decision-making by appropriate personnel, and governs communication of adverse benefit determinations. In addition, Concurrent Review is governed at both the state and federal level, which includes consumer protections such as external review for adverse benefit determinations after internal appeals options are exhausted.

The Plan delegates management of MH/SUD outpatient services, including Concurrent Review to United Behavioral Health d/b/a Optum Behavioral Health (OBH), its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor.

The Plan has national committees that approve M/S and MH/SUD outpatient services to be subject to Concurrent Review. Additionally, the Plan has a standard process for assessing the services that are subjected to Concurrent Review and whether they should be retained or removed from the list of services that are subject to Concurrent Review. *Addendum A* includes a list

of all service categories subject to outpatient Concurrent Review.

Concurrent Review of M/S outpatient services consists of the following:

The Plan requires INN M/S providers to submit a Concurrent Review request for outpatient services that are described on *Addendum A*. The INN provider's submission of a request (notification) triggers the Concurrent Review process.

The Plan requires INN M/S providers to timely request coverage of additional units of service or extensions of time for services previously approved in Prior Authorization. The Plan reclassifies M/S outpatient Concurrent Review coverage requests as preservice/Prior Authorization requests consistent with NCQA UM standards. The Plan follows the outpatient Prior Authorization process for these requests and uses the outpatient Prior Authorization process to review requests for coverage of additional units of service or extensions of time for previously approved services.

INN providers may submit Prior Authorization requests through the secure provider portal (www.uhcprovider.com), their connected electronic medical record, by telephone, or by fax (where required). Members may submit Prior Authorization requests by phone, fax, or mail, in accordance with Plan requirements. Providers and members communicate basic information to create a case. As outlined in the *UnitedHealthcare Care Provider Administrative Guide*, providers must submit advance notification with supporting documentation as soon as possible, but at least two weeks before the planned service, unless otherwise stated. The provider's submission of a request (notification) triggers the Prior Authorization process.

The Plan confirms receipt of the Prior Authorization request. Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. Non-clinical staff may administratively deny coverage if member benefits are exhausted. Non-clinical staff review cases to ensure availability of accurate and thorough case information. Non-clinical staff may approve coverage requests in scenarios where the member's plan documents allow and if a clinical review is not required. Requests that are submitted through the secure provider portal may also be approved based on the benefit plan coverage criteria, member diagnosis, and the clinical information submitted. Non-clinical staff refer cases that they cannot approve or administratively deny to initial clinical reviewers for medical necessity review.

First Level Clinical Review/Initial Review. Clinical reviewers (nurses) consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs to determine whether the applicable clinical criteria are met. The clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. The clinical reviewer can approve cases that meet applicable clinical criteria.

Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Peer clinical reviewers (physician or mid-level practitioner) consult clinical criteria when making clinical coverage benefit determinations. Peer clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs. The peer clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If a peer clinical reviewer issues an adverse benefit determination, then the Plan communicates the adverse benefit determination, including appeal rights, and offers a peer-to-peer conversation consistent with state, federal, and accreditation requirements.

Adverse Benefit Determination. For M/S, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when member benefits are exhausted. Modified coverage requests that are approved are recorded as partial denials.

Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based medical clinical policies or use clinical criteria from third party sources such as InterQual® or MCG® guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that outpatient Concurrent Review determinations are appropriate.

M/S monitors clinical reviewer and peer clinical reviewer application of clinical criteria through an annual inter-rater reliability (IRR) assessment that is provided by InterQual. Clinical reviewers and peer clinical reviewers are required to pass the IRR assessment with a score of 90% or better through three attempts. After a second failed IRR assessment, staff enter a remediation period and are required to review all cases with a supervisor for 30 days, or until 90% is achieved on the assessment. If the clinical reviewer achieves a passing score within the 30-day period, supervisors review a minimum of one case per week for the remainder of the 30-day period.

The Plan also conducts end-to-end case audits that are designed and approved by clinical leadership each year. The end-to-end audits include all stages of a case review, from intake through appeal. These audits are conducted monthly and approximately 1500 cases are reviewed per month. Results are reported to an oversight team. All deficiencies are remediated. Remediation may include corrective actions and/or additional education, as indicated.

The Plan routinely monitors Concurrent Review performance through its clinical performance oversight functions. Outcomes are monitored against timeliness requirements, performance guarantees, and for potential trends, including overall utilization.

The Plan's National Medical Care Management Committee (NMCMC) annually reviews overall UM program outcomes, including inpatient Concurrent Review outcomes, to confirm overall utilization is appropriate. The NMCMC is comprised of the Chief Medical Officer, and representatives from clinical policy, clinical advocacy and grievances, business standardization and advancement, regional chief medical officers, inpatient care management, lines of business, medical policy, clinical operations, and OBH. The Chair of the NMCMC must be an executive leader and licensed physician.

As of April 1, 2023, the Utilization Management Program Committee (UMPC) began overseeing the M/S UM program. The UMPC is responsible for the development and maintenance of the M/S Prior Authorization processes. The UMPC ensures that the UM program considers the factors and evidentiary standards for applying UM. The UMPC is comprised of:

- Chief Medical Officer, Medical Management (Co-Chair)
- Senior Vice President, Clinical Advancement (Co-Chair)
- Chief Medical Officer, UnitedHealthcare
- Senior Vice President, Clinical Appeals & Grievances
- Chief Medical Officer, Clinical Policy
- Chief Medical Officer, UnitedHealthcare Employer & Individual
- Chief Medical Officer, UnitedHealthcare Medicare & Retirement
- Chief Medical Officer, Community & State
- Chief Medical Officer, UnitedHealthcare Individual & Family Plans
- Vice President, Clinical Transformation & Affordability
- Senior Director, Mental Health Parity
- Vice President, Utilization Management Strategy & Implementation

One of the chairs must be an executive leader and a licensed physician. UMPC meets at least six times per year but may meet more frequently if needed.

Per the M/S policy entitled, *Performance Assessment and Incentives*, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons.

M/S generally structures UM processes to comply with federal Employee Retirement Income Security Act of 1974 (ERISA) requirements, NCQA UM standards, and state law, where applicable.

Concurrent Review of MH/SUD outpatient services consists of the following:

The Plan delegates management of MH/SUD outpatient services, including Concurrent Review, to United Behavioral Health d/b/a OBH, its delegated MH/SUD MBHO vendor.

The Plan classifies MH/SUD outpatient requests as either urgent Concurrent Review or preservice depending on whether the MH/SUD request meets the NCQA standard for urgent or standard preservice requests.

The Plan requires INN MH/SUD providers to submit a Concurrent Review request for outpatient services that are described on *Addendum A*. Provider notification triggers the outpatient Concurrent Review process. Outpatient Concurrent Review begins when INN provider requests coverage for additional units of service and/or periods of time beyond those initially authorized by the Plan.

INN providers may submit authorization requests through the secure provider portal (www.providerexpress.com), by telephone, or by fax (where required). Members may submit authorization requests by telephone, fax, or mail, in accordance with Plan requirements. Intensive Outpatient Program (IOP) providers notify the Plan of the need for additional days/services by telephone and Partial Hospitalization Program (PHP) providers notify the Plan of the need for additional days/services by telephone or the secure provider portal.

As described in the *Management of Behavioral Health Benefits Policy*, the Plan confirms receipt of the Concurrent Review request. Non-clinical staff confirm member eligibility and benefit coverage. Non-clinical staff may approve cases that do not require clinical evaluation or interpretation based on the member's diagnosis and the clinical information submitted by providers. Non-clinical staff refer cases that they cannot approve to the initial clinical reviewers.

First Level Clinical Review/Initial Review. Clinical decisions are made by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse benefit determinations are made by Medical Directors or psychologists. Clinical reviewers consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether a service is medically necessary by reviewing the member's clinical information, the applicable clinical criteria or guidelines, and the Plan benefit terms. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for certification, related diagnostic results, and history of related treatment and services. The clinical reviewer may approve cases that meet applicable clinical criteria.

Second Level Clinical Review/Peer Review. The initial clinical reviewer refers cases to a peer clinical reviewer for a peer-to-peer discussion if the case cannot be approved. The requesting provider is offered the opportunity to discuss the case with the peer clinical reviewer, consistent with state, federal, and accreditation requirements before an adverse benefit determination is issued. Only qualified peer clinical reviewers (e.g., Medical Directors or psychologists) can issue adverse benefit determinations. Peer clinical reviewers apply clinical criteria to member clinical information to determine coverage for additional units of service during an extended period of time. If the requesting provider fails to complete the peer-to-peer discussion, the peer clinical reviewer makes a determination based on the information available. If a peer clinical reviewer issues an adverse benefit determination, (e.g., that numbers of treatments or extensions of time are not authorized), then the Plan timely communicates the adverse benefit determination, including appeal rights, to the member and provider consistent with applicable state, federal, and accreditation requirements.

Adverse Benefit Determination. For MH/SUD, an adverse benefit determination is recorded as a clinical denial when it is based on clinical criteria and member clinical information.

IOP Practice Management. The Plan identifies INN MH/SUD IOP facilities and clinics that demonstrate effective performance

based on readmission rates, lengths of stay, and post-discharge outcomes for inclusion in Practice Management. INN MH/SUD facilities or clinics that meet these performance criteria do not have to obtain Prior Authorization for IOP services. Instead, the facilities submit claims post-service, which the Plan pays.

Platinum Designation. The Plan offers a Platinum Designation program to INN MH/SUD PHP providers based on facilities' quantitative practice patterns (effectiveness and efficiency benchmarks). The Platinum Designation program's effectiveness and efficiency benchmarks include targeted 30- and 90-day readmission rates, 7- and 30-day follow up after hospitalization, outlier length of stay, and outlier behavioral health episode spend. INN MH/SUD providers facilities that meet the Platinum Designation are required to notify the Plan of admissions to PHP and provide member information. The Plan covers the first 17 days of admission to PHP without review. Facilities notify the Plan if additional days are needed. The Plan evaluates INN MH/SUD facilities' performance annually as described in the *Optum National Network Manual*.

Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity clinical coverage determinations on objective, evidence-based behavioral clinical policies or use clinical criteria from third-party sources such as, American Society of Addiction Medicine (ASAM) Criteria®, Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System-Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) and Early Childhood Service Intensity Instrument (ECSII) guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that outpatient Concurrent Review determinations are appropriate.

MH/SUD monitors clinical reviewer and peer clinical reviewer application of clinical criteria through an annual IRR assessment. Clinical reviewers and peer clinical reviewers are required to pass the IRR assessment with a score of 90% or better through three attempts. After a second failed IRR assessment, the reviewer enters a remediation period and is required to review all cases with a supervisor for 30 days, or until 90% is achieved on the assessment. If the clinical reviewer achieves a passing score within the 30-day period, supervisors review a minimum of one case per week for the remainder of the 30-day period.

The Plan also conducts monthly quality audits of individual non-clinical staff, clinical reviewers, and peer clinical reviewers, including staff performing appeal functions. These audits are designed and approved by clinical leadership each year. A minimum of two audits are completed per staff, per month. The results of these real-time audits are shared with supervisors for staff oversight, and all findings are remediated. Remediation may include corrective actions and/or additional education, as indicated.

The Plan routinely monitors Concurrent Review performance through its clinical performance oversight functions. Outcomes are monitored for timeliness compliance, performance guarantee compliance, and potential trends, including overall utilization.

The Plan's national Clinical Quality & Operations Committee (CQOC) annually reviews overall UM program outcomes, including outpatient Concurrent Review outcomes, to confirm overall utilization is appropriate. The national CQOC is comprised of representatives from sub-committees, and representatives from the clinical quality improvement, UM, care engagement, medical operations, medical policy and standards, clinical operations, appeals, product, legal, compliance, network strategy, provider experience, accreditation, and benefits teams. The Chair of the CQOC must be an executive leader, board certified in psychiatry or psychiatric subspecialty and a licensed physician.

Per the MH/SUD policy entitled, *Core Principles and Practices*, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse clinical coverage benefit determinations (clinical denials) for financial reasons.

MH/SUD generally structures UM processes to comply with federal ERISA requirements, NCQA UM standards, and state law, where applicable.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- Concurrent Review

Benefit Classification(s)

- INN, outpatient

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHIC)
- UnitedHealthcare of Georgia, Inc. (UHCGA)

Plan Terms/Source Document(s)

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Concurrent Review is defined as “A clinical review of an extension of previously approved, ongoing course of treatment over a period of time or number of treatments conducted during an inpatient stay or ongoing ambulatory care. It is sometimes called a “continued stay review.””

The *Optum National Policy Definitions List* defines a Concurrent (Review) Request as:

“A request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care. In addition, the following should be considered when defining Concurrent Reviews:

- If a request to extend a course of treatment beyond the period of time or number of treatments previously approved by the organization does not meet the definition of urgent care, the request may be handled as a new request and decided within the time frame appropriate for the type of decision (e.g., standard pre-service or post-service review).
- In addition, a request made while a member is in the process of receiving care should be considered an urgent Concurrent (Review) Request if the care requested meets the definition of urgent, even if the organization did not previously approve the earlier care.”

The Plan’s Certificates of Coverage notifies members of Concurrent Review requirements:

“The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, Concurrent Review, case management, discharge planning, retrospective review or similar programs.”

The *2023 UnitedHealthcare Care Provider Administrative Guide* notifies providers of the Concurrent Review requirements. INN providers are required to comply with UM protocols established by the Plan:

“We determine the medical necessity of inpatient admissions through either concurrent or retrospective review. We require you to comply with our requests:

- For information, documents or discussions related to our reviews and discharge planning. This includes primary and secondary diagnosis, clinical information, treatment plan, admission order, patient status, discharge planning needs, barriers to discharge and discharge date. When available, provide access to electronic medical records (EMR).
- From our interdisciplinary care coordination team and/or Medical Director. This includes our requests that you help us engage our members directly face-to-face or by phone.
 - If you receive the request before 1 p.m. local time:
 - › Supply all requested information within 4 hours
 - If you receive our request after 1 p.m. local time:
 - › Provide the information within the same business day, but no later than 12 p.m. local time the next business

day”

The *Optum National Network Manual*, September 2023 Edition notifies providers of the Concurrent Review requirements. INN providers are required to comply with UM protocols established by the Plan:

“In most cases, inpatient admissions will be directed only to participating hospitals and attending psychiatrists.

All inpatient and sub-acute level of care admissions require notification or pre-authorization by the network provider or facility. Optum requires notification within one business day after an admission for a facility to request a pre-authorization unless a longer period is required by contract or state specific requirements. This includes, but is not limited to, mental health or substance abuse disorder services delivered as inpatient treatment, partial/day hospitalization or residential treatment.

Network providers are solely responsible for completing prior notification or obtaining preauthorization prior to providing inpatient or sub-acute level of care services. This includes timely provision of information necessary for concurrent review of continued stay or ongoing care requests prior to the delivery of services.

Should a provider fail to obtain or otherwise follow the required administrative procedures for notification or pre-authorization, Optum may, in accordance with applicable law, apply a reduction of payment to the network provider up to 100% of provider's reimbursement rate. Network provider payment reductions for failure to complete notification or obtain pre-authorization are solely the network provider's liability (i.e., the member cannot be billed for these reductions in payment).”

The role of the Plan's delegate, United Behavioral Health d/b/a OBH, is discussed in the *UMPD*:

“United Behavioral Health (UBH) performs the review of requests for coverage of behavioral health services (i.e., substance abuse, and mental health requests for services). UBH provides comprehensive behavioral health care delivery for members through a network of behavioral health practitioners, ancillary care providers, hospitals and other facilities.

For mental health, substance-related disorder services, and wraparound services, UBH uses its Clinical Criteria (see below), behavioral clinical policies and best practice guidelines to make coverage determinations. UBH adopts externally-developed clinical criteria, and creates internally-developed Clinical Criteria, where appropriate, based on its assessment of relevant guidance. UBH develops clinical criteria that supersedes its standard set or adopts externally-developed clinical criteria when required to do so by contract or regulation.

- Clinical Criteria (Level of Care Utilization System-LOCUS) – Standardized level of care assessment tool developed by the American Association of Community Psychiatrists used to make clinical determinations and placement decisions for mental health disorder benefits for adults ages 19 and older when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (Child and Adolescent Level of Care/Service Intensity Utilization System-CALOCUS-CASII) - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry (AACAP) and the American Association for Community Psychiatry (AACP) used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children and adolescents ages 6-18 when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (Early Childhood Service Intensity Instrument-ECSII) - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children ages 0-5 when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (State or Contract Specific Level of Care Guidelines) – Criteria used to make medical necessity determinations for mental health disorder benefits when there are explicit mandates or contractual requirements.
- Clinical Criteria (American Society of Addiction Medicine [ASAM]) - Criteria developed by the American Society of Addiction Medicine used to make clinical determinations for substance-related disorder benefits.
- Clinical Criteria (Optum Developed)
 - Optum Behavioral Clinical Policies: Criteria that stem from evaluation of new services or treatments or new applications of existing services or treatments and are used to make clinical determinations regarding proven or unproven services and treatments.

- Optum Supplemental Clinical Criteria: Criteria used to make clinical determinations for Applied Behavior Analysis, and Electroconvulsive Therapy.
- Optum's Supplement to the APA Psychological and Neuropsychological Testing Billing and Coding Guide: Additional criteria used regarding provider qualifications, coverage rationale, limitations, and developmental testing.

Licensed practitioners conduct all reviews with a focus on measurable outcome goals and objectives for treatment. A senior UBH Medical Director is responsible for directing and implementing behavioral health utilization management programs. A referral is sent to UBH when a member is identified as potentially benefiting from behavioral health services during a "medical event."

The UBH UM Program is staffed by clinical, non-clinical and administrative personnel. All clinical denials or adverse decisions are made by board certified psychiatrists, or, if the health plans choose, by a panel of other appropriate health care service reviewers. If the health plan chooses to use a panel to make adverse decisions, the panel contains at least one physician who is board certified in psychiatry. When the health care service under review is a mental health or substance abuse service, the adverse decision is made by a licensed physician who is board certified in psychiatry. All potential clinical denials are referred to a physician who is board certified in psychiatry for final determination. An evaluation of the overall effectiveness of the Behavioral Health UM Program is conducted annually to determine how well resources have been deployed to improve UM activities and the clinical care and service provided to members."

The Plan's terms require services to be medically necessary for coverage. INN providers are required to comply with the Plan's UM protocols including complying with Concurrent Review requirements.

List of M/S and MH/SUD Services Subject to NQTL

Addendum A, attached, lists the M/S and MH/SUD INN outpatient service categories subject to Concurrent Review.

Concurrent Review is one component of the UM program that evaluates whether a benefit or service is medically necessary.

- The "Member" tab lists the service categories for which the member is responsible for providing notification for both INN and out-of-network (OON) services. The "Member" tab includes all products in the scope of the analysis.
- The "Provider" tab lists the service categories for which the provider is responsible for providing notification for INN services. The "Provider" tab applies to all Plans in the scope of the analysis.

Step 2 – Factors Used in the Design and Application of the NQTL

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

The list of services subject to Concurrent Review was originally designed by enterprise clinical leadership. Concurrent Review was applied to new services when they became covered by the Plan and met certain criteria. Examples of Concurrent Review determinants that existed in the business at the time included:

- to monitor and prevent potential overutilization and under-utilization
- manage high-cost and prolonged-duration services
- ensure enrollee safety
- determine the appropriate level of care
- determine whether the service or item is medically necessary

The factors relied upon to determine which INN outpatient benefits were subjected to Concurrent Review were updated and replaced in 2021 with the factors Clinical Appropriateness, Value, and Variation as defined below. After this time, all M/S services subject to Concurrent Review must meet Clinical Appropriateness and all MH/SUD services subject to Concurrent Review must meet Clinical Appropriateness and at least one of the other factors.

Starting in 2022, any additions or deletions to the list of services subject to Concurrent Review were reviewed and approved through committees.

The Plan relies on the following factors to determine which INN outpatient services are added to the list of services subject to Concurrent Review. These factors apply to M/S and MH/SUD for the following:

- I. M/S: INN outpatient Services
 - II. MH/SUD: INN outpatient Services
- Clinical Appropriateness (Qualitative)
 - Whether the application of Concurrent Review promotes optimal clinical outcomes

Applies to M/S and MH/SUD services.
 - Value (Quantitative)
 - The cost of the outpatient service exceeding the administrative costs of subjecting the outpatient services to Concurrent Review by at least 1:1. Administrative costs of subjecting the outpatient service to Concurrent Review are determined using the national UM program operating costs, which is comprised of costs related to staffing. Administrative costs vary due to differences in the complexities of the requested treatment types, condition(s) treated, and/or clinical guidelines used. The cost of the outpatient service is determined using national outpatient utilization or claims data. The projected benefit cost savings of applying Concurrent Review is reviewed relative to the operating cost of administering Concurrent Review to determine Value. Only services that are provided to a minimum of 100 unique individuals are considered (this is the materiality threshold established by the Plan for purposes of the Value analysis).

Applies to MH/SUD and M/S services.
 - Variation (Quantitative)
 - The cost per episode of service (service units multiplied by unit cost) that trigger 2x the mean of the costs of other outpatient services. Consideration of this factor includes a review of internal claims data for service-specific costs and calculating for M/S and MH/SUD, respectively, an overall mean of the service-specific average cost per patient. For any given M/S or MH/SUD service, if the average allowed cost per patient's episode of care is twice the average cost per patient's episode of care across all other M/S or MH/SUD outpatient services, Concurrent Review is applied. Only services that are provided to a minimum of 20 unique individuals are considered (this is the materiality threshold established by the Plan for the purposes of the Variation analysis)

Applies to MH/SUD and M/S services

For M/S meeting Clinical Appropriateness is determinative in imposing the limitation. For MH/SUD meeting Clinical Appropriateness plus Value and/or Variation is determinative in imposing the limitation. The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL.

In 2023, to further refine how decisions are made to subject M/S and MH/SUD INN outpatient services to Concurrent Review, the enterprise adopted factors to be assessed when considering whether to remove or retain services on the list of services subject to Concurrent Review. These changes were implemented September 2023. The assessment first considered the factors for removal of the service from the Concurrent Review list. If the service met a removal factor, the Plan then assessed if the service met a retention factor. Services that met a retention factor were retained on the Concurrent Review list. Services that did not meet a removal factor remained on the Concurrent Review list based on the original add factors.

The Plan relies on the following factors to determine which INN outpatient benefits are removed from the list of services subject to Concurrent Review. These factors apply to M/S and MH/SUD benefits for the following:

- I. M/S: INN outpatient services
- II. MH/SUD: INN outpatient services

- **Low Value (Quantitative)**
 - Defined as services that do not result in a minimum savings of at least \$50 per review

Applies to M/S and MH/SUD services.
- **Consistency (Quantitative)**
 - Defined as consistent adherence to evidence-based guidelines as evidenced by adverse determination rate (ADR) of less than 5%

Applies to M/S and MH/SUD services.
- **Low Volume (Quantitative)**
 - Defined as services with fewer than 100 authorizations per year

Applies to M/S and MH/SUD services.

Please note that if the primary code within a code family meets the requirements for removal, the family of codes will be addressed in a similar fashion per medical policy and clinical practice patterns.

The Plan then relies on the following factors to determine which INN outpatient benefits are retained on the list of services subject to Concurrent Review. These factors apply to M/S and MH/SUD benefits for the following:

- I. M/S: INN outpatient services
 - II. MH/SUD: INN outpatient services
- **Services that are experimental, investigational, or unproven (EIU) (Qualitative)**
 - Defined as services that are classified as experimental, investigation or unproved based on medical/behavioral clinical policy

Applies to M/S and MH/SUD services.
 - **Patient Safety (Qualitative)**
 - As defined by the World Health Organization as “the absence of preventable harm to a patient and reduction of risk of unnecessary harm associated with health care to an acceptable minimum.”

Applies to M/S and MH/SUD services.
 - **Level of Care (Quantitative)**
 - Defined as Site of Service/Site of Care, and where volume is greater than 100 requests per year

Applies to M/S and MH/SUD services.
 - **High-Cost Drugs and Services that are greater than \$100,000 (Quantitative)**
 - Defined as services where the allowed amount is greater than \$100,000 per treated patient, per year

Applies to M/S and MH/SUD services.

For M/S meeting Clinical Appropriateness is determinative in imposing the limitation. For MH/SUD meeting Clinical Appropriateness plus Value and/or Variation is determinative in imposing the limitation. If the service met a removal factor, the Plan then assessed if the service met a retention factor. Services that met a retention factor were retained on the list of services subject to Concurrent Review. Meeting any one of the factors is determinative in retaining the limitation. The factors are not weighted in that no individual factor carries more value than another in retaining the NQTL.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factors used to add services to the list of services subject to outpatient Concurrent Review. These evidentiary standards and sources apply to benefits for the following:

- I. M/S: INN outpatient services
- II. MH/SUD: INN outpatient services

Factor – Clinical Appropriateness is defined as those outpatient services that are determined by internal medical experts to be in accordance with objective, evidence-based clinical criteria, and nationally recognized guidelines. The accompanying *Concurrent Review Factor Grid(s)* included with this analysis give details on the service categories subject to Concurrent Review. The *Concurrent Review Factor Grid(s)* detail the shared factors used as the basis for subjecting M/S and MH/SUD outpatient services to Concurrent Review.

- The Plan's evidentiary standards and sources that define and/or trigger the identification of the Clinical Appropriateness factor are:
 - Clinical criteria from nationally recognized third-party sources (e.g., InterQual or MCG for M/S services, and ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines for MH/SUD services)
 - Clinical Technology Assessment Committee (CTAC) and Medical Technology and Assessment Committee (MTAC) review
 - Objective, evidence-based medical/behavioral clinical policies, and nationally recognized guidelines approved by professional healthcare associations (e.g., clinical guidance from the American Medical Association, American Psychiatric Association, etc.)

These evidentiary standards and sources apply to M/S and MH/SUD services and are defined in a qualitative manner.

Factor – Value is defined as the cost of the outpatient service exceeding the administrative costs of subjecting the outpatient services to Concurrent Review by at least 1:1. Administrative costs of subjecting the outpatient service to Concurrent Review are determined using the national UM program operating costs, which is comprised of cost related to staffing. Administrative costs vary due to differences in the complexities of the requested treatment types, condition(s) treated, and/or clinical guidelines used. The cost of the outpatient service is determined using national outpatient utilization or claims data. The projected benefit cost savings of applying Concurrent Review is reviewed relative to the operating cost of administering Concurrent Review to determine Value. Only services that are provided to a minimum of 100 unique individuals are considered (this is the materiality threshold established by the Plan for the purposes of the Value analysis). The accompanying *Concurrent Review Factor Grid(s)* contain the calculated Value for each Concurrent Review service category for both M/S and MH/SUD, and the internal data used to determine these values.

- The Plan's evidentiary standard that defines and/or triggers the Value factor:
 - Value is defined as the cost of the outpatient service exceeding the administrative costs of subjecting the service to Concurrent Review by at least 1:1. Only services that are provided to a minimum of 100 unique individuals are considered (this is the materiality threshold established by the Plan for purposes of the Value analysis)

- The Plan's sources used to define the Value factor:
 - National internal claims data
 - National UM program operating costs
 - National UM authorization data

This evidentiary standard and sources apply to M/S and MH/SUD INN outpatient services and are defined in a quantitative manner.

Factor – Variation is defined as cost per episode of service (service units multiplied by unit cost) that trigger 2x the mean of the costs of other outpatient services. Consideration of this factor includes a review of internal claims data for service-specific costs and calculating for M/S and MH/SUD, respectively, an overall mean of the service-specific average cost per patient. For any given M/S or MH/SUD service, if the average allowed cost per patient's episode of care is twice the average cost per patient's episode of care across all other M/S or MH/SUD outpatient services, Concurrent Review is applied. Only services that are provided to a minimum of 20 unique individuals are considered (this is the materiality threshold established by the Plan for the purposes of the Variation analysis). The accompanying *Concurrent Review Factor Grid* reflect whether each category of M/S and MH/SUD INN services meets the Variation criteria, and contains the internal data used in the determination.

- The Plan's evidentiary standard that defines and/or triggers the Variation factor:
 - Variation is defined as cost per episode of service (service units multiplied by unit cost) that trigger 2x the mean of other outpatient services. Only services that are provided to a minimum of 20 unique individuals are considered (this is the materiality threshold established by the Plan for purposes of the Variation analysis)
- The Plan's source that defines and/or triggers the identification of the Variation factor:
 - National internal claims data

The evidentiary standard and source applies to M/S and MH/SUD INN outpatient services and are defined in a quantitative manner.

For M/S meeting Clinical Appropriateness is determinative in imposing the limitation. For MH/SUD meeting Clinical Appropriateness plus Value and/or Variation is determinative in imposing the limitation. The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL.

In 2023, to further refine how decisions are made to subject M/S and MH/SUD INN outpatient services to Concurrent Review, the enterprise adopted factors to be assessed when considering whether to remove or retain services on the list of services subject to Concurrent Review. These changes were implemented September 2023. The assessment first considered the factors for removal of the service from the list of services subject to Concurrent Review. If the service met a removal factor, the Plan then assessed if the service met a retention factor. Services that met a retention factor were retained on the list of services subject to Concurrent Review. Services that did not meet a removal factor remained on the list of services subject to Concurrent Review based on the original add factors.

The Plan relies on the following factors to determine which INN outpatient benefits are removed from the list of services that are subject to Concurrent Review. These factors apply to M/S and MH/SUD benefits for the following:

- I. M/S: INN outpatient services
- II. MH/SUD: INN outpatient services

Factor - Low Value is defined as services that do not result in a minimum savings of at least \$50 per review

- The Plan's evidentiary standard that triggers and/or defines the Low Value factor:

- Low Value is defined as services that do not result in a minimum savings of at least \$50 per review

- The Plan's sources used to define the Low Value factor:

- National internal claims data
- National UM program operating costs
- National UM authorization data

The evidentiary standard and the sources apply to M/S and MH/SUD INN outpatient services and are defined in a quantitative manner.

Factor - Consistency is defined as consistent adherence to evidence-based guidelines as evidenced by ADR of less than 5%

- The Plan's evidentiary standard that defines and/or triggers the Consistency factor:

- Consistency is defined as consistent adherence to evidence-based guidelines as evidenced by ADR of less than 5%

- The Plan's source used to define the Consistency factor:

- National internal UM outcomes data

The evidentiary standard and the source apply to M/S and MH/SUD INN outpatient services and are defined in a quantitative manner.

Factor - Low Volume is defined as services with fewer than 100 authorizations per year

- The Plan's evidentiary standard that defines and/or triggers the Low Volume factor:

- Low Volume is defined as services with fewer than 100 authorizations per year

- The Plan's source used to define the Low Volume factor:

- National internal UM outcomes data

This evidentiary standard and the source apply to M/S and MH/SUD INN outpatient services and are defined in a quantitative manner.

The Plan then relies on the following factors to determine which INN outpatient benefits are retained on the list of services that are subject to Concurrent Review. These factors apply to M/S and MH/SUD benefits for the following:

- I. M/S: INN outpatient services
- II. MH/SUD: INN outpatient services

Factor - Services that are EIU is defined as services that are classified as experimental, investigation or unproved based on medical/behavioral clinical policy

- The Plan's evidentiary standard that defines and/or triggers the Services that are EIU factor:

- Services that are classified as experimental, investigation or unproved based on medical policy

- The Plan's source used to define the Services that are EIU factor:

- Medical/behavioral clinical policies

This evidentiary standard and the source apply to M/S and MH/SUD INN outpatient services and are defined in a qualitative manner.

Factor - Patient Safety is defined as "the absence of preventable harm to a patient and reduction of risk of unnecessary harm

associated with health care to an acceptable minimum" by the World Health Organization.

- The Plan's evidentiary standards that define and/or trigger the Patient Safety factor:
 - Professional judgment of members of the Utilization Management Program Committee
 - Clinical criteria from nationally recognized third-party sources (e.g., InterQual for M/S services, and ASAM, LOCUS, CALOCUS-CASII and ECSII guidelines for MH/SUD services)
 - Objective, evidence-based medical/behavioral clinical policies and nationally recognized guidelines approved by professional healthcare associations (e.g., clinical guidance from the American Medical Association, American Psychiatric Association, etc.)
- The Plan's sources used to define the Patient Safety factor:
 - Professional judgment of members of the Utilization Management Program Committee
 - Clinical criteria from nationally recognized third-party sources (e.g., InterQual for M/S services, and ASAM, LOCUS, CALOCUS-CASII and ECSII guidelines for MH/SUD services)
 - Objective, evidence-based medical/behavioral clinical policies and nationally recognized guidelines approved by professional healthcare associations (e.g., clinical guidance from the American Medical Association, American Psychiatric Association, etc.)

These evidentiary standards and the sources apply to M/S and MH/SUD INN outpatient services and are defined in a qualitative manner.

Factor - Level of Care is defined as Site of Service/Site of Care, and where the volume is greater than 100 requests per year

- The Plan's evidentiary standards that define and/or trigger the Level of Care factor:
 - National internal UM outcomes data
 - National internal claims data
 - Place of service
- The Plan's sources used to define the Level of Care factor:
 - National internal UM outcomes data
 - National internal claims data
 - Place of service

These evidentiary standards and the sources apply to M/S and MH/SUD INN outpatient services and are defined in a quantitative manner.

Factor - High-Cost Drugs and Services that are greater than \$100,000 is defined as services where the allowed amount is greater than \$100,000 per treated patient, per year

- The Plan's evidentiary standard that defines and/or triggers the High-Cost Drugs and Services that are greater than \$100,000 factor:
 - National internal claims data
- The Plan's source used to define the High-Cost Drugs and Services that are greater than \$100,000 factor:
 - National internal claims data

This evidentiary standard and the source applies to M/S and MH/SUD INN outpatient services and are defined in a quantitative manner.

If the service met a removal factor, the Plan then assessed if the service met a retention factor. Services that met a retention factor were retained on the Concurrent Review list. Meeting any one of the factors is determinative in retaining the limitation. The factors are not weighted in that no individual factor carries more value than another in retaining the NQTL.

The factors and evidentiary standards used as the basis for subjecting MH/SUD INN outpatient benefits to Concurrent Review are comparable to, and applied no more stringently than, the factors and evidentiary standards used as the basis for subjecting M/S INN outpatient benefits to Concurrent Review "as written" and "in operation."

Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

As Written

The Plan conducted a comparative analysis of the strategies, processes, factors, evidentiary standards, and source information used to determine which M/S and MH/SUD INN outpatient services are subject to Concurrent Review and how Concurrent Review is applied to M/S and MH/SUD INN outpatient services “as written.” The Plan identified the factors and evidentiary standards used as the basis for subjecting M/S and MH/SUD INN outpatient benefits to Concurrent Review.

National internal committees apply the applicable factors and standards described in Steps 2 and 3 to M/S and MH/SUD services when determining whether the services should be subjected to Concurrent Review

Review of Factors and Evidentiary Standards

The Plan follows the Prior Authorization process for Concurrent Review of M/S and MH/SUD INN outpatient services. The Plan reviewed the factors that trigger an INN outpatient service to be added to, removed from, or retained on the list of services subject to Concurrent Review. The factors and evidentiary standards were applied to M/S and MH/SUD services comparably and not more stringently to MH/SUD services than to M/S services as evidenced by the attached *Concurrent Review Factor Grid(s)*.

Review of Operational Policies and Procedures

The Plan reviewed M/S and MH/SUD operational policies and procedures, IRR assessment processes, and UM annual oversight to confirm comparability and found MH/SUD policies, procedures, and processes to be comparable and no more stringent than M/S policies, procedures, and processes.

- Medical management operational policies and procedures establish the standards for how the Plan conducts outpatient Concurrent Review. The policies and procedures are consistent with state and federal law and accreditation requirements governing Concurrent Review. Timeframes for decisions, content of adverse benefit determinations, appeal rights and external review are all governed by state and federal law and accreditation requirements.
- The IRR assessment measures the consistency with which clinical reviewers and peer clinical reviewers apply the Plan's clinical criteria. IRR assessment processes apply to both M/S and MH/SUD outpatient services.
- UM oversight monitors and evaluates UM processes by reviewing program outcomes, clinical appeals, IRR assessment, and under- and over-utilization.

Review of Outpatient Concurrent Review Processes

The strategy for applying Concurrent Review to INN outpatient services is comparable for M/S and MH/SUD services and is applied no more stringently to MH/SUD INN outpatient services. The Plan conducted a review of the M/S and MH/SUD Concurrent Review processes to confirm comparability. The review focused on the following aspects of the process for both M/S and MH/SUD:

- Notification. INN M/S and MH/SUD providers are contractually responsible for requesting coverage for the

continuation of the course of treatment and/or for additional units of outpatient services that exceed the periods of time or units of service previously approved by the Plan, including clinical information for both M/S and MH/SUD. The provider can submit the authorization request through the secure provider portal, by telephone, or by fax (where required).

- **Timeframe to Submit.** INN M/S and MH/SUD providers should notify the Plan as soon as reasonably possible.
- **Clinical Reviews.** For M/S and MH/SUD outpatient Concurrent Review requests, clinical reviewers may gather more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs. The clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. The clinical reviewer may approve cases that meet applicable clinical criteria.
- **Review Timeframes.** M/S and MH/SUD outpatient Concurrent Review determination timeframes are defined by state, federal, and accreditation requirements for both urgent and non-urgent outpatient services. The same determination timeframes apply to M/S and MH/SUD determinations.
- **Determinations and Nonclinical Reviews, First Level Clinical Reviews, and Second Level / Peer Clinical Reviews.** For M/S outpatient Concurrent Review, non-clinical staff may administratively deny cases when member benefits are exhausted. For M/S and MH/SUD non-clinical staff may approve cases that do not require clinical evaluation or interpretation. M/S INN outpatient cases that are submitted through the provider portal may also be approved based on the member diagnosis and the clinical information submitted. Non-clinical staff refer coverage requests that they cannot approve or administratively deny to clinical reviewers. Clinical reviewers consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether an outpatient service is medically necessary. The clinical reviewer may approve the services based on their review. The clinical reviewer refers cases to a peer clinical reviewer for a peer-to-peer discussion if the case cannot be approved. Only qualified peer clinical reviewers may issue adverse benefit determinations. Peer-to-peer discussions are offered as required.
 - For MH/SUD INN outpatient Concurrent Review there are programs through which facilities or clinics that would otherwise need to request Concurrent Review are not required to do so.
- **Adverse Benefit Determinations and Peer-to-Peer Conversations.** The Plan offers INN outpatient providers the opportunity to discuss a potential adverse benefit determination before the Plan issues such determination. This process allows INN outpatient providers the opportunity to provide additional information prior to an adverse benefit determination being issued.
 - INN outpatient M/S and MH/SUD services
 - An adverse benefit determination is recorded as a clinical denial when it is based on clinical criteria and member clinical information and is recorded as an administrative denial when member benefits are exhausted/excluded.
- **Notification of Decisions to Providers and Members.** The Plan notifies M/S and MH/SUD INN providers and members of approvals and adverse benefit determinations, including applicable appeal rights, consistent with state, federal, and accreditation requirements.
- **Review of Staff Qualifications.** For M/S and MH/SUD, clinical staff qualifications align with the type of clinical review and state, federal, and accreditation requirements (NCQA).
 - M/S is staffed by clinical, non-clinical, and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., nurses, physicians, etc.) and all adverse benefit determinations are made by a physician or other appropriate health care professionals.
 - MH/SUD is staffed by clinical, non-clinical, and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse benefit determinations are made by Medical Directors or psychologists.
- **Clinical Criteria.** For M/S and MH/SUD, clinical reviewers and peer clinical reviewers base determinations on objective, evidence-based medical/behavioral clinical policies and use clinical criteria from third party sources such as InterQual, MCG, ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines.

In Operation

The Plan compared the strategies, processes, factors, evidentiary standards, and source information used to determine which M/S and MH/SUD INN outpatient services are subject to Concurrent Review and how Concurrent Review is applied “in operation.”

The Plan required INN M/S and MH/SUD providers to submit requests for coverage of additional units of outpatient services and/or extended periods of time for previously approved INN outpatient services. M/S and MH/SUD provider requests for INN services triggered the outpatient Concurrent Review process.

M/S and MH/SUD outpatient Concurrent Reviews included confirmation of member eligibility and benefit availability for the requested services. For both M/S and MH/SUD INN outpatient services, non-clinical staff approved coverage for outpatient services that did not require clinical review or interpretation.

M/S and MH/SUD outpatient cases that were not administratively approved in initial a review were referred to a clinical reviewer for further research and evaluation. The M/S and MH/SUD clinical reviewers applied benefit plan documents and medical necessity criteria to member clinical information. M/S and MH/SUD clinical reviewers could request additional clinical information if they were unable to approve cases based on the available member clinical information. The clinical reviewers may approve services based on their review.

If the requested clinical information was not received or if the case could not be approved, M/S and MH/SUD clinical reviewers referred cases to a peer clinical reviewer. For INN MH/SUD outpatient cases. The Plan offered peer-to-peer conversations so the INN MH/SUD provider could provide additional clinical information prior to the issuance of an adverse benefit determination. Only qualified peer clinical reviewers issued both M/S and MH/SUD adverse benefit determinations.

The Plan communicated all adverse benefit determinations for M/S and MH/SUD outpatient cases that did not meet applicable clinical criteria consistent with state, federal, and accreditation requirements, including appeal rights, as applicable.

The Plan monitors M/S and MH/SUD clinical and peer clinical reviewers’ application of clinical criteria through annual IRR assessments. The Plan also conducts monthly quality audits of individual non-clinical staff, clinical reviewers, and peer clinical reviewers, including staff performing appeal functions. The Plan routinely monitors Concurrent Review performance through its clinical performance oversight functions. In addition to comparing these “in operation” processes, the Plan reviewed medical necessity approval and denial rates, internal appeals outcomes, and external appeals outcomes related to Concurrent Review determinations for M/S and MH/SUD INN outpatient services. The results of these analyses are discussed in greater detail in Step 5.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan’s or issuer’s findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The findings of the Plan’s comparative analyses confirmed the strategies, processes, factors, evidentiary standards, and source information used to determine the MH/SUD INN outpatient services subject to Concurrent Review were comparable to, and applied no more stringently than, the strategies, processes, factors, evidentiary standards, and source information used to determine the M/S INN outpatient services subject to Concurrent Review “as written.” For M/S and MH/SUD INN outpatient benefits, the *Concurrent Review Factor Grid(s)* included with this analysis detail the shared factors used as the basis for adding, removing or retaining M/S and MH/SUD INN outpatient services on the list of services subject to Concurrent Review, as described above.

The Plan found the factors used to add, remove, or retain MH/SUD INN outpatient services on the list of services subject to Concurrent Review were comparable to, and applied no more stringently than, the factors used to add, remove, or retain M/S INN outpatient services on the list of services subject to Concurrent Review. INN M/S and MH/SUD outpatient services that met the applicable factor(s) were subject to Concurrent Review “in operation.”

The Plan used comparable processes to conduct outpatient Concurrent Review of INN M/S and MH/SUD providers’ requests for coverage of additional units of service or extended periods of time beyond those previously approved by the Plan. The Plan required M/S and MH/SUD INN providers to timely request coverage. The Plan used qualified staff to confirm member eligibility and benefit availability, and to request additional clinical information if necessary. The Plan issued approvals for M/S and MH/SUD outpatient services that met applicable clinical criteria or guidelines. Only qualified M/S and MH/SUD peer clinical reviewers issued adverse benefit determinations. The Plan gave INN providers the opportunity to discuss potential adverse benefit determinations with qualified peer clinical reviewers prior to issuing adverse benefit determinations. This afforded INN providers the opportunity to provide additional information.

The Plan operated monitoring and oversight programs to ensure that clinical reviewers and peer clinical reviewers rendered appropriate determinations. Both M/S and MH/SUD required clinical reviewers, including peer clinical reviewers, to successfully complete the annual IRR assessment. Clinical reviewers were required to pass the IRR assessment with a score of 90% or better to render UM decisions independently. The 2022 IRR M/S results were 97% and MH/SUD results were 96%, demonstrating that M/S and MH/SUD clinical reviewers comparably applied medical necessity criteria when making utilization review determinations.

INN outpatient medical necessity approval and denial rates and appeals outcomes data from 01/01/2022-12/31/2022 were evaluated where a minimum threshold of 100 cases were available to ensure a valid data set for analysis.

There is an insufficient number of MH/SUD INN outpatient cases from 01/01/2022-12/31/2022 to support an analysis of clinical outcomes data for UnitedHealthcare Insurance Company (UHC).

There is an insufficient number of MH/SUD INN outpatient cases from 01/01/2022-12/31/2022 to support an analysis of clinical outcomes data for UnitedHealthcare of Georgia (UHCGA).

The following definitions are applicable to the charts below:

- Total # of Requests Received: the aggregate number of INN outpatient Concurrent Review requests received
- Total # of Requests Approved: the aggregate number of INN outpatient Concurrent Review requests approved
- Total # of Requests Clinically Denied: the aggregate number of INN outpatient Concurrent Review requests that were denied for clinical reasons (request did not meet medical necessity). This does not include requests that were administratively denied.
- Approval Rate %: (Requests Approved / Requests Received)
- Clinical Denial Rate %: (Total number of Requests Clinically Denied / Total number of Requests Received)
- Total # of Clinical Denials reviewed upon appeal: Total (internal & external): the aggregate number of INN outpatient Concurrent Review clinical internal and external appeals received
- Total # of Clinical Denials Overturned upon appeal: Total (internal & external): the aggregate number of INN outpatient Concurrent Review clinical internal and external appeals overturned
- Clinical Denial Overturn Rate %: Total (Internal & External): percent of INN outpatient Concurrent Review clinical internal and external appeals overturned (Total # of Clinical Denials Overturned upon internal and external appeal/Total # of Clinical Denials reviewed upon internal and external appeal)
- Total # of Clinical Denials Upheld: Total (Internal & External): the aggregate number of INN outpatient Concurrent Review clinical internal and external appeals upheld
- Clinical Denial Uphold Rate %: Total (Internal & External): percent of INN outpatient Concurrent Review clinical internal and external appeals upheld (Total # of Clinical Denials Upheld upon internal and external appeal/Total # of Clinical Denials reviewed upon internal and external appeal)
- Total # of Clinical Denials reviewed upon internal appeal only: the aggregate number of INN outpatient Concurrent Review clinical internal appeals received
- Total # of Clinical Denials Overturned upon internal appeal only: the aggregate number of INN outpatient Concurrent

Concurrent Review – Outpatient In-Network Non-Quantitative Treatment Limitation (NQTL) Analysis

GA – UnitedHealthcare Insurance Company, UnitedHealthcare of Georgia, Inc.

12/29/2023



Review clinical internal appeals overturned

- Clinical Denial Overturn Rate %, internal appeal only: percent of INN outpatient Concurrent Review clinical internal appeals overturned (Total # of Clinical Denials Overturned upon internal appeal/Total # of Clinical Denials reviewed upon internal appeal)
- Total # of Clinical Denials Upheld upon internal appeal: the aggregate number of INN outpatient Concurrent Review clinical internal appeals upheld
- Clinical Denial Uphold Rate %, internal appeal only: percent of INN outpatient Concurrent Review clinical internal appeals upheld (Total # of Clinical Denials Upheld upon internal appeal/Total # of Clinical Denials reviewed upon internal appeal)
- Total # of Clinical Denials reviewed upon external appeal only: the aggregate number of INN outpatient Concurrent Review clinical external appeals received
- Total # of Clinical Denials Overturned upon external appeal only: the aggregate number of INN outpatient Concurrent Review clinical external appeals overturned
- Clinical Overturn Rate %, external appeal only: percent of INN outpatient Concurrent Review clinical external appeals overturned (Total # of Clinical Denials Overturned upon external appeal/Total # of Clinical Denials reviewed upon external appeal)
- Total # of Clinical Denials Upheld upon external appeal: the aggregate number of INN outpatient Concurrent Review clinical external appeals upheld
- Clinical Uphold Denial Rate %, external appeal only: percent of INN outpatient Concurrent Review clinical external appeals upheld (Total # of Clinical Denials Upheld upon external appeal/Total # of Clinical Denials reviewed upon external appeal)

UHC

Outcomes Data Concurrent Review Analysis:

	In-Network Outpatient	
	M/S	MH/SUD
Total # of Requests Received	267	5
Total # of Requests Approved	252	5
Total # of Requests Clinically Denied	12	0
Approval Rate %	94.38%	100.00%
Clinical Denial Rate %	4.49%	0.00%
Total # of Clinical Denials reviewed upon appeal--Total (Internal & External)	0	0
Total # of Clinical Denials Overturned upon appeal--Total (Internal & External)	0	0
Clinical Denial Overturn Rate %-- Total (Internal & External)	-	-
Total # of Clinical Denials Upheld--Total (Internal & External)	0	0
Clinical Denial Uphold Rate %--Total (Internal & External)	-	-
Total # of Clinical Denials reviewed upon internal appeal only	0	0
Total # of Clinical Denials Overturned upon internal appeal only	0	0
Clinical Denial Overturn Rate %, internal appeal only	-	-
Total # of Clinical Denials Upheld upon internal appeal only	0	0
Clinical Denial Uphold Rate %, internal appeal only	-	-
Total # of Clinical Denials reviewed upon external appeal only	0	0
Total # of Clinical Denials Overturned upon external appeal only	0	0
Clinical Overturn Rate %, external appeal only	-	-
Total # of Clinical Denials Upheld upon external appeal only	0	0
Clinical Uphold Denial Rate %, external appeal only	-	-

Concurrent Review – Outpatient In-Network Non-Quantitative Treatment Limitation (NQTL) Analysis

GA – UnitedHealthcare Insurance Company, UnitedHealthcare of Georgia, Inc.

12/29/2023



UHC GA

Outcomes Data Concurrent Review Analysis:

	In-Network Outpatient	
	M/S	MH/SUD
Total # of Requests Received	63	0
Total # of Requests Approved	60	0
Total # of Requests Clinically Denied	3	0
Approval Rate %	95.24%	-
Clinical Denial Rate %	4.76%	-
Total # of Clinical Denials reviewed upon appeal--Total (Internal & External)	0	0
Total # of Clinical Denials Overturned upon appeal--Total (Internal & External)	0	0
Clinical Denial Overturn Rate %- Total (Internal & External)	-	-
Total # of Clinical Denials Upheld--Total (Internal & External)	0	0
Clinical Denial Uphold Rate %--Total (Internal & External)	-	-
Total # of Clinical Denials reviewed upon internal appeal only	0	0
Total # of Clinical Denials Overturned upon internal appeal only	0	0
Clinical Denial Overturn Rate %, internal appeal only	-	-
Total # of Clinical Denials Upheld upon internal appeal only	0	0
Clinical Denial Uphold Rate %, internal appeal only	-	-
Total # of Clinical Denials reviewed upon external appeal only	0	0
Total # of Clinical Denials Overturned upon external appeal only	0	0
Clinical Overturn Rate %, external appeal only	-	-
Total # of Clinical Denials Upheld upon external appeal only	0	0
Clinical Uphold Denial Rate %, external appeal only	-	-

Conclusions

The Plan reviewed the M/S and MH/SUD Concurrent Review operational policies and procedures and concluded the methodology used to determine which MH/SUD INN outpatient services are subject to Concurrent Review “as written” were comparable to, and applied no more stringently than, the methodology used to determine which M/S INN outpatient services are subject to Concurrent Review “as written.” Additionally, the Plan concluded that how Concurrent Review is applied to MH/SUD INN outpatient services was comparable to, and applied no more stringently than, how Concurrent Review is applied to M/S INN outpatient services “as written.”

The Plan reviewed the M/S and MH/SUD processes, including responsibility for submission, timeframes for submission and review, notification to members and providers, clinical standards for review, staff qualifications, outcomes data, and IRR assessment results and concluded how the Plan conducts Concurrent Review for MH/SUD INN outpatient services “in operation” was comparable to, and applied no more stringently than, how the Plan conducts Concurrent Review for M/S INN outpatient services “in operation.”

Concurrent Review – Inpatient Out-of-Network NQTL Analysis

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical/surgical (M/S) benefits. This generally means that financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements, such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage.

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Concurrent Review is defined as “a clinical review of an extension of previously approved, ongoing course of treatment over a period of time or number of treatments conducted during an inpatient stay or ongoing ambulatory care. It is sometimes called a “continued stay review.” The *Optum National Policy Definitions List* defines a Concurrent (Review) Request as “a request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care.” Concurrent Review does not involve onsite reviews.

Concurrent Review is a component of the Plan’s Utilization Management (UM) program that helps ensure members receive appropriate coverage based on their specific clinical status and health care needs. The process is designed to achieve optimal clinical outcomes by applying objective, evidence-based clinical criteria, and nationally recognized guidelines and best practices. Concurrent Review is a UM process that involves applying the benefit plan language and/or clinical criteria to make the most appropriate clinical coverage benefit determination.

This document includes the following information:

- The Concurrent Review process for both M/S and MH/SUD inpatient services
- The description of the NQTL and application (Step 1)
- Factors used to determine which services are subject to the NQTL (Step 2)
- Evidentiary standards and sources used to define, trigger, and or implicate a factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

This analysis refers to the following attachments:

- *Addendum A* – Identifies the M/S and MH/SUD inpatient services that are subject to Concurrent Review
- *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions* - M/S policy that defines Concurrent Review
- *Optum National Policy Definitions List* - MH/SUD policy that defines Concurrent Review

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- *Utilization Management Program Description (UMPD) of United HealthCare Services, Inc. and UnitedHealthcare Insurance Company* - summarizes the philosophy, structure and standards that govern UHC's medical management, UM and utilization review responsibilities and functions
- *Management of Behavioral Health Benefits Policy* - Describes the mechanisms and processes designed to promote consistency in the management of behavioral health benefits and to ensure that members receive appropriate, high quality behavioral health services in a timely manner.
- *Certificates of Coverage* (for example: *COC23-INS-2018-LG-GA*, *COC23-INS-2018-SG-GA*, and *COC23-INS-RV-2018-LG-GA*) - Plan document that explains covered services, terms, conditions, and limitations of the member's policy
- *Schedule of Benefits* (SBN23-Medical-INS-2018-[Choice+Plus][Select+Plus][Doctors+Plus]-LG-GA, SBN23-Medical-INS-2018-[Choice+Plus][Select+Plus][Doctors+Plus]-SG-GA and SBN23-Medical-INS-RV-2018-HeritagePlus-LG-GA) - Plan document that outlines member responsibilities
- *Core Principles and Practices* - MH/SUD policy that outlines the Core Principles and Practices that should be used by personnel in their interactions with members, authorized member representatives, practitioners and facilities, related to the management of behavioral health benefits, coverage determinations and appeals/grievances of non-coverage determinations
- *Performance Assessment and Incentives* - M/S policy confirming that clinical reviewers are not incented to make denials for financial reasons

The Plan concludes that the Concurrent Review requirements for M/S and MH/SUD are comparable and applied no more stringently for MH/SUD out-of-network (OON) inpatient benefits both "as written" and "in operation."

Process

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Concurrent Review is defined as "a clinical review of an extension of previously approved, ongoing course of treatment over a period of time or number of treatments conducted during an inpatient stay or ongoing ambulatory care. It is sometimes called "continued stay review." The *Optum National Policy Definitions List* defines a Concurrent (Review) Request as "a request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care."

The Plan structures inpatient Concurrent Review processes to be compliant with all applicable federal and state laws, as well as the National Committee for Quality Assurance (NCQA) accreditation standards. NCQA confirms that the Plan's operations and policies identify appropriate timeframes for decisions, requires decision-making by appropriate personnel, and governs communication of adverse benefit determinations. In addition, Concurrent Review is governed at both the state and federal level, which includes consumer protections such as external review for adverse benefit determinations after internal appeals options are exhausted.

The Plan delegates management of MH/SUD inpatient services, including Concurrent Review for MH/SUD inpatient services, to United Behavioral Health d/b/a Optum Behavioral Health (OBH), its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor.

Addendum A includes a list of all service categories subject to inpatient Concurrent Review.

Concurrent Review of M/S Inpatient Admissions consists of the following:

Initial Concurrent Review. Members are required to ensure that OON facilities and providers timely notify the Plan (e.g., within 24 hours) of an unplanned (e.g., urgent/emergent) inpatient admission. Notification triggers the inpatient Concurrent Review process. OON facilities can notify the Plan by telephone or fax (where required).

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The Plan confirms receipt of the Concurrent Review request. Non-clinical staff confirm member eligibility and benefit coverage upon receipt of the notification. Non-clinical staff may approve coverage requests in scenarios where the member's plan documents allow and if a clinical review is not required. Non-clinical staff refer coverage requests that they cannot approve to initial clinical reviewers.

First Level Clinical Review/Initial Review. Clinical reviewers (nurses or physicians) consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether the inpatient admission is medically necessary by reviewing the member's clinical information, the applicable clinical criteria or guidelines, and the Plan benefit terms. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs to determine whether the applicable clinical criteria are met. The clinical reviewer may approve the admission based on their review.

Second Level Clinical Review/Peer Review. The initial clinical reviewer refers cases to a second level/peer clinical reviewer if the case cannot be approved. Peer clinical reviewers (physician or mid-level practitioner) consult clinical criteria when making clinical coverage benefit determinations. Peer clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs. Only qualified peer clinical reviewers (e.g., Medical Director) can issue adverse benefit determinations. The peer clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. If a peer clinical reviewer issues an adverse benefit determination, then the Plan timely communicates the adverse benefit determination, including appeal rights, and offers a peer-to-peer conversation consistent with state, federal, and accreditation requirements.

Adverse Benefit Determination. For M/S, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when benefits are exhausted. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials. Modified coverage requests that are approved are recorded as partial denials.

Ongoing Concurrent Review. OON M/S facilities may request coverage of additional days prior to the expiration of the last day of an approved inpatient admission. The Plan conducts ongoing Concurrent Reviews for additional days for approved inpatient M/S admissions as follows:

- General acute care facilities reimbursed on a per diem basis: every two days
- General acute care facilities reimbursed on a diagnosis related group (DRG) basis: when the inpatient admission meets the number of days stated in the provider participation agreement
- Skilled Nursing Facility (SNF) admissions: initial Concurrent Review at day three and then weekly. Subsequent reviews may be sooner if clinically appropriate
- Acute Inpatient Rehab (AIR) admissions: initial Concurrent Review at day five and then weekly. Subsequent reviews may be sooner if clinically appropriate
- Long Term Acute Care Hospital (LTACH) admissions: initial Concurrent Review at day 14 and then weekly

The Plan follows the initial Concurrent Review clinical review process when conducting ongoing Concurrent Reviews.

Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based medical clinical policies and clinical criteria from third party sources such as InterQual® or MCG® guidelines.

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Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that inpatient Concurrent Review determinations are appropriate.

M/S monitors clinical reviewer and peer clinical reviewer application of clinical criteria through an annual inter-rater reliability (IRR) assessment that is provided by InterQual. Clinical reviewers and peer clinical reviewers are required to pass the IRR assessment with a score of 90% or better through three attempts. After a second failed IRR assessment, staff enter a remediation period and are required to review all cases with a supervisor for 30 days, or until 90% is achieved on the assessment. If the clinical reviewer achieves a passing score within 30-day period, supervisors review a minimum of one case per week for the remainder of the 30-day period.

The Plan also conducts end-to-end case audits that are designed and approved by clinical leadership each year. The end-to-end audits include all stages of a case review, from intake through appeal. These audits are conducted monthly and approximately 1500 cases are reviewed per month. Results are reported to an oversight team. All deficiencies are remediated. Remediation may include corrective actions and/or additional education, as indicated.

The Plan routinely monitors Concurrent Review performance through its clinical performance oversight functions. Outcomes are monitored against timeliness requirements, performance guarantees, and for potential trends, including overall utilization.

The Plan's National Medical Care Management Committee (NMCMC) annually reviews overall UM program outcomes, including inpatient Concurrent Review outcomes, to confirm overall utilization is appropriate. The NMCMC is comprised of the Chief Medical Officer, and representatives from clinical policy, clinical advocacy and grievances, business standardization and advancement, regional chief medical officers, inpatient care management, lines of business, medical policy, clinical operations, and OBH. The Chair of the NMCMC must be an executive leader and licensed physician.

As of April 1, 2023, the Utilization Management Program Committee (UMPC) began overseeing the M/S UM program. The UMPC is responsible for the development and maintenance of the M/S Prior Authorization processes. The UMPC ensures that the UM program considers the factors and evidentiary standards for applying UM. The UMPC is comprised of:

- Chief Medical Officer, Medical Management (Co-Chair)
- Senior Vice President, Clinical Advancement (Co-Chair)
- Chief Medical Officer, UnitedHealthcare
- Senior Vice President, Clinical Appeals & Grievances
- Chief Medical Officer, Clinical Policy
- Chief Medical Officer, UnitedHealthcare Employer & Individual
- Chief Medical Officer, UnitedHealthcare Medicare & Retirement
- Chief Medical Officer, Community & State
- Chief Medical Officer, UnitedHealthcare Individual & Family Plans
- Vice President, Clinical Transformation & Affordability
- Senior Director, Mental Health Parity
- Vice President, Utilization Management Strategy & Implementation

One of the chairs must be an executive leader and a licensed physician. UMPC meets at least six times per year but may meet more frequently if needed.

Per the M/S policy entitled, *Performance Assessment and Incentives*, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons.

M/S generally structures UM processes to comply with federal Employee Retirement Income Security Act of 1974 (ERISA) requirements, NCQA UM standards, and state law where applicable.

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Concurrent Review of MH/SUD Inpatient Admissions consists of the following:

The Plan delegates management of MH/SUD inpatient services, including Concurrent Review, to United Behavioral Health d/b/a OBH, its delegated MH/SUD MBHO vendor.

Initial Concurrent Review. All OON inpatient admissions are subject to the Concurrent Review process. The Plan requires that members ensure that OON providers and facilities timely notify the Plan of inpatient admissions. Notification triggers the inpatient Concurrent Review process. Providers notify the Plan of the need for additional days/services by telephone.

As described in the *Management of Behavioral Health Benefits Policy*, upon receipt of admission notification, non-clinical staff confirm member eligibility and benefit coverage. Non-clinical staff may approve cases that do not require clinical evaluation or interpretation based on the member's diagnosis and the clinical information submitted by providers. Non-clinical staff refer cases that they cannot approve to initial clinical reviewers.

First Level Clinical Review/Initial Review. Clinical decisions are made by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse benefit determinations are made by Medical Directors. Clinical reviewers consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether an inpatient admission is medically necessary by reviewing the member's clinical information, the applicable clinical criteria or guidelines, and the Plan benefit terms. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for certification, related diagnostic results, and history of related treatment and services to determine whether the applicable clinical criteria are met. The clinical reviewer may approve the admission based on their review.

Second Level Clinical Review/Peer Review. The initial clinical reviewer refers cases to a peer clinical reviewer for a peer-to-peer discussion if the case cannot be approved. The requesting provider is offered the opportunity to discuss the case with the peer clinical reviewer, consistent with state, federal, and accreditation requirements before an adverse benefit determination is issued. Only qualified peer clinical reviewers (e.g., Medical Directors) can issue adverse benefit determinations. Peer clinical reviewers apply clinical criteria to member clinical information to determine coverage for an inpatient admission. If the requesting provider fails to complete the peer-to-peer discussion, the peer clinical reviewer makes a determination based on the information available. If a peer clinical reviewer issues an adverse benefit determination, (e.g., the admission is not medically necessary and is not approved), then the Plan timely communicates the adverse benefit determination, including appeal rights, to the member and provider consistent with applicable state, federal, and accreditation requirements.

Adverse Benefit Determination. For MH/SUD, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as a clinical denial when it is based on clinical criteria and member clinical information.

Ongoing Concurrent Review. OON providers may request coverage for additional days by contacting the Plan prior to expiration of the last covered day of an approved MH/SUD inpatient admission. The Plan's OON MH/SUD general acute care facilities are reimbursed on a per diem basis. The Plan conducts ongoing Concurrent Review for OON MH/SUD admissions depending on the applicable clinical criteria and the member's clinical presentation. Upon receipt of a request for coverage of additional days, the Plan reviews the medical necessity of inpatient admissions. Clinical reviewers and peer clinical reviewers follow the initial Concurrent Review process.

Clinical Criteria. Initial clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based behavioral clinical policies or use clinical criteria from third party sources such as American Society of Addiction Medicine (ASAM) Criteria®, Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization

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System-Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) and Early Childhood Service Intensity Instrument (ECSII) guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure inpatient Concurrent Review determinations are appropriate.

MH/SUD monitors clinical reviewer and peer clinical reviewer application of clinical criteria through an annual IRR assessment. Clinical reviewers and peer clinical reviewers are required to pass the IRR assessment with a score of 90% or better through three attempts. After a second failed IRR assessment, the reviewer enters a remediation period and is required to review all cases with a supervisor for 30 days, or until 90% is achieved on the assessment. If the clinical reviewer achieves a passing score within 30-day period, supervisors review a minimum of one case per week for the remainder of the 30-day period.

The Plan also conducts monthly quality audits of individual non-clinical staff, clinical reviewers, and peer clinical reviewers, including staff performing appeal functions. These audits are designed and approved by clinical leadership. A minimum of two audits are completed per staff, per month. The results of these real-time audits are shared with supervisors for staff oversight, and all findings are remediated. Remediation may include corrective actions and/or additional education, as warranted.

The Plan routinely monitors Concurrent Review program performance through its clinical performance oversight functions. Outcomes are monitored against timeliness requirements, performance guarantees, and for potential trends, including overall utilization.

The Plan's national Clinical Quality & Operations Committee (CQOC) annually reviews UM program outcomes, including inpatient Concurrent Review outcomes, to confirm overall utilization is appropriate. The national CQOC is comprised of representatives from sub-committees, and representatives from the clinical quality improvement, UM, care engagement, medical operations, medical policy and standards, clinical operations, appeals, product, legal, compliance, network strategy, provider experience, accreditation, and benefits teams. The Chair of the Clinical Quality & Operations Committee must be an executive leader, board certified in psychiatry or psychiatric subspecialty and a licensed physician.

Per the MH/SUD policy entitled, *Core Principles and Practices*, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons.

MH/SUD generally structures UM processes to comply with federal ERISA requirements, NCQA UM standards, and state law, where applicable.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- Concurrent Review

Benefit Classification(s)

- OON, inpatient

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHIC)
- UnitedHealthcare Insurance Company of the River Valley (UHICRV)

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Plan Terms/Source Document(s)

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Concurrent Review is defined as “a clinical review of an extension of previously approved, ongoing course of treatment over a period of time or number of treatments conducted during an inpatient stay or ongoing ambulatory care. It is sometimes called a “continued stay review.”” Concurrent Review does not involve onsite reviews.

The *Optum National Policy Definitions List* defines a Concurrent (Review) Request as “a request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care.”

The Plan’s *Certificates of Coverage* notify members of Concurrent Review requirements:

“The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, Concurrent Review, case management, discharge planning, retrospective review or similar programs.”

The role of the Plan’s delegate, United Behavioral Health d/b/a OBH, is discussed in the *UMPD*:

“United Behavioral Health (UBH) performs the review of requests for coverage of behavioral health services (i.e., substance abuse, and mental health requests for services). UBH provides comprehensive behavioral health care delivery for members through a network of behavioral health practitioners, ancillary care providers, hospitals and other facilities.

For mental health, substance-related disorder services, and wraparound services, UBH uses its Clinical Criteria (see below), behavioral clinical policies and best practice guidelines to make coverage determinations. UBH adopts externally-developed clinical criteria, and creates internally-developed Clinical Criteria, where appropriate, based on its assessment of relevant guidance. UBH develops clinical criteria that supersedes its standard set or adopts externally-developed clinical criteria when required to do so by contract or regulation.

- Clinical Criteria (Level of Care Utilization System-LOCUS) – Standardized level of care assessment tool developed by the American Association of Community Psychiatrists used to make clinical determinations and placement decisions for mental health disorder benefits for adults ages 19 and older when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (Child and Adolescent Level of Care/Service Intensity Utilization System-CALOCUS-CASII) – Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry (AACAP) and the American Association for Community Psychiatry (AACP) used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children and adolescents ages 6-18 when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (Early Childhood Service Intensity Instrument-ECSII) – Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children ages 0-5 when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (State or Contract Specific Level of Care Guidelines) – Criteria used to make medical necessity determinations for mental health disorder benefits when there are explicit mandates or contractual requirements.
- Clinical Criteria (American Society of Addiction Medicine [ASAM]) – Criteria developed by the American Society of Addiction Medicine used to make clinical determinations for substance-related disorder benefits.
- Clinical Criteria (Optum Developed)
 - Optum Behavioral Clinical Policies: Criteria that stem from evaluation of new services or treatments or new applications of existing services or treatments and are used to make clinical determinations regarding proven or unproven services and treatments.

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Licensed practitioners conduct all reviews with a focus on measurable outcome goals and objectives for treatment. A senior UBH Medical Director is responsible for directing and implementing behavioral health utilization management programs. A referral is sent to UBH when a member is identified as potentially benefiting from behavioral health services during a “medical event.”

The UBH UM Program is staffed by clinical, non-clinical and administrative personnel. All clinical denials or adverse decisions are made by board certified psychiatrists, or, if the health plans choose, by a panel of other appropriate health care service reviewers. If the health plan chooses to use a panel to make adverse decisions, the panel contains at least one physician who is board certified in psychiatry. When the health care service under review is a mental health or substance abuse service, the adverse decision is made by a licensed physician who is board certified in psychiatry. All potential clinical denials are referred to a physician who is board certified in psychiatry for final determination. An evaluation of the overall effectiveness of the Behavioral Health UM Program is conducted annually to determine how well resources have been deployed to improve UM activities and the clinical care and service provided to members.”

The Plan’s terms require services to be medically necessary for coverage.

List of M/S and MH/SUD Services Subject to NQTL

Addendum A, attached, lists the M/S and MH/SUD OON inpatient service categories subject to Concurrent Review.

Concurrent Review is one component of the UM program that evaluates whether a benefit or service is medically necessary.

- The “Member” tab lists the service categories for which the member is responsible for providing notification for both in-network (INN) and OON services. The “Member” tab includes all products in the scope of the analysis.
- The “Provider” tab lists the service categories for which the provider is responsible for providing notification for INN services. The “Provider” tab applies to all Plans in the scope of the analysis.

Step 2 – Factors Used in the Design and Application of the NQTL

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

The Plan relies on the following factor to determine which OON inpatient services are subject to initial Concurrent Review (design). This factor applies to M/S and MH/SUD for the following:

- I. M/S: General Hospital, Specialty Hospital, SNF, AIR, LTACH
 - II. MH/SUD: Inpatient and residential facilities
- **All M/S and MH/SUD Inpatient Admissions – Initial Concurrent Review (Qualitative)**
 - All unplanned M/S and MH/SUD inpatient admissions are subject to initial Concurrent Review

The Plan relies on the following factor to determine which OON inpatient services are subject to ongoing Concurrent Review (design). This factor applies to M/S and MH/SUD for the following:

- I. M/S: General Hospital, Specialty Hospital, SNF, AIR, LTACH
 - II. MH/SUD: Inpatient and residential facilities
- **All M/S and MH/SUD Inpatient Admissions Request for Additional Days – Ongoing Concurrent Review (Qualitative)**
 - All M/S and MH/SUD inpatient admissions are subject to ongoing Concurrent Review if coverage of additional days is requested after initial Concurrent Review approved days expire

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The factors apply to M/S and MH/SUD services. The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL. All Concurrent Reviews are subject to Clinical Appropriateness and must have medical necessity criteria.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below is the evidentiary standard and source used to define, trigger, and/or implicate the factor used in designing and applying the Plan's initial Concurrent Review requirement to OON inpatient services. This evidentiary standard and source apply to the following:

- I. M/S: General Hospital, Specialty Hospital, SNF, AIR, LTACH
- II. MH/SUD: Inpatient and residential facilities

Factor – All M/S and MH/SUD Inpatient Admissions – Initial Concurrent Review includes all inpatient admissions.

- The Plan's evidentiary standard and source that define and/or trigger the factor are provider notification of an inpatient admission

The Plan's evidentiary standard and source apply to M/S and MH/SUD services and are defined in a qualitative manner.

Below is the evidentiary standard and source used to define, trigger, and/or implicate the factors used in designing and applying the Plan's ongoing Concurrent Review requirement to OON inpatient services. This evidentiary standard and source apply to the following:

- I. M/S: General Hospital, Specialty Hospital, SNF, AIR, LTACH
- II. MH/SUD: Inpatient and residential facilities

Factor – All M/S and MH/SUD Inpatient Admissions Request for Additional Days – Ongoing Concurrent Review includes all inpatient admissions for which a provider requests coverage of additional days.

- The Plan's evidentiary standard and source that define and/or trigger the factor is an inpatient admission for which a provider requests coverage of additional days

The Plan's evidentiary standard and source apply to M/S and MH/SUD services and is defined in a qualitative manner.

The factors and evidentiary standards used as the basis for subjecting MH/SUD OON inpatient services to Concurrent Review are comparable to, and applied no more stringently than, the factors used as the basis for subjecting M/S OON inpatient benefits to Concurrent Review "as written" and "in operation." The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL.

Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

As Written

The Plan conducted a comparative analysis of the strategies, processes, factors, evidentiary standards, and source information used to determine which M/S and MH/SUD OON inpatient services are subject to Concurrent Review and how Concurrent Review is applied to M/S and MH/SUD OON inpatient services “as written.” The Plan identified the factors and evidentiary standards used as the basis for subjecting M/S and MH/SUD benefits to Concurrent Review.

National internal committees apply the applicable factors and standards described in Steps 2 and 3 to M/S and MH/SUD services when determining which services to subject to Concurrent Review.

Review of Factors and Evidentiary Standards

The Plan reviewed the factors that trigger an OON inpatient service to be subject to Concurrent Review. The factors and evidentiary standards were applied to M/S and MH/SUD services comparably and not more stringently to MH/SUD services than to M/S services as evidenced by the attached *Concurrent Review Factor Grid(s)*.

Review of Operational Policies and Procedures

The Plan reviewed M/S and MH/SUD operational policies and procedures, IRR assessment processes, and UM annual oversight to confirm comparability and found MH/SUD policies, procedures, and processes to be comparable and no more stringent than M/S policies, procedures, and processes.

- Medical management operational policies and procedures establish the standards for how the Plan conducts inpatient Concurrent Review. The policies and procedures are consistent with state and federal law and accreditation requirements governing Concurrent Review. Timeframes for decisions, content of adverse benefit determinations, appeal rights and external review are all governed by state and federal law and accreditation requirements.
- The IRR assessment measures the consistency with which clinical reviewers and peer clinical reviewers apply the Plan's clinical criteria. IRR assessment processes apply to M/S and MH/SUD inpatient services.
- UM oversight monitors and evaluates UM processes by reviewing program outcomes, clinical appeals, IRR assessments, and under- and over-utilization.

Review of Inpatient Concurrent Review Processes

The strategy for applying both initial and ongoing Concurrent Review to OON inpatient services is comparable for M/S and MH/SUD services and is applied no more stringently to MH/SUD OON inpatient services. The Plan conducted a review of the M/S and MH/SUD Concurrent Review processes to confirm comparability. The review focused on the following aspects of the process for both M/S and MH/SUD:

- Notification. The member is responsible for ensuring OON facilities and providers notify the Plan of an inpatient admission for M/S and MH/SUD.
- Timeframe to Submit. The timeframe for the provider or member to notify of an admission was reviewed and determined that MH/SUD was comparable and no more stringent. Members or OON facilities should notify the Plan as soon as possible for scheduled and non-scheduled M/S and MH/SUD admissions.
- Clinical Reviews. For M/S and MH/SUD inpatient Concurrent Reviews, clinical reviewers may gather more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations,

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clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for certification, related diagnostic results, and history of related treatment and services, and photographs. The clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. The clinical reviewer may approve cases that meet applicable clinical criteria.

- Review Timeframes. M/S and MH/SUD inpatient Concurrent Review determination timeframes are defined by state, federal, and accreditation requirements. The same determination timeframes apply to M/S and MH/SUD determinations.
- Determinations and Nonclinical Reviews, First Level Clinical Reviews, and Second Level Peer Clinical Reviews.
 - For M/S, non-clinical staff may approve requests for coverage of cases in scenarios where the Plan identified applicable clinical criteria always indicate that an inpatient level of care is medically necessary. Non-clinical staff refer coverage requests that they cannot approve to clinical reviewers. Clinical reviewers (nurses) determine whether the inpatient admission is medically necessary. The clinical reviewer may approve the admission based on their review. If the case cannot be approved by the clinical reviewer, it is referred to a peer (physician) clinical reviewer. Only qualified peer clinical reviewers (e.g., Medical Directors) may issue adverse benefit determinations. Peer-to-peer discussions are offered as required.
 - For MH/SUD, non-clinical staff refer coverage requests that they cannot approve to clinical reviewers. Clinical reviewers (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether an inpatient admission is medically necessary. The clinical reviewer may approve the admission based on their review. The clinical reviewer refers cases to a peer clinical reviewer for a peer-to-peer discussion if the case cannot be approved. Only qualified peer clinical reviewers (e.g., Medical Directors) may issue adverse benefit determinations. Peer-to-peer discussions are offered as required.
- Adverse Benefit Determinations and Peer-to-Peer Conversations.
 - OON inpatient M/S services
 - The Plan offers OON M/S facilities and providers the opportunity to discuss adverse benefit determinations after the adverse benefit determination is issued. Only M/S peer clinical reviewers (e.g., Medical Directors) may issue adverse benefit determinations for coverage of M/S inpatient services.
 - For M/S, adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded. Modified coverage requests that are approved are recorded as partial denials.
 - OON inpatient MH/SUD services
 - The Plan offers OON inpatient MH/SUD facilities and providers the opportunity to discuss a potential adverse benefit determination before the Plan issues such determination. This process allows OON inpatient MH/SUD facilities and providers the opportunity to provide additional information and/or modify their request prior to an adverse benefit determination being issued.
 - For MH/SUD, an adverse benefit determination is recorded as a clinical denial when it is based on clinical criteria and member clinical information. If during the course of the peer-to-peer conversation the provider withdraws their original request and submits a new request, the case is approved.
- Notification of Decisions to Providers and Members. The Plan notifies M/S and MH/SUD OON facilities, providers, and members of approvals and adverse benefit determinations, including applicable appeal rights consistent with state, federal, and accreditation requirements.
- Review of Staff Qualifications. For M/S and MH/SUD, clinical staff qualifications align with the type of clinical review and state, federal, and accreditation requirements (NCQA).
 - M/S is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., nurses, physicians, etc.) and all adverse benefit determinations are made by Medical Directors.
 - MH/SUD is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse determinations are made by Medical Directors.
- Clinical Criteria. For M/S and MH/SUD, clinical reviewers and peer clinical reviewers base determinations on

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objective, evidence-based medical/behavioral clinical policies and use clinical criteria from third party sources such as InterQual, MCG, ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines.

- Ongoing Concurrent Review. All M/S and MH/SUD requests for coverage of additional days trigger ongoing Concurrent Review.

In Operation

The Plan compared the strategies, processes, factors, evidentiary standards, and source information used to determine which M/S and MH/SUD OON inpatient services are subject to Concurrent Review and how Concurrent Review is applied “in operation.”

Initial Concurrent Review

All OON M/S and MH/SUD inpatient services are subject to the Concurrent Review process. The Plan required members to ensure that OON facilities and providers timely notified the Plan of inpatient admissions. Notification triggered the initial Concurrent Review process for OON M/S and MH/SUD inpatient admissions.

M/S and MH/SUD initial Concurrent Reviews included confirmation of member eligibility and benefit availability for the requested services. During the initial reviews for M/S and MH/SUD OON inpatient services, non-clinical staff approved coverage for inpatient admissions that did not require clinical review or interpretation and where member’s plan documents allowed. All OON M/S inpatient admissions and MH/SUD inpatient admissions were subject to initial Concurrent Review.

M/S and MH/SUD inpatient cases that were not administratively approved in initial Concurrent Review were referred to a clinical reviewer for further research and evaluation. The M/S and MH/SUD clinical reviewers applied benefit plan documents and medical necessity criteria to member clinical information. M/S and MH/SUD clinical reviewers could request additional clinical information if they were unable to approve cases based on the available member clinical information. The clinical reviewers may approve the admission based on their review when clinical criteria were not met.

If the requested clinical information was not received or if the case could not be approved, M/S and MH/SUD clinical reviewers referred cases to a peer clinical reviewer. For OON MH/SUD inpatient cases, the Plan offered peer-to-peer conversations so the OON MH/SUD provider could provide additional clinical information prior to the issuance of an adverse benefit determination. For OON M/S cases, the Plan offered peer-to-peer conversations at the time of issuing an adverse benefit determination. Only qualified peer clinical reviewers issued M/S and MH/SUD adverse benefit determinations.

The Plan communicated all adverse benefit determinations for M/S and MH/SUD inpatient cases that did not meet applicable clinical criteria consistent with state, federal, and accreditation requirements, including appeal rights, as applicable.

Ongoing Concurrent Review

All OON M/S and MH/SUD inpatient admissions were subject to ongoing Concurrent Review if an OON M/S or MH/SUD facility sought coverage of additional days for an approved admission. OON M/S and MH/SUD facilities were required to request coverage of additional days prior to expiration of the last day of an approved admission.

For all OON M/S and MH/SUD inpatient admissions, the Plan follows the initial Concurrent Review clinical review process when conducting ongoing Concurrent Reviews.

The Plan offered OON MH/SUD facilities the opportunity to discuss a potential adverse benefit determination with a peer clinical reviewer prior to issuing the adverse benefit determination. The Plan offered OON M/S facilities the opportunity to discuss an adverse benefit determination with a peer clinical reviewer when it issued the adverse benefit determination.

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The Plan communicated all adverse benefit determinations issued for M/S and MH/SUD inpatient cases that did not meet clinical criteria consistent with state, federal and accreditation requirements, including appeal rights, as applicable. Only qualified peer clinical reviewers issued adverse benefit determinations for M/S and MH/SUD inpatient admissions.

The Plan monitors M/S and MH/SUD clinical and peer clinical reviewers' application of clinical criteria through annual IRR assessments. The Plan also conducts quality audits of cases. The Plan routinely monitors Concurrent Review performance through its clinical performance oversight functions. In addition to comparing these "in operation" processes, the Plan reviewed medical necessity approval and denial rates, internal appeals outcomes, and external appeals outcomes related to Concurrent Review determinations for M/S and MH/SUD OON inpatient services. The results of these analyses are discussed in greater detail in Step 5.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The findings of the Plan's comparative analyses confirmed the strategies, processes, factors, evidentiary standards, and source information used to determine the MH/SUD OON inpatient services subject to initial and ongoing Concurrent Review were comparable to, and applied no more stringently than, the strategies, processes, factors, evidentiary standards, and source information used to determine the M/S OON inpatient services subject to initial and ongoing Concurrent Review "as written."

The Plan found the factors used to subject OON MH/SUD inpatient services to initial and ongoing Concurrent Review were comparable to and applied no more stringently than the factors used to subject OON M/S inpatient services to initial and ongoing Concurrent Review "in operation." All M/S and MH/SUD inpatient admissions were subject to initial Concurrent Review. All M/S and MH/SUD inpatient admissions were subject to ongoing Concurrent Review if coverage of additional days was requested after initial Concurrent Review approved days expire.

The Plan used comparable processes to conduct initial and ongoing Concurrent Review of OON M/S and MH/SUD inpatient admissions. The Plan required members to ensure that OON M/S and MH/SUD facilities timely notify the Plan of inpatient admissions. The Plan used qualified staff to confirm member eligibility and benefit availability, and to request additional clinical information if necessary. The Plan issued approvals for M/S and MH/SUD inpatient admissions that met applicable clinical criteria or guidelines. Only qualified M/S and MH/SUD peer clinical reviewers issued adverse benefit determinations. The Plan gave OON MH/SUD facilities the opportunity to discuss potential adverse benefit determinations with qualified peer clinical reviewers prior to issuing adverse benefit determinations. This afforded OON MH/SUD facilities the opportunity to convert potential denials to approvals and avoid adverse benefit determinations. The Plan did not offer the opportunity to avoid potential adverse benefit determinations to OON M/S facilities and only offered the peer-to-peer review at the time the adverse benefit determination was issued.

The Plan operated monitoring and oversight programs to ensure that clinical reviewers and peer clinical reviewers rendered appropriate determinations. Both M/S and MH/SUD required clinical reviewers, including peer clinical reviewers, to successfully complete the annual IRR assessment. Clinical reviewers were required to pass the IRR assessment with a score of 90% or better to render UM decisions independently. The 2022 IRR M/S results were 97% and MH/SUD results were 96%, demonstrating that M/S and MH/SUD clinical reviewers comparably applied medical necessity criteria when making utilization review determinations.

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OON inpatient medical necessity approval and denial rates and appeals outcomes data from 01/01/2022-12/31/2022 were evaluated where a minimum threshold of 100 cases were available to ensure a valid data set for analysis.

There is an insufficient number of MH/SUD OON inpatient cases from 01/01/2022-12/31/2022 to support an analysis of clinical outcomes data for UnitedHealthcare Insurance Company (UHIC)

There is an insufficient number of MH/SUD OON inpatient cases from 01/01/2022-12/31/2022 to support an analysis of clinical outcomes data for UnitedHealthcare Insurance Company of the River Valley (UHICRV).

The following definitions are applicable to the charts below:

- Total # of Requests Received: the aggregate number of OON inpatient Concurrent Review requests received
- Total # of Requests Approved: the aggregate number of OON inpatient Concurrent Review requests approved
- Total # of Requests Clinically Denied: the aggregate number of OON inpatient Concurrent Review requests that were denied for clinical reasons (request did not meet medical necessity)
- Approval Rate %: (Requests Approved / Requests Received)
- Clinical Denial Rate %: (Total number of Requests Clinically Denied / Total number of Requests Received) (not administrative)
- Total # of Clinical Denials reviewed upon appeal: Total (internal & external): the aggregate number of OON inpatient Concurrent Review clinical internal and external appeals received
- Total # of Clinical Denials Overturned upon appeal: Total (internal & external): the aggregate number of OON inpatient Concurrent Review clinical internal and external appeals overturned
- Clinical Denial Overturn Rate %: Total (Internal & External): percent of OON inpatient Concurrent Review clinical internal and external appeals overturned (Total # of Clinical Denials Overturned upon internal and external appeal/Total # of Clinical Denials reviewed upon internal and external appeal)
- Total # of Clinical Denials Upheld: Total (Internal & External): the aggregate number of OON inpatient Concurrent Review clinical internal and external appeals upheld
- Clinical Denial Uphold Rate %: Total (Internal & External): percent of OON inpatient Concurrent Review clinical internal and external appeals upheld (Total # of Clinical Denials Upheld upon internal and external appeal/Total # of Clinical Denials reviewed upon internal and external appeal)
- Total # of Clinical Denials reviewed upon internal appeal only: the aggregate number of OON inpatient Concurrent Review clinical internal appeals received
- Total # of Clinical Denials Overturned upon internal appeal only: the aggregate number of OON inpatient Concurrent Review clinical internal appeals overturned
- Clinical Denial Overturn Rate %, internal appeal only: percent of OON inpatient Concurrent Review clinical internal appeals overturned (Total # of Clinical Denials Overturned upon internal appeal/Total # of Clinical Denials reviewed upon internal appeal)
- Total # of Clinical Denials Upheld upon internal appeal: the aggregate number of OON inpatient Concurrent Review clinical internal appeals upheld
- Clinical Denial Uphold Rate %, internal appeal only: percent of OON inpatient Concurrent Review clinical internal appeals upheld (Total # of Clinical Denials Upheld upon internal appeal/Total # of Clinical Denials reviewed upon internal appeal)
- Total # of Clinical Denials reviewed upon external appeal only: the aggregate number of OON inpatient Concurrent Review clinical external appeals received
- Total # of Clinical Denials Overturned upon external appeal only: the aggregate number of OON inpatient Concurrent Review clinical external appeals overturned
- Clinical Overturn Rate %, external appeal only: percent of OON inpatient Concurrent Review clinical external appeals overturned (Total # of Clinical Denials Overturned upon external appeal/Total # of Clinical Denials reviewed upon external appeal)

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- Total # of Clinical Denials Upheld upon external appeal: the aggregate number of OON inpatient Concurrent Review clinical external appeals upheld
- Clinical Uphold Denial Rate %, external appeal only: percent of OON inpatient Concurrent Review clinical external appeals upheld (Total # of Clinical Denials Upheld upon external appeal/Total # of Clinical Denials reviewed upon external appeal)

UHC

Outcomes Data Concurrent Review Analysis:	Out-of-Network Inpatient	
	M/S	MH/SUD
Total # of Requests Received	118	42
Total # of Requests Approved	85	40
Total # of Requests Clinically Denied	33	1
Approval Rate %	72.03%	95.24%
Clinical Denial Rate %	27.97%	2.38%
Total # of Clinical Denials reviewed upon appeal--Total (Internal & External)	0	0
Total # of Clinical Denials Overturned upon appeal--Total (Internal & External)	0	0
Clinical Denial Overturn Rate %- Total (Internal & External)	-	-
Total # of Clinical Denials Upheld--Total (Internal & External)	0	0
Clinical Denial Uphold Rate %--Total (Internal & External)	-	-
Total # of Clinical Denials reviewed upon internal appeal only	0	0
Total # of Clinical Denials Overturned upon internal appeal only	0	0
Clinical Denial Overturn Rate %, internal appeal only	-	-
Total # of Clinical Denials Upheld upon internal appeal only	0	0
Clinical Denial Uphold Rate %, internal appeal only	-	-
Total # of Clinical Denials reviewed upon external appeal only	0	0
Total # of Clinical Denials Overturned upon external appeal only	0	0
Clinical Overturn Rate %, external appeal only	-	-
Total # of Clinical Denials Upheld upon external appeal only	0	0
Clinical Uphold Denial Rate %, external appeal only	-	-

UHCRCV

Outcomes Data Concurrent Review Analysis:	Out-of-Network Inpatient	
	M/S	MH/SUD
Total # of Requests Received	5	0
Total # of Requests Approved	2	0
Total # of Requests Clinically Denied	1	0
Approval Rate %	40.00%	-
Clinical Denial Rate %	20.00%	-
Total # of Clinical Denials reviewed upon appeal--Total (Internal & External)	0	0
Total # of Clinical Denials Overturned upon appeal--Total (Internal & External)	0	0
Clinical Denial Overturn Rate %- Total (Internal & External)	-	-
Total # of Clinical Denials Upheld--Total (Internal & External)	0	0
Clinical Denial Uphold Rate %--Total (Internal & External)	-	-
Total # of Clinical Denials reviewed upon internal appeal only	0	0
Total # of Clinical Denials Overturned upon internal appeal only	0	0
Clinical Denial Overturn Rate %, internal appeal only	-	-
Total # of Clinical Denials Upheld upon internal appeal only	0	0
Clinical Denial Uphold Rate %, internal appeal only	-	-
Total # of Clinical Denials reviewed upon external appeal only	0	0
Total # of Clinical Denials Overturned upon external appeal only	0	0
Clinical Overturn Rate %, external appeal only	-	-
Total # of Clinical Denials Upheld upon external appeal only	0	0
Clinical Uphold Denial Rate %, external appeal only	-	-

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Conclusions

The Plan reviewed the M/S and MH/SUD Concurrent Review operational policies and procedures and concluded the methodology used to determine which MH/SUD OON inpatient services are subject to Concurrent Review “as written” were comparable to, and applied no more stringently than, the methodology used to determine which M/S OON inpatient services are subject to Concurrent Review “as written.” Additionally, the Plan concluded that how Concurrent Review is applied to MH/SUD OON inpatient services was comparable to, and applied no more stringently than, how Concurrent Review is applied to M/S OON inpatient services “as written.”

The Plan reviewed the M/S and MH/SUD processes, including responsibility for submission, timeframes for submission and review, notification to members and providers, clinical standards for review, staff qualifications, outcomes data, and IRR assessment results and concluded how the Plan conducts Concurrent Review for MH/SUD OON inpatient services “in operation” was comparable to, and applied no more stringently than, how the Plan conducts Concurrent Review for M/S OON inpatient services “in operation.”

Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical/surgical (M/S) benefits. This generally means that the financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements, such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage.

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Concurrent Review is defined as “a clinical review of an extension of previously approved, ongoing course of treatment over a period of time or number of treatments conducted during an inpatient stay or ongoing ambulatory care. It is sometimes called a “continued stay review.”” The *Optum National Policy Definitions List* defines a Concurrent (Review) Request as “a request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care. Concurrent Review does not involve onsite reviews.”

Concurrent Review is a component of the Plan’s Utilization Management (UM) program that helps ensure members receive appropriate coverage based on their specific clinical status and health care needs. The process is designed to achieve optimal clinical outcomes by applying objective, evidence-based clinical criteria and nationally recognized guidelines and best practices. Concurrent Review is a UM process that involves applying the benefit plan language and/or clinical criteria to make the most appropriate clinical coverage benefit determination.

This document includes the following information:

- The Concurrent Review process for M/S and MH/SUD outpatient services
- The description of the NQTL and application (Step 1)
- Factors used to determine which services are subject to the NQTL (Step 2)
- Evidentiary standards and sources used to define, trigger and or implicate a factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

This analysis refers to the following attachments:

- *Addendum A* – Identifies the M/S and MH/SUD outpatient services that are subject to Concurrent Review
- *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions* – M/S policy that defines Concurrent Review
- *Optum National Policy Definitions List* – MH/SUD policy that defines Concurrent Review
- *Utilization Management Program Description (UMPD) of United HealthCare Services, Inc. and UnitedHealthcare Insurance Company* - Summarizes the philosophy, structure and standards that govern UHC’s medical management, UM and utilization review responsibilities and functions
- *Management of Behavioral Health Benefits Policy* - Describes the mechanisms and processes designed to promote

consistency in the management of behavioral health benefits and to ensure that members receive appropriate, high quality behavioral health services in a timely manner

- *Concurrent Review Factor Grid(s) (2023 Prior Auth_Concurrent Rev Factor Grid)* - Details the service categories subject to Concurrent Review and the shared factors and evidentiary standards used as the basis for subjecting M/S and MH/SUD outpatient benefits to Concurrent Review
- *Certificates of Coverage* (for example: *COC23-INS-2018-LG-GA* and *COC23-INS-2018-SG-GA*) - Plan document that explains covered services, terms, conditions, and limitations of the member's policy
- *Schedule of Benefits* (SBN23-Medical-INS-2018-[Choice+Plus][Select+Plus][Doctors+Plus]-LG-GA and SBN23-Medical-INS-2018-[Choice+Plus][Select+Plus][Doctors+Plus]-SG-GA) - Plan document that outlines member responsibilities
- *Core Principles and Practices* - MH/SUD policy that outlines the core principles and practices that should be used by personnel in their interactions with members, authorized member representatives, practitioners and facilities, related to the management of behavioral health benefits, coverage determinations and appeals/grievances of non-coverage determinations
- *Performance Assessment and Incentives* - M/S policy confirming that clinical reviewers are not incented to make denials for financial reasons

The Plan concludes that the Concurrent Review requirements for M/S and MH/SUD are comparable and applied no more stringently for MH/SUD out-of-network (OON) outpatient benefits both "as written" and "in operation."

Process

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Concurrent Review is defined as "a clinical review of an extension of previously approved, ongoing course of treatment over a period of time or number of treatments conducted during an inpatient stay or ongoing ambulatory care. It is sometimes called "continued stay review."" The *Optum National Policy Definitions List* defines a Concurrent (Review) Request as "a request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care."

The Plan structures outpatient Concurrent Review processes to be compliant with all applicable federal and state requirements, as well as the National Committee for Quality Assurance (NCQA) accreditation standards. NCQA confirms that the Plan's operations and policies identify appropriate timeframes for decisions, requires decision-making by appropriate personnel, and governs communication of adverse benefit determinations. In addition, Concurrent Review is governed at both the state and federal level, which includes consumer protections such as external review for adverse benefit determinations after internal appeals options are exhausted.

The Plan delegates management of MH/SUD outpatient services, including Concurrent Review to United Behavioral Health d/b/a Optum Behavioral Health (OBH), its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor.

The Plan has national committees that approve M/S and MH/SUD outpatient services to be subject to Concurrent Review. Additionally, the Plan has a standard process for assessing the services that are subjected to Concurrent Review and whether they should be retained or removed from the list of services that are subject to Concurrent Review. *Addendum A* includes a list of all service categories subject to outpatient Concurrent Review.

Concurrent Review of M/S outpatient services consists of the following:

Members are required to ensure that OON M/S providers submit clinical information for Concurrent Review for outpatient services that are described on *Addendum A*. The member's benefit plan document (e.g., *Schedule of Benefits*) identifies the services for which the member is responsible for obtaining Prior Authorization and by extension Concurrent Review. The OON provider can request Concurrent Review on behalf of the member.

The Plan requires members, or OON M/S providers on the member's behalf, to timely request coverage of additional units of service or extensions of time for services previously approved in Prior Authorization. The Plan reclassifies M/S outpatient Concurrent Review coverage requests as preservice/Prior Authorization requests consistent with NCQA UM standards. The Plan follows the outpatient Prior Authorization process for these requests and uses the outpatient Prior Authorization process to review requests for coverage of additional units of service or extensions of time for previously approved services.

Members may submit Prior Authorization requests by phone, fax, or mail, in accordance with Plan requirements. OON providers may submit authorization requests on behalf of the member by phone or by fax (where required). Providers and members communicate basic information to create a case. The member or OON provider's submission of a request (notification) triggers the Prior Authorization process.

The Plan confirms receipt of the Prior Authorization request. Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification and non-clinical staff may administratively deny coverage if member benefits are exhausted. Non-clinical staff review cases to ensure availability of accurate and thorough case information. Non-clinical staff may approve coverage requests in scenarios where the member's plan documents allow and if a clinical review is not required. Non-clinical staff refer cases that they cannot approve or administratively deny to the initial clinical reviewers for medical necessity review.

First Level Clinical Review/Initial Review. Clinical reviewers (nurses) consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs to determine whether the applicable clinical criteria are met. The clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. The clinical reviewer can approve cases that meet applicable clinical criteria.

Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Peer clinical reviewers (physician or mid-level practitioner) consult clinical criteria when making clinical coverage benefit determinations. Peer clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs. The peer clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If a peer clinical reviewer issues an adverse benefit determination, then the Plan communicates the adverse benefit determination, including appeal rights, and offers a peer-to-peer conversation consistent with state, federal, and accreditation requirements.

Adverse Benefit Determination. For M/S, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when member benefits are exhausted. Modified coverage requests that are approved are recorded as partial denials.

Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity benefit determinations on objective, evidence-based medical clinical policies or use clinical criteria from third party sources such as InterQual® or MCG® guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that outpatient Concurrent Review determinations are appropriate.

M/S monitors clinical reviewer and peer clinical reviewer application of clinical criteria through an annual inter-rater reliability (IRR) assessment that is provided by InterQual. Clinical reviewers and peer clinical reviewers are required to pass the IRR

assessment with a score of 90% or better through three attempts. After a second failed IRR assessment, staff enter a remediation period and are required to review all cases with a supervisor for 30 days, or until 90% is achieved on the assessment. If the clinical reviewer achieves a passing score within 30-day period, supervisors review a minimum of one case per week for the remainder of the 30-day period.

The Plan also conducts end-to-end case audits that are designed and approved by clinical leadership each year. The end-to-end audits include all stages of a case review, from intake through appeal. These audits are conducted monthly and approximately 1500 cases are reviewed per month. Results are reported to an oversight team. All deficiencies are remediated. Remediation may include corrective actions and/or additional education, as indicated.

The Plan routinely monitors Concurrent Review performance through its clinical performance oversight functions. Outcomes are monitored against timeliness requirements, performance guarantees, and for potential trends, including overall utilization.

The Plan's National Medical Care Management Committee (NMCMC) annually reviews overall UM program outcomes, including inpatient Concurrent Review outcomes, to confirm overall utilization is appropriate. The NMCMC is comprised of the Chief Medical Officer, and representatives from clinical policy, clinical advocacy and grievances, business standardization and advancement, regional chief medical officers, inpatient care management, lines of business, medical policy, clinical operations, and OBH. The Chair of the NMCMC must be an executive leader and licensed physician.

As of April 1, 2023, the Utilization Management Program Committee (UMPC) began overseeing the M/S UM program. The UMPC is responsible for the development and maintenance of the M/S Prior Authorization processes. The UMPC ensures that the UM program considers the factors and evidentiary standards for applying UM. The UMPC is comprised of:

- Chief Medical Officer, Medical Management (Co-Chair)
- Senior Vice President, Clinical Advancement (Co-Chair)
- Chief Medical Officer, UnitedHealthcare
- Senior Vice President, Clinical Appeals & Grievances
- Chief Medical Officer, Clinical Policy
- Chief Medical Officer, UnitedHealthcare Employer & Individual
- Chief Medical Officer, UnitedHealthcare Medicare & Retirement
- Chief Medical Officer, Community & State
- Chief Medical Officer, UnitedHealthcare Individual & Family Plans
- Vice President, Clinical Transformation & Affordability
- Senior Director, Mental Health Parity
- Vice President, Utilization Management Strategy & Implementation

One of the chairs must be an executive leader and a licensed physician. UMPC meets at least six times per year but may meet more frequently if needed.

Per the M/S policy entitled, *Performance Assessment and Incentives*, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons.

M/S generally structures UM processes to comply with federal Employee Retirement Income Security Act of 1974 (ERISA) requirements, NCQA UM standards, and state law, where applicable.

Concurrent Review of MH/SUD outpatient services consists of the following:

The Plan delegates management of MH/SUD outpatient services, including Concurrent Review, to United Behavioral Health d/b/a OBH, its delegated MH/SUD MBHO vendor.

The Plan classifies MH/SUD outpatient requests as either urgent Concurrent Review or preservice depending on whether the MH/SUD request meets the NCQA standard for urgent or standard preservice requests.

Members are required to ensure that the rendering OON provider submits clinical information for Concurrent Review for outpatient services that are described on *Addendum A*. The OON provider must provide clinical information on the member's behalf. The member's benefit plan document (e.g., *Schedule of Benefits*) identifies the services for which the member is responsible for obtaining Concurrent Review. Provider notification triggers the outpatient Concurrent Review process. Concurrent Review begins when OON providers request coverage for additional units of service and/or periods of time beyond those initially authorized by the Plan.

Outpatient OON providers notify the Plan of the need for additional days/services by telephone or by fax (where required).

As described in the *Management of Behavioral Health Benefits Policy*, the Plan confirms receipt of the Concurrent Review request. Non-clinical staff confirm member eligibility and benefit coverage. Non-clinical staff may approve cases that do not require clinical evaluation or interpretation based on the member's diagnosis and the clinical information submitted by providers. Non-clinical staff refer cases that they cannot approve to the initial clinical reviewers.

First Level Clinical Review/Initial Review. Clinical decisions are made by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse benefit determinations are made by Medical Directors or psychologists. Clinical reviewers consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether a service is medically necessary by reviewing the member's clinical information, the applicable clinical criteria or guidelines, and the Plan benefit terms. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for certification, related diagnostic results, and history of related treatment and services. The clinical reviewer may approve cases that meet applicable clinical criteria.

Second Level Clinical Review/Peer Review. The initial clinical reviewer refers cases to a peer clinical reviewer for a peer-to-peer discussion if the case cannot be approved. The requesting provider is offered the opportunity to discuss the case with the peer clinical reviewer, consistent with state, federal, and accreditation requirements before an adverse determination is issued. Only qualified peer clinical reviewers (e.g., Medical Directors or psychologists) can issue adverse benefit determinations. Peer clinical reviewers apply clinical criteria to member clinical information to determine coverage for additional units of service during an extended period of time. If the requesting provider fails to complete the peer-to-peer discussion, the peer clinical reviewer makes a determination based on the information available. If a peer clinical reviewer issues an adverse benefit determination, (e.g., that numbers of treatments or extensions of time are not authorized), then the Plan timely communicates the adverse benefit determination, including appeal rights, to the member and provider consistent with applicable state, federal, and accreditation requirements.

Adverse Benefit Determination. For MH/SUD, an adverse benefit determination is recorded as a clinical denial when it is based on clinical criteria and member clinical information.

Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity clinical coverage determinations on objective, evidence-based behavioral clinical policies or use clinical criteria from third-party sources such as, American Society of Addiction Medicine (ASAM) Criteria®, Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System-Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) and Early Childhood Service Intensity Instrument (ECSII) guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that outpatient Concurrent Review determinations are appropriate.

MH/SUD monitors clinical reviewer and peer clinical reviewer application of clinical criteria through an annual IRR assessment. Clinical reviewers and peer clinical reviewers are required to pass the IRR assessment with a score of 90% or better through three attempts. After a second failed IRR assessment, the reviewer enters a remediation period and is required to review all cases with a supervisor for 30 days, or until 90% is achieved on the assessment. If the clinical reviewer achieves a passing

score within 30-day period, supervisors review a minimum of one case per week for the remainder of the 30-day period.

The Plan also conducts monthly quality audits of individual non-clinical staff, clinical reviewers, and peer clinical reviewers, including staff performing appeal functions. These audits are designed and approved by clinical leadership each year. A minimum of two audits are completed per staff, per month. The results of these real-time audits are shared with supervisors for staff oversight, and all findings are remediated. Remediation may include corrective actions and/or additional education, as indicated.

The Plan routinely monitors Concurrent Review performance through its clinical performance oversight functions. Outcomes are monitored for timeliness compliance, performance guarantee compliance, and potential trends, including overall utilization.

The Plan's national Clinical Quality & Operations Committee (CQOC) annually reviews overall UM program outcomes, including outpatient Concurrent Review outcomes, to confirm overall utilization is appropriate. The national CQOC is comprised of representatives from sub-committees, and representatives from the clinical quality improvement, UM, care engagement, medical operations, medical policy and standards, clinical operations, appeals, product, legal, compliance, network strategy, provider experience, accreditation, and benefits teams. The Chair of the CQOC must be an executive leader, board certified in psychiatry or psychiatric subspecialty and a licensed physician.

Per the MH/SUD policy entitled, *Core Principles and Practices*, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse clinical coverage benefit determinations (clinical denials) for financial reasons.

MH/SUD generally structures UM processes to comply with federal ERISA requirements, NCQA UM standards, and state law, where applicable.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- Concurrent Review

Benefit Classification(s)

- OON, outpatient

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHIC)

Plan Terms/Source Document(s)

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Concurrent Review is defined as “a clinical review of an extension of previously approved, ongoing course of treatment over a period of time or number of treatments conducted during an inpatient stay or ongoing ambulatory care. It is sometimes called a “continued stay review.”

The *Optum National Policy Definitions List* defines a Concurrent (Review) Request as:

“A request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care. In addition, the following should be considered when defining Concurrent Reviews:

- If a request to extend a course of treatment beyond the period of time or number of treatments previously approved by the organization does not meet the definition of urgent care, the request may be handled as a new request and decided within the time frame appropriate for the type of decision (e.g., standard pre-service or post-service review).

- In addition, a request made while a member is in the process of receiving care should be considered an urgent Concurrent (Review) Request if the care requested meets the definition of urgent, even if the organization did not previously approve the earlier care”

The Plan’s *Certificates of Coverage* notifies members of Concurrent Review requirements:

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, Concurrent Review, case management, discharge planning, retrospective review or similar programs.

The role of the Plan’s delegate, United Behavioral Health d/b/a OBH, is discussed in the *UMPD*:

“United Behavioral Health (UBH) performs the review of requests for coverage of behavioral health services (i.e., substance abuse, and mental health requests for services). UBH provides comprehensive behavioral health care delivery for members through a network of behavioral health practitioners, ancillary care providers, hospitals and other facilities.

For mental health, substance-related disorder services, and wraparound services, UBH uses its Clinical Criteria (see below), behavioral clinical policies and best practice guidelines to make coverage determinations. UBH adopts externally-developed clinical criteria, and creates internally-developed Clinical Criteria, where appropriate, based on its assessment of relevant guidance. UBH develops clinical criteria that supersedes its standard set or adopts externally-developed clinical criteria when required to do so by contract or regulation.

- **Clinical Criteria (Level of Care Utilization System-LOCUS)** – Standardized level of care assessment tool developed by the American Association of Community Psychiatrists used to make clinical determinations and placement decisions for mental health disorder benefits for adults ages 19 and older when State or Contract Specific Level of Care Guidelines do not apply.
- **Clinical Criteria (Child and Adolescent Level of Care/Service Intensity Utilization System-CALOCUS-CASII)** - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry (AACAP) and the American Association for Community Psychiatry (AACP) used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children and adolescents ages 6-18 when State or Contract Specific Level of Care Guidelines do not apply.
- **Clinical Criteria (Early Childhood Service Intensity Instrument-ECSII)** - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children ages 0-5 when State or Contract Specific Level of Care Guidelines do not apply.
- **Clinical Criteria (State or Contract Specific Level of Care Guidelines)** - Criteria used to make medical necessity determinations for mental health disorder benefits when there are explicit mandates or contractual requirements.
- **Clinical Criteria (American Society of Addiction Medicine [ASAM])** - Criteria developed by the American Society of Addiction Medicine used to make clinical determinations for substance-related disorder benefits.
- **Clinical Criteria (Optum Developed)**
 - Optum Behavioral Clinical Policies: Criteria that stem from evaluation of new services or treatments or new applications of existing services or treatments and are used to make clinical determinations regarding proven or unproven services and treatments.
 - Optum Supplemental Clinical Criteria: Criteria used to make clinical determinations for Applied Behavior Analysis and Electroconvulsive Therapy.
 - Optum’s Supplement to the APA Psychological and Neuropsychological Testing Billing and Coding Guide: Additional criteria used regarding provider qualifications, coverage rationale, limitations, and developmental testing.

Licensed practitioners conduct all reviews with a focus on measurable outcome goals and objectives for treatment. A senior UBH Medical Director is responsible for directing and implementing behavioral health utilization management programs. A referral is sent to UBH when a member is identified as potentially benefiting from behavioral health services during a “medical event.”

The UBH UM Program is staffed by clinical, non-clinical and administrative personnel. All clinical denials or adverse decisions are made by board certified psychiatrists, or, if the health plans choose, by a panel of other appropriate health care service reviewers. If the health plan chooses to use a panel to make adverse decisions, the panel contains at least one physician who is board certified in psychiatry. When the health care service under review is a mental health or substance abuse service, the adverse decision is made by a licensed physician who is board certified in psychiatry. All potential clinical denials are referred to a physician who is board certified in psychiatry for final determination. An evaluation of the overall effectiveness of the Behavioral Health UM Program is conducted annually to determine how well resources have been deployed to improve UM activities and the clinical care and service provided to members.”

The Plan’s terms require services to be medically necessary for coverage.

List of M/S and MH/SUD Services Subject to NQTL

Addendum A, attached, lists the M/S and MH/SUD OON outpatient service categories subject to Concurrent Review.

Concurrent Review is one component of the UM program that evaluates whether a benefit or service is medically necessary.

- The “Member” tab lists the service categories for which the member is responsible for providing notification for both in-network (INN) and OON services. The “Member” tab includes all products in the scope of the analysis.
- The “Provider” tab lists the service categories for which the provider is responsible for providing notification for INN services. The “Provider” tab applies to all Plans in the scope of the analysis.

Step 2 – Factors Used in the Design and Application of the NQTL

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

The list of services subject to Concurrent Review was originally designed by enterprise clinical leadership. Concurrent Review was applied to new services when they became covered by the Plan and met certain criteria. Examples of Concurrent Review determinants that existed in the business at this time included:

- to monitor and prevent potential overutilization and under-utilization
- manage high-cost and prolonged-duration services
- ensure enrollee safety
- determine the appropriate level of care
- determine whether the service or item is medically necessary

The factors relied upon to determine which OON outpatient benefits were subject to Concurrent Review were updated and replaced 2021 with the factors Clinical Appropriateness, Value, and Variation as defined below. After this time, all M/S services subject to Prior Authorization must meet Clinical Appropriateness and all MH/SUD services subject to Prior Authorization must meet Clinical Appropriateness and at least one of the other factors.

Starting in 2022, any additions or deletions to the list of services subject to Concurrent Review were reviewed and approved through committees.

The Plan relies on the following factors to determine which OON outpatient services are added to the list of services subject to Concurrent Review. These factors apply to M/S and MH/SUD for the following:

- I. M/S: OON outpatient services
 - II. MH/SUD: OON outpatient services
- Clinical Appropriateness (Qualitative)
 - Whether the application of Concurrent Review promotes optimal clinical outcomes

Applies to M/S and MH/SUD services.

- Value (Quantitative)
 - The cost of the outpatient service exceeding the administrative costs of subjecting the outpatient services to Concurrent Review by at least 1:1. Administrative costs of subjecting the outpatient service to Concurrent Review are determined using the national UM program operating costs, which is comprised of costs related to staffing. Administrative costs vary due to differences in the complexities of the requested treatment types, condition(s) treated, and/or clinical guidelines used. The cost of the outpatient service is determined using national outpatient utilization or claims data. The projected benefit cost savings of applying Concurrent Review is reviewed relative to the operating cost of administering Concurrent Review to determine Value. Only services that are provided to a minimum of 100 unique individuals are considered (this is the materiality threshold established by the Plan for purposes of the Value analysis)

Applies to MH/SUD and M/S services.

- Variation (Quantitative)
 - The cost per episode of service (service units multiplied by unit cost) that trigger 2x the mean of the costs of other outpatient services. Consideration of this factor includes a review of internal claims data for service-specific costs and calculating for M/S and MH/SUD, respectively, an overall mean of the service-specific average cost per patient. For any given M/S or MH/SUD service, if the average allowed cost per patient's episode of care is twice the average cost per patient's episode of care across all other M/S or MH/SUD outpatient services, Concurrent Review is applied. Only services that are provided to a minimum of 20 unique individuals are considered (this is the materiality threshold established by the Plan for the purposes of the Variation analysis)

Applies to MH/SUD and M/S services.

For M/S meeting Clinical Appropriateness is determinative in imposing the limitation. For MH/SUD meeting Clinical Appropriateness plus Value and/or Variation is determinative in imposing the limitation. The factors are not weighted in that no individual factor carries more value than another in imposing or removing the NQTL.

In 2023, to further refine how decisions are made to subject M/S and MH/SUD OON outpatient services to Concurrent Review, the enterprise adopted factors to be assessed when considering whether to remove or retain services on the list of services subject to Concurrent Review. These changes were implemented September 2023. The assessment first considered the factors for removal of the service from the Concurrent Review list. If the service met a removal factor, the Plan then assessed if the service met a retention factor. Services that met a retention factor were retained on the Concurrent Review list. Services that did not meet a removal factor remained on the Concurrent Review list based on the original add factors.

The Plan relies on the following factors to determine which OON outpatient benefits are removed from the list of services subject to Concurrent Review. These factors apply to M/S and MH/SUD benefits for the following:

- I. M/S: OON outpatient services
- II. MH/SUD: OON outpatient services

- Low Value (Quantitative)
 - Defined as services that do not result in a minimum savings of at least \$50 per review

Applies to M/S and MH/SUD services.

- Consistency (Quantitative)
 - Defined as consistent adherence to evidence-based guidelines as evidenced by adverse determination rate (ADR) of less than 5%

Applies to M/S and MH/SUD services.

- Low Volume (Quantitative)
 - Defined as services with fewer than 100 authorizations per year

Applies to M/S and MH/SUD services.

Please note that if the primary code within a code family meets the requirements for removal, the family of codes will be addressed in a similar fashion per medical policy and clinical practice patterns.

The Plan then relies on the following factors to determine which OON outpatient benefits are retained on the list of services subject to Concurrent Review. These factors apply to M/S and MH/SUD benefits for the following:

- I. M/S: OON outpatient services
- II. MH/SUD: OON outpatient services

- Services that are experimental, investigational, or unproven (EIU) (Qualitative)
 - Defined as services that are classified as experimental, investigation or unproved based on medical/behavioral clinical policy

Applies to M/S and MH/SUD services.

- Patient Safety (Qualitative)
 - As defined by the World Health Organization as “the absence of preventable harm to a patient and reduction of risk of unnecessary harm associated with health care to an acceptable minimum.”

Applies to M/S and MH/SUD services.

- Level of Care (Quantitative)
 - Defined as Site of Service/Site of Care, and where volume is greater than 100 requests per year

Applies to M/S and MH/SUD services.

- High-Cost Drugs and Services that are greater than \$100,000 (Quantitative)
 - Defined as services where the allowed amount is greater than \$100,000 per treated patient, per year

Applies to M/S and MH/SUD services.

For M/S meeting Clinical Appropriateness is determinative in imposing the limitation. For MH/SUD meeting Clinical Appropriateness plus Value and/or Variation is determinative in imposing the limitation. If the service met a removal factor, the Plan then assessed if the service met a retention factor. Services that met a retention factor were retained on the list of services subject to Concurrent Review. Meeting any one of the factors is determinative in retaining the limitation. The factors are not weighted in that no individual factor carries more value than another in retaining the NQTL.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factors used to add services to the list of services subject to outpatient Concurrent Review. These evidentiary standards and sources apply to benefits for the following:

- I. M/S: OON outpatient services
- II. MH/SUD: OON outpatient services

Factor – Clinical Appropriateness is defined as those outpatient services that are determined by internal medical experts to be in accordance with objective, evidence-based clinical criteria, and nationally recognized guidelines. The accompanying *Concurrent Review Factor Grid(s)* included with this analysis gives details on the service categories subject to Concurrent Review. The *Concurrent Review Factor Grid(s)* detail the shared factors used as the basis for subjecting M/S and MH/SUD outpatient services to Concurrent Review.

- The Plan's evidentiary standards and sources that define and/or trigger the identification of the Clinical Appropriateness factor are:
 - Clinical criteria from nationally recognized third-party sources (e.g., InterQual or MCG for M/S services, and ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines for MH/SUD services)
 - Clinical Technology Assessment Committee (CTAC) and Medical Technology and Assessment Committee (MTAC) review
 - Objective, evidence-based medical/behavioral clinical policies, and nationally recognized guidelines approved by professional healthcare associations (e.g., clinical guidance from the American Medical Association, American Psychiatric Association, etc.)

The Plan's evidentiary standards and sources apply to M/S and MH/SUD services and are defined in a qualitative manner.

Factor – Value is defined as the cost of the outpatient service exceeding the administrative costs of subjecting the outpatient services to Concurrent Review by at least 1:1. Administrative costs of subjecting the outpatient service to Concurrent Review are determined using the national UM program operating costs, which is comprised of cost related to staffing. Administrative costs vary due to differences in the complexities of the requested treatment types, condition(s) treated, and/or clinical guidelines used. The cost of the outpatient service is determined using national outpatient utilization or claims data. The projected benefit cost savings of applying Concurrent Review is reviewed relative to the operating cost of administering Concurrent Review to determine Value. Only services that are provided to a minimum of 100 unique individuals are considered (this is the materiality threshold established by the Plan for the purposes of the Value analysis). The accompanying *Concurrent Review Factor Grid(s)* contain the calculated Value for each Concurrent Review service category for both M/S and MH/SUD, and the internal data used to determine these values.

- The Plan's evidentiary standard that defines and/or triggers the Value factor:
 - Value is defined as the cost of the outpatient service exceeding the administrative costs of subjecting the service to Concurrent Review by at least 1:1. Only services that are provided to a minimum of 100 unique individuals are considered (this is the materiality threshold established by the Plan for purposes of the Value analysis)

- The Plan's sources used to define the Value factor:
 - National internal claims data
 - National UM program operating costs
 - National UM authorization data

This evidentiary standard and sources apply to M/S and MH/SUD OON outpatient services and are defined in a quantitative manner.

Factor – Variation is defined as cost per episode of service (service units multiplied by unit cost) that trigger 2x the mean of the costs of other outpatient services. Consideration of this factor includes a review of internal claims data for service-specific costs and calculating for M/S and MH/SUD, respectively, an overall mean of the service-specific average cost per patient. For any given M/S or MH/SUD service, if the average allowed cost per patient's episode of care is twice the average cost per patient's episode of care across all other M/S or MH/SUD outpatient services, Concurrent Review is applied. Only services that are provided to a minimum of 20 unique individuals are considered (this is the materiality threshold established by the Plan for the purposes of the Variation analysis). The accompanying *Concurrent Review Factor Grid(s)* reflect whether each category of M/S and MH/SUD OON services meets the Variation criteria, and contains the internal data used in the determination.

- The Plan's evidentiary standard that defines and/or triggers the Variation factor:
 - Variation is defined as cost per episode of service (service units multiplied by unit cost) that trigger 2x the mean of other outpatient services. Only services that are provided to a minimum of 20 unique individuals are considered (this is the materiality threshold established by the Plan for purposes of the Variation analysis)
- The Plan's source that defines and/or triggers the identification of the Variation factor:
 - National internal claims data

This evidentiary standard and source applies to M/S and MH/SUD OON outpatient services and are defined in a quantitative manner.

For M/S meeting Clinical Appropriateness is determinative in imposing the limitation. For MH/SUD meeting Clinical Appropriateness plus Value and/or Variation is determinative in imposing the limitation. The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL.

In 2023, to further refine how decisions are made to subject M/S and MH/SUD OON outpatient services to Concurrent Review, the enterprise adopted factors to be assessed when considering whether to remove or retain services on the list of services subject to Concurrent Review. These changes were implemented September 2023. The assessment first considered the factors for removal of the service from the list of services subject to Concurrent Review. If the service met a removal factor, the Plan then assessed if the service met a retention factor. Services that met a retention factor were retained on the list of services subject to Concurrent Review. Services that did not meet a removal factor remained on the list of services subject to Concurrent Review based on the original add factors.

The Plan relies on the following factors to determine which OON outpatient benefits are removed from the list of services that are subject to Concurrent Review. These factors apply to M/S and MH/SUD benefits for the following:

- I. M/S: OON outpatient services
- II. MH/SUD: OON outpatient services

Factor - Low Value is defined as services that do not result in a minimum savings of at least \$50 per review

- The Plan's evidentiary standard that triggers and/or defines the Low Value factor:
 - Low Value is defined as services that do not result in a minimum savings of at least \$50 per review

- The Plan's sources used to define the Low Value factor:
 - National internal claims data
 - National UM program operating costs
 - National UM authorization data

The evidentiary standard and the sources apply to M/S and MH/SUD OON outpatient services and are defined in a quantitative manner.

Factor - Consistency is defined as consistent adherence to evidence-based guidelines as evidenced by ADR of less than 5%

- The Plan's evidentiary standard that defines and/or triggers the Consistency factor:
 - Consistency is defined as consistent adherence to evidence-based guidelines as evidenced by ADR of less than 5%
- The Plan's source used to define the Consistency factor:
 - National internal UM outcomes data

The evidentiary standard and the source apply to M/S and MH/SUD OON outpatient services and are defined in a quantitative manner.

Factor - Low Volume is defined as services with fewer than 100 authorizations per year

- The Plan's evidentiary standard that defines and/or triggers the Low Volume factor:
 - Low Volume is defined as services with fewer than 100 authorizations per year
- The Plan's source used to define the Low Volume factor:
 - National internal UM outcomes data

This evidentiary standard and the source apply to M/S and MH/SUD OON outpatient services and are defined in a quantitative manner.

The Plan then relies on the following factors to determine which OON outpatient benefits are retained on the list of services that are subject to Concurrent Review. These factors apply to M/S and MH/SUD benefits for the following:

- I. M/S: OON outpatient services
- II. MH/SUD: OON outpatient services

Factor - Services that are EIU is defined as services that are classified as experimental, investigation or unproved based on medical/behavioral clinical policy

- The Plan's evidentiary standard that defines and/or triggers the Services that are EIU factor:
 - Services that are classified as experimental, investigation or unproved based on medical policy
- The Plan's source used to define the Services that are EIU factor:
 - Medical/behavioral clinical policies

This evidentiary standard and the source apply to M/S and MH/SUD OON outpatient services and are defined in a qualitative manner.

Factor - Patient Safety is defined as "the absence of preventable harm to a patient and reduction of risk of unnecessary harm

associated with health care to an acceptable minimum" by the World Health Organization.

- The Plan's evidentiary standards that define and/or trigger the Patient Safety factor:
 - Professional judgment of members of the Utilization Management Program Committee
 - Clinical criteria from nationally recognized third-party sources (e.g., InterQual for M/S services, and ASAM, LOCUS, CALOCUS-CASII and ECSII guidelines for MH/SUD services)
 - Objective, evidence-based medical/behavioral clinical policies and nationally recognized guidelines approved by professional healthcare associations (e.g., clinical guidance from the American Medical Association, American Psychiatric Association, etc.)
- The Plan's sources used to define the Patient Safety factor:
 - Professional judgment of members of the Utilization Management Program Committee
 - Clinical criteria from nationally recognized third-party sources (e.g., InterQual for M/S services, and ASAM, LOCUS, CALOCUS-CASII and ECSII guidelines for MH/SUD services)
 - Objective, evidence-based medical/behavioral clinical policies and nationally recognized guidelines approved by professional healthcare associations (e.g., clinical guidance from the American Medical Association, American Psychiatric Association, etc.)

These evidentiary standards and the sources apply to M/S and MH/SUD OON outpatient services and are defined in a qualitative manner.

Factor - Level of Care is defined as Site of Service/Site of Care, and where the volume is greater than 100 requests per year

- The Plan's evidentiary standards that define and/or trigger the Level of Care factor:
 - National internal UM outcomes data
 - National internal claims data
 - Place of service
- The Plan's sources used to define the Level of Care factor:
 - National internal UM outcomes data
 - National internal claims data
 - Place of service

These evidentiary standards and the sources apply to M/S and MH/SUD OON outpatient services and are defined in a quantitative manner.

Factor - High-Cost Drugs and Services that are greater than \$100,000 is defined as services where the allowed amount is greater than \$100,000 per treated patient, per year

- The Plan's evidentiary standard that defines and/or triggers the High-Cost Drugs and Services that are greater than \$100,000 factor:
 - National internal claims data
- The Plan's source used to define the High-Cost Drugs and Services that are greater than \$100,000 factor:
 - National internal claims data

This evidentiary standard and the source applies to M/S and MH/SUD OON outpatient services and are defined in a quantitative manner.

If the service met a removal factor, the Plan then assessed if the service met a retention factor. Services that met a retention

factor were retained on the Concurrent Review list. Meeting any one of the factors is determinative in retaining the limitation. The factors are not weighted in that no individual factor carries more value than another in retaining the NQTL.

The factors and evidentiary standards used as the basis for subjecting MH/SUD OON outpatient benefits to Concurrent Review are comparable to, and applied no more stringently than, the factors and evidentiary standards used as the basis for subjecting M/S OON outpatient benefits to Concurrent Review "as written" and "in operation."

Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

As Written

The Plan conducted a comparative analysis of the strategies, processes, factors, evidentiary standards, and source information used to determine which M/S and MH/SUD OON outpatient services are subject to Concurrent Review and how Concurrent Review is applied to M/S and MH/SUD OON outpatient services “as written.” The Plan identified the factors and evidentiary standards used as the basis for subjecting M/S and MH/SUD OON outpatient benefits to Concurrent Review.

National internal committees apply the applicable factors and standards described in Steps 2 and 3 to M/S and MH/SUD services when determining whether the services should be subjected to Concurrent Review.

Review of Factors and Evidentiary Standards

The Plan follows the Prior Authorization process for Concurrent Review of M/S and MH/SUD OON outpatient services. The Plan reviewed the factors that trigger an OON outpatient service to be added to, removed from, or retained on the list of services subject to Concurrent Review. The factors and evidentiary standards were applied to M/S and MH/SUD services comparably and not more stringently to MH/SUD services than to M/S services as evidenced by the attached *Concurrent Review Factor Grid(s)*

Review of Operational Policies and Procedures

The Plan reviewed M/S and MH/SUD operational policies and procedures, IRR assessment processes, and UM annual oversight to confirm comparability and found MH/SUD policies, procedures, and processes to be comparable and no more stringent than M/S policies, procedures, and processes.

- Medical management operational policies and procedures establish the standards for how the Plan conducts outpatient Concurrent Review. The policies and procedures are consistent with state and federal law and accreditation requirements governing Concurrent Review. Timeframes for decisions, content of adverse benefit determinations, appeal rights and external review are all governed by state and federal law and accreditation requirements.
- The IRR assessment measures the consistency with which clinical reviewers and peer clinical reviewers apply the Plan's clinical criteria. IRR assessment processes apply for both M/S and MH/SUD outpatient services.
- UM oversight monitors and evaluates UM processes by reviewing program outcomes, clinical appeals, IRR assessment, and under- and over-utilization.

Review of Outpatient Concurrent Review Processes

The strategy for applying Concurrent Review to OON outpatient services is comparable for M/S and MH/SUD services and is applied no more stringently to MH/SUD OON outpatient services. The Plan conducted a review of the M/S and MH/SUD Concurrent Review processes to confirm comparability. The review focused on the following aspects of the process for both

M/S and MH/SUD:

- **Notification.** The member is responsible for ensuring the OON provider requests coverage for the continuation of the course of treatment and/or for additional units of outpatient services that exceed the periods of time or units of service previously approved by the Plan. The provider can submit the authorization request by telephone, or by fax (where required).
- **Timeframe to Submit.** Members and OON M/S and MH/SUD providers should notify the Plan as soon as reasonably possible.
- **Clinical Reviews.** For M/S and MH/SUD outpatient Concurrent Review requests, clinical reviewers may gather more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for certification, related diagnostic results, history of related treatment and services, and photographs. The clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. The clinical reviewer may approve cases that meet applicable clinical criteria.
- **Review Timeframes.** M/S and MH/SUD outpatient Concurrent Review determination timeframes are defined by state, federal, and accreditation requirements for both urgent and non-urgent outpatient services. The same determination timeframes apply to M/S and MH/SUD determinations.
- **Determinations and Nonclinical Reviews, First Level Clinical Reviews, and Second Level Clinical Reviews.** For M/S outpatient Concurrent Review, non-clinical staff may administratively deny cases when member benefits are exhausted. For M/S and MH/SUD non-clinical staff may approve cases that do not require clinical evaluation or interpretation. Non-clinical staff refer coverage requests that they cannot approve or administratively deny to clinical reviewers. Clinical reviewers consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether an outpatient service is medically necessary. The clinical reviewer may approve the services based on their review. The clinical reviewer refers cases to a peer clinical reviewer for a peer-to-peer discussion if the case cannot be approved. Only qualified peer clinical reviewers may issue adverse benefit determinations. Peer-to-peer discussions are offered, as required.
- **Adverse Benefit Determinations and Peer-to-Peer Conversations.** The Plan offers OON outpatient providers the opportunity to discuss a potential adverse benefit determination before the Plan issues such determination. This process allows OON outpatient providers the opportunity to provide additional information prior to an adverse benefit determination being issued.
 - **OON outpatient M/S and MH/SUD services**
 - An adverse benefit determination is recorded as a clinical denial when it is based on clinical criteria and member clinical information and is recorded as an administrative denial when member benefits are exhausted/excluded.
- **Notification of Decisions to Providers and Members.** The Plan notifies M/S and MH/SUD OON providers and members of approvals and adverse benefit determinations, including applicable appeal rights, consistent with state, federal, and accreditation requirements.
- **Review of Staff Qualifications.** For M/S and MH/SUD, clinical staff qualifications align with the type of clinical review and state, federal, and accreditation requirements (NCQA).
 - M/S is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., nurses, physicians, etc.) and all adverse benefit determinations are made by a physician or other appropriate health care professionals.
 - MH/SUD is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse benefit determinations are made by Medical Directors or psychologists.
- **Clinical Criteria.** For M/S and MH/SUD, clinical reviewers and peer clinical reviewers base determinations on objective, evidence-based medical/behavioral clinical policies and use clinical criteria from third party sources such as InterQual, MCG, ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines.

In Operation

The Plan compared the strategies, processes, factors, evidentiary standards, and source information used to determine which

M/S and MH/SUD OON outpatient services are subject to Concurrent Review and how Concurrent Review is applied “in operation.”

The Plan required members to ensure OON M/S and MH/SUD providers submit requests for coverage of additional units of outpatient services and/or extended period of time for OON outpatient services previously approved. M/S and MH/SUD provider requests for OON services triggered the outpatient Concurrent Review process.

M/S and MH/SUD outpatient Concurrent Reviews included confirmation of member eligibility and benefit availability for the requested services. For both M/S and MH/SUD OON outpatient services, non-clinical staff approved coverage for outpatient services that did not require clinical review or interpretation.

M/S and MH/SUD outpatient Concurrent Reviews that were not administratively approved in initial review were referred to a clinical reviewer for further research and evaluation. The M/S and MH/SUD clinical reviewers applied benefit plan documents and medical necessity criteria to member clinical information. M/S and MH/SUD clinical reviewers could request additional clinical information if they were unable to approve cases based on the available member clinical information. The clinical reviewers may approve services based on their review.

If the requested clinical information was not received or if the case could not be approved, M/S and MH/SUD clinical reviewers referred cases to a peer clinical reviewer. For OON MH/SUD outpatient cases, the Plan offered peer-to-peer conversations so the OON MH/SUD provider could provide additional clinical information prior to the issuance of an adverse benefit determination. Only qualified peer clinical reviewers issued both M/S and MH/SUD adverse benefit determinations.

The Plan communicated all adverse benefit determinations for M/S and MH/SUD outpatient cases that did not meet applicable clinical criteria consistent with state, federal, and accreditation requirements, including appeal rights, as applicable.

The Plan monitors M/S and MH/SUD clinical and peer clinical reviewers’ application of clinical criteria through annual IRR assessments. The Plan also conducts monthly quality audits of individual non-clinical staff, clinical reviewers, and peer clinical reviewers, including staff performing appeal functions. The Plan routinely monitors Concurrent Review performance through its clinical performance oversight functions. In addition to comparing these “in operation” processes, the Plan reviewed medical necessity approval and denial rates, internal appeals outcomes, and external appeals outcomes related to Concurrent Review determinations for M/S and MH/SUD OON outpatient services. The results of these analyses are discussed in greater detail in Step 5.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan’s or issuer’s findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The findings of the Plan’s comparative analyses confirmed the strategies, processes, factors, evidentiary standards, and source information used to determine the MH/SUD OON outpatient services subject to Concurrent Review were comparable to, and applied no more stringently than, the strategies, processes, factors, evidentiary standards, and source information used to determine the M/S OON outpatient services subject to Concurrent Review “as written.” For M/S and MH/SUD OON outpatient benefits, the *Concurrent Review Factor Grid(s)* included with this analysis detail the shared factors used as the basis for adding, removing or retaining M/S and MH/SUD OON outpatient services on the list of services subject to Concurrent Review, as described above.

The Plan found the factors used to add, remove, or retain MH/SUD OON outpatient services on the list of services subject to Concurrent Review were comparable to, and applied no more stringently than, the factors used to add, remove, or retain M/S OON outpatient services on the list of services subject to Concurrent Review. OON M/S and MH/SUD outpatient services that

met the applicable factor(s) were subject to Concurrent Review “in operation.”

The Plan used comparable processes to conduct outpatient Concurrent Review of OON M/S and MH/SUD providers’ requests for coverage of additional units of service or extended periods of time beyond those previously approved by the Plan. The Plan required M/S and MH/SUD OON providers to timely request coverage. The Plan used qualified staff to confirm member eligibility and benefit availability, and to request additional clinical information if necessary. The Plan issued approvals for M/S and MH/SUD outpatient services that met applicable clinical criteria or guidelines. Only qualified M/S and MH/SUD peer clinical reviewers issued adverse benefit determinations. The Plan gave OON MH/SUD providers the opportunity to discuss potential adverse benefit determinations with qualified peer clinical reviewers prior to issuing adverse benefit determinations. This afforded OON providers the opportunity to provide additional information.

The Plan operated monitoring and oversight programs to ensure that clinical reviewers and peer clinical reviewers rendered appropriate determinations. Both M/S and MH/SUD required clinical reviewers, including peer clinical reviewers, to successfully complete the annual IRR assessment. Clinical reviewers were required to pass the IRR assessment with a score of 90% or better to render UM decisions independently. The 2022 IRR M/S results were 97% and MH/SUD results were 96%, demonstrating that M/S and MH/SUD clinical reviewers comparably applied medical necessity criteria when making utilization review determinations.

OON outpatient medical necessity approval and denial rates and appeals outcomes data from 01/01/2022-12/31/2022 were evaluated where a minimum threshold of 100 cases were available to ensure a valid data set for analysis.

There is an insufficient number of MH/SUD OON outpatient cases from 01/01/2022-12/31/2022 to support an analysis of clinical outcomes data for UnitedHealthcare Insurance Company (UHC).

The following definitions are applicable to the charts below:

- Total # of Requests Received: the aggregate number of OON outpatient Concurrent Review requests received
- Total # of Requests Approved: the aggregate number of OON outpatient Concurrent Review requests approved
- Total # of Requests Clinically Denied: the aggregate number of OON outpatient Concurrent Review requests that were denied for clinical reasons (request did not meet medical necessity). This does not include requests that were administratively denied.
- Approval Rate %: (Requests Approved / Requests Received)
- Clinical Denial Rate %: (Total number of Requests Clinically Denied / Total number of Requests Received)
- Total # of Clinical Denials reviewed upon appeal: Total (internal & external): the aggregate number of OON outpatient Concurrent Review clinical internal and external appeals received
- Total # of Clinical Denials Overturned upon appeal: Total (internal & external): the aggregate number of OON outpatient Concurrent Review clinical internal and external appeals overturned
- Clinical Denial Overturn Rate %: Total (Internal & External): percent of OON outpatient Concurrent Review clinical internal and external appeals overturned (Total # of Clinical Denials Overturned upon internal and external appeal/Total # of Clinical Denials reviewed upon internal and external appeal)
- Total # of Clinical Denials Upheld: Total (Internal & External): the aggregate number of OON outpatient Concurrent Review clinical internal and external appeals upheld
- Clinical Denial Uphold Rate %: Total (Internal & External): percent of OON outpatient Concurrent Review clinical internal and external appeals upheld (Total # of Clinical Denials Upheld upon internal and external appeal/Total # of Clinical Denials reviewed upon internal and external appeal)
- Total # of Clinical Denials reviewed upon internal appeal only: the aggregate number of OON outpatient Concurrent Review clinical internal appeals received
- Total # of Clinical Denials Overturned upon internal appeal only: the aggregate number of OON outpatient Concurrent Review clinical internal appeals overturned
- Clinical Denial Overturn Rate %, internal appeal only: percent of OON outpatient Concurrent Review clinical internal appeals overturned (Total # of Clinical Denials Overturned upon internal appeal/Total # of Clinical Denials reviewed upon internal appeal)

- Total # of Clinical Denials Upheld upon internal appeal: the aggregate number of OON outpatient Concurrent Review clinical internal appeals upheld
- Clinical Denial Uphold Rate %, internal appeal only: percent of OON outpatient Concurrent Review clinical internal appeals upheld (Total # of Clinical Denials Upheld upon internal appeal/Total # of Clinical Denials reviewed upon internal appeal)
- Total # of Clinical Denials reviewed upon external appeal only: the aggregate number of OON outpatient Concurrent Review clinical external appeals received
- Total # of Clinical Denials Overturned upon external appeal only: the aggregate number of OON outpatient Concurrent Review clinical external appeals overturned
- Clinical Overturn Rate %, external appeal only: percent of OON outpatient Concurrent Review clinical external appeals overturned (Total # of Clinical Denials Overturned upon external appeal/Total # of Clinical Denials reviewed upon external appeal)
- Total # of Clinical Denials Upheld upon external appeal: the aggregate number of OON outpatient Concurrent Review clinical external appeals upheld
- Clinical Uphold Denial Rate %, external appeal only: percent of OON outpatient Concurrent Review clinical external appeals upheld (Total # of Clinical Denials Upheld upon external appeal/Total # of Clinical Denials reviewed upon external appeal)

UHC

Outcomes Data Concurrent Review Analysis:

	Out-of-Network Outpatient		
	M/S	MH/SUD	
Total # of Requests Received	0	3	Low volume (of some classifications) is not sufficient for analysis. (quantity of 100 each, is required for a valid sample)
Total # of Requests Approved	0	3	
Total # of Requests Clinically Denied	0	0	
Approval Rate %	-	100.00%	
Clinical Denial Rate %	-	0.00%	
Total # of Clinical Denials reviewed upon appeal--Total (Internal & External)	0	2	Low volume (of some classifications) is not sufficient for analysis. (quantity of 100 each, is required for a valid sample)
Total # of Clinical Denials Overturned upon appeal--Total (Internal & External)	0	0	
Clinical Denial Overturn Rate %-- Total (Internal & External)	-	0.00%	
Total # of Clinical Denials Upheld--Total (Internal & External)	0	2	
Clinical Denial Uphold Rate %--Total (Internal & External)	-	100.00%	
Total # of Clinical Denials reviewed upon internal appeal only	0	2	Low volume (of some classifications) is not sufficient for analysis. (quantity of 100 each, is required for a valid sample)
Total # of Clinical Denials Overturned upon internal appeal only	0	0	
Clinical Denial Overturn Rate %, internal appeal only	-	0.00%	
Total # of Clinical Denials Upheld upon internal appeal only	0	2	
Clinical Denial Uphold Rate %, internal appeal only	-	100.00%	
Total # of Clinical Denials reviewed upon external appeal only	0	0	Low volume (of some classifications) is not sufficient for analysis. (quantity of 100 each, is required for a valid sample)
Total # of Clinical Denials Overturned upon external appeal only	0	0	
Clinical Overturn Rate %, external appeal only	-	-	
Total # of Clinical Denials Upheld upon external appeal only	0	0	
Clinical Uphold Denial Rate %, external appeal only	-	-	

Conclusions

The Plan reviewed the M/S and MH/SUD Concurrent Review operational policies and procedures and concluded the methodology used to determine which MH/SUD OON outpatient services are subject to Concurrent Review “as written” were comparable to, and applied no more stringently than, the methodology used to determine which M/S OON outpatient services are subject to Concurrent Review “as written.” Additionally, the Plan concluded that how Concurrent Review is applied to MH/SUD OON outpatient services was comparable to, and applied no more stringently than, how Concurrent Review is applied to M/S OON outpatient services “as written.”

The Plan reviewed the M/S and MH/SUD processes, including responsibility for submission, timeframes for submission and review, notification to members and providers, clinical standards for review, staff qualifications, outcome data, and IRR assessment results and concluded how the Plan conducts Concurrent Review for MH/SUD OON outpatient services “in

operation” was comparable to, and applied no more stringently than, how the Plan conducts Concurrent Review for M/S OON outpatient services “in operation.”

Credentialing Program Non-Quantitative Treatment Limitation (NQTL) Analysis

GA – UnitedHealthcare Insurance Company, UnitedHealthcare of Georgia, Inc., UnitedHealthcare Insurance Company of the River Valley, and UnitedHealthcare of Georgia, Inc. Individual Exchange Medical Policy
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Overview

Pursuant to a federal law called the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical and surgical (M/S) benefits. This generally means that financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements, such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage.

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors considered in the design and application of the NQTL (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4). Findings and conclusions both “as written” and “in operation” are presented (Step 5).

Specific NQTL

Credentialing is performed to determine if a provider or facility meets standards to join (credential) or maintain (recredential) its status in the Plan’s network of participating providers. The Plan uses its credentialing and recredentialing processes to validate that its network of contracted providers and facilities providing inpatient, outpatient, and emergency services meet the baseline criteria, as applicable, to the state and practicing specialty. The Plan requires all providers/facilities to be credentialed.

The credentialing process is triggered by a provider or facility seeking to join or continue participation in the Plan’s network. Its purpose is to determine whether the provider or facility has the appropriate level of education/licensure/certification and satisfies additional qualifications (as applicable) to provide covered care to Plan members. The Plan uses credentialing processes and plans based on National Committee for Quality Assurance (NCQA) standards and applicable state or federal regulatory requirements when determining whether to credential M/S and MH/SUD providers or facilities.

This document includes the following information:

- Process for credentialing both M/S and MH/SUD providers and facilities
- Description of the NQTL and application (Step 1)
- Factors used to facilitate credentialing for both M/S and MH/SUD (Step 2)
- Evidentiary standards and sources used to define and/or trigger each of the identified factors (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

The analysis refers to the following attachments:

- *Certificates of Coverage* (COC23-INS-2018-LG-GA, COC23-INS-2018-SG-GA, COC23-HMO-2018-LG-GA, COC23-HMO-2018-SG-GA, COC23-INS-RV-2018-LG-GA, COC23-INS-RV-2018-SG-GA, Policy23-HMO-2022-LEX-GA) Plan document that explains covered services, terms, conditions, and limitations of the member’s policy

The Plan concludes that its methodologies for credentialing for M/S and MH/SUD providers and facilities are comparable and applied no more stringently for MH/SUD providers and facilities than for M/S providers and facilities both “as written” and “in

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operation.”

Process

For both M/S and MH/SUD, the Plan uses comparable credentialing processes.

For M/S, the *UnitedHealthcare (UHC) Credentialing Plan* defines Credential, Credentialing, or Recredentialing as “the process of assessing and validating the applicable criteria and qualifications of Licensed Independent Practitioners and Facilities to become or continue as Participating Licensed Individual Providers (PLIPs) and Participating Facilities, as set forth in the Credentialing Plan and pursuant to Credentialing Authorities.”

For MH/SUD, the *United Behavioral Health (UBH) Credentialing Plan* defines Credentialing or Recredentialing as “the process of assessing and validating the applicable criteria and qualifications of providers to become or continue as Participating Providers, as set forth in the Credentialing Plan.”

Key steps in the credentialing process for both M/S and MH/SUD include:

- The provider/facility submits a completed application to the Plan to be included in the Plan’s provider network
- The Plan confirms the information in the application
- If the provider/facility passes the credentialing requirements as outlined in the respective credentialing plan, the provider/facility is credentialed

Credentialing Plan

The purpose of the applicable credentialing plan is to explain the policy for credentialing. All providers/facilities included in the M/S and MH/SUD network are subject to the applicable credentialing plan. Providers/facilities that provide health care services to Covered Persons under their out-of-network benefits or on an emergency basis are not subject to the credentialing plans.

Credentialing Plan Approval

For M/S, the National Peer Review and Credentialing Policy Committee (NPRCPC) has the authority to approve the *UHC Credentialing Plan*. M/S has the right to change the *UHC Credentialing Plan* to meet regulatory requirements or other organizational or business needs with the Quality Oversight Committee approval. The *UHC Credentialing Plan* can be referenced on the website <https://www.uhcprovider.com/en/resource-library/Join-Our-Network.html> to access the regulatory and accreditation timeframes.

The NPRCPC is comprised of stakeholders from multiple UHC regions and meets regularly. The primary role of the NPRCPC is to ensure that the Regional Peer Review Committees (RPRCs) do not rely on an improper or discriminatory basis for making their decisions. The NPRCPC has the final decision-making authority on all disciplinary actions the RPRC recommends that affect restriction, suspension, or termination of participation status of physicians or health care professionals. In addition, this committee is responsible for review and approval of the *UHC Credentialing Plan* and interpretation of the *UHC Credentialing Plan* as needed. The NPRCPC, when authorized by applicable state or federal law, endeavors to conduct its activities in a manner that constitutes peer review.

For MH/SUD, the Plan delegates credentialing of behavioral health network providers to its affiliate UBH d/b/a Optum Behavioral Health (OBH). The Quality Improvement Committee (QIC) has oversight of the Credentialing Committee and delegates overall responsibility and authority to its standing Credentialing Committee for credentialing. The QIC also delegates to the Credentialing Committee the authority to administer the *UBH Credentialing Plan*. The Credentialing Committee is responsible for administering the *UBH Credentialing Plan* and reviewing and approving policies related to credentialing

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activities on behalf of OBH, subject to oversight by the QIC. The *UBH Credentialing Plan* can be referenced on the website <https://www.providerexpress.com/content/dam/ope-provexpr/us/pdfs/clinResourcesMain/guidelines/credPlans/credPlanUBH.pdf>.

The Credentialing Committee is multidisciplinary and must include at least two OBH Medical Directors. The committee is comprised of at a minimum two external participating clinicians. The committee must have at least seven voting members present to form a quorum. At least one representative of the quorum will be a Medical Director and two must be external clinicians. An OBH Medical Director chairs the Credentialing Committee; other OBH Medical Directors will serve as co-chairs and will chair the meeting in the absence of the chairperson. The Credentialing Committee meets at least monthly.

The OBH Credentialing Committee Chair has responsibility to see that the *UBH Credentialing Plan* and policies are administered fairly to all clinicians and organizational providers, to monitor the ongoing quality of clinician and organizational provider services, and to immediately restrict or terminate a participating clinician's or organizational provider's agreement.

Detailed Process for Credentialing

For M/S and MH/SUD, credentialing is a peer-review process designed to review certain information pertinent to the respective Credentialing Entity's decision whether to contract a provider or facility, either initially or on an ongoing basis. The process described in the credentialing plans will be initiated only after the Credentialing Entity makes a preliminary determination that it wishes to pursue contracting or re-contracting with the applicant.

The credentialing process begins when a provider/facility submits a completed application.

Application Verification

For M/S, staff will collect information to assess whether an applicant meets the minimum credentialing requirements for practice location, specialty, and any other business needs.

A Medical Director may approve initial credentialing or recredentialing applications determined to meet all credentialing criteria. If credentialing criteria are not met, the Medical Director forwards all documentation to the National Credentialing Committee (NCC) for determination. All completed applications are also forwarded to the NCC for determination.

The NCC will make credentialing decisions pursuant to the *UHC Credentialing Plan*. The NCC is comprised of PLIPs from the Credentialing Entities, UHC Medical Directors, and a designated Medical Director Chairperson unless a different committee composition is otherwise required by applicable credentialing authorities. The NCC has discretion to ask for missing information or to deny the application as incomplete. The NCC may request further information not covered by the application if necessary to make a determination. Upon receipt of a complete application, the NCC will render a decision in accordance with the timeframes as specified by the *UHC Credentialing Plan*.

Credentialing decisions are communicated to the applicant and the Plan. If an application is not accepted or participation is terminated, the non-acceptance or termination letter will include the reason(s) for the decision. The Plan permits appeals from adverse credentialing or sanctions monitoring decisions as required by the NCQA, the Center for Medicare and Medicaid Services (CMS), and other applicable state and federal regulatory authorities. Any appeal process related to the termination, suspension, or non-renewal of providers/facilities will be communicated to the affected provider/facility with the notice of termination, suspension, or non-renewal.

For MH/SUD, credentialing decisions and actions of OBH will be guided primarily by (a) consideration of each applicant's potential contribution to the objective of providing effective and efficient health care services to UBH's members, (b) UBH's need for clinicians and organizational providers within its service area, and (c) judging each applicant for credentialing and recredentialing without discrimination due to age, race, gender, color, religion, ethic/national identity, ancestry, disability,

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marital status, covered veteran status, sexual orientation, status with respect to public assistance, blindness or partial blindness, handicap, physical or mental impairment, victims of domestic violence, types of patients seen, or any other characteristic protected under state, federal, or local law.

The Credentialing Committee is responsible for making credentialing decisions about inclusion of providers and facilities in the network. Applications that meet all the credentialing criteria and require no further review by the Credentialing Committee are sent to the Medical Director for approval. Applications that require additional review are presented to the Credentialing Committee. In this instance the Credentialing Committee has the sole discretion to make a credentialing exception to the required criteria, such as network need. Decisions to make exceptions based on appropriate factors are done in compliance with state and federal regulations. The Credentialing Committee may also at its sole discretion and determination, make the decision to deny the application for network participation.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- Credentialing

Benefit Classification(s)

- Applies to all in-network (INN) M/S and MH/SUD providers and facilities providing covered services in the Inpatient, Outpatient, and Emergency Care classifications as described in the credentialing plans

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHIC)
- UnitedHealthcare of Georgia, Inc. (UHCGA)
- UnitedHealthcare Insurance Company of the River Valley (UHICRV)
- UnitedHealthcare of Georgia, Inc. Individual Exchange Medical Policy (UHC GA)

Plan Terms

The Plan's credentialing process confirms public information about the professionals' and facilities' licenses and other credentials but does not assure the quality of their services. These professionals and facilities are independent practitioners and entities that are solely responsible for the care they deliver.

List of M/S and MH/SUD Benefits Subject to NQTL

Applies to all INN M/S and MH/SUD providers and facilities providing covered services in the Inpatient, Outpatient, and Emergency Care classifications as described in the Credentialing Plan.

Step 2 – Factors Used in the Design and Application of the NQTLs

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

The Plan relies on the following factors to determine if a provider or facility meets standards to join (credential) or maintain (recredential) its status in the Plan's network of participating providers, determine credentialing for M/S and MH/SUD INN inpatient and outpatient services. These factors apply to both M/S and MH/SUD benefits in the following classifications:

- INN M/S providers and facilities providing covered services in the Inpatient, Outpatient, and Emergency classification
- INN MH/SUD providers and facilities providing covered services in the Inpatient, Outpatient, and Emergency

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classification

- The provider or facility completes and attests to the accuracy of the content of the application (Qualitative)
 - Applies to both M/S and MH/SUD
- The Plan verifies certain information (Qualitative)
 - Applies to both M/S and MH/SUD
- The provider or facility continues to meet the applicable requirements (Qualitative)
 - Applies to both M/S and MH/SUD

The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factors used in credentialing. These evidentiary standards and sources apply to the following benefit classifications:

- I. INN M/S providers and facilities providing covered services in the Inpatient, Outpatient, and Emergency classification
- II. INN MH/SUD providers and facilities providing covered services in the Inpatient, Outpatient, and Emergency classification

Factor – Completed Application is defined as the provider or facility completes and attests to the accuracy of the content of the application.

- The Plan's evidentiary standard and source that triggers and/or defines the identification of the factor:
 - Submission of application

This evidentiary standard and source applies to both M/S and MH/SUD INN providers and facilities providing covered services in the Inpatient, Outpatient, and Emergency Care classifications as described in the credentialing plans. This evidentiary standard and source is defined in a qualitative manner.

Factor – The Plan verifies certain information is defined as primary source verification in the application.

- The Plan's evidentiary standard and source that triggers and/or defines the identification of the factor:
 - The UHC and UBH Credentialing Plans describe the information, i.e., primary source verification, which is required

This evidentiary standard and source applies to both M/S and MH/SUD INN providers and facilities providing covered services in the Inpatient, Outpatient, and Emergency Care classifications as described in the credentialing plans. This evidentiary standard and source is defined in a qualitative manner.

Factor – The provider or facility continues to meet the applicable requirements is defined as what is set forth in the credentialing plans while they are contracted with the Plan.

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- The Plan's evidentiary standards and sources that trigger and/or define the identification of the factor:
 - State and federal regulatory requirements
 - National accreditation standards, for example NCQA credentialing standards

These evidentiary standards and sources apply to both M/S and MH/SUD INN providers and facilities providing covered services in the Inpatient, Outpatient, and Emergency Care classifications as described in the credentialing plans. These evidentiary standards and sources are defined in a qualitative manner.

The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL.

Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

As Written

The Plan conducted a comparative analysis of the strategies, processes, factors, evidentiary standards, and source information used to determine if a provider or facility meets standards to join (credential) or maintain (recredential) their status in the Plan's network of participating providers for M/S and MH/SUD “as written.”

For M/S, the NCC is responsible for implementing the *UHC Credentialing Plan*. The NCC is comprised of PLIPs, UHC Medical Directors, and a designated Medical Director Chairperson, unless a different committee composition is otherwise required by applicable credentialing authorities. The NCC makes the credentialing decision and informs providers within applicable state or federally mandated timeframes.

For MH/SUD, the Plan delegates credentialing of behavioral health network providers to its affiliate OBH.

The OBH Credentialing Committee is responsible for implementing its *UBH Credentialing Plan*. The OBH Credentialing Committee is multi-disciplinary and must have at least two Optum Medical Directors as members. At least two of the 12 members must be external participating clinicians from each major discipline (i.e., MD, PhD, and MSW). The OBH Credentialing Committee informs providers of credentialing decisions within applicable state or federally mandated timeframes.

The M/S and MH/SUD credentialing committees have similar composition, in that they both include licensed providers with expertise in the relevant disciplines as well as Medical Directors. They also both follow applicable state or federal regulations for response timeframes. In addition, the *UHC* and *UBH Credentialing Plans* are both accredited by NCQA and are reviewed annually.

At times, UHC and OBH may delegate credentialing to third parties. The Plan performs oversight of delegated credentialing as outlined in the *UHC* and *UBH Credentialing Plans*.

The Plan conducted a comparative analysis of the application criteria and required documentation for both M/S and MH/SUD providers.

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Crosswalk of M/S and MH/SUD Credentialing Application and Required Documentation Professional	
M/S credentialing application requirements (<i>UHC Credentialing Plan</i> , uhcprovider.com/content/dam/provider/docs/public/resources/join-network/Credentialing-Plan.pdf , page 22, Attachment A, 11)	MH/SUD credentialing application requirements (<i>UBH Credentialing Plan</i> , providerexpress.com/content/dam/ope-provexpr/us/pdfs/clinResourcesMain/guidelines/credPlans/credPlanUBH.pdf , page 5-6, sections 4.1)
Licensed Individual Providers (LIP) application credentialing criteria: A release granting the Credentialing Entity permission to review the records of and to contact any professional society, hospital, insurance company, present or past employer, professional peer, clinical instructor, or other person, entity, institution, or organization that does or may have records or professional information about the Applicant.	A current and signed attestation/release by the Clinician granting UBH unlimited permission to review records of and to contact any professional society, hospital, insurance carrier, employer, entity, institution or organization that has or may have records/information concerning the Applicant.
A listing of degrees or certifications received from appropriate professional schools, residency training programs, or other specialty training programs appropriate for the type of participation sought, if applicable. May not be required at the time of recredentialing unless it has changed and will impact the LIP's specialty.	A complete list of all professional education/training completed.
Hospital admitting privileges, or coverage arrangements.	For physicians: hospital admitting privileges or a process for providing inpatient care for members in need of a higher level of care, (signed attestation form may be used).
Applicant's current professional liability insurance policy, including the name of insurer, policy number, expiration date, and coverage limits; (Note: M/S standard liability is \$1million/\$3million or an amount or type as otherwise specified by applicable state law)	Professional liability malpractice insurance with liability limits of \$1/\$3 million for physicians and \$1/\$1 million for non-physician Clinicians, or in an amount or type as otherwise specified by applicable state law. This can include evidence of participation in state patient compensation or catastrophic loss funds, if applicable.
Limitations on ability to perform functions of the position with or without accommodation;	Reasons for any inability to perform the essential functions of the position, with or without accommodation.
History of loss or limitation of privileges or disciplinary activity;	Disclosure of any and all loss or limitation of professional privileges or disciplinary activity.
Absence of current, illegal drug use;	Presence of illegal drug use.
History of loss of license and felony convictions;	Disclosure of any and all loss of professional license(s). Disclosure of any and all felony convictions.
Completeness and accuracy of the information provided in the Application. (Page 9, section 4.2)	A signed attestation regarding the correctness and completeness of the application.
Affirmative responses to Disclosure Questions on the Credentialing Application. Applicant is required to provide details on all affirmative responses to Disclosure Questions on the Credentialing Application, which may be reviewed by a Medical Director, and at the discretion of the Medical Director, may be reviewed by Credentialing Committee for a determination of LIP's acceptance into Credentialing	Completed disclosure statements including questions on license disciplinary actions; criminal felony convictions or civil judgments that involved dishonesty, fraud, deceit or misrepresentation; disciplinary actions by any federal programs; any other disciplinary actions or restrictions; and responses to applicable "Yes" answers

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Entity's Network.	
M/S Required Documentation (Pages 7-9, section 4.2 unless noted otherwise)	MH/SUD Required Documentation (Pages 5-6, sections 4.1)
Insurance or State-approved alternative. The Applicant must maintain errors and omissions (malpractice) insurance through insurers licensed in their State, or show similar financial commitments made through an appropriate State approved alternative, in the minimum amounts required by UnitedHealth Group's Provider Guidelines. The Credentialing Entity may require a copy of the Applicant's current Certificate of Coverage or may allow the Applicant's attestation to current, adequate insurance of State-approved alternative. The pertinent Participation Agreement may require coverage that exceeds the minimum established by this Credentialing Plan.	Professional liability malpractice insurance with liability limits of \$1/\$3 million for physicians and \$1/\$1 million for non-physician Clinicians, or in an amount or type as otherwise specified by applicable state law. This can include evidence of participation in state patient compensation or catastrophic loss funds, if applicable.
Work History. The Credentialing Entity will obtain a five-year work history. Gaps longer than six months must be explained by the LIP and found acceptable by the Credentialing Committee.	List of five-year work history including month and year, on application or copy of resume/CV, complete explanations for gaps in work history of six months or more.
A copy of the Applicant's current Drug Enforcement Agency ("DEA") or Controlled Dangerous Substance ("CDS") Certificate in each state where the Applicant intends to practice, if applicable.	For prescribers: a current copy of the DEA and/or CDS certificate (where required by state), if applicable; in each state where the physician or prescribing Clinician practices.
M/S does not require, MH/SUD only requests "if applicable."	Copy of Educational Commission for Foreign Medical Graduates (ECFMG) certificate, if applicable.
(Page 22, Attachment A) Any other documents or information that the Credentialing Entity determines are necessary for it to effectively and/or efficiently review the Applicants' qualifications.	Any other documents required by state regulations or client requirement.
(Page 8, Section 4.2) Medicare/Medicaid Sanctions Review and Medicare Opt Out Eligibility. Regardless of the contracted line of business, for example, Medicare, Medicaid or Commercial the Applicant must not be ineligible, excluded, debarred or precluded from participation in the Medicare and/or Medicaid and related state and federal programs, or terminated for cause from Medicare or any state's Medicaid or Children's Health Insurance Program (CHIP) program and must be without any sanctions levied by the Office of Inspector General (OIG), the CMS Preclusion List or other disciplinary action by any federal or state entities identified by CMS. Credentialing Entity will, at a minimum,	Proof of participation and meeting CMS Medicare and Medicaid requirements.

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verify reported information from the Office of Inspector General (OIG), the CMS Preclusion list and Medicare Opt Out.	
Crosswalk of M/S and MH/SUD Credentialing Application Facility/ Organizational Providers	
M/S credentialing application requirements (<i>UHC Credentialing Plan</i> , uhcprovider.com/content/dam/provider/docs/public/resources/join-network/Credentialing-Plan.pdf , page 12, Section 7)	MH/ SUD credentialing application requirements (<i>UBH Credentialing Plan</i> , providerexpress.com/content/dam/operovexpr/us/pdfs/clinResourcesMain/guidelines/credPlans/credPlanUBH.pdf , page 12, sections 6.0)
Current required license(s)	Current, applicable and required state license(s) showing the Organizational Provider is in good standing with state and federal regulatory bodies.
Insurance. The Applicant must maintain general/comprehensive liability insurance as well as errors and omissions (malpractice) insurance for at least the “per occurrence” and aggregate limits established by UnitedHealth Group’s Provider Guidelines with an insurer licensed to provide medical malpractice insurance in the Applicant’s State of practice, or show similar financial commitments made through an appropriate State approved alternative, as determined by the Credentialing Entity. The pertinent Participation Agreement may require coverage that exceeds the minimum established by this Credentialing Plan (Note: M/S standard liability is \$1million/\$3million or an amount or type as otherwise specified by applicable state law)	Maintains professional and general liability insurance (malpractice) of \$5 million/occurrence and \$5 million/aggregate for inpatient mental health and/or inpatient rehabilitation substance abuse disorder services and \$1 million/occurrence and \$3 million/aggregate for all other levels of mental health and/or substance use disorder services. UBH does accept umbrellas policy amounts to supplement professional and general liability insurance coverage. All limit requirements listed above are waived, if an Organizational Provider is covered under a Federal, State, County, or Municipal policy/law.
Medicare/Medicaid Sanctions Review. Regardless of the contracted line of business, for example, Medicare, Medicaid or Commercial, the Applicant must not be ineligible, excluded or debarred from participation in the Medicare and/or Medicaid and related State and Federal programs or terminated for cause from Medicare or any state’s Medicaid or CHIP program and must be without any sanctions levied by the Office of Inspector General (OIG), the General Services Administration (GSA) and the CMS Preclusion list or other disciplinary action by any Federal or State entities identified by CMS. Exceptions to this requirement may only be	Medicare/Medicaid Sanctions Review. Regardless of the contracted line of business (Medicare, Medicaid, or Commercial), the Applicant must not be ineligible, excluded, debarred, or precluded from participation in Medicare and/or Medicaid and related state and federal programs, or terminated for cause from Medicare or any state's Medicaid or CHIP program and must be without any sanctions levied by the Office of Inspector General (OIG), the General Services Administration Systems for Awards Management (SAM), and the CMS Preclusion list or other disciplinary action by any federal or state entities identified by CMS.

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granted when there are issues of network adequacy, and an OIG waiver has been granted.	
<p>Appropriate Accreditation or Satisfactory Alternative. The Credentialing Entity must obtain a copy of the accreditation report or evidence from the Accrediting Body.</p> <p>If the Applicant is not accredited or does not hold alternative certification by an agency recognized by the Credentialing Entity in Attachment C, a site visit of the organization is required, and results must be found to be satisfactory as defined by the Credentialing Entity in Attachment D.</p> <p>In lieu of a site visit by the Credentialing Entity, a CMS or State quality review may be used if it is not more than three years old. The organization must provide evidence in the form of a final report or letter from CMS or the State, stating that it has been reviewed and passed inspection.</p>	<p>Current, valid accreditation from an agency recognized by UBH in Attachment A. UBH will conduct primary source verification for all accreditations.</p> <p>If an Organizational Provider is not accredited or certified by an agency recognized by UBH, a site review is required, and the Organizational Provider must achieve a site visit score of 80% or higher. If, during the initial credentialing process, the Organizational Provider does not meet the scoring criteria, UBH will notify the Organizational Provider that they do not meet current standards, provide feedback on the deficiencies, and inform the Organizational Provider that they may reapply after six (6) months, at which time a re-audit will be required before the initial credentialing process can commence.</p> <p>In lieu of a site visit by UBH, the Organizational Provider must have been reviewed or received certification by CMS or State Licensing Agency within the past three (3) years. UBH has determined that CMS requirements for Organizational Providers fully meet UBH Organizational Provider site requirements. UBH obtains a copy of the CMS or State Licensing Agency's report from the Organizational Provider</p>

The results of the comparative analysis of the credentialing application and documentation requirements confirms that M/S and MH/SUD have comparable requirements for credentialing providers and facilities.

In Operation

Both M/S and MH/SUD use the credentialing and recredentialing process to ensure their network of contracted providers have the appropriate qualifications to provide care to Plan members according to the *UHC* and *UBH Credentialing Plans*.

A comparative analysis of the number of credentialing applications received, denied, credentialed, and cancelled for organizations and clinicians was conducted in 2022 for both M/S and MH/SUD) as shown in the chart below. [The credentialing application approval rates do not reflect any material differences in the credentialing process.]

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GA Credentialing Data - CY2022				
Organization Applications	Med/Surg	%	MH/SUD	%
Received	105		18	
Cancelled Applications*	0		2	
Applications Reviewed	105	100%	16	100%
Denied	14	13.33%	0	0.00%
Credentialed	91	86.67%	16	100.00%
Clinician Applications	Med/Surg	%	MH/SUD	%
Received	1,594		773	
Cancelled Applications*	8		12	
Applications Reviewed	1,586	100%	761	100%
Denied	105	6.62%	1	0.13%
Credentialed	1,481	93.38%	760	99.87%

* Cancelled

applications include the following:

- Not eligible to apply
- Incomplete
- Nonresponse
- Withdrawn
- Already Par

Additionally, the Plan compared the average time it takes to complete the initial credentialing for both providers and facilities. This time is calculated from date of receipt of a completed credentialing application to date of committee decision for providers/facilities that pass. The 2022 average number of days to complete initial credentialing are provided below:

2022 Measurement	M/S	MH/SUD
Number of Days for initial Provider Credentialing	13.65	11.2
Number of Days for initial Facility Credentialing	5.73	5.9

The results of the comparison of the average time to complete the initial credentialing process confirms that both M/S and MH/SUD are meeting applicable state/federal requirements.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The above analysis confirmed the strategies, processes, factors, evidentiary standards, and source information used to determine if an MH/SUD provider or facility meets credentialing or recredentialing standards were comparable to, and applied no more stringently than, the strategies, processes, factors, evidentiary standards, and source information used to determine if an M/S provider or facility meets credentialing or recredentialing standards, both “as written” and “in operation.” The Plan identified the factors and evidentiary standards used to determine if a provider or facility meets credentialing standards apply to both M/S and MH/SUD.

The findings of the parity analysis revealed the *UBH Credentialing Plan* for MH/SUD network providers was comparable to,

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and applied no more stringently than, the *UHC Credentialing Plan* for M/S network providers. The parity analysis also revealed that credentialing application requirements for MH/SUD network providers are comparable to, and applied no more stringently than, the application requirements for M/S network providers.

In addition, the findings revealed there were no significant disparate credentialing outcomes for MH/SUD providers as compared to M/S providers.

Lastly, the amount of time it takes to complete initial credentialing for both M/S and MH/SUD providers and facilities was comparable and both M/S and MH/SUD meet applicable state and federal requirements.

Conclusions

In light of the above findings, the Plan concludes that the credentialing requirements for M/S and MH/SUD providers and facilities are comparable and applied no more stringently for MH/SUD than for M/S, both “as written” and “in operation.”

Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical/surgical (M/S) benefits. This generally means that the financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements such as, deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs, which may limit the scope or duration of benefits for treatment under a plan or coverage.

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

The Plan excludes coverage of technologies (e.g., services, interventions, devices, medically administered M/S and MH/SUD drugs, etc.) determined to be experimental, investigational, or unproven (EIU) for specific diagnoses based on medical/behavioral clinical policies and Plan documents. The Plan develops evidence-based medical/behavioral clinical policies for select M/S and MH/SUD technologies. The medical/behavioral clinical policies may identify specific technologies that are categorically considered EIU or that are considered EIU under certain circumstances.

This document includes the following information:

- Process for determining if a technology is EIU for both M/S and MH/SUD technologies
- Description of the NQTL and application (Step 1)
- Factors used to determine which technologies are subject to the NQTL (Step 2)
- Evidentiary standards and sources used to define, trigger and/or implicate a factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

This analysis refers to the following attachments:

- *2023 UnitedHealthcare Provider Administrative Guide* - Informs providers of the EIU limitation. The *UnitedHealthcare Provider Administrative Guide* can be accessed on the website <https://www.uhcprovider.com/en/admin-guides.html>
- September 2023, *Optum National Network Manual* - Informs providers of the EIU limitation. The *Optum National Network Manual* can be accessed on the website <https://public.providerexpress.com/content/open-provexpr/us/en/clinical-resources/guidelines-policies/optum-network-manual.html>
- *Certificates of Coverage* (COC23-INS-2018-LG-GA, COC23-INS-2018-SG-GA, COC23-HMO-2018-LG-GA, COC23-HMO-2018-SG-GA, COC23-INS-RV-2018-LG-GA, COC23-INS-RV-2018-SG-GA, Policy23-HMO-2022-IEX-GA) Plan document that explains covered services, terms, conditions, and limitations of the member’s policy
- *Schedule of Benefits* (for example: *Schedule of Benefits SBN23-Medical-INS-2018-[Choice+Plus][Select+Plus][Doctors+Plus]-LG-GA*, *SBN23-Medical-INS-2018-[Choice+Plus][Select+Plus][Doctors+Plus]-SG-GA*, *SBN23-Medical-INS-RV-2018-HeritagePlus-LG-GA*, *SBN23-Medical-INS-RV-2018-HeritagePlus-SG-GA*, and *SBN23-Medical-HMO-2022-IEX-GA-ADV*) - Plan document that outlines

member responsibilities

- M/S medical clinical policies are publicly available: [Medical & Drug Policies and Coverage Determination Guidelines for UnitedHealthcare Commercial Plans | UHCprovider.com](#)
- MH/SUD behavioral clinical policies are publicly available: [Guidelines/Policies/Manuals \(providerexpress.com\)](#)
- *UnitedHealthcare (UHC) Hierarchy of Clinical Evidence* – M/S policy that defines the order of clinical evidence to ensure a transparent and consistent approach within UnitedHealthcare
- *Behavioral Health Hierarchy of Clinical Evidence* – MH/SUD policy that defines the order of clinical evidence to ensure a transparent and consistent approach to the review and development of Optum’s Clinical Technology Assessments and Behavioral Clinical Policies
- *Clinical Technology Assessment Committee (CTAC) Charter* – document that outlines the purpose, structure, responsibility, and membership of the committee that develops internal medical criteria and reviews and approves externally developed criteria for MH/SUD
- *Clinical Quality and Operations Committee (CQOC) Charter* – document that outlines the purpose, structure, responsibility, and membership of the committee that oversees CTAC
- *Medical Technology Assessment Committee (MTAC) Charter* – policy that outlines the purpose, responsibility, structure, and membership of the committee that develops internal medical criteria and reviews and approves externally developed criteria for M/S
- *National Medical Care Management Committee (NMCMC) Charter* – document that outlines the purpose, responsibility, membership, and structure of the committee that oversees the MTAC
- *Utilization Management Program Committee Charter* – document that outlines the purpose, responsibility, functions, and composition of the committee that oversees the M/S utilization management program
- *Applying Benefit Plan and Review Criteria* Standard Operating Procedure - outlines the hierarchy of authorities to be reviewed (i.e., state/federal laws and regulations followed by Benefit Plan criteria) when making coverage determinations
- *Utilization Management Program Description (UMPD) of United HealthCare Services, Inc. and UnitedHealthcare Insurance Company* – M/S summarizes the philosophy, structure and standards that govern UHC’s medical management, utilization management (UM) and utilization review responsibilities and functions
- *Clinical Review Criteria Operational Policy* - The purpose of this operational policy is to document that UHC will use evidence-based clinical review criteria to support clinical review decisions for UM programs, and to ensure that the clinical review process is applied consistently
- *Clinical Criteria Development Selection and Application Policy* - addresses Optum’s selection, development, and use of clinical criteria in making benefit determinations
- *UnitedHealthcare Commercial Omnibus Codes* – M/S policy that outlines technologies that are considered EIU
- *UnitedHealthcare Individual Exchange Omnibus Codes* – M/S policy that outlines technologies that are considered EIU

The Plan concludes that the methodologies used to determine whether a M/S or MH/SUD technology is EIU are comparable and applied no more stringently to MH/SUD technologies for all benefit classifications, both “as written” and “in operation.”

Process

The Plan uses the following standard process to determine whether a technology is EIU:

The Plan uses committees to assess technologies and conduct a thorough review of the scientifically based clinical evidence and peer-reviewed literature in accordance with the *Hierarchies of Clinical Evidence* to develop medical/behavioral clinical policies that apply to the technologies.

For both M/S and MH/SUD, reviews for potential or identified EIU technologies are triggered either by a request from a

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member or provider pre-service (i.e., Prior Authorization) or by coding edits in the claims system (i.e., Retrospective Review) that are derived from the medical policies.

For M/S, the Medical Technology Assessment Committee (MTAC) is responsible for developing and maintaining evidence-based medical clinical policies. MTAC uses scientifically based clinical evidence and the *UHC Hierarchy of Clinical Evidence* in its development, assessment, and approval processes. MTAC conducts its processes in a timely manner to ensure transparency and consistency, and to identify safe and effective M/S technologies for members.

MTAC members include medical directors with diverse medical and surgical specialties and sub-specialties, representatives from business segments, legal services, consumer affairs, medical policy development and operations teams, and benefit interpretation team. MTAC voting members include medical directors with the following specialties (note that some doctors have multiple specialties):

- Plastic Surgery
- Internal Medicine (x7)
- Medical Oncology
- Thoracic and Cardiothoracic Vascular Surgery (x2)
- Preventative Medicine
- Pediatrics
- Diagnostic Radiology and Vascular/Interventional Radiology
- Ophthalmology
- Physical Medicine & Rehabilitation Pain Medicine
- Family Practice
- Emergency Medicine

When assessing the safety and efficacy of technologies used to treat M/S conditions, MTAC first looks for any strong and compelling scientific evidence such as statistically robust, well-designed, randomized, controlled trials, and cohort studies. In addition, MTAC will look for multi-site observational studies and single site observational studies.

In the absence of any strong and compelling scientific evidence, MTAC assesses technologies by looking at any national consensus statements and/or publications by recognized authorities such as clinical position papers published by professional specialty societies and Center for Medicare and Medicaid Services (CMS) National Coverage Determinations (NCDs).

MTAC will not deem a technology unproven solely based on a lack of randomized controlled trials, particularly for new and emerging technologies.

The National Medical Care Management Committee (NMCMC) annually reviews and validates medical necessity criteria endorsed by MTAC. The NMCMC is comprised of the Chief Medical Officer, and representatives from clinical policy, clinical advocacy and grievances, business standardization and advancement, regional chief medical officers, inpatient care management, lines of business, medical policy, clinical operations, and Optum Behavioral Health. The Chair of the NMCMC must be an executive leader and licensed physician.

As of April 1, 2023, the Utilization Management Program Committee (UMPC) began overseeing the M/S UM program. The UMPC is responsible for the development and maintenance of the M/S Prior Authorization, Concurrent Review, and Retrospective Review processes. The UMPC ensures that the UM program considers the factors and evidentiary standards for applying UM. The UMPC is comprised of:

- Chief Medical Officer, Medical Management (Co-Chair)

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- Senior Vice President, Clinical Advancement (Co-Chair)
- Chief Medical Officer, UnitedHealthcare
- Senior Vice President, Clinical Appeals & Grievances
- Chief Medical Officer, Clinical Policy
- Chief Medical Officer, UnitedHealthcare Employer & Individual
- Chief Medical Officer, UnitedHealthcare Medicare & Retirement
- Chief Medical Officer, Community & State
- Chief Medical Officer, UnitedHealthcare Individual & Family Plans
- Vice President, Clinical Transformation & Affordability
- Senior Director, Mental Health Parity
- Vice President, Utilization Management Strategy & Implementation

One of the chairs must be an executive leader and a licensed physician. UMPC meets at least six times per year but may meet more frequently if needed. MTAC reports to the UMPC.

The Plan delegates UM of MH/SUD services to United Behavioral Health d/b/a OBH, its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor.

For MH/SUD, the Clinical Technology Assessment Committee (CTAC) is responsible for reviewing new or evolving technologies and then developing and maintaining evidence-based behavioral clinical policies for behavioral health technologies. CTAC uses scientifically based clinical evidence and the *Behavioral Health Hierarchy of Clinical Evidence* in its development, assessment, and approval processes. CTAC conducts its processes in a timely manner to ensure transparency and consistency, and to identify safe and effective MH/SUD technologies for members.

CTAC members include behavioral health medical directors, senior leaders of clinical operations, research and development, clinical review, legal, compliance, and policy. CTAC voting members include six psychiatrists and one licensed independent social worker (LISW), plus two co-chairs, both of whom are psychiatrists.

When assessing the safety and efficacy of technologies used to treat MH/SUD conditions, CTAC first looks for any strong and compelling scientific evidence such as statistically robust, well-designed, randomized, controlled trials, and cohort studies. CTAC will also look for systematic reviews and meta-analyses, large prospective trials, cross-sectional studies, retrospective studies, surveillance studies, case reviews/case series, anecdotal/editorial statements, or professional opinions.

In the absence of any strong and compelling scientific evidence, CTAC assesses technologies by looking at any national consensus statements and/or publications by recognized authorities such as clinical position papers published by professional specialty societies and CMS NCDs.

CTAC will not deem a technology unproven solely based on a lack of randomized controlled trials, particularly for new and emerging technologies.

CTAC obtains approval from the Clinical Quality and Operations Committee (CQOC). The CQOC is comprised of representatives from sub-committees and representatives from the clinical quality improvement, UM, care engagement, medical operations, medical policy and standards, clinical operations, appeals, product, legal, compliance, network strategy, provider experience, accreditation, and benefits teams. The Chair of the CQOC is appointed by the Chief Medical Officer and must be an executive leader and licensed physician.

M/S and MH/SUD technologies assessed by the MTAC and CTAC committees as not being safe, clinically effective, and/or appropriate are determined to be EIU. Once a technology has been assessed, a medical/behavioral clinical policy is

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developed which outlines the applicable committee's findings. This includes a summary of the clinical evidence and the identification of specific technologies or uses of technologies considered to be EIU. All medical/behavioral clinical policies are reviewed and/or updated at least once annually.

M/S and MH/SUD medical/behavioral clinical policies are publicly available.

- M/S medical clinical policies: [Medical & Drug Policies and Coverage Determination Guidelines for UnitedHealthcare Commercial Plans | UHCprovider.com](#)
- MH/SUD behavioral clinical policies: [Guidelines/Policies/Manuals \(providerexpress.com\)](#)

For M/S and MH/SUD conditions, the Plan does not cover technologies determined to be EIU. There may be unspecified M/S and MH/SUD diagnoses for which there are no proven treatments. The Plan does not deny emergency services as EIU, including those submitted with an unspecified diagnosis. The M/S *Clinical Review Criteria Operational Policy* and MH/SUD *Clinical Criteria Development/Selection and Application* policy outline the processes that ensure clinical policies are developed consistently.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- EIU: The Plan excludes coverage of technologies determined to be EIU for specific diagnoses based on medical/behavioral clinical policies and Plan documents. The Plan develops evidence-based medical/behavioral clinical policies for select M/S and MH/SUD technologies (e.g., services, interventions, devices, medically administered M/S and MH/SUD drugs, etc.). The medical/behavioral clinical policies may identify specific technologies that are categorically considered EIU or that are considered unproven under certain circumstances

Benefit Classification(s)

- In-network (INN) inpatient, out-of-network (OON) inpatient, INN outpatient, and OON outpatient

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHC)
- UnitedHealthcare of Georgia, Inc. (UHCGA)
- UnitedHealthcare Insurance Company of the River Valley (UHCVR)
- UnitedHealthcare of Georgia, Inc. Individual Exchange Medical Policy (IEX)

Plan Terms/Source Document(s)

The Plan's *Certificate of Coverage*, defines EIU as:

UHC

- "Experimental or Investigational Service(s) – medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications, or devices that, at the time we make a determination regarding coverage in a particular case, are determined to be any of the following:
 - Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified as appropriate for proposed use in any of the following:
 - *AHFS Drug Information (AHFS DI)* under therapeutic uses section;

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- *Elsevier Gold Standard's Clinical Pharmacology* under the indications section;
- *DRUGDEX System by Micromedex* under the therapeutic uses section and has a strength recommendation rating of class I, class IIa, or class IIb; or
- *National Comprehensive Cancer Network (NCCN)* drugs and biologics compendium category of evidence 1, 2A, or 2B.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are FDA approved under the Humanitarian Use Device exemption are not Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase I, II or III clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

Exceptions:

- Clinical trials for which Benefits are available as described under Clinical Trials in Section 1: Covered Health Care Services.
- We may, as we determine, consider an otherwise Experimental or Investigational Service to be a Covered Health Care Service for that Sickness or condition if:
 - You are not a participant in a qualifying clinical trial, as described under Clinical Trials in Section 1: Covered Health Care Services, and you have a Sickness or condition that is likely to cause death within one year of the request for treatment.
 - Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that Sickness or condition.”
- “Unproven Service(s) - services, including medications, that are not determined to be effective for treatment of the medical condition or not determined to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.
 - Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
 - Well-conducted cohort studies from more than one institution. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

We have a process by which we compile and review clinical evidence with respect to certain health care services. From time to time, we issue medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at www.myuhc.com. Please note:

- If you have a Life-Threatening Illness or condition (one that is likely to cause death within one year of the request for treatment) we may, as we determine, consider an otherwise Unproven Service to be a Covered Health Care Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that Sickness or condition.”

UHC GA/UHCGA/UHICRV

- “Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

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This exclusion does not apply to Covered Health Care Services provided during a clinical trial for which Benefits are provided as described under Clinical Trials in Section 1: Covered Health Care Services.”

- “Unproven Service(s) - services, including medications, that are not determined to be effective for treatment of the medical condition or not determined to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.
 - Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
 - Well-conducted cohort studies from more than one institution. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

We have a process by which we compile and review clinical evidence with respect to certain health care services. From time to time, we issue medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at www.myuhc.com. Please note:

- If you have a Life-Threatening Illness or condition (one that is likely to cause death within one year of the request for treatment) we may, as we determine, consider an otherwise Unproven Service to be a Covered Health Care Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that Sickness or condition.”

List of M/S and MH/SUD Technologies Subject to NQTL

For M/S and MH/SUD this NQTL applies to all INN inpatient, OON inpatient, INN outpatient, and OON outpatient technologies determined to be EIU

- Plan documents provide that technologies considered EIU are excluded from coverage
- Additionally, for both M/S and MH/SUD, certain medical policies identify technologies that have been determined to be EIU, while other medical policies exclude coverage of technologies for some, but not all, conditions based on EIU status
- M/S maintains a medical clinical policy which identifies the codes that have been determined to be EIU (see *Omnibus Policy*)
- Additionally, other technologies may be determined to be EIU for certain medical conditions. These are identified in the applicable medical clinical policies. M/S medical clinical policies are publicly available: [Medical & Drug Policies and Coverage Determination Guidelines for UnitedHealthcare Commercial Plans | UHCprovider.com](#)
- MH/SUD behavioral clinical policies are publicly available: [Guidelines/Policies/Manuals \(providerexpress.com\)](#)
- The following MH/SUD behavioral clinical policies address technologies that are fully denied because they have been deemed to be EIU:
 - *Complementary and Alternative Medicine (CAM) Treatments For Behavioral And Substance Use Disorders*
 - *Computer Based Treatment for Cognitive Behavioral Therapy (CBTCBT) for Substance Use Disorders*
 - *Cranial Electrotherapy Stimulation*
 - *Neurofeedback/Biofeedback For Behavioral And Substance Use Disorders*
 - *Wilderness Therapy*
- The following MH/SUD policies address technologies that are partially denied as they have been deemed to be EIU in certain scenarios which are outlined in the policies:
 - *Applied Behavior Analysis (ABA)*
 - *Transcranial Magnetic Stimulation*

Step 2 – Factors Used to Determine if a Technology is Experimental, Investigational or Unproven

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

The Plan relies on the following factor to determine whether technologies are EIU for M/S and MH/SUD. This factor applies to M/S and MH/SUD benefits for the following:

- I. All M/S INN inpatient, OON inpatient, INN outpatient, and OON outpatient technologies subject to UM
 - II. All MH/SUD INN inpatient, OON inpatient, INN outpatient, and OON outpatient technologies subject to UM
- M/S and MH/SUD Committee Considerations (Qualitative) including clinical efficacy, safety, appropriateness of the proposed technology, and whether the technology is an unproven treatment for a specific diagnosis

The factor applies to M/S and MH/SUD technologies.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factor used in determining whether a MH/SUD or M/S technology is EIU. These evidentiary standards apply to the following:

- I. All M/S INN inpatient, OON inpatient, INN outpatient, and OON outpatient technologies subject to UM
- II. All MH/SUD INN inpatient, OON inpatient, INN outpatient, and OON outpatient technologies subject to UM

Factor – M/S and MH/SUD Committee Considerations, including clinical efficacy, safety, appropriateness of the proposed technology, and whether the technology is an unproven treatment for a specific diagnosis

- Clinical Effectiveness – A characteristic of care that is in accordance with objective, evidence-based clinical criteria, and nationally recognized guidelines as determined by internal medical experts. Clinically appropriate care is more likely to be effective
- Safety of Technologies - A state in which hazards and conditions leading to physical or psychological harm are minimized to preserve the health and wellbeing of a person receiving health care
- Appropriateness of the Proposed Technology - The technology is suitable for the member's clinical presentation and the expected health benefits from the medical service are clinically significant and exceed the expected natural history of recovery and the expected health risks by a sufficient margin
- Unproven Treatment for Specific Diagnosis – the technology is only proven for certain diagnoses

The Plan's evidentiary standards and sources that trigger and/or define the M/S and MH/SUD Committee Considerations factor:

- The Plan uses scientifically based clinical evidence and the *UHC* and *Behavioral Health Hierarchies of Clinical Evidence* to determine which M/S and MH/SUD technologies are safe and effective and, therefore, eligible for benefit coverage. The *UHC* and *Behavioral Health Hierarchies of Clinical Evidence* detail the order of clinical evidence that is used to determine which health technologies are safe and effective. To be deemed safe and effective, a health

technology does not need to have evidence in every category

- M/S assesses the following categories of evidence when determining whether a technology is EIU:
 - Scientifically based clinical evidence
 - Peer-reviewed literature
 - *UHC Hierarchy of Clinical Evidence*
 - In the absence of strong and compelling scientific evidence, medical policies may be based upon:
 - National guidelines and consensus statements
 - CMS NCD
 - Clinical position papers based upon rigorous review of scientific evidence or clinical registry data from professional specialty societies when their statements are based upon referenced clinical evidence, e.g., American College of Physicians (ACP), The Society for Post-Acute and Long-Term Care Medicine (AMDA), American Academy of Family Physicians (AAFP), American College of Obstetricians and Gynecologists (ACOG), American College of Cardiology (ACC), etc.
- MH/SUD assesses the following categories of evidence when determining whether a technology is EIU:
 - Scientifically based clinical evidence
 - Peer-reviewed literature
 - *Behavioral Health Hierarchy of Clinical Evidence*
 - In the absence of strong and compelling scientific evidence, behavioral clinical policies/clinical criteria may be based upon:
 - National consensus statements
 - Publications by recognized authorities such as government sources and/or professional societies

Note: Anecdotal/editorial statements and professional opinions are only used to support adoption of behavioral clinical policies /clinical criteria when no other source is available.

These evidentiary standards and sources apply to M/S and MH/SUD technologies and are defined in a qualitative manner.

The factor and evidentiary standards used as the basis for determining which MH/SUD technologies are EIU are comparable to, and applied no more stringently than, the factor and evidentiary standards used as the basis for determining which M/S technologies are EIU both “as written” and “in operation.”

Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

As Written

The Plan conducted an “as written” comparative analysis of the strategies, processes, factors, evidentiary standards, and source information used by M/S and MH/SUD to assess whether a technology is EIU and to develop objective evidence-based medical/behavioral clinical policies.

The Plan uses the following standard process to assess the safety and efficacy of technologies:

The Plan uses committees to assess technologies and conduct a thorough review of the scientifically based clinical evidence and peer-reviewed literature in accordance with the *Hierarchies of Clinical Evidence* to develop medical/behavioral clinical policies that apply to the technologies. The subject matter experts in the committees follow a consistent and comparable process to assess

and review technologies and apply comparable *UHC* and *Behavioral Health Hierarchies of Clinical Evidence* (discussed in greater detail below). National internal committees evaluate the applicable factor and standards described in Steps 2 and 3 when determining EIU.

Review of Factor and Evidentiary Standards. M/S and MH/SUD committees both consider clinical efficacy, safety, and appropriateness of the proposed technology, and whether the technology is an unproven treatment for a specific diagnosis when assessing whether a technology is EIU. In doing so, both M/S and MH/SUD consider the respective *UHC* and *Behavioral Health Hierarchies of Clinical Evidence* to assess the clinical efficacy, safety, and appropriateness of the proposed technologies. The *UHC* and *Behavioral Health Hierarchies of Clinical Evidence* are comparable. Both use the following categories of sources (with source-specific differences if the source is specific to M/S or MH/SUD):

- Well-designed evidence-based studies
- Observational studies
- Case studies
- Consensus statements
- Clinical and professional opinion papers

Review of Operational Policies and Procedures. The Plan reviewed M/S and MH/SUD operational policies and procedures to confirm comparability and found MH/SUD policies, procedures, and processes to be comparable and no more stringent than M/S policies, procedures, and processes.

The MTAC assesses the safety and efficacy of technologies used to treat M/S conditions. MTAC uses scientifically based clinical evidence and *UHC Hierarchy of Clinical Evidence* in its development, assessment, and approval processes. MTAC conducts its processes in a timely manner to ensure transparency and consistency, and to identify safe and effective M/S technologies for members.

The NMCMC reviews and validates medical clinical policies endorsed by MTAC. As of April 1, 2023, UMPC began reviewing and validating the medical clinical policies endorsed by MTAC.

The CTAC assesses the safety and efficacy of technologies used to treat MH/SUD conditions. CTAC uses scientifically based clinical evidence and *UHC Hierarchy of Clinical Evidence* in its development, assessment, and approval processes. CTAC conducts its processes in a timely manner to ensure transparency and consistency, and to identify safe and effective MH/SUD technologies for members.

The CQOC reviews and validates behavioral clinical policies endorsed by CTAC.

The Plan reviewed and compared the stated purpose of the *UHC* and *Behavioral Health Hierarchies of Clinical Evidence*. The *UHC Hierarchy of Clinical Evidence* states that its purpose is to define the order of clinical evidence to ensure a transparent and consistent approach within the Plan. The *UHC Hierarchy of Clinical Evidence* further states that the Plan uses scientifically based clinical evidence to identify safe and effective technologies for members. The *Behavioral Health Hierarchy of Clinical Evidence* policy statement reflects that scientifically based clinical evidence is used to evaluate behavioral health treatments, technologies for members, and that the hierarchy is used to determine which technologies are safe and effective and potentially eligible for benefit coverage. CTAC's technology assessment process for MH/SUD technologies, including CTAC's application of the *Behavioral Health Hierarchy of Clinical Evidence*, is comparable to, and applied no more stringently than, MTAC's technology assessment process for M/S technologies, including MTAC's application of the *UHC Hierarchy of Clinical Evidence*.

When assessing the safety and efficacy of technologies used to treat M/S and MH/SUD conditions, both MTAC and CTAC first look for any strong and compelling scientific evidence such as statistically robust, well-designed, randomized, controlled trials,

and cohort studies. In addition, MTAC will look for multi-site observational studies and single site observational studies. CTAC will also look for systematic reviews and meta-analyses, large prospective trials, cross-sectional studies, retrospective studies, surveillance studies, case reviews/case series, anecdotal/editorial statements, and professional opinions.

In the absence of any strong and compelling scientific evidence, MTAC and CTAC assess technologies by looking at any national consensus statements and/or publications by recognized authorities such as clinical position papers published by professional specialty societies and CMS NCDs.

Neither MTAC nor CTAC will deem a technology unproven solely based on a lack of randomized controlled trials, particularly for new and emerging technologies.

M/S and MH/SUD committees use comparable evidentiary standards and sources to evaluate clinical efficacy, safety, appropriateness of the proposed technologies, and whether the technology is unproven treatment for a specified diagnosis to develop or approve medical/behavioral clinical policies.

M/S and MH/SUD technologies assessed by the MTAC and CTAC committees as not being safe, clinically effective, and/or appropriate are determined to be EIU. Once a technology has been assessed, a medical/behavioral clinical policy is developed which outlines the applicable committee's findings. This includes a summary of the clinical evidence and the identification of specific technologies or uses of technologies considered to be EIU. For both M/S and MH/SUD, all medical/behavioral clinical policies are reviewed and/or updated at least once annually.

As part of the Plan's comparative analysis, the Plan reviewed and compared the MTAC and CTAC charters. The Plan first reviewed the mission/role/scope of the committees, as set forth in their charters. MTAC's mission is to review the scientifically based clinical evidence used in the development of medical policies and clinical programs in an effort to ensure transparency and consistency and to identify safe and effective technologies for members. The purpose of CTAC is to provide a framework by which the organization evaluates and addresses new developments in technology and new applications of existing technology. The CTAC charter also states that it reviews the scientifically based clinical evidence utilized in the development of policies and clinical programs in an effort to ensure transparency, consistency and to identify safe and effective technologies for members.

The Plan also reviewed and compared the composition of the MTAC and CTAC committees. Both committees include both voting members and non-voting members. The Plan reviewed each committee's membership requirements for voting members and non-voting members.

The Plan also reviewed the responsibilities/goals of the committees. The responsibilities/goals of MTAC include the development of evidence-based position statements on selected medical technologies; assessments of the evidence supporting new and emerging technologies; and review and approval of clinical criteria within new or existing medical policies. Similarly, the responsibilities/goals of CTAC include evaluating new behavioral health technologies and new applications of existing behavioral health technologies.

In Operation

The Plan compared the strategies, processes, factors, evidentiary standards, and source information MH/SUD uses to assess whether a technology is EIU and develop evidence-based behavioral clinical policies to the strategies, processes, factors, evidentiary standards, and source information M/S uses to assess whether a technology is EIU and develop evidence-based medical clinical policies "in operation."

M/S MTAC assessment of EIU technologies and development of medical clinical policies is reviewed and validated by

NMCMC/UMPC. Similarly, CTAC assessment of EIU technologies and development of behavioral clinical policies is reviewed and validated by the CQOC.

M/S and MH/SUD committees both consider the *UHC* and *Behavioral Health Hierarchies of Clinical Evidence* to assess the clinical efficacy, safety, and appropriateness of the proposed technologies.

The Plan also reviewed and compared how the *UHC* and *Behavioral Health Hierarchies of Clinical Evidence* addressed technology assessments where strong and compelling scientific evidence is lacking. In that scenario, both M/S and MH/SUD *UHC* and *Behavioral Health Hierarchies of Clinical Evidence* assess technologies by looking at any national consensus statements and/or publications by recognized authorities, such as clinical position papers published by professional specialty societies and CMS NCD.

Both M/S and MH/SUD UM processes are guided by their respective *Utilization Management Program Descriptions*. Clinical reviewers utilize medical/behavioral clinical policies when making clinical coverage benefit determinations regarding EIU technologies.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The findings of the Plan's analyses confirmed the strategies, processes, factors, evidentiary standards, and source information used to assess EIU technologies and develop MH/SUD behavioral clinical policies were comparable to, and applied no more stringently than, the strategies, processes, factors, evidentiary standards, and source information used to assess EIU technologies and develop the M/S medical clinical policies "as written" and "in operation."

The MH/SUD policies, procedures, and processes were found to be comparable and no more stringent than M/S policies, procedures, and processes.

As discussed above, both M/S and MH/SUD committees follow comparable technology assessment processes, including consideration of comparable hierarchies of clinical evidence.

Conclusions

The Plan concluded the methodologies MH/SUD used to assess whether a technology is EIU and develop evidence-based behavioral clinical policies were comparable to, and applied no more stringently than, the methodologies M/S used to assess whether a technology is EIU and develop evidence-based medical clinical policies, both "as written" and "in operation."

Geographic Restrictions Non-Quantitative Treatment Limitation (NQTL) Analysis

GA – UnitedHealthcare Insurance Company, UnitedHealthcare of Georgia, Inc., UnitedHealthcare Insurance Company of the River Valley
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Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical and surgical (M/S) benefits. This generally means that financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements, such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

The out-of-network (OON), out-of-area, geographic service limitation (geographic restrictions requirement) is intended to encourage members to utilize in-network (INN) providers. The geographic restrictions requirement does not limit coverage for OON benefits within the member’s state of residence, nor does it limit INN services nationally. The goal is to promote access to evidence-based care and improved treatment outcomes.

This document includes the following information:

- Geographic restrictions process for both M/S and MH/SUD services
- The description of the NQTL and application (Step 1)
- Factors used to determine which services are subject to the NQTL (Step 2)
- Evidentiary standards and sources used to define, trigger and/or implicate a factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

This analysis refers to the following attachments:

- *Certificates of Coverage* (COC23-INS-2018-LG-GA, COC23-INS-2018-SG-GA, COC23-HMO-2018-LG-GA, COC23-HMO-2018-SG-GA, COC23-INS-RV-2018-LG-GA, COC23-INS-RV-2018-SG-GA) Plan document that explains covered services, terms, conditions, and limitations of the member’s policy.

The Plan concludes that the geographic restrictions requirements for M/S and MH/SUD are comparable and applied no more stringently for OON benefits both “as written” and “in operation.”

Process

The OON, out-of-area, geographic service limitation (geographic restrictions requirement) is intended to encourage members to utilize INN providers, with the goal being to promote access to evidence-based care and improve treatment outcomes. Health care services from an OON provider for non-emergent, sub-acute inpatient, or outpatient services at any of the following non-hospital facilities: alternate facility, freestanding facility, inpatient rehabilitation facility, or skilled nursing facility received

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outside of the member's State of Residence are not covered. This applies to facility based services that could be Inpatient or Outpatient.

A member's request for care is assessed to determine whether the servicing provider is an INN or OON provider and within a level of care subject to the restriction. Service requests within these levels of care, rendered by an OON provider at certain non-hospital, sub-acute, non-emergent facilities, and programs that are out of the member's state of residence, as defined in Plan documents, are denied administratively as a non-covered benefit.

The limitation does not apply in the case of an emergency.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- Geographic Restrictions

Benefit Classification(s)

- OON, inpatient and outpatient services as described in the Plan benefit documents
- Under the Plan benefit documents, services received at the following facilities are subject to the OON geographic restriction:
 - Health care services from an OON provider for non-emergent, sub-acute inpatient, or outpatient services at any of the following non-hospital facilities: alternate facility, freestanding facility, residential treatment facility, inpatient rehabilitation facility, or skilled nursing facility received outside of the member's State of Residence

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHIC)
- UnitedHealthcare of Georgia, Inc. (UHCGA)
- UnitedHealthcare Insurance Company of the River Valley (UHICRV)

Plan Terms

The Plan's *Certificate of Coverage* states: "Health care services from an Out-of-Network provider for non-emergent, sub-acute inpatient, or outpatient services at any of the following non-hospital facilities: alternate facility, freestanding facility, residential treatment facility, inpatient rehabilitation facility and skilled nursing facility received outside of the covered person's State of Residence. For the purpose of this exclusion, the 'State of Residence' is the state where the covered person is a legal resident, plus any geographically bordering adjacent state or, for a covered person who is a student, the state where they attend school during the school year. This exclusion does not apply in the case of an Emergency or if authorization through network exception has been obtained in advance."

List of M/S and MH/SUD Services Subject to NQTL

- Health care services from an OON provider for non-emergent, sub-acute inpatient, or outpatient services at any of the following non-hospital facilities: alternate facility, freestanding facility, inpatient rehabilitation facility, or skilled nursing facility received outside of the member's State of Residence.

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Step 2 – Factor Used to Determine Geographic Restriction Applies

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

The Plan relies on the following factor to determine whether OON services are subject to geographic restrictions for both M/S and MH/SUD:

- Whether the OON facility is providing non-emergent, sub-acute inpatient and/or outpatient services located outside of the member's state of residence (Qualitative)

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factor used to determine whether OON services are subject to geographic restrictions for both M/S and MH/SUD services:

Factor – Whether the OON facility is providing non-emergent, sub-acute inpatient, and/or outpatient services located outside of the member's state of residence

- The Plan's evidentiary standards that trigger and/or define the factor:
 - Facility is OON; AND
 - Facility provides non-emergent, sub-acute inpatient and/or outpatient services; AND
 - Facility is located outside of the member's state of residence
 - "State of Residence" is defined as:
 - "The state where the member is a legal resident; plus, any geographically bordering adjacent state;" or
 - "For a member who is a student, the state where the student is attending school, during the school year"

The Plan's sources used to define the factor:

- Provider Directory
- Treatment type requested and/or billed, e.g., revenue codes, Healthcare Common Procedure Coding System (HCPCS), etc.
- Facility service location/address
- Member address
- Plan benefit documents

These evidentiary standards and sources apply to both M/S and MH/SUD services. These standards are defined in a qualitative manner.

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Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

As Written

The Plan conducted a comparative analysis of the strategies, processes, factor, evidentiary standards, and source information used to develop the geographic restriction requirement. The Plan identified the shared factor and evidentiary standards used as the basis for subjecting both M/S and MH/SUD benefits to the geographic restrictions for OON services.

The Plan reviewed M/S and MH/SUD the state of residence definitions and triggering events for the geographic restrictions to confirm comparability. In addition, the same sources of information were used to define the factor for both M/S and MH/SUD.

In Operation

The Plan compared the shared strategies, processes, factor, evidentiary standards, and source information used to determine which M/S and MH/SUD OON services are subject to geographic restrictions “in operation.”

The Plan conducted an analysis of the number of non-emergent facility claims that were denied as being OON for Georgia situated members received between 01/01/22 – 12/31/22. The results of this analysis are below:

Data Parameters:

- Inpatient non-emergent facility claims
- Outpatient non-emergent facility claims
- Georgia situated fully insured commercial members
- Received dates of claims between 01/01/22 – 12/31/22
- Data was further analyzed excluding denials for providers in the same state or adjacent to the member's state of residence

Georgia Geographic Restrictions Data - 2022 - UHIC	Totals	%
Total Inpatient and Outpatient non-emergent facility claims for GA situated Fully Insured Commercial members received between 01/01/22 - 12/31/22 which were denied as out-of-network for all states	621	100%
All non-emergent facility services denied as out-of-network for Providers in members state of residence or Adjacent States (GA, TN, SC, FL, AL)	296	47.67%
All non-emergent facility services denied as out-of-network, excluding Providers in members state of residence or Adjacent States for M/S Providers	325	52.33%
All non-emergent facility services denied as out-of-network, excluding Providers in members state of residence or Adjacent States for MH/SUD Providers	0	0.00%

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Georgia Geographic Restrictions Data - 2022 - UHC of GA	Totals	%
Total Inpatient and Outpatient non-emergent facility claims for GA situated Fully Insured Commercial members received between 01/01/22 - 12/31/22 which were denied as out-of-network for all states	258	100%
All non-emergent facility services denied as out-of-network for Providers in members state of residence or Adjacent States (GA,TN, SC, FL, AL)	122	47.29%
All non-emergent facility services denied as out-of-network, excluding Providers in members state of residence or Adjacent States for M/S Providers	136	52.71%
All non-emergent facility services denied as out-of-network, excluding Providers in members state of residence or Adjacent States for MH/SUD Providers	0	0.00%

Georgia Geographic Restrictions Data - 2022 - UHC of RV	Totals	%
Total Inpatient and Outpatient non-emergent facility claims for GA situated Fully Insured Commercial members received between 01/01/22 - 12/31/22 which were denied as out-of-network for all states	23	100%
All non-emergent facility services denied as out-of-network for Providers in members state of residence or Adjacent States (GA,TN, SC, FL, AL)	22	95.65%
All non-emergent facility services denied as out-of-network, excluding Providers in members state of residence or Adjacent States for M/S Providers	1	4.35%
All non-emergent facility services denied as out-of-network, excluding Providers in members state of residence or Adjacent States for MH/SUD Providers	0	0.00%

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The findings of the analysis confirmed the strategies, processes, factor, evidentiary standards, and source information used to subject certain MH/SUD OON services to geographic restrictions were comparable to, and applied no more stringently than, the strategies, processes, factor, evidentiary standards, and source information used to subject certain M/S OON services to geographic restrictions “as written.”

Additionally, the same triggering events for the geographic restrictions were applied to both M/S and MH/SUD services and state of residence was defined similarly for all services. The same sources of information were used to define the factor used to determine whether the geographic restriction applies.

Conclusions

The Plan reviewed the M/S and MH/SUD OON triggering events and state of residence definitions and concluded the methodology used to determine which MH/SUD OON services are subject to geographic restrictions “as written” were comparable to, and applied no more stringently than, the methodology used to determine which M/S OON services are subject to geographic restrictions “as written.” Additionally, the Plan concluded the way in which geographic restrictions were

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applied to MH/SUD OON services were comparable to, and applied no more stringently than, the way in which geographic restrictions were applied to M/S OON services “as written.”

The Plan concluded that MH/SUD processes, triggering events, definitions, and how the Plan applies geographic restrictions for MH/SUD OON services were comparable to, and applied no more stringently than how the Plan applies geographic restrictions for M/S OON services “in operation.”

Overview

Pursuant to a federal law called the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical and surgical (M/S) benefits. This generally means that financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements, such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

In-network (INN) facility reimbursement is the process by which the Plan establishes reimbursement for INN facility-based services.

This document includes the following information:

- Description of process for negotiating reimbursement rates for INN facility-based services for both M/S and MH/SUD facilities
- Description of the NQTL and application (Step 1)
- Factors used to negotiate reimbursement rates for INN facility-based services for both M/S and MH/SUD facilities (Step 2)
- Evidentiary standards and sources used to define and/or trigger each of the identified factors (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

The analysis refers to the following attachments:

- *Certificates of Coverage* (COC23-INS-2018-LG-GA, COC23-INS-2018-SG-GA, COC23-HMO-2018-LG-GA, COC23-HMO-2018-SG-GA, COC23-INS-RV-2018-LG-GA, COC23-INS-RV-2018-SG-GA, Policy23-HMO-2022-LEX-GA) Plan document that explains covered services, terms, conditions, and limitations of the member’s policy.

The Plan concludes that the INN facility reimbursement requirements for M/S and MH/SUD are comparable and applied no more stringently both “as written” and “in operation.”

Process

Negotiation

For both M/S and MH/SUD facilities, the Plan uses a substantially similar process to negotiate and establish reimbursement rates for INN facility services. The Plan delegates negotiation of reimbursement rates for MH/SUD facility providers to United Behavioral Health d/b/a Optum Behavioral Health (OBH), its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor.

Key steps in the INN facility reimbursement negotiation process for both M/S and MH/SUD services include:

- The facility submits a completed application to the Plan to be included in the Plan's provider network
- The Plan reviews the facility reimbursement proposal
- Based on the above, the Plan accepts the reimbursement proposal or negotiates reimbursement rates with the facility using the factors described

Detailed process for the INN facility reimbursement negotiation:

Facilities newly seeking to join the Plan provider network submit a reimbursement proposal to the Plan. The Plan may either accept the facility's proposal or may negotiate reimbursement rates with the facility. Existing market rates are used as the baseline for negotiating rates. For MH/SUD providers, the Plan prepares an analysis of market dynamics that the Plan contracting team may access to inform negotiations. For M/S services, the Plan may document the market dynamic factors that inform a provider-specific negotiation. The Plan does not apply defined formulae to establish base rates or standard fee schedules. Both M/S and MH/SUD facilities that participate in the Plan provider network may negotiate reimbursement adjustments upon contract renewal or changing market circumstances by submitting a reimbursement proposal to the Plan. The Plan may either accept the facility's proposal or may negotiate reimbursement rates with the facility.

For facilities already in the network, the existing facility contract rates are used as the contract negotiation baseline. The Plan may take market dynamics into consideration when negotiating reimbursement rates with facilities. For MH/SUD providers, the Plan prepares an analysis of market dynamics that the Plan contracting team may access to inform negotiations. For M/S services, the Plan may document the market dynamic factors that inform a provider-specific negotiation. The Plan does not apply defined formulae to establish base rates or standard fee schedules.

Inpatient M/S – General Acute Care, Children's, and Long-Term Acute Care Facilities

The Plan contracts for inpatient M/S services using one of four key inpatient reimbursement methodologies: MS-Diagnosis Related Group (DRG), Per Case, Per Diem, and Percentage Payment Rate (PPR). While these methodologies provide a starting point, the rate categories, rate category definitions, and rate types can be modified based on negotiations with facilities.

In addition, a given contract will often feature a combination of inpatient reimbursement methodologies. For example, within a Per Diem contract, it's not uncommon for cases associated with a defined list of cardiac and/or musculoskeletal MS-DRGs to be reimbursed on a per-case basis, while all other M/S cases are reimbursed on a per diem basis.

The following provides an overview of the inpatient reimbursement methodologies used by the Plan:

- **MS-DRG** – The facility is paid using a single, negotiated base rate. The base rate is multiplied by the Centers for Medicare & Medicaid Services (CMS) MS-DRG relative weight for the MS-DRG assigned to the case. Contracts are written to use the current version of the MS-DRGs and relative weights

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- **Per Case** – The facility is paid using negotiated M/S case rates. The per case rate is paid for the entire case, regardless of the MS-DRG assigned to the case or the length of stay. There may be separate per case rates for medical cases versus surgical cases. This reimbursement method is rarely used for M/S cases; it's more likely to be used for specific types of cases "carved out" from M/S per diem rates. Examples of services that may be carved out include high-cost drugs, implants, obstetrics, NICU, and outliers
- **Per Diem** – The facility is paid using negotiated M/S per diem rates. The per diem rate is multiplied by the number of days corresponding to the per diem type. There may be separate per diem rates for medical cases versus surgical cases
- **PPR** – The facility is paid a percentage of charges. The PPR rate is multiplied by the eligible charges for the case

In addition, M/S agreements may include negotiated escalators or deflators, which automatically increase or modify rates for subsequent contract years. The escalators or deflators may also be based on quality and efficiency metrics.

Inpatient MH/SUD – Inpatient and Residential

The Plan contracts for inpatient MH/SUD services using the following methodology:

- **Per Diem** – The facility is paid using negotiated MH/SUD per diem rates. The per diem rate is multiplied by the number of days corresponding to the per diem type

In addition, MH/SUD agreements may include negotiated escalators or deflators, which automatically increase or modify rates for subsequent contract years. The escalators or deflators may also be based on quality and efficiency metrics.

Outpatient M/S – General Acute Care, Children's, and Long-Term Acute Care Facilities

The Plan contracts for outpatient M/S facility services using standardized reimbursement templates, each of which is organized around one of five key outpatient reimbursement methodologies: Ambulatory Payment Classifications (APC), Per Case, Per Visit, Per Unit, and PPR. While these templates provide a starting point, the rate categories, rate category definitions, and rate types reflected in the templates can be modified based on negotiations with providers.

In addition, a given contract will often feature a combination of outpatient reimbursement methodologies. For example, within a fixed outpatient contract, services may be subject to Per Case, Per Visit, and Per Unit reimbursement. At the same time, contract variations would allow any or all services to be subject to PPR reimbursement. It is also possible for a single outpatient claim (except for claims paid on a Per Case basis) to be paid using more than one of these reimbursement methodologies. For example, some services on a given claim may be subject to Per Visit reimbursement, while other services may be subject to Per Unit reimbursement.

The following provides an overview of the outpatient reimbursement methodologies used:

- **APC** – The facility is paid using a single, negotiated APC conversion factor for services subject to such reimbursement under the Medicare outpatient prospective payment system (OPPS). The conversion factor is multiplied by the relative weights for the APCs assigned to the case by the OPPS pricing software. Services not subject to APC payment are paid using facility fee schedules (see Per Unit below). Contracts are written to use the current version of the APCs and relative weights
- **Per Case** – The facility is paid using negotiated per case rates for certain types of outpatient cases, including outpatient surgery, observation, emergency room, and urgent care. All services provided during the encounter are included in the per case payment and are not separately reimbursable

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- **Per Visit** – The facility is paid using negotiated per visit rates for certain types of outpatient services. The per visit rate is multiplied by the number of visits billed on a given claim. If a given claim spans multiple dates of service, then the visits on each of the separate days are reimbursable. Examples of services that may be subject to Per Visit reimbursement include, IV therapy, oncology treatment, and dialysis
- **Per Unit** – The facility paid is using a negotiated facility fee schedule for certain types of outpatient services, including laboratory, pathology, and radiology. The per unit rate is multiplied by the number of units billed for a given Current Procedural Technology® (CPT), or Healthcare Common Procedure Coding System (HCPCS) code on a given claim. Facility fee schedules are generally based on a percentage of the CMS rate
- **PPR** – The facility is paid a percentage of charges. The PPR rate is multiplied by the eligible charges for the case

M/S agreements may include negotiated escalators or deflators, which automatically increase or modify rates for subsequent contract years. The escalators or deflators may also be based on quality and efficiency metrics.

Outpatient MH/SUD – Intensive Outpatient Programs and Partial Hospitalization Programs

The Plan contracts for outpatient MH/SUD facility services are negotiated and mutually agreed upon with the facility. The starting point is usually a proposal from the engaged facility. The Plan will use other available information including market dynamics and CMS guidelines (when available) as benchmarks to support its negotiation position.

The Plan contracts for MH/SUD services using the following methodology:

- **Per Diem** – The facility is paid using negotiated MH/SUD per diem rates

In addition, MH/SUD agreements may include negotiated escalators or deflators, which automatically increase or modify rates for subsequent contract years. The escalators or deflators may also be based on quality and efficiency metrics.

Ongoing Monitoring

The Plan convenes ongoing working groups that include representatives from both the M/S and MH/SUD network strategy and pricing teams to align business processes and ensure adherence to as-written standards and comparability in operation.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- INN Facility Reimbursement

Benefit Classification(s)

- INN, facility-based

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHIC)
- UnitedHealthcare of Georgia, Inc. (UHCGA)
- UnitedHealthcare Insurance Company of the River Valley (UHICRV)
- UnitedHealthcare of Georgia, Inc. Individual Exchange Medical Policy (UHC GA)

Plan Terms/Source Document(s)

In each of the plans *Certificate of Coverage*, the following is referenced:

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under public records or other applicable laws.

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“What Is Our Relationship with Providers and Groups?”

We have agreements in place that govern the relationship between us, our Groups and Network providers, some of which are affiliated providers. Network providers enter into agreements with us to provide Covered Health Care Services to Covered Persons.”

List of M/S and MH/SUD Services Subject to NQTL

- INN acute inpatient
- INN subacute inpatient
- INN facility-based outpatient services

Step 2 – Factors Used in the Design and Application of the NQTL

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/ SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

The Plan relies on the following factors to establish reimbursement rates for M/S and MH/SUD facilities.

For facilities newly seeking to join the network, existing market rates are used as the baseline for negotiating rates. For facilities already in the network, the existing facility contract rates are used as the contract negotiation baseline.

The factors are:

- Facility assessment (Qualitative)
 - Facility’s licensure, certification, and/or accreditation (e.g., acute care facility; subacute care facility; ancillary facility, etc.)
- Services and diagnoses/conditions the facility offers (Quantitative)
- Market dynamics (Quantitative and Qualitative)
 - Facility leverage within a given geographic market
 - Network need
 - Facility member volume
 - Facility proposed rate relative to market pricing
 - Market Target Rates
 - Market Prevailing Rates
 - Availability of industry standard value-based reimbursement models

The factors apply to both M/S and MH/SUD services. The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factors used in establishing INN facility reimbursement rates. These evidentiary standards and sources apply to the following:

- I. M/S and MH/SUD inpatient and outpatient facility services

Factor – Facility assessment

- The Plan’s evidentiary standards and sources that trigger and/or define the facility assessment factor:
 - Facility’s licensure
 - Certification
 - Accreditation

This evidentiary standards and sources apply to both M/S and MH/SUD INN facility reimbursement and are defined in a qualitative manner.

Factor – Services and diagnoses/conditions the facility purports to offer or treat to offer

- The Plan’s evidentiary standard and source that triggers and/or defines the services and diagnoses/conditions the facility purports to offer or treat factor:
 - Most current version of industry standard code sets, e.g., revenue, MS-DRG (derived by International Classification of Diseases (ICD)/Diagnostic and Statics Manual (DSM), CPT, HCPCS, etc.

This evidentiary standards and sources apply to both M/S and MH/SUD INN facility reimbursement and are defined in a quantitative manner.

Factor – Market dynamics

- The Plan’s evidentiary standards and sources that define and/or trigger the market dynamics factor:
 - Facility leverage: facilities associated with large health systems within a given geographic market generally have more leverage
 - Internal research
 - Network need: supply and demand for a facility service is evaluated by looking at the volume of facilities with the same or similar programs and/or services within the relevant geographic region relative to the Plan’s membership and its network access and/or availability standards
 - Facility directory, state Geographic Access reports and member reported access data
 - Facility member volume: measured by looking at the volume of members treated by the facility, and/or volume of services billed by the facility in a given year relative to the same or similar program types in the same geographic market during the same timeframe

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- Internal claims data
- Facility proposed rate relative to market pricing, targeted and prevailing rates: internally derived average market pricing based upon available data including internal claims data, state published rates, CMS Prospective Payment System (PPS)
 - Applicable CMS PPS, MS-DRG, state rate, and internal claims data
- Availability of industry standard and proprietary value-based reimbursement models: value-based programs that reward health care providers with incentive payments for the quality of care they deliver
 - CMS value-based programs
 - Internally developed value-based programs

These evidentiary standards and sources apply to both M/S and MH/SUD INN facility reimbursement and are defined in a qualitative and quantitative manner. In addition, all of these standards are considered and used to define the factors.

The factors and evidentiary standards used as the basis for establishing the Plan's MH/SUD INN facility reimbursement rates are comparable to, and applied no more stringently than, the factors used as the basis for negotiating and establishing the Plan's M/S INN facility reimbursement rates "as written" and "in operation." The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL.

Step 4 – NQTL "As Written" and "In Operation" Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

The Plan convenes ongoing working groups that include representatives from both the M/S and MH/SUD network strategy and pricing teams to align business processes and ensure adherence to as-written standards and comparability in operation

As Written

The Plan compared the strategies, processes, factors, evidentiary standards, and source information used to negotiate and establish INN facility reimbursement "as written."

The Plan identified the shared factors and evidentiary standards used as the basis for determining offered reimbursement rates to M/S and MH/SUD facilities. The factors and evidentiary standards are applied to both M/S and MH/SUD facilities comparably and not more stringently to MH/SUD facilities.

Review of processes by which INN facility reimbursement is established

Both M/S and MH/SUD INN facility reimbursements are established through mutually negotiated rates based on facility assessment, services or programs provided, and market dynamics including facility leverage, network need, facility member volume, facility proposed rate relative to market pricing and/or availability of industry standard, and proprietary value-based reimbursement models.

In Operation

The Plan compared the methodologies and processes used to negotiate and establish MH/SUD INN facility reimbursement to assess whether the methodologies and processes are comparable to, and applied no more stringently than, the methodologies and processes used to negotiate and establish reimbursement for M/S INN facility-based services "in

operation.”

Given the variety of reimbursement methodologies used for inpatient M/S services, there is no meaning basis for a comparative analysis with MH/SUD. Although the median rates for MH/SUD and M/S facility outpatient rates differ, both M/S and MH/SUD INN outpatient facility reimbursements are established through mutually negotiated rates based on facility type, services or programs provided, market dynamics including facility leverage, network need, facility member volume, facility proposed rate relative to market pricing and/or availability of industry standard and proprietary value-based reimbursement models.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the plan's or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the plan or coverage is or is not in compliance with MHPAEA.

Findings

The analysis reviewed the strategies and processes by which INN facility reimbursement is negotiated and established including, what services or programs are provided, what market dynamics may influence negotiation including, facility leverage, supply and demand, facility volume, and/or proposed rates relative to market pricing.

The findings of that analysis confirmed the strategies, processes, factors, evidentiary standards, and source information used to negotiate and establish reimbursements for MH/SUD INN facility services and/or programs were comparable to, and applied no more stringently than, the strategies, processes, factors, evidentiary standards, and source information used to negotiate and establish facility reimbursement for M/S INN facility services and/or programs “as written.”

The Plan determined that M/S facility-based services are reimbursed under a variety of different reimbursement models, including MS-DRG, Case Rates, Per Diem rates, and value-based models. Current industry norms for MH/SUD facility-based services are more narrowly limited to the Per Diem reimbursement model only.

Based on the key distinction in the variety of industry standard reimbursement models available for M/S facility-based services as compared to the dominant model, Per Diem reimbursement for MH/SUD facility-based reimbursement, a comparison of M/S and MH/SUD facility-based rates is complex. The Plan continues to collaborate with MH/SUD facility-based providers to explore development of value-based reimbursement models.

The Plan determined that the process to negotiate and establish MS/SUD INN facility reimbursement rates were comparable to, and applied no more stringently than, the process to negotiate and establish M/S INN facility reimbursement rates “in operation.”

Conclusions

Based upon these findings, the Plan concluded the INN facility reimbursement strategy for MH/SUD was comparable to, and applied no more stringently than, the INN facility reimbursement strategy for M/S “as written.”

Additionally, the Plan concluded the factors, evidentiary standards, and source information used to negotiate and establish MH/SUD INN facility reimbursement rates were comparable to, and applied no more stringently than, the factors, evidentiary standards and source information used to negotiate and establish M/S INN facility reimbursement rates “in operation.”

Overview

Pursuant to a federal law called the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical and surgical (M/S) benefits. This generally means that financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

In-network (INN) provider reimbursement is the process by which the Plan establishes reimbursement for INN professional services.

This document includes the following information:

- Process for negotiating and establishing reimbursement rates for INN professional services for both M/S and MH/SUD providers
- Description of the NQTL and application (Step 1)
- Factors used to negotiate reimbursement rates for INN professional services for both M/S and MH/SUD providers (Step 2)
- Evidentiary standards and sources used to define and/or trigger each of the identified factors (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

The analysis refers to the following attachments:

- *Certificates of Coverage* (COC23-INS-2018-LG-GA, COC23-INS-2018-SG-GA, COC23-HMO-2018-LG-GA, COC23-HMO-2018-SG-GA, COC23-INS-RV-2018-LG-GA, COC23-INS-RV-2018-SG-GA, Policy23-HMO-2022-IEG-GA) Plan document that explains covered services, terms, conditions, and limitations of the member’s policy.

The Plan concludes that its methodologies for negotiating and establishing INN reimbursement rates for M/S and MH/SUD professional services are comparable and applied no more stringently for MH/SUD providers than for M/S providers both “as written” and “in operation.”

Process

For both M/S and MH/SUD providers, the Plan uses a comparable process to negotiate and establish reimbursement rate(s) for INN professional services. The Plan delegates negotiation of reimbursement rates for MH/SUD providers to United Behavioral Health d/b/a Optum Behavioral Health (OBH), its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor.

Key steps in the INN professional services reimbursement negotiation process for both M/S and MH/SUD services include:

- The provider submits a completed application to the Plan to be included in the Plan's provider network
- Based on the above, the Plan offers a contract and reimbursement rate package to the provider for the services/programs the provider intends to offer
- If the provider rejects the contract proposal, the Plan may negotiate with the provider using the factors described

Detailed process for the INN professional services reimbursement negotiation:

For M/S professionals, the Plan contracts for services using standardized reimbursement templates. These templates are organized by Medicare carrier locality and reflect 100% of Geographic Practice Cost Indices (GPCI)-adjusted Centers for Medicare & Medicaid Services (CMS) reimbursement for a given rate year. The Plan uses the following fee sources to create these templates:

- CMS Resource Based Relative Value Scale (RBRVS) is determined by calculating the CMS relative value units (RVU):
 - The CMS RVU for a given service or procedure is derived using the following mathematical formula: $(\text{work RVU} \times \text{work GPCI}) + (\text{PE RVU} \times \text{PE GPCI}) + (\text{MP RVU} \times \text{MP GPCI}) \times \text{CF}$. This is also referred to as the CMS benchmark rate
 - Definitions:
 - Work = Provider work reflects the provider's work when performing a procedure or service including provider's technical skills, physical effort, mental effort and judgment, stress related to patient risk, and the amount of time required to perform the service or procedure
 - PE = Provider Expense reflects the costs for medical supplies, office supplies, clinical and administrative staff, and pro rata costs of building space, utilities, medical equipment, and office equipment
 - MP = Malpractice Insurance expense reflects the cost of professional liability insurance based on an estimate of the relative risk associated with procedure or service
 - CF = Conversion Factor
 - GPCI = Geographic Practice Cost Indices
- Applicable CMS RVU
- FAIR Health Medicare GapFill PLUS database
- CMS Clinical Lab Fee Schedule
- CMS DMEPOS (Durable Medical Equipment, Prosthetics/Orthotics, and Supplies) Fee Schedule
- CMS ASP (Average Sales Pricing) and RJ Health ASP (for drug pricing)
- CMS Ambulance Fee Schedule
- Optum RBRVS (for codes not priced by CMS) M/S providers only
- CMS Carrier Priced Fees (for codes referred to the local carrier for pricing)
- Within these templates, Current Procedural Technology® (CPT), Healthcare Common Procedure Coding System (HCPCS) codes are organized into 54 type of service categories:
 - Evaluation & Management – 4 categories
 - Surgery – 15 categories
 - Radiology – 10 categories
 - Laboratory/Pathology – 3 categories
 - Medicine – 10 categories

- Obstetrics – 1 category
- Immunizations/Injectables – 5 categories
- DME & Supplies – 5 categories
- Ambulance – 1 category

This standardized structure enables the Plan to tailor fee schedules around specific CPT/HCPCS codes, generally the highest volume codes, billed by different types of providers. Thus, the fee schedules are not specialty-specific; but instead based on the codes most likely to be billed by a particular provider.

Before creating a new fee schedule for a negotiation, the Plan determines if there is an existing fee schedule that will meet the needs of the negotiation; for example, if the negotiation is with a primary care group in Atlanta the Plan would look to find other primary care group fee schedules for that geographic locality that included the relevant codes. If no existing fee schedule fits the factual scenario, then the creation of a new fee schedule will be approved.

The Plan does not maintain designated “go-out” or “base rate” fee schedules for M/S services. Rather, the Plan begins with the standardized structure described here and then negotiates a percentage of CMS reimbursement with providers for the service categories listed above, applying the factors described in Step 2 and evidentiary sources described in Step 3 below. Any CPT/HCPCS codes not reflected in the fee schedule templates are paid at a negotiated percentage of charges.

For MH/SUD professionals, the Plan follows a comparable process. The Plan starts with the CMS national physician fee schedule rate for the service type and practitioner type at issue and then determines the percentage of CMS reimbursement based upon CMS locality fee schedules and the factors, evidentiary standards, and sources described in Steps 2 and 3 below. The Plan maintains five (5) internally developed standard fee schedules based on the CMS national physician fee schedule rates and the CMS geography-specific rates for the provider’s area. Individual or group MH/SUD care providers are assigned to one of these standardized fee schedules based on their geographic location.

For both M/S and MH/SUD professional providers, the Plan uses CMS annual national RVUs and other data to determine whether routine, non-negotiation-based adjustments to the fee schedules may be necessary. If an RVU is not available for a particular code, the Plan uses other sources such as the FairHealth Medicare Gap Fill Database and then market research to determine an appropriate rate.

Providers already in the network may also negotiate for non-routine adjustments upon contract renewal or changing market circumstances. For both M/S and MH/SUD professional providers, the fee schedule rates are negotiable, and the Plan assesses the market dynamic factors listed in Step 2 to reach agreement with providers.

Ongoing Monitoring

The Plan convenes ongoing working groups that include representatives from both the M/S and MH/SUD network strategy and pricing teams to align business processes and ensure adherence to as-written standards and comparability in operation.

The Plan also compares the allowed amounts for common CPT codes paid to M/S providers and MH/SUD providers relative to Medicare (CMS) rates on an annual basis to assess whether its methodology used to reimburse MH/SUD providers is comparable to, and applied no more stringently than, its methodology used to reimburse M/S providers “in operation.” If MH/SUD providers are not found to be comparable, the Plan works with the Network strategy team to implement applicable MH/SUD reimbursement rate adjustments. Impacts of the adjustment are then assessed during the next annual comparison.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- INN Professional Provider Reimbursement

Benefit Classification(s)

- INN, professional services

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHIC)
- UnitedHealthcare of Georgia, Inc. (UHCGA)
- UnitedHealthcare Insurance Company of the River Valley (UHICRV)
- UnitedHealthcare of Georgia, Inc. Individual Exchange Medical Policy (UHC GA)

Plan Terms/Source Document(s)

In each of the Plan's *Certificate of Coverage*, the following is referenced:

"What Is Our Relationship with Providers and Groups?"

We have agreements in place that govern the relationship between us, our Groups and Network providers, some of which are affiliated providers. Network providers enter into agreements with us to provide Covered Health Care Services to Covered Persons."

List of M/S and MH/SUD Services Subject to NQTL

- For M/S, INN professional services rendered by independently licensed health care professionals, e.g., primary care and specialty care
- For MH/SUD, INN professional services rendered by independently licensed behavioral health care professionals, e.g., psychotherapy, medication management, etc.

Step 2 – Factors Used in the Design and Application of the NQTL

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

The Plan relies on the following factors to establish reimbursement rates for M/S and MH/SUD professionals:

- Provider type (Qualitative) (e.g., physician vs. non-physician) and/or specialty including provider licensure, board certification, education, and training
- Services and/or Procedures Provided (Quantitative) is based on 100% of GPCI-adjusted CMS reimbursement for a given rate year

The Plan relies on the following factor in negotiating with professional providers after issuing standard reimbursement rates:

- Market dynamics (Quantitative and Qualitative) that may influence the offered rate include:
 - Provider leverage
 - Network need
 - Provider member volume
 - Market/Specialty Prevailing Rates

The factors apply to both M/S and MH/SUD services. Although the factors are not weighted, the Plan's standard fee schedules are based largely on the services/procedures, by code, a provider is most likely to provide and bill. While that factor is not most important in determining ultimate reimbursement, it does serve as the initial consideration.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factors used in establishing the standard INN professional services reimbursement rates. These evidentiary standards and sources apply to the following:

- I. M/S professional providers (e.g., physician or non-physician)
- II. MH/SUD professional providers (e.g., physician or non-physician)

Factor – Provider type and/or specialty including provider licensure, board certification, education, and training

- The Plan's evidentiary standard and source that triggers and/or defines the provider type factor is:
 - Provider application

This evidentiary standard and source applies to both M/S and MH/SUD providers INN reimbursement and is defined in a qualitative manner.

Factor – Services and/or procedures provided

- The Plan's evidentiary standards and sources that trigger and/or define the identification of the services and/or procedures provided factor (as applicable based on the respective services or procedures):
 - Most current version of industry standard code sets, e.g., CPT, HCPCS, etc.
 - CMS RBRVS
 - CMS RVU for a given service or procedure
 - FairHealth Medicare Gap Fill Database
 - CMS Clinical Lab Fee Schedule
 - CMS Durable Medical Equipment, Prosthetics/Orthotics, and Supplies (DMEPOS) Fee Schedule
 - CMS Average Sales Pricing (ASP) and RJ Health ASP (for drug pricing)
 - CMS Ambulance Fee Schedule
 - Optum RBRVS (for codes not priced by CMS)
 - CMS Carrier Priced Fees (for codes referred to the local carrier for pricing)

These evidentiary standards and sources apply to both M/S and MH/SUD providers INN reimbursement and are defined in a quantitative manner.

Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factors used in negotiating INN professional services reimbursement rates after issuing standard reimbursement rates. These evidentiary standards and sources apply to the following:

- I. M/S professional providers (e.g., physician or non-physician)

II. MH/SUD professional providers (e.g., physician or non-physician)

Factor – Market dynamics

- The Plan’s evidentiary standards and sources that define and/or trigger the identification of market dynamics that may influence the offered rate factor:
 - Provider leverage: providers owned or employed by large health systems within a given geographic market have more leverage than those who are not, e.g., solo practitioner
 - Market research
 - Network need: Supply and demand for a provider type is evaluated by looking at the volume of network providers of the same or similar provider type within the relevant geographic region relative to the Plan’s membership and its network access and/or availability standards. Specialists unique to their market may have more leverage due to the network need for that provider type
 - Provider directory, state Quest (f/k/a GeoAccess) reports and member reported access data
 - Provider member volume: measured by looking at the volume of members treated by the provider, and/or volume of services billed by the provider, in a given year, relative to the same or similar provider types in the same geographic market during the same timeframe
 - Provider claims data
 - Market/Specialty Prevailing Rates: internally derived average market pricing based upon available data including internal claims data and state published rates
 - State rate and internal claims data

These evidentiary standards and sources apply to both M/S and MH/SUD providers INN reimbursement and are defined in a quantitative and qualitative manner. In addition, all of these standards are considered and used to define the factors.

The factors and evidentiary standards used as the basis for negotiating and establishing the Plan’s MH/SUD INN professional services reimbursement rates are comparable to, and applied no more stringently than, the factors used as the basis for negotiating and establishing the Plan’s M/S INN professional services reimbursement rates “as written” and “in operation.” The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL.

Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer’s analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert’s qualifications and the extent to which the Plan or issuer ultimately relied upon each expert’s evaluations in setting recommendations regarding both.

The Plan convenes ongoing workgroups that include representatives from both the M/S and MH/SUD network strategy and pricing teams to align business processes and ensure adherence to as-written standards and comparability in operation.

As Written

The Plan compared the strategies, processes, factors, evidentiary standards, and source information used to negotiate and establish INN provider reimbursement for M/S and MH/SUD professional services “as written.”

The Plan identified the shared factors and evidentiary standards used as the basis for determining offered reimbursement rates to M/S and MH/SUD providers. The factors and evidentiary standards are applied to both M/S and MH/SUD providers comparably and not more stringently to MH/SUD providers.

Review of processes by which INN reimbursement is established

Both M/S and MH/SUD INN provider reimbursement for professional services are based upon provider type, service and/or procedures provided, including the CMS RVU, and market dynamics including, provider leverage, network need, and/or provider member volume.

In Operation

The Plan compared the allowed amounts for common CPT codes paid to M/S providers and MH/SUD providers relative to 2022 Medicare (CMS) rates to assess whether its methodology used to reimburse MH/SUD providers is comparable to, and applied no more stringently than, its methodology used to reimburse M/S providers for full year (FY) 2022 “in operation.”

Data Included in Analysis

FY 2022 INN provider allowed amounts derived from claims reporting.

Provider Type

Rationale as to why Primary Care Physicians (PCPs) were compared to psychiatrists:

- Both are cognitive-based specialties, unlike orthopedic surgeons or gastroenterologists, which are procedure-based specialties. PCPs diagnose, treat, and provide preventive medical care. PCPs commonly diagnose and treat behavioral health conditions, including medication management. Psychiatrists diagnose, treat, and prevent disorders of the mind
- Both PCPs and psychiatrists meet with patients for a period of time, take histories, write prescriptions, refer out to specialists (in the case of PCPs) or psychologists/therapists (in the case of PCPs and psychiatrists), and conduct periodic follow-up
- Both generally bill similar procedure codes, e.g., 99213

Rationale as to why Physician Assistants/Nurse Practitioners were compared to psychologists/therapists:

- All are non-physicians
- Their education and/or training requirements are similar

CPT Codes Included in Analysis

99214, 99213, 90792, 90791, 90834

M/S Physicians & Non-Physicians: 99213 & 99214

- These codes were selected because they are among the highest volume codes billed by medical professionals and are used by primary care physicians, non-physicians, such as physician assistants and nurse practitioners, and psychiatrists
- 99213 is an office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making
- 99214 is an office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making

MH/SUD Physicians: 90792 & 99213

- 90792 is a psychiatric diagnostic interview examination. It is performed at the outset of an illness. It requires elicitation of complete medical and psychiatric history, mental status examination, and establishment of initial diagnosis. Almost every member who utilizes MH/SUD services has one of these visits
- 99213 is an evaluation and management code for an existing patient. It was selected because it is the most common service performed by physician psychiatrists in most states

MH/SUD Non-Physicians: 90791 & 90834

- 90791 is a psychiatric diagnostic interview examination. It is performed at the outset of an illness. It requires elicitation of complete medical and psychiatric history, mental status examination, and establishment of initial diagnosis. Almost every member who utilizes MH/SUD services has one of these visits
- 90834 is a 45-minute therapy session. It was selected because it is the most common service provided by a non-physician licensed mental health provider

Relativities are averaged together to determine a combined relativity for M/S and one for MH/SUD.

Testing Methodology

The Plan developed three tests for evaluating in-network professional services reimbursement statistical comparability. Passing any one test demonstrates that comparability has been met. The Plan compared the median, average, and range of MH/SUD and M/S reimbursement relative to CMS to determine that MH/SUD reimbursement is statistically comparable to M/S reimbursement. No test carries any weight over the other.

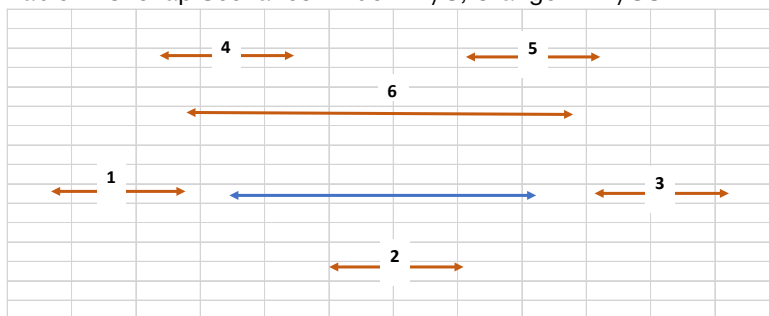
Testing for Comparability

- Median of M/S no greater than 110% of MH/SUD Median = Comparable, or
- Average of M/S no greater than 110% of MH/SUD Average = Comparable, or
- The range between the 25th and 75th percentile is compared. Comparing the ranges produce the following scenarios (see Overlap and Table 1 Overlap scenarios):

Overlap (M/S Range used as base)

1 = MH/SUD < M/S	Not comparable
2 = MH/SUD w/n M/S	Comparable
3 = MH/SUD > M/S	Comparable
4 = MH/SUD overlaps M/S Low	Overlap >80%, then comparable
5 = MH/SUD overlaps M/S High	Comparable
6 = MH/SUD covers M/S range	Comparable

Table 1: Overlap Scenarios. Blue = M/S, Orange =MH/SUD



In-Network Professional Services Reimbursement Non-Quantitative Treatment Limitation (NQTL) Analysis

GA – UnitedHealthcare Insurance Company, UnitedHealthcare of Georgia, Inc., UnitedHealthcare Insurance Company of the River Valley, and UnitedHealthcare of Georgia, Inc. Individual Exchange Medical Policy
12/29/2023



The chart below demonstrates comparability for plan year 2022:

State	Georgia	
Median Test	MD	Non-MD
M/S Median as % of CMS	87%	80%
BH Median as % of CMS	88%	89%
M/S to BH Ratio	99%	89%
M/S to BH Ratio < 110%	Yes	Yes
Range Test	MD	Non-MD
M/S Range as % of CMS	78% - 117%	72% - 96%
BH Range as % of CMS	88% - 88%	89% - 89%
Overlap Scenario*	2 <i>BH w/n Med</i>	2 <i>BH w/n Med</i>
Overlap Percentage	100%	100%
Overlap Percentage > 80%	Yes	Yes
Average Test	MD	Non-MD
M/S Average as % of CMS	119%	96%
BH Average as % of CMS	98%	101%
M/S to BH Ratio	121%	95%
M/S to BH Ratio < 110%	Does not Pass	Yes
Pass Test	Yes	Yes

The Plan concludes the above testing and comparison is sufficient to demonstrate comparability in operation.

The Plan concludes the above testing and comparison is not sufficient to demonstrate comparability in operation. The Plan intends to continue to monitor its INN provider reimbursement outcomes “in operation” and will conduct a follow-up comparative analysis of M/S and MH/SUD INN physician and non-physician reimbursement outcomes in 2024, after the planned MH/SUD market fee schedule adjustment has been completed.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The analysis reviewed the strategies and processes by which reimbursement for INN professional services is established. The findings of that analysis confirmed the strategies, processes, factors, evidentiary standards, and source information used to negotiate and establish provider reimbursements for MH/SUD INN professional services were comparable to, and applied no more stringently than, the strategies, processes, factors, evidentiary standards, and source information used to negotiate and establish provider reimbursement for M/S INN professional services “as written.”

The findings of the comparative analysis revealed the reimbursement for MH/SUD physicians (psychiatrists) and M/S Physicians were statistically comparable. Reimbursement for MH/SUD non-physicians and M/S non-physicians were statistically comparable “in-operation.” Specifically, for Georgia providers billing the codes described in Step 4, the median, average, and range of MH/SUD and M/S reimbursement relative to CMS were statistically comparable as evidenced in the

comparability chart above (Step 4). Comparable rates between M/S and MH/SUD also demonstrate that the factors used during the reimbursement negotiation (e.g., provider leverage) were applied in a consistent manner.

Conclusions

Based upon these findings, the Plan concluded that the methodologies to negotiate and establish INN provider reimbursement for MH/SUD INN professional services was comparable to, and applied no more stringently than, the methodologies to negotiate and establish the INN provider reimbursement for M/S INN professional services “as written.”

Because the reimbursement for MH/SUD physicians and non-physicians compared to M/S physicians and non-physicians was no more stringent, the Plan’s methodologies to negotiate and establish reimbursement for MH/SUD INN professional services is comparable to, and applied no more stringently than, its methodologies to negotiate and establish reimbursement for M/S INN professional services “in operation.”

Medical Necessity Non-Quantitative Treatment Limitation (NQTL) Analysis

GA – UnitedHealthcare Insurance Company, UnitedHealthcare of Georgia, Inc., UnitedHealthcare Insurance Company of the River Valley, and UnitedHealthcare of Georgia, Inc. Individual Exchange Medical Policy
12/29/2023



Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical/surgical (M/S) benefits. This generally means that the financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements such as, deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs, which may limit the scope or duration of benefits for treatment under a plan or coverage.

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

The Plan covers M/S and MH/SUD services/technologies (e.g., services, interventions, devices, medically administered M/S and MH/SUD drugs, etc.) that are medically necessary. Medical necessity refers to the principle that healthcare services, technologies and treatments should be in accordance with generally accepted standards of medical practice, appropriate for the member’s disorder, disease, or symptoms, cost-effective, and essential for diagnosing, preventing, or treating a medical condition. The concept of medical necessity takes into account the best interests of the patient and the evidence-based standards of medical practice. It helps ensure that healthcare resources are allocated efficiently and that patients receive appropriate care based on their medical needs. The Plan makes medical necessity clinical coverage determinations using externally developed, evidence-based clinical criteria (also known as medical necessity criteria) such as InterQual®, MCG®, American Society of Addiction Medicine (ASAM) Criteria¹, Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System-Child and Adolescent Service Intensity Instrument (CALOCUS-CASII), and Early Childhood Service Intensity Instrument (ECSII) guidelines as well as internally developed objective, evidence-based, medical/behavioral clinical policies.

Application of medical necessity criteria is integral to the utilization management (UM) processes of a medical necessity clinical coverage benefit determination.

The Plan publishes its medical necessity criteria, which are available through www.uhcprovider.com (M/S) and www.providerexpress.com (MH/SUD), and upon request.

This document includes the following information:

- Process for developing and approving medical necessity criteria for both M/S and MH/SUD services and technologies
- Description of the NQTL and application (Step 1)
- Factors used to determine which services and technologies are subject to the NQTL (Step 2)
- Evidentiary standards and sources used to define, trigger and/or implicate a factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

¹ Only ASAM Criteria are used to make substance use disorder (SUD) medical necessity coverage determinations, unless otherwise mandated by state law or contract.

Medical Necessity Non-Quantitative Treatment Limitation (NQTL) Analysis

GA – UnitedHealthcare Insurance Company, UnitedHealthcare of Georgia, Inc., UnitedHealthcare Insurance Company of the River Valley, and UnitedHealthcare of Georgia, Inc. Individual Exchange Medical Policy
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This analysis refers to the following attachments:

- *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions* - M/S policy that defines Medical Necessity
- *Optum National Policy Definitions List* - MH/SUD policy that defines Medical Necessity
- *UnitedHealthcare (UHC) Hierarchy of Clinical Evidence* – M/S policy that defines the hierarchy of clinical evidence to ensure a transparent and consistent approach within UnitedHealthcare
- *Behavioral Health Hierarchy of Clinical Evidence* – MH/SUD policy that defines the hierarchy of clinical evidence to ensure a transparent and consistent approach to the review and development of Optum’s Clinical Technology Assessments and Behavioral Clinical Policies
- *2023 UnitedHealthcare Provider Administrative Guide* - Informs providers of the Prior Authorization process. The *UnitedHealthcare Provider Administrative Guide* can be accessed on the website <https://www.uhcprovider.com/en/admin-guides.html>
- *September 2023 Optum National Network Manual*- Informs providers of the Prior Authorization process. The *Optum National Network Manual* can be accessed on the website <https://public.providerexpress.com/content/openprovexpr/us/en/clinical-resources/guidelines-policies/optum-network-manual.html>
- *Utilization Management Program Description (UMPD) of United HealthCare Services, Inc. and UnitedHealthcare Insurance Company* -summarizes the philosophy, structure and standards that govern UHC’s medical management, UM and utilization review responsibilities and functions
- *Certificates of Coverage* (COC23-INS-2018-LG-GA, COC23-INS-2018-SG-GA, COC23-HMO-2018-LG-GA, COC23-HMO-2018-SG-GA, COC23-INS-RV-2018-LG-GA, COC23-INS-RV-2018-SG-GA, Policy23-HMO-2022-LEX-GA) Plan document that explains covered services, terms, conditions, and limitations of the member’s policy
- *Schedule of Benefits* (for example: *Schedule of Benefits SBN23-Medical-INS-2018-[Choice+Plus][Select+Plus][Doctors+Plus]-LG-GA, SBN23-Medical-INS-2018-[Choice+Plus][Select+Plus][Doctors+Plus]-SG-GA, SBN23-Medical-INS-RV-2018-HeritagePlus-LG-GA, SBN23-Medical-INS-RV-2018-HeritagePlus-SG-GA, and SBN23-Medical-HMO-2022-LEX-GA-ADV*)) - Plan document that outlines member responsibilities
- *Utilization Management Program Committee Charter*– document that outlines the purpose, responsibility, functions, and composition of the committee that oversees the M/S utilization management program
- *Clinical Technology Assessment Committee (CTAC) Charter* – document that outlines the purpose, structure, responsibility and membership of the committee that develops internal medical criteria and reviews and approves externally developed criteria for MH/SUD
- *Clinical Quality and Operations Committee (CQOC) Charter* – document that outlines the purpose, structure, responsibility, and membership of the committee that oversees CTAC
- *Medical Technology Assessment Committee (MTAC) Charter* – policy that outlines the purpose, responsibility, structure and membership of the committee that develops internal medical criteria and reviews and approves externally developed criteria for M/S
- *National Medical Care Management Committee (NMCMC) Charter* – document that outlines the purpose, responsibility, membership, and structure of the committee that oversees the MTAC
- *Applying Benefit Plan and Review Criteria Standard Operating Procedure* - outlines the hierarchy of authorities to be reviewed (i.e., state/federal laws and regulations followed by Benefit Plan criteria) when making coverage determinations
- *Clinical Review Criteria Operational Policy*- The purpose of this operational policy is to document that UHC will use evidence-based clinical review criteria to support clinical review decisions for UM programs, and to ensure that the clinical review process is applied consistently
- *Clinical Criteria Development Selection and Application Policy*- addresses Optum’s selection, development, and use of clinical criteria in making benefit determinations

The Plan concludes that the methodologies used to develop and approve medical necessity criteria and medical/behavioral clinical policies for M/S and MH/SUD services and technologies are comparable and applied no more stringently for MH/SUD both “as written” and “in operation.”

Process

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Medical Necessity is defined as: “Health care services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms, that are all of the following.

- In accordance with Generally Accepted Standards of Medical Practice.
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.”

The *September 2022, Optum National Network Manual* defines Medical Necessity as “Generally, the evaluation of health care services to determine whether the services meet plan criteria for coverage; are medically appropriate and necessary to meet basic health needs; are consistent with the diagnosis or condition; are rendered in a cost-effective manner; and are consistent with national medical practice guidelines regarding type, frequency and duration of treatment. This definition may vary according to Member Benefit Plans or state laws (also referred to as Clinical Necessity).”

The Plan delegates UM of MH/SUD services to United Behavioral Health d/b/a Optum Behavioral Health (OBH), its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor.

Both M/S and MH/SUD have UM program descriptions that are the foundation for the objectives and guidelines of the Plan’s UM strategy. Medical necessity criteria or medical/behavioral clinical policies are not included in the UM program descriptions.

The Plan develops internal, objective, evidence-based, clinical policies and approves third-party, externally developed medical necessity criteria. Where available, both M/S and MH/SUD use externally developed evidence-based medical necessity criteria (e.g., InterQual, MCG, ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII) when making clinical coverage determinations. When M/S or MH/SUD technologies (e.g., services, interventions, devices, medically administered drugs, etc.) fall outside the scope of externally developed medical necessity criteria, internally developed, evidence-based, medical/behavioral clinical policies are used when making medical necessity clinical coverage determinations. All M/S and MH/SUD internally developed medical and behavioral clinical policies are reviewed at least annually. The *M/S Clinical Review Criteria Operational Policy* and *MH/SUD Clinical Criteria Development/Selection and Application Policy* outline the processes to ensure medical necessity criteria are developed consistently.

The Plan uses the following standard process to review externally developed medical necessity criteria:

The Medical Technology Assessment Committee (MTAC) assesses externally developed clinical criteria for M/S services and technologies. MTAC uses scientifically based, clinical evidence and the *UHC Hierarchy of Clinical Evidence* in its assessment and approval processes. MTAC conducts its processes in a timely manner to ensure transparency and consistency, and to identify safe and effective M/S services and technologies for members.

MTAC is comprised of, but not limited to, medical directors with diverse medical and surgical specialties and sub-specialties, representatives from business segments, legal services, consumer affairs, medical policy development and operations teams, benefit interpretation team, and other guests, as needed. MTAC voting members include medical directors with the following specialties (note that some doctors have multiple specialties):

- Plastic Surgery
- Internal Medicine (x7)
- Medical Oncology

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- Thoracic and Cardiothoracic Vascular Surgery (x2)
- Preventative Medicine
- Pediatrics
- Diagnostic Radiology and Vascular/Interventional Radiology
- Ophthalmology
- Physical Medicine & Rehabilitation Pain Medicine
- Family Practice
- Emergency Medicine

The National Medical Care Management Committee (NMCMC) annually reviews and validates medical necessity criteria endorsed by MTAC. The NMCMC is comprised of the Chief Medical Officer, and representatives from clinical policy, clinical advocacy and grievances, business standardization and advancement, regional chief medical officers, inpatient care management, lines of business, medical policy, clinical operations, and Optum Behavioral Health. The Chair of the NMCMC must be an executive leader and licensed physician.

As of April 1, 2023, the Utilization Management Program Committee (UMPC) began overseeing the M/S UM program. The UMPC is responsible for the development and maintenance of the M/S Prior Authorization, Concurrent Review, and Retrospective Review processes. The UMPC ensures that the UM program considers the factors and evidentiary standards for applying UM. The UMPC is comprised of:

- Chief Medical Officer, Medical Management (Co-Chair)
- Senior Vice President, Clinical Advancement (Co-Chair)
- Chief Medical Officer, UnitedHealthcare
- Senior Vice President, Clinical Appeals & Grievances
- Chief Medical Officer, Clinical Policy
- Chief Medical Officer, UnitedHealthcare Employer & Individual
- Chief Medical Officer, UnitedHealthcare Medicare & Retirement
- Chief Medical Officer, Community & State
- Chief Medical Officer, UnitedHealthcare Individual & Family Plans
- Vice President, Clinical Transformation & Affordability
- Senior Director, Mental Health Parity
- Vice President, Utilization Management Strategy & Implementation

One of the chairs must be an executive leader and a licensed physician. UMPC meets at least six times per year but may meet more frequently if needed. MTAC reports to the UMPC.

The Clinical Quality and Operations Committee (CQOC) assesses and approves the use of externally developed clinical criteria for MH/SUD services. CQOC uses scientifically based, clinical evidence and the *Behavioral Health Hierarchy of Clinical Evidence* in its assessment and approval processes. CQOC conducts its processes in a timely manner to ensure transparency and consistency, and to identify safe and effective MH/SUD services for members. The CQOC is comprised of representatives from sub-committees, representatives from the clinical quality improvement, UM, care engagement, medical operations, medical policy and standards, clinical operations, appeals, product, legal, compliance, network strategy, provider experience, accreditation, and benefits teams. The Chair is appointed by the Chief Medical Officer and must be an executive leader and licensed physician.

The Plan uses the following standard process to develop and approve *internal* medical necessity criteria:

The Plan uses committees to assess technologies and conduct a thorough review of scientifically based clinical evidence and peer-reviewed literature in accordance with the *UHC* and *Behavioral Health Hierarchies of Clinical Evidence* to develop medical/behavioral clinical policies that apply to the technologies.

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MTAC develops and approves medical clinical policies for M/S services and technologies when externally developed criteria are not available. MTAC uses scientifically based clinical evidence and the *UHC Hierarchy of Clinical Evidence* in its development and approval processes. MTAC conducts its processes in a timely manner to ensure transparency and consistency, and to identify safe and effective M/S services and technologies for members.

When assessing the safety, efficacy, and appropriateness of the services/technologies used to treat M/S conditions, MTAC first looks for any strong and compelling scientific evidence such as statistically robust, well-designed, randomized, controlled, trials and cohort studies. In addition, MTAC will look for multi-site observational studies and single site observational studies.

In the absence of any strong and compelling scientific evidence, MTAC assesses technologies by looking for any national consensus statements and/or publications by recognized authorities such as clinical position papers published by professional specialty societies and Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations (NCD).

MTAC will not deem a technology unproven solely based on a lack of randomized controlled trials, particularly for new and emerging technologies.

The NMCMC annually reviews and validates medical clinical policies endorsed by MTAC. If NMCMC determines that any medical clinical policies are not appropriately supported by clinical evidence, then NMCMC refers the medical clinical policy back to MTAC. As of April 1, 2023, UMPC began reviewing and validating the medical clinical policies endorsed by MTAC. If UMPC determines that any medical clinical policies are not appropriately supported by clinical evidence, then UMPC refers the medical clinical policy back to MTAC.

The CQOC develops and approves behavioral clinical policies for MH/SUD services when externally developed criteria are not available. CQOC uses scientifically based clinical evidence and the *Behavioral Health Hierarchy of Clinical Evidence* in its development and approval processes. CQOC conducts its processes in a timely manner to ensure transparency and consistency, and to identify safe and effective MH/SUD services for members.

The Clinical Technology Assessment Committee (CTAC) is a sub-committee of CQOC and is responsible for reviewing new or evolving technologies and then developing and maintaining evidence-based behavioral clinical policies for behavioral health technologies. CTAC's purpose is to make determinations regarding technologies that may or may not be experimental, investigational, or unproven (EIU). CTAC members include behavioral health medical directors, senior leaders of clinical operations, research and development, clinical review, legal, compliance, and policy. CTAC voting members include six psychiatrists and one licensed independent social worker (LISW), plus two co-chairs, both of whom are psychiatrists. CTAC obtains approval of its determinations from the CQOC.

When assessing the safety efficacy, and appropriateness of services/technologies used to treat MH/SUD conditions, CQOC and CTAC first look for scientifically based clinical evidence and peer reviewed literature. In addition, the committees will look for any strong and compelling scientific evidence such as statistically robust, well-designed, randomized, controlled trials and cohort studies. In addition, CTAC (for EIU) and CQOC will also look for systematic reviews and meta-analyses, large prospective trials, cross-sectional studies, retrospective studies, surveillance studies, case reviews/case series, anecdotal/editorial statements, and professional opinions.

In the absence of any strong and compelling scientific evidence, CQOC (and CTAC for potential EIU technologies) assesses services and technologies by looking for any national consensus statements and/or publications by recognized authorities such as clinical position papers published by professional specialty societies and CMS NCDs.

CQOC (and CTAC for potential EIU technologies) will not deem a service or technology unproven solely based on a lack of randomized controlled trials, particularly for new and emerging technologies.

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The CQOC reviews and validates behavioral clinical policies endorsed by CTAC. If CQOC determines that any behavioral clinical policies are not appropriately supported by clinical evidence, then CQOC refers the behavioral clinical policy back to CTAC.

Internally developed medical and behavioral clinical policies are publicly available here:

- M/S: Medical & Drug Policies and Coverage Determination Guidelines for UnitedHealthcare Commercial Plans | UHCprovider.com (<http://www.uhcprovider.com/en/policies-protocols/clinical-guidelines.html>)
- MH/SUD: Guidelines/Policies/Manuals (<http://www.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies.html>)

The Plan uses the following standard process to apply medical necessity criteria:

M/S and MH/SUD clinical reviewers follow an established process of reviewing state/federal laws and regulations, followed by Plan documents when making medical necessity coverage benefit determinations. The criteria chosen for review are based on the treatment type, diagnosis, and services requested. Where available, both M/S and MH/SUD use externally developed evidence-based medical necessity criteria (e.g., InterQual, MCG, ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII) when making medical necessity coverage benefit determinations. When M/S or MH/SUD technologies (e.g., services, interventions, devices, medically administered drugs, etc.) fall outside the scope of externally developed medical necessity criteria, internally developed, evidence-based, medical/behavioral clinical policies are used when making medical necessity clinical coverage determinations. There is no duplication between internally and externally developed medical necessity criteria. This means that there are either externally developed medical necessity criteria available or there are internally developed medical/behavioral clinical policies available. M/S and MH/SUD clinical reviewers do not have to make a choice between using internal or external medical necessity criteria.

Second level, or peer review, medical necessity coverage benefit determinations include clinical judgment. The M/S *Peer Clinical Review Operational Policy* and the MH/SUD *Management of Behavioral Health Benefits Policy* outline the processes. Clinicians use their clinical judgment when they apply evidence-based medical necessity criteria to each member's specific clinical condition. Clinicians use their independent clinical judgment when they evaluate whether the member's clinical condition meets the medical necessity criteria per the applicable externally developed medical necessity criteria or internal medical/behavioral clinical policies.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- Medical Necessity

Benefit Classification(s)

- In-Network (INN) Inpatient, Out-of-Network (OON) Inpatient, INN Outpatient, and OON Outpatient

Please note that the Prior Authorization, Concurrent Review, and Retrospective Review NQTLs describe the services in scope for UM. These NQTLs also describe the factors and evidentiary standards used to determine whether a covered service is subject to a medical necessity review.

The Plan notes that not all covered services are subject to a medical necessity review.

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHIC)
- UnitedHealthcare of Georgia, Inc. (UHCGA)

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- UnitedHealthcare Insurance Company of the River Valley (UHCIRV)
- UnitedHealthcare of Georgia, Inc. Individual Exchange Medical Policy (UHC GA)

Plan Terms/Source Document(s)

In each of the Plan products, Medically Necessary is the Plan term used to guide UM decision-making for both M/S and MH/SUD services and technologies. Medically Necessary is generally defined as follows:

UHC GA

- “Medically Necessary – health care services are all of the following as determined by us or our designee:
 - In accordance with Generally Accepted Standards of Medical **Care**.
 - Clinically appropriate, in terms of type, frequency, extent, service site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms.
 - Not mainly for your convenience or that of your doctor or other health care provider.
 - Not more costly than an alternative drug, service(s), service site or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

*Generally Accepted Standards of Medical **Care*** are evidence based independent standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties. Valid, evidence-based sources reflecting *Generally Accepted Standards of Care* include credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or **nationally recognized clinical practice guidelines** may be considered. We have the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be determined by us.

We develop and maintain clinical policies that describe the *Generally Accepted Standards of Medical **Care*** scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by us and revised from time to time), are available to Covered Persons through www.myuhc.com/exchange or the telephone number on your ID card. They are also available to Physicians and other health care professionals on UHCprovider.com.”

UHC, UHCGA and UHCIRV

- **Medically Necessary - health care services, that are all of the following as determined by us or our designee.**
 - In accordance with *Generally Accepted Standards of Care*.
 - Clinically appropriate, in terms of type, frequency, extent, service site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms.
 - Not mainly for your convenience or that of your doctor or other health care provider.
 - Not more costly than an alternative drug, service(s), service site or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

Generally Accepted Standards of Care are evidence based independent standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties. Valid, evidence-based sources reflecting generally accepted standards of care include credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational

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studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or nationally recognized clinical practice guidelines may be considered. We have the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be determined by us.

We develop and maintain clinical policies that describe the *Generally Accepted Standards of Care* scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by us and revised from time to time), are available to Covered Persons through www.myuhc.com/exchange or the telephone number on your ID card. They are also available to Physicians and other health care professionals on UHCprovider.com.

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Medical Necessity is defined as follows:

“Health care services provided for the purpose of preventing, evaluating, diagnosing, or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms, that are all of the following.

- In accordance with Generally Accepted Standards of Medical Practice.
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.”

The *2023 United Healthcare Provider Administrative Guide* Chapter 7 describes Plan medical necessity processes as follows

“We base coverage decisions, including medical necessity decisions, on:

- Member’s benefits.
- State and federal requirements.
- The contract between us and the plan sponsor.
- Medicare guidelines including NCDs and local coverage determination (LCD) guidelines.
- Medicare Benefit Policy Manual (MA members).
- UnitedHealthcare medical policies, medical benefit drug policies, coverage determination guidelines, utilization review guidelines and MA coverage summaries.

Our employees, contractors and delegates do not receive financial incentives for issuing non-coverage decisions or denials. We and our delegates do not offer incentives for underutilization of care/services or for barriers to care/service. We do not hire, promote, or terminate employees or contractors based on whether they deny benefits.

We use tools such as UnitedHealthcare medical policies and third-party resources (such as InterQual® criteria and other guidelines), to assist us in administering health benefits and determining coverage.

These tools and resources are not equivalent to the practice of medicine or medical advice, and you should use them in addition to independent, qualified medical judgment.”

The *Optum National Policy Definitions List* defers to the definition of Medical Necessity as set forth in member Plan documents: “This term is variable and defined in the member’s applicable Plan or Coverage document.”

The *September 2023, Optum National Network Manual* defines Medical Necessity as:

“Generally, the evaluation of health care services to determine whether the services meet plan criteria for coverage; are medically appropriate and necessary to meet basic health needs; are consistent with the diagnosis or condition; are

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rendered in a cost-effective manner; and are consistent with national medical practice guidelines regarding type, frequency and duration of treatment. This definition may vary according to Member Benefit Plans or state laws (also referred to as Clinical Necessity).”

List of M/S and MH/SUD Services and Technologies Subject to NQTL

All M/S and MH/SUD INN inpatient, OON inpatient, INN outpatient, and OON outpatient services and technologies subject to UM.

Step 2 – Factor Used to Develop and Approve Medical and Behavioral Clinical Policies

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

The Plan relies on the following factor to develop and approve medical necessity criteria. This factor applies to both M/S and MH/SUD benefits for the following:

- I. All M/S INN inpatient, OON inpatient, INN outpatient, and OON outpatient services and technologies subject to UM
 - II. All MH/SUD INN inpatient, OON inpatient, INN outpatient, and OON outpatient services and technologies subject to UM
- M/S and MH/SUD Committee Considerations (Qualitative) including clinical efficacy, safety of the service or technology, and appropriateness of the proposed service or technology when developing and approving medical/behavioral clinical policies and medical necessity criteria

This factor applies to M/S and MH/SUD services and technologies.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factor used in developing or approving medical necessity criteria. These evidentiary standards and sources apply for the following:

- I. All M/S INN inpatient, OON inpatient, INN outpatient, and OON outpatient services and technologies subject to UM
- II. All MH/SUD INN inpatient, OON inpatient, INN outpatient, and OON outpatient services and technologies subject to UM

Factor – M/S and MH/SUD Committee Considerations, including clinical efficacy, safety of the service or technology, and appropriateness of the proposed service or technology when developing and approving medical/behavioral clinical policies and medical necessity criteria

- Clinical Effectiveness – Is a characteristic of care that is in accordance with objective, evidence-based clinical criteria, and nationally recognized guidelines as determined by internal medical experts. Clinically appropriate care is more likely to be effective
- Safety of Service or Technology - Is a state in which hazards and conditions leading to physical or psychological harm are minimized to preserve the health and wellbeing of a person receiving health care
- Appropriateness of the Proposed Service or Technology – The service or technology is suitable for the member’s clinical presentation and the expected health benefits from the medical service or technology are clinically significant and exceed the expected natural history of recovery and the expected health risks by a

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sufficient margin

- The Plan's evidentiary standard and sources that define and/or trigger the M/S and MH/SUD Committee Considerations factor:
 - The Plan uses scientifically based clinical evidence and the *UHC* and *Behavioral Health Hierarchies of Clinical Evidence* to determine which M/S and MH/SUD services or technologies are safe and effective and, therefore, eligible for benefit coverage. The *UHC* and *Behavioral Health Hierarchies of Clinical Evidence* detail the hierarchy of clinical evidence that is preferred when assessing which health services or technologies are safe and effective. To be deemed safe and effective, a health service or technology only has to have evidence in at least one category.
 - M/S assesses evidence from the following when developing or approving medical clinical policies/medical necessity criteria:
 - Scientifically based clinical evidence
 - Peer-reviewed literature
 - *UHC Hierarchy of Clinical Evidence*
 - In the absence of strong and compelling scientific evidence, medical policies may be based upon:
 - National guidelines and consensus statements
 - CMS NCDs
 - Clinical position papers based upon rigorous review of scientific evidence or clinical registry data from professional specialty societies when their statements are based upon referenced clinical evidence, e.g., American College of Physicians (ACP), The Society for Post-Acute and Long-Term Care Medicine (AMDA), American Academy of Family Physicians (AAFP), American College of Obstetricians and Gynecologists (ACOG), American College of Cardiology (ACC), etc.
 - InterQual or MCG (for review of external medical necessity criteria)
 - MH/SUD assesses evidence from the following when developing or approving behavioral clinical policies/medical necessity criteria:
 - Scientifically based clinical evidence
 - Peer-reviewed literature
 - *Behavioral Health Hierarchy of Clinical Evidence*
 - In the absence of strong and compelling scientific evidence, behavioral clinical policies/clinical criteria may be based upon:
 - National consensus statements
 - Publications by recognized authorities such as government sources and/or professional societies
 - ASAM Criteria, LOCUS, CALOCUS-CASII, and ECSII (for review of external medical necessity criteria)

Note: Anecdotal/editorial statements and professional opinions are only used to support adoption of behavioral clinical policies /clinical criteria when no other source is available.

These evidentiary standards and sources apply to M/S and MH/SUD services and technologies and are defined in a qualitative manner.

The factor and evidentiary standards used as the basis for developing and approving MH/SUD medical necessity criteria are comparable to, and applied no more stringently than, the factor and evidentiary standards used as the basis for developing and approving M/S medical necessity criteria “as written” and “in operation.”

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Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

As Written

The Plan conducted a comparative analysis of the strategies, processes, factor, evidentiary standards, and source information MH/SUD uses to

- develop internal, objective, evidence-based, behavioral clinical policies and
- approve third-party, externally developed clinical criteria
- to the strategies, processes, factors, evidentiary standards, and source information M/S uses to:
- develop internal, objective, evidence-based, medical clinical policies and
- approve third-party, externally developed clinical criteria

for use in UM clinical coverage determinations and found they were comparable to, and no more stringently applied than, the strategies, processes, factors, evidentiary standards, and source information used by M/S “as written.”

National internal committees evaluate the applicable factors and standards described in Steps 2 and 3 when developing and approving Medical Necessity criteria.

Review of Factor and Evidentiary Standards

When developing and approving medical and behavioral clinical policies/medical necessity criteria, M/S and MH/SUD committees both consider clinical efficacy, safety, and appropriateness of the proposed services or technologies.

The M/S and MH/SUD *UHC* and *Behavioral Health Hierarchies of Clinical Evidence* are comparable. Both use the following categories of sources (with source-specific differences if the source is specific to M/S or MH/SUD):

- Well-designed evidence-based studies
- Observational studies
- Case studies
- Consensus statements
- Clinical and professional opinion papers

Review of Operational Policies and Procedures

The Plan reviewed the following M/S and MH/SUD operational policies and procedures to confirm comparability and found MH/SUD policies, procedures, and processes to be comparable and no more stringent than M/S policies, procedures, and processes.

M/S

- *UHC Hierarchy of Clinical Evidence*
 - The purpose of this document is to outline the hierarchy of clinical evidence that is used to determine which M/S health services or technologies are safe and effective and, therefore, eligible for benefit coverage. In developing the hierarchy, UnitedHealthcare uses scientifically based clinical evidence to identify safe and effective health services or technologies for members.
- *MTAC Charter*
 - MTAC's mission is to review the scientifically based clinical evidence used in the development of UnitedHealthcare medical policies and clinical programs in an effort to ensure transparency and consistency and to identify safe and effective health services or technologies for UHC members. MTAC's Charter outlines the structure, objectives, responsibilities and scope of the activities carried out by the committee

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- *NMCMC Charter*
 - The NMCMC is responsible for overseeing the development, implementation and evaluation of the UnitedHealthcare UM program
- *Utilization Management Program Committee Charter*
 - The UMPC is responsible for oversight of the UM program and the development and maintenance of the scope and processes of prior authorization, concurrent review, and retrospective review, including defining the services that require prior authorization, concurrent review, and post-service review
- *Applying Benefit Plan and Review Criteria Standard Operating Procedure*
 - This standard operating procedure outlines the hierarchy of authorities to be reviewed (i.e., state/federal laws and regulations followed by Benefit Plan criteria) when making clinical coverage determinations
- *UMPD of United HealthCare Services, Inc. and UnitedHealthcare Insurance Company*
 - This document summarizes the philosophy, structure and standards that govern UHC's medical management, utilization management and utilization review responsibilities and functions
- *Clinical Review Criteria Operational Policy*
 - The purpose of this operational policy is to document that UHC will use evidence-based clinical review criteria to support clinical review decisions for UM programs, and to ensure that the clinical review process is applied consistently

MH/SUD

- *Behavioral Health Hierarchy of Clinical Evidence*
 - The purpose of this document is to outline the hierarchy of clinical evidence that is used to determine which MH/SUD health services or technologies are safe and effective and, therefore, eligible for benefit coverage. In developing the hierarchy, Optum uses scientifically based clinical evidence to identify safe and effective health services or technologies for members
- *CTAC Charter*
 - CTAC is responsible for reviewing new or evolving technologies and then developing and maintaining evidence-based behavioral clinical policies for behavioral health technologies
- *CQOC Charter*
 - The role and purpose of the CQOC is to review and approve externally developed medical necessity criteria, develop behavioral clinical policies when externally developed criteria is not available, and to review and validate CTAC's assessment of EIU technologies
- *Management of Behavioral Health Benefits*
 - The purpose of this policy is to describe the mechanisms and processes designed to promote consistency in the management of behavioral health benefits and ensure that members receive appropriate, high quality behavioral health services or technologies in a timely manner
- *Clinical Criteria Development Selection and Application Policy*
 - This document addresses Optum's selection, development, and use of clinical criteria in making benefit determinations. Optum uses written clinical criteria consistent with National Committee for Quality Assurance (NCQA) and Utilization Review Accreditation Commission (URAC) requirements and applicable laws and regulations
 - Optum selects and uses clinical criteria that are consistent with generally accepted standards of care, including objective criteria that are based on sound clinical evidence. Optum uses the criteria to make standardized coverage determinations and to inform discussions about evidence-based practices and discharge planning

Where available, both M/S and MH/SUD use externally developed evidence-based medical necessity criteria (e.g., InterQual, MCG, ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII) when making clinical coverage determinations. When M/S or MH/SUD technologies (e.g., services, interventions, devices, medically administered drugs, etc.) fall outside the scope of externally developed medical necessity criteria, internally developed, evidence-based, medical/behavioral clinical policies are used when making medical necessity clinical coverage determinations.

MTAC and CQOC (and CTAC for EIU) develop internal clinical policies only. MTAC and CQOC review and approve externally

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developed medical necessity criteria. In either case, a comparable process is followed. In some cases, the Plan is obligated by State regulations to use certain externally developed medical necessity criteria. The committees assess the clinical efficacy, safety, and appropriateness of the proposed services or technologies used for the treatment of health care conditions based upon the scientific evidence. CTAC's technology assessment process for MH/SUD potential EIU technologies, including the *Behavioral Health Hierarchy of Clinical Evidence*, is comparable to, and applied no more stringently than, MTAC's assessment process for M/S technologies including the *UHC Hierarchy of Clinical Evidence*. Additionally, CQOC's assessment process for MH/SUD services, including the *Behavioral Health Hierarchy of Clinical Evidence*, is comparable to, and applied no more stringently than, MTAC's assessment process for M/S services including the *UHC Hierarchy of Clinical Evidence*.

All M/S and MH/SUD medical/behavioral clinical policies are reviewed at least annually.

Review of processes to review *externally* developed medical necessity criteria

A standard and comparable process is followed to review externally developed, third party medical necessity criteria. The MTAC assesses externally developed clinical criteria for M/S services or technologies. MTAC uses scientifically based, clinical evidence and the *UHC Hierarchy of Clinical Evidence* in its assessment and approval processes. MTAC conducts its processes in a timely manner to ensure transparency and consistency, and to identify safe and effective M/S services or technologies for members.

The CQOC assesses externally developed clinical criteria for MH/SUD services. CQOC uses scientifically based clinical evidence and the *Behavioral Health Hierarchy of Clinical Evidence* in its development, assessment, and approval processes. CQOC conducts its processes in a timely manner to ensure transparency and consistency, and to identify safe and effective MH/SUD services for members.

Both M/S and MH/SUD committees use comparable evidentiary standards and sources to evaluate clinical efficacy, safety, and appropriateness of the proposed services or technologies to approve medical/behavioral clinical policies.

Further, both committees are comprised of licensed clinicians with applicable specialties and are chaired by executive-level medical directors.

ASAM Criteria, LOCUS, CALOCUS-CASII, and ECSII are widely recognized as best-in-class externally developed medical necessity criteria sources. The MH/SUD external medical necessity criteria is developed by nationally recognized organizations. The Plan uses InterQual medical necessity criteria for M/S services or technologies because InterQual monitors more than 3,000 guidelines, guideline issuers and medical societies for newly published medical literature, and an independent clinical review panel drawn from more than 1,000 experts provides authoritative peer review. The M/S and MH/SUD medical necessity criteria sets apply to specific clinical conditions and do not overlap.

Review of processes to develop and approve *internal* medical necessity criteria.

MTAC develops and approves medical clinical policies for M/S services or technologies. MTAC uses scientifically based clinical evidence and the *UHC Hierarchy of Clinical Evidence* in its development, assessment, and approval processes. MTAC conducts its processes in a timely manner to ensure transparency and consistency, and to identify safe and effective M/S services or technologies for members.

CQOC (and CTAC for EIU technologies) develops and approves behavioral clinical policies for MH/SUD services and technologies. CQOC/CTAC uses scientifically based clinical evidence and the *Behavioral Health Hierarchy of Clinical Evidence* in its development, assessment, and approval processes. CQOC/CTAC conducts its processes in a timely manner to ensure transparency and consistency, and to identify safe and effective MH/SUD services and technologies for members.

When assessing services and technologies used to treat M/S and MH/SUD conditions, both MTAC and CQOC/CTAC first look for any strong and compelling scientific evidence such as statistically robust, well-designed, randomized, controlled, trials and cohort studies. In addition, MTAC will look for multi-site observational studies and single site observational studies. CQOC/CTAC will also look for systematic reviews and meta-analyses, large prospective trials, cross-sectional studies,

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retrospective studies, surveillance studies, case reviews/case series, anecdotal/editorial statements, and professional opinions.

In the absence of any strong and compelling scientific evidence, MTAC and CQOC/CTAC assess services and technologies by looking for any national consensus statements and/or publications by recognized authorities such as clinical position papers published by professional specialty societies and CMS NCDs.

Neither MTAC nor CQOC/CTAC will deem a technology unproven solely based on a lack of randomized controlled trials, particularly for new and emerging technologies.

Both M/S and MH/SUD committees use comparable evidentiary standards and sources to evaluate clinical efficacy, safety, and appropriateness of the proposed services and technologies to develop or approve medical/behavioral clinical policies.

Review of Medical Necessity Processes

M/S and MH/SUD clinical reviewers follow a hierarchy of authority when making medical necessity determinations. Both M/S and MH/SUD clinical reviewers follow the established process of reviewing state/federal laws and regulations, followed by Plan documents when making clinical coverage benefit determinations (see enclosed M/S *Applying Benefit Plan and Review Criteria Standard Operating Procedure* and MH/SUD *Clinical Criteria Development Selection and Application Policy*). Internally developed clinical policies or externally developed third party medical necessity criteria are then reviewed. The criteria chosen for review are based on the treatment type, diagnosis, and services requested. As there is no duplication between internally and externally developed medical necessity criteria, M/S and MH/SUD clinical reviewers do not have to make a choice between using internal or external medical necessity criteria.

The Plan generally assesses the appropriate application of its medical necessity criteria in operation by comparing the results of its mandatory M/S and MH/SUD Inter-Rater Reliability (IRR) assessment outcomes.

In Operation

The Plan conducted a comparative analysis of the strategies, processes, factors, evidentiary standards, and source information MH/SUD uses to

- develop internal, objective, evidence-based, behavioral clinical policies and
- approve third-party, externally developed clinical criteria

to the strategies, processes, factors, evidentiary standards, and source information M/S uses to:

- develop internal, objective, evidence-based, medical clinical policies and
- approve third-party, externally developed clinical criteria

for use in UM clinical coverage determinations and found they were comparable to, and no more stringently applied than, the strategies, processes, factors, evidentiary standards, and source information used by M/S “in operation.”

Review of Factor and Evidentiary Standards

When reviewing and developing medical/behavioral clinical policies and medical necessity criteria, M/S and MH/SUD committees both consider clinical efficacy, safety, and appropriateness of the proposed services and technologies. The *UHC* and *Behavioral Health Hierarchies of Clinical Evidence* are comparable. The factors and evidentiary standards were applied to both M/S and MH/SUD services and technologies comparably and not more stringently to MH/SUD services than to M/S services and technologies “in operation.”

Review of Operational Policies and Procedures

The Plan reviewed M/S and MH/SUD operational policies and procedures to confirm comparability and found MH/SUD policies, procedures, and processes to be comparable and no more stringent than M/S policies, procedures, and processes. The M/S *Clinical Review Criteria Operational Policy* and MH/SUD *Clinical Criteria Development/Selection and Application Policy* outline the processes to ensure medical necessity criteria are developed consistently. Second level, or peer review, determinations include clinical judgment; the M/S *Peer Clinical Review Operational Policy* and the MH/SUD

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Management of Behavioral Health Benefits Policy outline the processes. Clinicians use their clinical judgment when they apply evidence-based medical necessity criteria to each member's specific clinical condition. Clinicians use their independent clinical judgment when they evaluate whether the member's clinical condition meets the medical necessity criteria per the applicable externally developed medical necessity criteria or internal medical/behavioral clinical policies. Further, review of the committee charters confirms that both committees are comprised of licensed clinicians with applicable specialties and are chaired by executive-level medical directors.

Review of process to develop and approve medical necessity criteria

The strategy for developing and approving medical necessity criteria is comparable for both M/S and MH/SUD and applied no more stringently to MH/SUD services and technologies. The Plan conducted a review of the M/S and MH/SUD processes to confirm comparability. The review focused on the following aspects of the process for both M/S and MH/SUD:

- The committees follow standard processes outlined in their respective charters and apply their respective *Hierarchies of Clinical Evidence* when developing, assessing, and approving medical/behavioral clinical policies and medical necessity criteria.
 - MTAC reviewed and approved the use of third-party externally developed medical necessity criteria and developed new medical clinical policies when external criteria were not available
 - NMCMC reviewed and validated the MTAC assessment and approval of medical necessity criteria.
 - Similarly, CQOC reviewed and approved the use of third-party externally developed medical necessity criteria and developed new behavioral clinical policies when external criteria were not available.
 - CTAC developed behavioral clinical policies for EIU.
 - CQOC reviewed and approved EIU behavioral clinical policies developed by CTAC
- If NMCMC or CQOC determine that any internally developed medical/behavioral clinical policies are not appropriately supported by clinical evidence, then NMCMC or CQOC refer the medical necessity criteria back to MTAC or CTAC.

Review of Use of Medical Necessity Criteria

M/S and MH/SUD utilize medical and behavioral clinical policies and medical necessity criteria when making medical necessity clinical coverage benefit determinations related to M/S and MH/SUD services and technologies. All M/S and MH/SUD clinical staff and peer reviewers who make clinical coverage benefit determinations utilizing medical and behavioral clinical policies and medical necessity criteria are required to participate in an IRR assessment to ensure clinical policies and medical necessity criteria are applied in a consistent and appropriate manner "in operation." Clinical staff are required to achieve a passing score of at least 90%. The IRR assessment process identifies areas of improvement for clinical staff who do not achieve a passing score and additional training is provided on the use and application of the relevant policies. If necessary, remediation planning, and training will be directed by a supervisor/manager.

Second level, or peer review, medical necessity benefit coverage determinations include clinical judgment. The M/S *Peer Clinical Review Operational Policy* and the MH/SUD *Management of Behavioral Health Benefits Policy* outline the processes. Clinicians use their clinical judgment when they apply evidence-based medical necessity criteria to each member's specific clinical condition. Clinicians use their independent clinical judgment when they evaluate whether the member's clinical condition meets the medical necessity criteria per the applicable externally developed medical necessity criteria or internal medical/behavioral clinical policies.

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Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan's or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The findings of the Plan's analyses confirmed the strategies, processes, factor, evidentiary standards, and source information used to develop MH/SUD medical necessity criteria and behavioral clinical policies and review externally developed criteria were comparable to, and applied no more stringently than, the strategies, processes, factor, evidentiary standards, and source information used to develop the M/S medical necessity criteria and medical clinical policies and review externally developed criteria "as written" and "in operation."

The MH/SUD policies, procedures, and processes were found to be comparable and no more stringent than M/S policies, procedures, and processes.

The Plan used comparable processes and methodologies to assess and develop internal medical/behavioral clinical policies and externally developed medical necessity criteria.

M/S and MH/SUD clinical reviewers follow the same established process of reviewing state/federal laws and regulations, followed by Plan documents when making clinical coverage benefit determinations. Further, all M/S and MH/SUD clinical staff who recommend or make clinical coverage determinations are required to take and pass an annual IRR assessment on the tools they use. The 2022 IRR M/S results were 97% and MH/SUD results were 96%, demonstrating that M/S and MH/SUD clinical reviewers appropriately applied medical and behavioral clinical policies/medical necessity criteria when making medical necessity clinical coverage determinations.

The Plan's Medical Necessity definitions for M/S and MH/SUD are the same, as published in the Plan documents. Additionally, both M/S and MH/SUD clinical reviewers follow the established process of reviewing state/federal laws and regulations, followed by Plan documents and then medical/behavioral clinical policies when making clinical coverage benefit determinations.

Conclusions

The Plan concluded the methodologies used to develop MH/SUD internal evidence-based behavioral clinical policies and approve MH/SUD externally developed medical necessity criteria for use in medical necessity clinical coverage benefit determinations were comparable to, and applied no more stringently than, the methodologies used to develop M/S internal evidence-based medical clinical policies and approve M/S externally developed medical necessity criteria for use in medical necessity clinical coverage benefit determinations both "as written" and "in operation."

Overview

Pursuant to a federal law called the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical and surgical (M/S) benefits. This generally means that financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA protections include:

- Financial requirements such as, deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs, which may limit the scope or duration of benefits for treatment under a plan or coverage.

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors considered in the design and application of the NQTL (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTLs

The Plan assesses the adequacy of its network based on regulatory requirements.

This document includes the following information:

- Process for both M/S and MH/SUD network management – network adequacy
- Description of the NQTL and application (Step 1)
- Factors used to facilitate network management – network adequacy for both M/S and MH/SUD (Step 2)
- Evidentiary standards and sources used to define and/or trigger each of the identified factors (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

The Plan concludes M/S and MH/SUD network management – network adequacy processes are comparable and applied to MH/SUD no more stringently both “as written” and “in operation.”

Process

The Plan assesses network adequacy based on access standards that are in accordance with the Centers for Medicare & Medicaid Services (CMS) and/or applicable state laws. When determining whether to recruit providers in a given geographic market (such as a county or metropolitan area), the Plan considers network adequacy and access reports.

Key steps in the network management process for both M/S and MH/SUD services include:

- The Plan determines Time, Distance, and Provider Threshold requirements based on state/federal requirements
- The Plan conducts M/S and MH/SUD network adequacy reporting (by state/county) to determine if Time, Distance, and Provider Threshold requirements are met
- If network adequacy requirements are not met, the Plan actively seeks to add providers to the network in that specialty or provider type

For M/S and MH/SUD, the Plan conducts M/S and MH/SUD network adequacy reporting (by state/county) on a regular basis (no less than quarterly) to determine if Time, Distance, and Provider Threshold requirements are met. The network adequacy report incorporates both M/S and MH/SUD provider specialties. M/S and MH/SUD utilize the network adequacy report and ensure that the Network Variation Tracker (NVT) and Analytics tools are used when inconsistencies are identified.

For M/S, the results of the network adequacy report are sent to the UnitedHealthcare Network (UHN) Regional Director of Network Deficiencies through an NVT. If network gaps are identified, a network recruitment plan is developed by the M/S Provider Relations and Contracting teams.

For MH/SUD, the results of the network adequacy report are sent to the National Quality Improvement Committees (NQIC) as well as the respective Health Plan Oversight Committee through the NVT. The Health Plan Oversight Committee assesses and reviews the results and recommends interventions, as needed. If a network gap is identified, a network recruitment plan is developed by the MH/SUD Provider Relations and Contracting teams.

For M/S and MH/SUD, if there is a validated/confirmed supply gap, the Plan language for both M/S and MH/SUD allows members to seek an exception and receive services from an out-of-network (OON) provider at the in-network (INN) benefit level.

The Plan notes that MH/SUD network adequacy standards are reviewed during the product filing and/or annual reporting process by the regulator as applicable.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- Network Management – Network Adequacy

Benefit Classification(s)

- Applies to all INN, inpatient and outpatient services

Plan(s) at Issue

- Applies to all Plans

Plan Terms/Source Document(s)

Per the Plan's member portal, "UnitedHealthcare networks consist of a variety of primary care and behavioral professionals, specialists, hospitals, and other facilities. To help provide members with reasonable access to providers who meet their needs, we look at the number of providers and the types of services offered within a geographic area. Additionally, we conduct an assessment of how well the network meets members' cultural needs and preferences, as well as any special healthcare needs. We make outreach to providers, as needed, in order to recruit them to our network. We also accept requests from employers, members, and providers to accommodate needs and preferences." (<https://www.uhc.com/legal/provider/commercial-plans>)

List of M/S and MH/SUD Benefits Subject to NQTL

Applies to all INN M/S and MH/SUD services

Step 2 – Factors Used in the Design and Application of the NQTLs

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

The Plan relies on the following factors to determine network adequacy. These factors apply to both M/S and MH/SUD benefits in the following classifications:

- I. M/S INN inpatient/outpatient services
 - II. MH/SUD INN inpatient/outpatient services
- State-specific standards (Quantitative)
 - When state regulations identify a quantifiable network adequacy measurement for geographic and numeric availability of providers

Applies to both M/S and MH/SUD services.

- Centers for Medicare & Medicaid Services (CMS)/Health Services Delivery (HSD) table (Quantitative)

Applies to both M/S and MH/SUD services.

The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factors used in determining network adequacy. These evidentiary standards and sources apply to the following benefit classifications:

- I. M/S INN inpatient/outpatient services
- II. MH/SUD INN inpatient/outpatient services

Factor – State-specific standards is defined as state regulations identifying a quantifiable network adequacy measurement for geographic and numeric availability of providers.

The Plan's evidentiary standard and source that defines and/or triggers the identification of the factor:

- Applicable state regulatory requirements

These evidentiary standards and sources apply to both M/S and MH/SUD INN inpatient/outpatient services. This evidentiary standard and source is defined in a quantitative manner.

Factor – Centers for Medicare & Medicaid Services (CMS)/Health Services Delivery (HSD) table is defined as CMS guidance for time/distance standards for various types of providers and facilities.

The Plan's evidentiary standard and source that defines and/or triggers the identification of the factor:

- CMS/HSD table (located under downloads in the following website: cms.gov/medicare/medicare)

[advantage/medicareadvantageapps\)](#)

These evidentiary standards and sources apply to both M/S and MH/SUD INN inpatient/outpatient services. This evidentiary standard and source is defined in a quantitative manner.

These evidentiary standards and sources are applicable to both M/S and MH/SUD services. In addition, all of these standards/sources are considered and used to define the factors.

Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

As Written

The Plan conducted a comparative analysis of the strategies, processes, factors, evidentiary standards, and source information used to determine network adequacy for M/S and MH/SUD “as written.” The Plan identified that the factors and evidentiary standards used as the basis for determining network adequacy apply to both M/S and MH/SUD.

Both M/S and MH/SUD run network adequacy reports no less than quarterly to assess the continued adequacy of the network. These reports compare the provider network against network adequacy standards, which are in accordance with CMS and/or applicable state established time and distance thresholds. If a network adequacy report identifies a potential network gap, both M/S and MH/SUD network teams will work to close the gap through provider recruitment.

Both M/S and MH/SUD have processes in place to authorize benefit coverage at the INN benefit level for services provided by an OON provider upon member or provider request if a validated/confirmed supply gap is identified.

In Operation

The Plan conducted a comparative analysis of the methodology and process MH/SUD used to assess network adequacy to determine whether the methodology and process is comparable to, and applied no more stringently than, the methodology and process M/S used to assess network adequacy “in operation.” The analysis confirmed the methodology and process the Plan used to assess MH/SUD network adequacy is comparable to, and applied no more stringently than, the methodology and process the Plan used to assess M/S network adequacy “in operation.”

M/S and MH/SUD network teams both review network adequacy data no less than quarterly, and if there is a gap identified, both M/S and MH/SUD network teams work to close the gap through provider recruitment.

The outcomes of the network adequacy review are discussed at least quarterly and include findings and subsequent planned actions and interventions for provider recruitment.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The above analysis confirmed the strategies, processes, factors, evidentiary standards, and source information used to determine MH/SUD network adequacy were comparable to, and applied no more stringently than, the strategies, processes, factors, evidentiary standards, and source information used to determine M/S network adequacy “as written.”

Both MH/SUD and M/S run network adequacy reports at least quarterly which are in accordance with CMS and/or state established time and distance thresholds to assess the continued adequacy of the network. Additionally, both M/S and MH/SUD have processes in place to authorize benefit coverage at the INN benefit level for services provided by an OON provider if a network gap is identified. When a network gap is identified, the Plan will work with the member’s network provider to coordinate care through an OON provider.

In addition, the above analysis revealed the process and methodology MH/SUD used to assess network adequacy “in operation” was comparable to, and applied no more stringently than, the process and methodology M/S used to assess network adequacy.

Conclusions

In light of the above findings, the Plan concluded the M/S and MH/SUD network management – network adequacy processes are applied to M/S and MH/SUD networks comparably and are applied no more stringently to MH/SUD both "as written" and "in operation.”

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Overview

Pursuant to a federal law called the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical and surgical (M/S) benefits. This generally means that financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA protections include:

- Financial requirements, such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

Out-of-network (OON) emergency care reimbursement is the process by which the Plan establishes reimbursement for OON emergency claims as defined in the member’s plan documents. The methodologies applicable to emergency services reimbursement may also be applicable to reimbursement for out of network services provided in network facilities.

This document includes the following information:

- Process for establishing OON emergency care reimbursement rates for both M/S and MH/SUD services
- The description of the NQTL and application (Step 1)
- Factors used to determine which services are subject to the NQTL (Step 2)
- Evidentiary standards and sources used to define, trigger and/or implicate a factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

The analysis refers to the following attachments:

- *Certificates of Coverage* (COC23-INS-2018-LG-GA, COC23-INS-2018-SG-GA, COC23-HMO-2018-LG-GA, COC23-HMO-2018-SG-GA, COC23-INS-RV-2018-LG-GA, COC23-INS-RV-2018-SG-GA, Policy23-HMO-2022-IEG-GA) Plan document that explains covered services, terms, conditions, and limitations of the member’s policy
- *Schedule of Benefits* (for example: *Schedule of Benefits SBN23-Medical-INS-2018-[Choice+Plus][Select+Plus][Doctors+Plus]-LG-GA*, *SBN23-Medical-INS-2018-[Choice+Plus][Select+Plus][Doctors+Plus]-SG-GA*, *SBN23-Medical-INS-RV-2018-HeritagePlus-LG-GA*, *SBN23-Medical-INS-RV-2018-HeritagePlus-SG-GA*, and *SBN23-Medical-HMO-2022-IEG-GA-ADV*) - Plan document that outlines member responsibilities

The Plan concludes that its methodology for establishing M/S and MH/SUD OON emergency care services reimbursement rates is comparable and applied no more stringently for MH/SUD than for M/S both “as written” and “in operation.”

Process

For both M/S and MH/SUD emergency care services, the Plan uses a comparable process to establish reimbursement rate(s).

Key steps in the OON emergency care reimbursement rate process for both M/S and MH/SUD conditions include:

- OON emergency services reimbursement methodologies are created in accordance with state and federal requirements
- The OON emergency services reimbursement methodology is applied as one singular reimbursement structure for OON emergency services for both M/S and MH/SUD conditions
- The Plan adheres to the OON emergency care reimbursement methodology when making an OON claims payment

The Plan determines reimbursements for OON emergency care services in accordance with state and federal regulatory requirements. These requirements may govern reimbursement for OON providers of services at in-network (INN) facilities. The methodology used to reimburse OON emergency care services applies to emergency services rendered for the treatment of both M/S and MH/SUD conditions. The OON reimbursement methodology exists as a singular structure and applies to both M/S and MH/SUD. OON benefit programs are defined in the *Certificate of Coverage* and/or *Schedule of Benefits*.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- OON Emergency Care Reimbursement

Benefit Classification(s)

- OON, emergency care

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHIC)
- UnitedHealthcare of Georgia, Inc. (UHCGA)
- UnitedHealthcare Insurance Company of the River Valley (UHICRV)
- UnitedHealthcare of Georgia, Inc. Individual Exchange Medical Policy (UHC GA)

Plan Terms/Source Documents

The Plan's *Certificate of Coverage* defines emergency health care services.

UHIC/UHCGA

“Emergency Health Care Services - with respect to an Emergency:

- An appropriate medical screening exam (as required under section 1867 of the *Social Security Act* or as would be required under such section if such section applied to an Independent Freestanding Emergency Department) that is within the capability of the emergency department of a Hospital, or an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency, and
- Such further medical exam and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital or an Independent Freestanding Emergency Department, as applicable, as are required

Out-of-Network Reimbursement: Out-of-Network Emergency Care Non-Quantitative Treatment Limitations
Analysis



GA – UnitedHealthcare Insurance Company, UnitedHealthcare of Georgia, Inc., UnitedHealthcare Insurance Company of the River Valley, and UnitedHealthcare of Georgia, Inc. Individual Exchange Medical Policy
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under section *1867 of the Social Security Act*, or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient. regardless of the department of the Hospital in which such further exam or treatment is provided). For the purpose of this definition, "to stabilize" has the meaning as given such term in section *1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3))*.

Emergency Health Care Services include items and services otherwise covered under the Policy when provided by an out-of-Network provider or facility (regardless of the department of the Hospital in which the items and services are provided) after the patient is stabilized and as part of outpatient observation, or an Inpatient Stay or outpatient stay that is connected to the original Emergency, unless each of the following conditions are met:

- a) The attending Emergency Physician or treating provider determines the patient is able to travel using nonmedical transportation or non-Emergency medical transportation to an available Network provider or facility located within a reasonable distance taking into consideration the patient's medical condition.
- b) The provider furnishing the additional items and services satisfies notice and consent criteria in accordance with applicable law.
- c) The patient is in such a condition to receive information as stated in b) above and to provide informed consent in accordance with applicable law.
- d) The provider or facility satisfies any additional requirements or prohibitions as may be imposed by state law.
- e) Any other conditions as specified by the Secretary.

The above conditions do not apply to unforeseen or urgent medical needs that arise at the time the service is provided regardless of whether notice and consent criteria has been satisfied.”

UHCRV/UHC GA

“Emergency Health Care Services - with respect to an Emergency:

- A medical screening exam (as required under section 1867 of the Social Security Act or as would be required under such section if such section applied to an Independent Freestanding Emergency Department) that is within the capability of the emergency department of a Hospital or an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency, and
- Such further medical exam and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital or an Independent Freestanding Emergency Department, as applicable, as are required under section *1867 of the Social Security Act*, or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further exam or treatment is provided).
- Emergency Health Care Services include items and services otherwise covered under the Policy when provided by an out-of-Network provider or facility (regardless of the department of the Hospital in which the items and services are provided) after the patient is stabilized and as part of outpatient observation, or an Inpatient Stay or outpatient stay that is connected to the original Emergency, unless each of the following conditions are met:
 - a) The provider or facility, as described above, determines the patient is able to travel using nonmedical transportation or non-Emergency medical transportation.
 - b) The provider furnishing the additional items and services satisfies notice and consent criteria in accordance with applicable law.
 - c) The patient is in such a condition to receive information as stated in b) above and to provide informed consent in accordance with applicable law.
 - d) Any other conditions as specified by the Secretary.”

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The Plan's *Schedule of Benefits* informs Members of how OON Emergency Health Care Services are reimbursed.

"Emergency Health Care Services provided by an out-of-Network provider will be reimbursed as set forth under Allowed Amounts as described at the end of this Schedule of Benefits.

List of M/S and MH/SUD Services Subject to NQTL

- OON facility and professional emergency services for the treatment of M/S and MH/SUD conditions
- OON professional services provided in network facilities

Step 2 – Factors Used in the Design and Application of the NQTLs

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

The Plan relies on the following factor to determine OON emergency care reimbursement rates for M/S and MH/SUD conditions. These factors apply to both M/S and MH/SUD benefits in the following classifications:

- I. OON emergency services for M/S conditions
- II. OON emergency services for MH/SUD conditions

- State and Federal Regulations (Qualitative)
Applies to both M/S and MH/SUD conditions

As there is only one factor, the weight of the factor is not applicable.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factor used in determining OON emergency care reimbursement rates. The evidentiary standards and sources apply to the following benefit classifications:

- I. OON emergency services for M/S conditions
- II. OON emergency services for MH/SUD conditions

Factor – State and Federal Laws and Regulations is defined as a set of rules to establish standards for healthcare transactions

The Plan's evidentiary standards and sources that define and/or trigger the identification of the factor:

- No Surprises Act reimbursement methodology less INN member cost share:
 - An amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act;
 - If there is no such applicable All-Payer Model Agreement, an amount determined by a specified state law; or
 - If there is no such applicable All-Payer Model Agreement or specified state law, the lesser of the billed charge or the Plan's or issuer's median contracted rate (a/k/a qualifying payment amount (QPA)) for the same or similar item

GA – UnitedHealthcare Insurance Company, UnitedHealthcare of Georgia, Inc., UnitedHealthcare Insurance Company of the River Valley, and UnitedHealthcare of Georgia, Inc. Individual Exchange Medical Policy
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or service in the relevant geographic region

- Applicable state law
- Reimbursement amount determined by applicable All-Payer Model Agreement
- Reimbursement amount determined by applicable state law
- Contracted rates for the same or similar items or services provided by facilities of the same or similar facility type in the relevant geographic region

These evidentiary standards and sources apply to both M/S and MH/SUD OON emergency services. These evidentiary standards and sources are defined in a qualitative manner.

The factor and evidentiary standards used as the basis for establishing OON emergency care reimbursement for MH/SUD conditions are comparable to, and applied no more stringently than, the factor and evidentiary standards used as the basis for establishing OON emergency care reimbursement for M/S conditions "as written" and "in operation." As there is only one factor, the weight of the factor is not applicable.

Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

As Written

The Plan conducted a comparative analysis of the strategies, processes, factors, evidentiary standards, and source information used to establish reimbursement for OON emergency care for M/S and MH/SUD conditions “as written.” The Plan identified the factor and evidentiary standards used as the basis for determining M/S and MH/SUD OON emergency care reimbursement.

OON reimbursement is defined in the plan documents. Language defining the OON reimbursement methodologies reflects a singular structure and is inclusive of M/S and MH/SUD conditions. Plan benefits are administered according to the singular structure for all OON services.

The Plan applies the factor, sources, and evidentiary standards for each reimbursement methodology to both M/S and MH/SUD conditions. Both use state and/or federal requirements to establish OON emergency care reimbursement rates.

In Operation

The Plan conducted a comparative analysis of the methodology and process used to establish OON reimbursement for MH/SUD emergency care to determine whether the methodology and process is comparable to, and applied no more stringently than, the methodology and process used to establish OON reimbursement for M/S emergency care “in operation.”

The methodology used for determining provider reimbursements for OON emergency care applies to both M/S and MH/SUD conditions.

GA – UnitedHealthcare Insurance Company, UnitedHealthcare of Georgia, Inc., UnitedHealthcare Insurance Company of the River Valley, and UnitedHealthcare of Georgia, Inc. Individual Exchange Medical Policy
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Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The findings of the comparative analysis revealed the process and methodology used for OON emergency care reimbursement for MH/SUD conditions “as written” and “in operation” was comparable to, and applied no more stringently than, the process and methodology used for OON emergency care reimbursement for M/S conditions.

Conclusions

Based upon these findings, the Plan concluded the methodology and processes that the Plan uses for OON emergency care reimbursement for MH/SUD conditions was comparable to the methodology and processes that is used for OON emergency care reimbursement for M/S conditions “as written” and “in operation.”

Overview

Pursuant to a federal law called the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical and surgical (M/S) benefits. This generally means that financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA protections include:

- Financial requirements such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage.

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

Out-of-network (OON) inpatient and outpatient reimbursement is the process by which the Plan establishes reimbursement for OON inpatient and outpatient claims as defined in the member’s plan documents.

This document includes the following information:

- OON inpatient and outpatient services reimbursement process for both M/S and MH/SUD services
- The description of the NQTL and application (Step 1)
- Factors used to determine which services are subject to the NQTL (Step 2)
- Evidentiary standards and sources used to define, trigger and/or implicate a factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

The analysis refers to the following attachments:

- *Certificates of Coverage* (for example: *COC23-INS-2018-LG-GA*, *COC23-HMO-2018-LG-GA*, *COC23-INS-2018-SG-GA*, and *COC23-INS-RV-2018-LG-GA*) - Plan document that explains covered services, terms, conditions, and limitations of the member’s policy
- *Schedule of Benefits* (for example: *Schedule of Benefits SBN23-Medical-INS-2018-[Choice+Plus][Select+Plus][Doctors+Plus]-LG-GA*, *SBN23-Medical-INS-2018-[Choice+Plus][Select+Plus][Doctors+Plus]-SG-GA*, *SBN23-Medical-INS-RV-2018-HeritagePlus-LG-GA* and *SBN23-Medical-INS-RV-2018-HeritagePlus-SG-GA*) - Plan document that outlines member responsibilities

The Plan concludes that the OON inpatient and outpatient reimbursement process for M/S and MH/SUD services are comparable and applied no more stringently both “as written” and “in operation.”

Process

Key steps in the non-emergency OON inpatient and outpatient reimbursement process for both M/S and MH/SUD services include:

- OON Reimbursement methodologies are created in accordance with state and federal requirements
- The client/employer group chooses one or more of the OON reimbursement methodologies described below for use

by the Plan

- The chosen OON reimbursement methodology is applied as one singular reimbursement structure for both M/S and MH/SUD OON services. For example, if the policy elects the Maximum Non-Network Reimbursement Program (MNRP) at 110%, that is applied to all claims, both M/S and MH/SUD
- The Plan adheres to the selected OON reimbursement methodology for both M/S and MH/SUD claims when making an OON payment

OON benefit programs are defined in the *Certificate of Coverage* and/or *Schedule of Benefits*.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- OON reimbursement: Inpatient and outpatient services

Benefit Classification(s)

- OON, inpatient and outpatient

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHIC)
- UnitedHealthcare of Georgia, Inc. (UHCGA)
- UnitedHealthcare Insurance Company of the River Valley (UHCVR)

Plan Terms / Source Document(s)

The Plan's *Schedule of Benefits* notifies members of OON reimbursement processes.

"Out-of-Network Benefits apply to Covered Health Care Services that are provided by an out-of-Network Physician or other out-of-Network provider, or Covered Health Care Services that are provided at an out-of-Network facility.

Covered Health Care Services provided at certain Network facilities by an out-of-Network Physician, when not Emergency Health Care Services, will be reimbursed as set forth under Allowed Amounts as described at the end of this Schedule of Benefits. For these Covered Health Care Services, "certain Network facility" is limited to a hospital (as defined in 1861(e) of the Social Security Act), a hospital outpatient department, a critical access hospital (as defined in 1861(mm)(1) of the Social Security Act), an ambulatory surgical center as described in section 1833(i)(1)(A) of the Social Security Act, and any other facility specified by the Secretary."

List of M/S and MH/SUD Services Subject to NQTL

- OON inpatient and outpatient services

Step 2 – Factors Used in the Design and Application of the NQTL

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

The Plan relies on the following factors to determine OON reimbursement rates for M/S and MH/SUD inpatient and outpatient services. These factors apply to both M/S and MH/SUD benefits in the following classifications:

- I. M/S OON inpatient/outpatient services
 - II. MH/SUD OON inpatient/outpatient services
- Federal and State Regulations (Qualitative)
 - State or federal law may impact permissible out of network reimbursement options available to customers. This factor is applicable to:

- OON non-emergency inpatient or outpatient services provided in an In-Network (INN), or OON facility rendered for the treatment of M/S or MH/SUD conditions

Applies to both M/S and MH/SUD services.

- Extended Non-Network Reimbursement Program (ENRP) methodology (Quantitative) This factor is applicable to:
 - OON non-emergency inpatient or outpatient services provided in an OON facility rendered for the treatment of M/S or MH/SUD conditions processed at the INN benefit level

Applies to both M/S and MH/SUD services.

- Usual, Customary and Reasonable (UCR) (Quantitative) This factor is applicable to:
 - OON non-emergency inpatient or outpatient services provided in an OON facility rendered for the treatment of M/S or MH/SUD conditions
 - OON inpatient and outpatient services rendered for the treatment of M/S or MH/SUD conditions

Applies to both M/S and MH/SUD services.

- MNRP (Quantitative). This factor is applicable to:
 - OON non-emergency inpatient or outpatient services provided in an OON facility rendered for the treatment of M/S or MH/SUD conditions
 - OON inpatient and outpatient services rendered for the treatment of M/S or MH/SUD conditions

Applies to both M/S and MH/SUD services.

- Shared Savings (Quantitative) This factor is applicable to:
 - OON non-emergency inpatient or outpatient services provided in an INN or OON facility rendered for the treatment of M/S or MH/SUD conditions
 - OON inpatient and outpatient services rendered for the treatment of M/S or MH/SUD conditions

Applies to both M/S and MH/SUD services.

- Outlier Cost Management (OCM) (Quantitative) This factor is applicable to:
 - OON non-emergency inpatient or outpatient services provided in an INN or OON facility rendered for the treatment of M/S or MH/SUD conditions
 - OON professional services rendered for the treatment of M/S or MH/SUD conditions

Applies to both M/S and MH/SUD services.

The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factors used in determining OON reimbursement for inpatient and outpatient services. These evidentiary standards and sources apply to the following benefit classifications:

- I. M/S OON inpatient/outpatient services
- II. MH/SUD OON inpatient/outpatient services

Factor – Federal and State Laws and Regulations is defined as a set of rules to establish standards for healthcare transactions.

- The Plan's evidentiary standards and sources that define and/or trigger the identification of the factor:
 - State or federal law may impact the range of permissible out of network reimbursement options.
 - An amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act;
 - If there is no such applicable All-Payer Model Agreement, an amount determined by a specified state law; or
 - If there is no such applicable All-Payer Model Agreement or specified state law, the lesser of the billed charge or the Plan's or issuer's median contracted rate (a/k/a qualifying payment amount (QPA)) for the same or similar item or service in the relevant geographic region
 - Applicable state law
 - Reimbursement amount determined by applicable All-Payer Model Agreement
 - Reimbursement amount determined by applicable state law
 - Contracted rates for the same or similar items or services provided by facilities of the same or similar facility type in the relevant geographic region

This evidentiary standard and source applies to both M/S and MH/SUD OON inpatient/outpatient services. This evidentiary standard and source is defined in a qualitative manner.

Factor – ENRP methodology is defined as a program that can be used to determine eligible expense(s) when an OON provider is processed under the network benefits. Reimbursement under ENRP is based on a percentage of the Medicare rate.

- The Plan's evidentiary standards and sources that define and/or trigger the identification of the factor:
 - The ENRP reimbursements are based on a percentage of the Centers for Medicare & Medicaid Services (CMS) benchmark rate (e.g., Physician Fee Schedule or CMS diagnosis related group (DRG) rate) for a procedure or service type within a given geographic region
 - CMS Standards and Fee Schedules in relevant geographic market
 - CMS DRG rates allowed by CMS
 - When a rate is not published by CMS for the service, the Plan uses a gap methodology established by OptumInsight and/or a third-party vendor that uses a relative value scale or similar methodology

These evidentiary standards and sources apply to both M/S and MH/SUD OON inpatient/outpatient services. These evidentiary standards and sources are defined in a quantitative manner.

Factor – UCR is defined as a guideline for reimbursing providers based on a determination of prevailing fees per service in a specified geographical area.

- The Plan's evidentiary standards and sources that define and/or trigger the identification of the factor:
 - UCR reimbursements are based upon a percentile of Fair Health (FH) benchmark data (for professionals) and Viant (for facilities) for a procedure or service type within a given geographic region
 - Type and location of service
 - Provider type and/or specialty
 - FH benchmark rate
 - Viant benchmark rate

These evidentiary standards and sources apply to both M/S and MH/SUD OON inpatient/outpatient services. These evidentiary standards and sources are defined in a quantitative manner.

Factor –MNRP is defined as a Medicare-based methodology to reimburse the provider/facility. MNRP reimbursements are based upon a percentage of the CMS benchmark rate (e.g., Physician Fee Schedule or CMS DRG rate) for a procedure or service type within a given geographic region. The CMS Medicare Physician and Facility Fee Schedule generates one rate for each Current Procedural Technology® (CPT)/Healthcare Common Procedure Coding System (HCPCS)/DRG code. If there is no CMS rate for a particular service or facility type, the rate is gap-filled with national industry standard fee source rates. When a rate is not published by CMS for the service and a gap methodology does not apply to the service, the reimbursement rate is based on a percentage of the provider's billed charge.

- The Plan's evidentiary standards and sources that define and/or trigger the identification of the factor:
 - CMS Standards and Fee Schedules in relevant geographic market
 - CMS DRG rates allowed by CMS
 - When a rate is not published by CMS for the service, a gap methodology established by OptumInsight and/or a third-party vendor that national industry standard fee source rate or similar methodology

These evidentiary standards and sources apply to both M/S and MH/SUD OON inpatient/outpatient services. These evidentiary standards and sources are defined in a quantitative manner.

Factor – Shared Savings (MultiPlan Wrap Network) is defined as OON benefits that allow the Plan to obtain a discount off an OON provider's billed charge. It involves OON providers that have contracted with a third-party vendor to allow members access to the discount.

- The Plan's evidentiary standards and sources that define and/or trigger the identification of the factor:
 - MultiPlan (a third-party vendor)
 - MultiPlan uses the Data iSight tool to determine the pricing for claims
 - The Data iSight tool is used to determine the pricing for claims. The Data iSight tool determines the pricing based on data that is publicly available and also applies common industry-wide modifiers or adjustments. It also takes into account the geographical area, and for professional services, the relative amount of time, level of skill, and intensity of the services performed
 - Wrap Network consists of an expansive contracted vendor network
 - Fee Negotiation discounts negotiated prior to payment and administered by Multiplan

These evidentiary standards and sources apply to both M/S and MH/SUD OON inpatient/outpatient services. These evidentiary standards and sources are defined in a quantitative manner.

Factor – OCM is defined OON provider claims reimbursed at the Plan's INN level of benefits/member cost share when no other OON reimbursement program is applicable. OCM claims are initially processed using industry-recognized reimbursement methodology.

- The Plan's evidentiary standard and sources that define and/or trigger the identification of the factor:
 - MultiPlan (a third-party vendor) is used to process claims under the OCM program

- MultiPlan uses the Data iSight tool to determine the pricing for claims
- Data iSight tool is used to determine the pricing for claims. The Data iSight tool determines the pricing based on data that is publicly available and also applies common industry-wide modifiers or adjustments. It also takes into account the geographical area, and for professional services, the relative amount of time, level of skill, and intensity of the services performed.

These evidentiary standard and sources apply to both M/S and MH/SUD OON inpatient/outpatient services. These evidentiary standard and sources are defined in a quantitative manner.

The factors and evidentiary standards used as the basis for determining MH/SUD OON inpatient/outpatient reimbursement are comparable to, and applied no more stringently than, the factors and evidentiary standards used as the basis for subjecting M/S OON inpatient/outpatient reimbursement “as written” and “in operation.”

The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL.

Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

As Written

The Plan conducted a comparative analysis of the strategies, processes, factors, evidentiary standards, and source information used to determine OON reimbursement for M/S and MH/SUD inpatient/outpatient services “as written.” The Plan identified the factors and evidentiary standards used as the basis for determining M/S and MH/SUD OON inpatient/outpatient reimbursement.

OON reimbursement is defined in the Plan documents (*Schedule of Benefits*). Language defining the OON reimbursement methodologies reflect a singular structure and is inclusive of M/S and MH/SUD inpatient/outpatient services. Plan benefits are administered according to the singular structure for all OON services.

The Plan applies the strategies, processes, factors, sources, and evidentiary standards for each reimbursement methodology to both M/S and MH/SUD services. Both use one or more of the following: state, or federal requirements; ENRP, UCR, MNRP; Shared Savings; or OCM to establish OON reimbursement rates.

In Operation

The Plan compared the strategies, processes, factors, evidentiary standards, and source information used to determine M/S and MH/SUD ONN inpatient/outpatient services reimbursement “in operation.”

The methodologies for determining OON provider reimbursements for services and treatments apply to both MH/SUD and M/S.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The findings of the comparative analysis revealed the process and methodology MH/SUD used to determine OON inpatient and outpatient reimbursement “as written” and “in operation” was comparable to, and applied no more stringently than, the process and methodology M/S used to determine OON inpatient and outpatient reimbursement.

Conclusions

Based upon these findings, the Plan concluded the methodology and processes that M/S and MH/SUD use to determine OON reimbursement was comparable “as written” and “in operation.”

Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical and surgical (M/S) benefits. This generally means that financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits must be comparable to and cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA protections include:

- Financial requirements such as, deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs, which may limit the scope or duration of benefits for treatment under a plan or coverage

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

Prescription Drug List (PDL) a/k/a formulary design is a component of the Plan’s utilization management (UM) program. The goal of PDL/formulary design is to assess the prescription drug’s place in therapy.

This document includes the following information:

- PDL process for both M/S and MH/SUD prescription drugs
- The description of the NQTL and application (Step 1)
- Factors used to determine prescription drugs tier placement and/or benefit coverage (Step 2)
- Evidentiary standards and sources used to define, trigger and/or implicate a factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

This analysis does not refer to any attachments.

The Plan concludes that the PDL/formulary design requirements for M/S and MH/SUD are comparable and applied no more stringently for prescription drug benefits both “as written” and “in operation.”

Process

The Pharmacy & Therapeutics (P&T) Committee assesses a prescription drug’s place in therapy and its relative safety and efficacy in order to provide a clinical recommendation/designation used in determining coverage and tier assignment. The P&T Committee is comprised of individuals from diverse clinical disciplines, including, behavioral health. Additional physician specialists with specific expertise are consulted as part of the clinical evaluation of new and existing drugs.

The Pharmacy & Therapeutics Committee consists of physicians specializing in Obstetrics & Gynecology, Endocrinology/Metabolism, Hematology/Oncology, Rheumatology, Geriatrics, Cardiology, Gastroenterology, Psychiatry, Pediatrics & Internal Medicine, and Internal Medicine. The committee also consists of 4 pharmacists, one of which specializes in Geriatrics & Psychiatry. There is a requirement that the committee consist of at least one physician specializing in psychiatry.

To approve clinical drug policies, the established committee follows a standard process. The P&T Committee evaluates the FDA approved product labeling, peer-reviewed medical literature, published clinical practice guidelines, including randomized clinical trials, drug comparison studies, outcomes research data, pharmacoeconomic studies, comparisons of efficacy, side effects, potential for off-label use and claims data analysis, as relevant, as part of the review and approval process of clinical policies. The P&T Committee assesses external clinical evidence and nationally recognized evidence-based guidelines and benchmarks, as well as a prescription drug's place in therapy, and its relative safety and efficacy to approve clinical drug policies for select M/S and MH/SUD prescription drugs.

The UnitedHealthcare (UHC) Prescription Drug List Management Committee (PDL MC) makes tiering decisions by considering clinical, economic/financial and pharmacoeconomic evidence for populations with an incentive based PDL. The PDL MC makes benefit exclusion decisions using the same types of evidence. This information is provided by UHC Evidence Based Decision Support Committees, including but not limited to, the UHC P&T Committee as outlined above.

PDL a/k/a formulary design is based on the Plan's policy to assign tiers for prescription drugs. Newly launched generic prescription drugs are also reviewed to determine initial tier placement on the PDL and/or benefit coverage. A generic prescription drug includes a prescription drug that is chemically equivalent to a brand drug or that the Plan identifies as a generic based on available data resources including, but not limited to, the daily Medi-Span file load memo that classifies drugs as either brand or generic based on several factors. Generics will be considered for initial tier placement and/or benefit coverage equal to that of the current placement of the brand prescription drug.

The Plan reviews the number of M/S and MH/SUD prescription drugs by tier on a tri-annual basis. The results are reviewed with the UM Committee to determine if any changes should be made in the PDL/formulary design.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- PDL a/k/a Formulary Design

Benefit Classification(s)

- Prescription Drugs

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHIC)
- UnitedHealthcare of Georgia, Inc. (UHCGA)
- UnitedHealthcare Insurance Company of the River Valley (UHICRV)

Plan Terms

- "Benefits are available for Prescription Drug Products at a Network Pharmacy and are subject to Copayments and/or Co-insurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is placed."

List of M/S and MH/SUD Services Subject to NQTL

- All prescription drugs are part of the Plan's PDL a/k/a formulary design
- The PDLs generally contain brand and generics that provide the highest overall value on Tiers 1 and 2, with brand and generics that provide the lowest overall value on Tiers 3 and 4

Step 2 – Factors Used to Determine Formulary Design Applies

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

The Plan relies on the following factors to determine the PDL for both M/S and MH/SUD prescription drugs:

- Assessment of the prescription drug's place in therapy (Qualitative)
 - Goal is to promote optimal drug use based on review of FDA approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off-label use and claims data analysis

Applies to M/S and MH/SUD prescription drugs

- Relative safety and efficacy (Qualitative)
 - Goal is to promote optimal drug use by performing a comprehensive efficacy comparison as well as reviewing the type and frequency of side effects and potential drug interactions among alternative drug products

Applies to M/S and MH/SUD prescription drugs

- Available therapeutic equivalent prescription drugs (Quantitative)
 - Goal is to promote optimal drug use in therapeutic classes with several alternative drug products. A trial of clinically appropriate, lower cost alternative(s) may be appropriate prior to coverage of a more expensive alternative

Applies to M/S and MH/SUD prescription drugs

The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL. The factors apply to both M/S and MH/SUD prescription drugs.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factors used in determining the PDL. These evidentiary standards and sources apply to both M/S and MH/SUD prescription drugs.

Factor – Assessment of the prescription drug's place in therapy

- The Plan's evidentiary standard and source that defines and/or triggers the assessment of the prescription drug's place in therapy factor:
 - FDA-approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off-label use, and claims data analysis as relevant

This evidentiary standard and source applies to both M/S and MH/SUD prescription drugs and is defined in a qualitative manner.

Factor – Relative safety and efficacy

- The Plan’s evidentiary standard and source that defines and/or triggers the relative safety and efficacy factor:
 - FDA approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off label use and claims data analysis as relevant

This evidentiary standard and source applies to both M/S and MH/SUD prescription drugs and is defined in a qualitative manner.

Factor – Available therapeutic equivalent prescription drugs

- The Plan’s evidentiary standard and source that defines and/or triggers the available therapeutic equivalent prescription drugs factor:
 - FDA-approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off-label use, and claims data analysis as relevant

This evidentiary standard and source applies to both M/S and MH/SUD prescription drugs and is defined in a quantitative manner.

The factors and evidentiary standards used as the basis for determining the PDL for MH/SUD prescription drugs are comparable to, and applied no more stringently than, the factors used as the basis for determining the PDL for M/S prescription drugs “as written” and “in operation.” The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL.

Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer’s analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert’s qualifications and the extent to which the Plan or issuer ultimately relied upon each expert’s evaluations in setting recommendations regarding both.

As Written

The Plan compared the strategies, processes, factors, evidentiary standards, and source information used to determine which M/S and MH/SUD prescription drugs are subject to PDL a/k/a formulary design “as written.”

The Plan identified the shared factors and evidentiary standards used as the basis for subjecting M/S and MH/SUD benefits to formulary design for prescription drugs. The factors and evidentiary standards are applied to both M/S and MH/SUD prescription drugs comparably and not more stringently to MH/SUD prescription drugs.

Review of Operational Policies and Procedures

The P&T Committee assesses the prescription drug’s place in therapy and its relative safety and efficacy in order to provide a clinical recommendation/designation used in determining coverage and tier assignment. The UHC PDL MC makes tiering and benefit exclusion decisions by considering clinical, economic/financial and pharmacoeconomic evidence for populations with an incentive based PDL. The PDL MC makes benefit exclusion decisions using the same types of evidence.

The P&T Committee is comprised of individuals from diverse clinical disciplines including, behavioral health. Additional physician specialists with specific expertise are consulted as part of the clinical evaluation of new and existing drugs.

The P&T Committee consists of physicians specializing in Obstetrics & Gynecology, Endocrinology/Metabolism, Hematology/Oncology, Rheumatology, Geriatrics, Cardiology, Gastroenterology, Psychiatry, Pediatrics & Internal Medicine, and Internal Medicine. The committee also consists of 4 pharmacists, one of which specializes in Geriatrics & Psychiatry.

Physician specialists with specific expertise are consulted for clinical evaluation of a drug using P&T committee members if the specific specialty is represented and outside consultants are used if the specialty is not represented in the P&T committee. As part of the clinical evaluation of new drugs or for some existing drugs with new evidence, these consults are routinely done.

In Operation

The Plan compared the strategies, processes, factors, evidentiary standards, and source information used to determine which M/S and MH/SUD prescription drugs are subject to formulary design “in operation.”

The Plan reviewed the number of M/S and MH/SUD prescription drugs by tier on a tri-annual basis. The results are reviewed by the UHC UM Committee to determine if any changes should be made in the PDL/formulary design.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The findings of the analysis revealed the strategies, processes, factors, evidentiary standards, and source information the Plan used to administer the PDL a/k/a formulary design for MH/SUD prescription drugs were comparable to, and applied no more stringently than, the strategies, processes, factors, evidentiary standards, and source information used to administer the PDL a/k/a formulary design for M/S prescription drugs “as written.”

Further, both M/S and MH/SUD utilize generally accepted types of data, evidentiary sources, and trend analyses to create and maintain the PDL/formulary design.

The Plan evaluates the number of M/S and MH/SUD prescription drugs by tier on a tri-annual basis.

The findings of the analysis revealed for all prescription drugs covered under the pharmacy benefit, the Plan uses the same PDL MC to determine tier placement and/or benefit coverage. The Committee does not distinguish between M/S and MH/SUD prescription drugs, and the processes are administered in the same fashion and not applied more stringently to MH/SUD prescription drugs. The tiering for M/S and MH/SUD prescription drugs shows the majority are placed on Tiers 1 and 2 allowing for easier access and is in compliance with MHPAEA.

The findings of the Prescription Drug Tier Analysis (see data below) indicated the percent of prescription drugs by tiers for MH/SUD prescription drugs were comparable to the percent of prescription drugs by tiers for M/S prescription drugs. Data is for (January, May, and September 2022). The Plan also notes that the U.S. Department of Labor has indicated generally that outcomes data are not dispositive of parity compliance.

The following are results of each analysis in 2022:

- January 2022 –
 - 59.0% of MH/SUD drugs are on Tiers 1 and 2
 - 53.3% of M/S drugs are on Tiers 1 and 2
- May 2022 –
 - 57.9% of MH/SUD drugs are on Tiers 1 and 2

Prescription Drug List (PDL) a/k/a Formulary Design Non-Quantitative Treatment Limitation (NQTL) Analysis

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- 52.9% of M/S drugs are on Tiers 1 and 2
- September 2022 –
 - 56.9% of MH/SUD drugs are on Tiers 1 and 2
 - 52.8% of M/S drugs are on Tiers 1 and 2

These evaluations were based on the Advantage PDL, which is the most commonly used PDL.

Conclusions

Based upon these findings, the Plan concluded that the methodologies to administer the PDL a/k/a formulary design for MH/SUD prescription drugs were comparable to, and applied no more stringently than, the methodologies to administer the PDL a/k/a formulary design for M/S prescription drugs “as written.”

Based on the above review and data, the Plan concluded the methodologies to administer the PDL a/k/a formulary design for MH/SUD prescription drugs were comparable to, and applied no more stringently than, the methodologies to administer the PDL a/k/a formulary design for M/S prescription drugs “in operation.”

Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical and surgical (M/S) benefits. This generally means that financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits are comparable to and no more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA protections include:

- Financial requirements such as, deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs, which may limit the scope or duration of benefits for treatment under a plan or coverage

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

Per the Outpatient Prescription Drug *Schedule of Benefits*, “Before certain Prescription Drug Products are dispensed to you, your Physician, your pharmacist or you are required to [\[notify\]](#) [\[obtain prior authorization from\]](#) us or our designee. The reason for [\[notifying\]](#) [\[obtaining prior authorization from\]](#) us is to determine whether the Prescription Drug Product, in accordance with our approved guidelines, is each of the following:

- It meets the definition of a Covered Health Care Service.
- It is not an Experimental or Investigational or Unproven Service.

We may also require you to [\[notify\]](#) [\[obtain prior authorization from\]](#) us or our designee so we can determine whether the Prescription Drug Product, in accordance with our approved guidelines, was prescribed by a Specialist.”

[“\[Certain Prescription Drug Products for which Benefits are described under this Prescription Drug Rider are subject to step therapy requirements. In order to receive Benefits for such Prescription Drug Products you must use a different Prescription Drug Product\(s\) first.](#)

[You may find out whether a Prescription Drug Product is subject to step therapy requirements by contacting us at \[\\[www.myuhc.com\\]\]\(#\) or the telephone number on your ID card.\]”](#)

“Benefits for Prescription Drug Products are subject to the supply limits that are stated in the “Description and Supply Limits” column of the Benefit Information table. For a single Co-payment and/or Co-insurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed. Supply limits are subject, from time to time, to our review and change. This may limit the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may find out whether a Prescription Drug Product has a supply limit for dispensing by contacting us at [\[www.myuhc.com\]](#) or the telephone number on your ID card.”

The *Certificate of Coverage* defines Covered Health Care Service as “health care services, including supplies or Pharmaceutical Products, which we determine to be all of the following:

- Provided for the purpose of preventing, evaluating, diagnosing, or treating a sickness, injury, mental illness, substance-related and addictive disorders, condition, disease or its symptoms.

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- Medically Necessary
- Described as a Covered Health Care Service in the Certificate under Section 1: Covered Health Care Services and in the Schedule of Benefits
- Not excluded in the Certificate under Section 2: Exclusions and Limitations”

Prior Authorization is a component of the Plan’s utilization management (UM) program that helps members receive appropriate coverage based on their specific clinical status and health care needs. The process is designed to achieve optimal clinical outcomes by applying objective, evidence-based clinical criteria and nationally recognized guidelines and best practices.

Prior Authorization for prescription drugs commences prior to a drug being covered. Prior Authorization is a UM process that involves applying clinical criteria to member clinical information in order to render a clinical coverage benefit determination.

The goal of Prior Authorization, Step Therapy, and Quantity Limits is to ensure cost-effective and clinically effective prescription drugs are covered to achieve a positive clinical outcome. Prior Authorization, Step Therapy, and Quantity Limits apply to prescription drugs provided to a member at the point-of-sale. Drug products are selected for Quantity Limits to encourage Food and Drug Administration (FDA) labeling, prevent abuse, address safety concerns, prevent pharmacy billing errors and encourage dose optimization.

Prior Authorization, Step Therapy, and Quantity Limits for prescription drugs begin after a provider or member requests coverage for a prescription drug and receipt of clinical information. The provider or member’s submission of a request (notification) triggers the Prior Authorization, Step Therapy, and Quantity Limits process. Quantity Limits trigger a Prior Authorization if the member is seeking more than the quantity limit set.

Note: The comparative analysis “as written” and “in operation” are the same for Prior Authorization, Step Therapy and Quantity Limits; therefore, the analysis has been combined.

This document includes the following information:

- Prior Authorization, Step Therapy, and Quantity Limits process for both M/S and MH/SUD prescription drugs
- The description of the NQTL and application (Step 1)
- Factors used to determine which prescription drugs are subject to the NQTL (Step 2)
- Evidentiary standards and sources used to define, trigger, and/or implicate a factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

This analysis refers to the following attachments:

- *UnitedHealthcare Provider Administrative Guide* - [2023 UnitedHealthcare Care Provider Administrative Guide \(uhcprovider.com\)](https://uhcprovider.com)- Informs providers of the Prior Authorization process
- *Certificates of Coverage* (for example: *COC23-INS-2018-LG-GA*, *COC23-HMO-2018-LG-GA*, *COC23-INS-2018-SG-GA*, and *COC23-INS-RV-2018-LG-GA*)- Plan document that explains covered services, terms, conditions, and limitations of the member’s policy
- *Schedule of Benefits* (for example: *SBN23-Pharmacy-INS-2018-Pharmacy+Network+and+Out-of-Network-LG-GA*, *SBN23-Pharmacy-INS-2018-Pharmacy+Network+and+Out-of-Network-SG-GA*, *SBN23-Pharmacy-HMO-2018-Pharmacy+Network-LG-GA*, *SBN23-Pharmacy-HMO-2018-Pharmacy+Network+and+Out-of-Network-SG-GA*, *SBN23-Pharmacy-HMO-2018-Pharmacy+Network-SG-GA*, *SBN23-Pharmacy-INS-RV-2018-NET-OON-Hybrid-LG-GA* and *SBN23-Pharmacy-INS-RV-2018-NET-OON-SG-GA*) Plan document that outlines member responsibilities.
- Drugs with Clinical Programs dated 12/01/2023.

The Plan concludes that the Prior Authorization, Step Therapy, and Quantity Limit requirements for M/S and MH/SUD are comparable and applied no more stringently for M/S or MH/SUD prescription drug benefits both "as written" and "in operation.”

Process

For all prescription drugs covered under the pharmacy benefit, the Plan uses the same policies and procedures to create clinical criteria and develop clinical drug policies through a single Pharmacy & Therapeutics (P&T) Committee.

The P&T Committee is comprised of individuals from diverse clinical disciplines including, behavioral health. Additional physician specialists with specific expertise are consulted as part of the clinical evaluation of new and existing drugs.

The Pharmacy & Therapeutics Committee consists of physicians specializing in Obstetrics & Gynecology, Endocrinology/Metabolism, Hematology/Oncology, Rheumatology, Geriatrics, Cardiology, Gastroenterology, Psychiatry, Pediatrics & Internal Medicine, and Internal Medicine. The committee also consists of 4 pharmacists, one of which specializes in Geriatrics & Psychiatry. There is a requirement that the committee consist of at least one physician specializing in psychiatry.

To approve clinical drug policies, the established committee follows a standard process. The P&T Committee evaluates the FDA approved product labeling, peer-reviewed medical literature, published clinical practice guidelines, including randomized clinical trials, drug comparison studies, outcomes research data, pharmacoeconomic studies, comparisons of efficacy, side effects, potential for off-label use and claims data analysis, as relevant, as part of the review and approval process of clinical policies. The P&T Committee assesses external clinical evidence and nationally recognized evidence-based guidelines and benchmarks, as well as a prescription drug's place in therapy, and its relative safety and efficacy to approve clinical drug policies for select M/S and MH/SUD prescription drugs.

Per the Outpatient Prescription Drug *Schedule of Benefits*, "Before certain Prescription Drug Products are dispensed to you, your Physician, your pharmacist or you are required to [\[notify\] \[obtain prior authorization from\]](#) us or our designee. The reason for [\[notifying\] \[obtaining prior authorization from\]](#) us is to determine whether the Prescription Drug Product, in accordance with our approved guidelines, is each of the following:

- It meets the definition of a Covered Health Care Service.
- It is not an Experimental or Investigational or Unproven Service.

We may also require you to [\[notify\] \[obtain prior authorization from\]](#) us or our designee so we can determine whether the Prescription Drug Product, in accordance with our approved guidelines, was prescribed by a Specialist."

["\[Certain Prescription Drug Products for which Benefits are described under this Prescription Drug Rider are subject to step therapy requirements. In order to receive Benefits for such Prescription Drug Products you must use a different Prescription Drug Product\(s\) first.](#)

[You may find out whether a Prescription Drug Product is subject to step therapy requirements by contacting us at \[www.myuhc.com\]\(http://www.myuhc.com\) or the telephone number on your ID card.\]"](#)

"Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Co-payment and/or Co-insurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed. Supply limits are subject, from time to time, to our review and change. This may limit the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may find out whether a Prescription Drug Product has a supply limit for dispensing by contacting us at www.myuhc.com or the telephone number on your ID card."

The *Certificate of Coverage* defines Covered Health Care Service as "health care services, including supplies or Pharmaceutical Products, which we determine to be all of the following:

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- Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms.
- Medically Necessary
- Described as a Covered Health Care Service in the Certificate under Section 1: Covered Health Care Services and in the Schedule of Benefits
- Not excluded in the Certificate under Section 2: Exclusions and Limitations”

The Plan structures prescription drug Prior Authorization processes to be compliant with all applicable federal and state laws, as well as the National Committee for Quality Assurance (NCQA) accreditation standards. NCQA confirms that Plan operations and policies identify appropriate time frames for decisions, requires decision-making by appropriate personnel, and governs communication of adverse benefit determinations. In addition, Prior Authorization is governed at both the state and federal level, which includes consumer protections such as external review for adverse benefit determinations after internal appeals options are exhausted, as applicable.

Prior Authorization, Step Therapy and Quantity Limits review of M/S and MH/SUD prescription drugs consists of the following:

Prior Authorization, Step Therapy, and Quantity Limits for prescription drugs begin after a provider or member requests coverage for a prescription drug and receipt of clinical information. The provider or member's submission of a request (notification) triggers the Prior Authorization, Step Therapy, and Quantity Limits process. Quantity Limits trigger a Prior Authorization if the member is seeking more than the quantity limit set. A Prior Authorization (including Quantity Limits) or Step Therapy request may be submitted by telephone or electronically. The Plan confirms receipt of the Prior Authorization, Step Therapy or Quantity Limit request. Non-clinical staff confirm member eligibility and benefit plan coverage. The Plan can administratively deny cases for lack of eligibility or benefit coverage.

Determinations. Clinical reviewers (Medical Director or healthcare professional) consult clinical drug policies when making clinical coverage benefit determinations. The clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical drug policies in the case review to assess whether a prescription drug should be covered. The Prior Authorization, Step Therapy, or Quantity Limit request is approved based on whether the member's clinical condition meets criteria for coverage as determined by the application of clinical drug policies. Only qualified clinical reviewers (e.g., physicians or pharmacists) can issue adverse benefit determinations. If an adverse benefit determination is issued, then the adverse benefit determination and appeal rights are communicated to the member and provider.

Adverse Benefit Determinations. For prescription drugs, an adverse benefit determination is an administrative or clinical review decision resulting in a reduction or termination, non-coverage or non-certification of a prescription drug. Adverse benefit determinations are recorded as administrative denials when member eligibility and benefit coverage cannot be confirmed, or benefits are exhausted. Adverse benefit determinations are recorded as clinical denials when they are based on clinical drug policies and member clinical information

Clinical Criteria. Clinical reviewers base Prior Authorization clinical coverage benefit determinations on objective, evidence-based clinical drug policies.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- Prescription Drug Prior Authorization, Step Therapy, and/or Quantity Limits

Benefit Classification(s)

- Prescription Drugs

Prescription Drug Prior Auth/Step Therapy Non-Quantitative Treatment Limitation (NQTL) Analysis

GA – UnitedHealthcare Insurance Company, UnitedHealthcare of Georgia, Inc. and UnitedHealthcare Insurance Company of the River Valley
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Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHIC)
- UnitedHealthcare of Georgia, Inc. (UHCGA)
- UnitedHealthcare Insurance Company of the River Valley (UHICRV)

Plan Terms/Source Document(s)

The Plan's *Certificates of Coverage* notify members of the Prior Authorization requirements. Members or providers are required to comply with UM protocols established by the Plan.

Per the Outpatient Prescription Drug *Schedule of Benefits*, "Before certain Prescription Drug Products are dispensed to you, your Physician, your pharmacist or you are required to [\[notify\]](#) [\[obtain prior authorization from\]](#) us or our designee. The reason for [\[notifying\]](#) [\[obtaining prior authorization from\]](#) us is to determine whether the Prescription Drug Product, in accordance with our approved guidelines, is each of the following:

- It meets the definition of a Covered Health Care Service.
- It is not an Experimental or Investigational or Unproven Service.

We may also require you to [\[notify\]](#) [\[obtain prior authorization from\]](#) us or our designee so we can determine whether the Prescription Drug Product, in accordance with our approved guidelines, was prescribed by a Specialist."

["\[Certain Prescription Drug Products for which Benefits are described under this Prescription Drug Rider are subject to step therapy requirements. In order to receive Benefits for such Prescription Drug Products you must use a different Prescription Drug Product\(s\) first.](#)

[You may find out whether a Prescription Drug Product is subject to step therapy requirements by contacting us at \[\\[www.myuhc.com\\]\]\(#\) or the telephone number on your ID card.\]"](#)

"Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Co-payment and/or Co-insurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed. Supply limits are subject, from time to time, to our review and change. This may limit the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may find out whether a Prescription Drug Product has a supply limit for dispensing by contacting us at [\[www.myuhc.com\]](#) or the telephone number on your ID card."

The *Certificate of Coverage* defines Covered Health Care Service as "health care services, including supplies or Pharmaceutical Products, which we determine to be all of the following:

- Provided for the purpose of preventing, evaluating, diagnosing, or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms.
- Medically Necessary
- Described as a Covered Health Care Service in the Certificate under Section 1: Covered Health Care Services and in the Schedule of Benefits
- Not excluded in the Certificate under Section 2: Exclusions and Limitations"

The *2023 UnitedHealthcare Care Provider Administrative Guide* notifies providers of the Prior Authorization requirements. In-network providers are required to comply with UM protocols established by the Plan.

"We develop medical policies, medical benefit drug policies, coverage determination guidelines, and utilization review guidelines to support the administration of medical benefits. You may request a copy of our medical policies and guidelines by calling our care management team at 1-877-842-3210 or 1-888-478-4760 (Individual Exchange Plans). They are only for informational purposes; they are not medical advice. You are responsible for deciding what care to give our

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members. Members should talk to their health care providers before making medical decisions. Drug policies for commercial members covered under the pharmacy benefit are on uhcprovider.com/pharmacy.

Benefit coverage is determined by the following:

- Laws that may require coverage
- The member's benefit plan document
 - Summary Plan Description
 - Schedule of Benefits
 - Certificate of Coverage

The member's benefit plan document identifies which services are covered, which are excluded, and which are subject to limitations. If there is a conflict, the member's benefit plan document supersedes our policies and guidelines.

We develop our policies and guidelines as needed. We regularly review and update them. They are subject to change. We believe the information in these policies and guidelines is accurate and current as of the publication date. We also use tools developed by third parties, such as InterQual criteria, to help us manage health benefits. If you believe we should consider new or additional clinical evidence pertaining to a specific medical policy, complete this form for UnitedHealthcare medical policy review. Do not submit protected health information using this form. If you have questions or concerns about a specific service for a member, refer to the appropriate benefits, claims or prior authorization/notification process."

List of M/S and MH/SUD Services Subject to NQTL

See list of Drugs with Clinical Programs dated 12/01/2023:

Step 2 – Factors Used to in the Design and Application of the NQTL

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

The Plan relies on the following factors to determine whether prescription drugs are subject to Prior Authorization, Step Therapy, or Quantity Limits for both M/S and MH/SUD:

- Assessment of the prescription drug's place in therapy (Qualitative)
 - Goal is to promote optimal drug use based on review of FDA approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off-label use and claims data analysis

Applies to M/S and MH/SUD prescription drugs.

- Availability of clinically similar lower cost medications to treat the condition (Quantitative)
 - Goal is to promote optimal drug use in therapeutic classes with several alternative drug products. A trial of clinically appropriate, lower cost alternative(s) may be appropriate prior to coverage of a more expensive alternative

Applies to M/S and MH/SUD prescription drugs.

- Value to implement Prior Authorization/ Step Therapy (Qualitative)
 - Goal is to evaluate whether inclusion of contingency edits or inclusion in Diagnosis to Prescription match (Dx2Rx) or Silent Authorization is appropriate or whether a coverage review is required to determine whether conditions of coverage are met. Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of

automated approval and re-approval processes varies by program and/or therapeutic class

Applies to M/S and MH/SUD prescription drugs.

- Relative safety and efficacy (Qualitative)
 - Goal is to promote optimal drug use by performing a comprehensive efficacy comparison as well as reviewing the type and frequency of side effects and potential drug interactions among alternative drug products

Applies to M/S and MH/SUD prescription drugs.

- Prevention of off-label use or unproven uses (Qualitative)
 - Goal is to promote optimal drug use by evaluating the potential for the drug to be used for indications other than what is included on FDA approved product labeling

Applies to M/S and MH/SUD prescription drugs.

The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL. The factors apply to both M/S and MH/SUD prescription drugs.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below are the sources and evidentiary standards used to define, trigger, and/or implicate the factor used in designing or applying the Plan's Prior Authorization, Step Therapy, or Quantity Limits requirement to prescription drugs.

Factor – Assessment of the prescription drug's place in therapy - Goal is to promote optimal drug use based on review of FDA approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off-label use and claims data analysis.

- The Plan's evidentiary standards and sources that define and/or trigger the assessment of the prescription drug's place in therapy factor:
 - State and/or Federal regulations and guidelines
 - FDA-approved product labeling
 - Review of external clinical evidence
 - FDA-approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off-label use, and claims data analysis as relevant
 - Nationally recognized evidence-based guidelines and benchmarks
 - FDA-approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off-label use, and claims data analysis as relevant

These evidentiary standards and sources apply to both M/S and MH/SUD prescription drugs. These evidentiary standards and sources are defined in a qualitative manner.

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Factor – Availability of clinically similar lower cost medications to treat the condition - Goal is to promote optimal drug use in therapeutic classes with several alternative drug products. A trial of clinically appropriate, lower cost alternative(s) may be appropriate prior to coverage of a more expensive alternative.

- The Plan's evidentiary standards and sources that define and/or trigger the availability of clinically similar lower cost medications to treat the condition factor:
 - State and/or Federal regulations and guidelines
 - FDA-approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off-label use, and claims data analysis as relevant
 - Review of external clinical evidence
 - FDA-approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off-label use, and claims data analysis as relevant
 - Nationally recognized evidence-based guidelines and benchmarks
 - FDA-approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off-label use, and claims data analysis as relevant

These evidentiary standards and sources apply to both M/S and MH/SUD prescription drugs. These evidentiary standards and sources are defined in a quantitative manner.

Factor – Value to implement Prior Authorization/Step Therapy - Goal is to evaluate whether inclusion of contingency edits or inclusion in Diagnosis to Prescription match (Dx2Rx) or Silent Authorization is appropriate or whether a coverage review is required to determine whether conditions of coverage are met. Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.

- The Plan's evidentiary standards and sources that define and/or trigger the value to implement Prior Authorization/Step Therapy factor:
 - State and/or Federal regulations and guidelines
 - FDA-approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off-label use, and claims data analysis as relevant
 - Review of external clinical evidence
 - FDA-approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off-label use, and claims data analysis as relevant
 - Nationally recognized evidence-based guidelines and benchmarks
 - FDA-approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off-label use, and claims data analysis as relevant

These evidentiary standards and sources apply to both M/S and MH/SUD prescription drugs. These evidentiary standards and sources are defined in a qualitative manner.

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Factor – Relative safety and efficacy - Goal is to promote optimal drug use by performing a comprehensive efficacy comparison as well as reviewing the type and frequency of side effects and potential drug interactions among alternative drug products.

- The Plan's evidentiary standards and sources that define and/or trigger the Relative safety and efficacy factor:
 - State and/or Federal regulations and guidelines
 - FDA-approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off-label use, and claims data analysis as relevant
 - Review of external clinical evidence
 - FDA-approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off-label use, and claims data analysis as relevant
 - Nationally recognized evidence-based guidelines and benchmarks
 - FDA-approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off-label use, and claims data analysis as relevant

These evidentiary standards and sources apply to both M/S and MH/SUD prescription drugs. These evidentiary standards and sources are defined in a qualitative manner.

Factor – Prevention of off-label use or unproven uses - Goal is to promote optimal drug use by evaluating the potential for the drug to be used for indications other than what is included on FDA approved product labeling.

- The Plan's evidentiary standards and sources that define and/or trigger the Prevention of off-label use or unproven uses factor:
 - State and/or Federal regulations and guidelines
 - FDA-approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off-label use, and claims data analysis as relevant
 - Review of external clinical evidence
 - FDA-approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off-label use, and claims data analysis as relevant
 - Nationally recognized evidence-based guidelines and benchmarks
 - FDA-approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off-label use, and claims data analysis as relevant

These evidentiary standards and sources apply to both M/S and MH/SUD prescription drugs. These evidentiary standards and sources are defined in a qualitative manner.

These are the factors and evidentiary standards used in designing or applying the Plan's Prior Authorization, Step Therapy, or Quantity Limits requirement to prescription drugs. The factors are not weighted in that no individual factor carries more value

than another in imposing the NQTL.

Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

As Written

The Plan conducted a comparative analysis of the strategies, processes, factors, evidentiary standards, and source information used to determine which M/S and MH/SUD prescription drugs are subject to Prior Authorization, Step Therapy, or Quantity Limits and how Prior Authorization, Step Therapy, or Quantity Limits are administered “as written.” The Plan identified the factors and evidentiary standards used as the basis for subjecting M/S and MH/SUD prescription drugs to Prior Authorization, Step Therapy, or Quantity Limits for each benefit classification.

Review of Factors and Evidentiary Standards

For each prescription drug subject to Prior Authorization, Step Therapy, or Quantity Limits the Plan reviewed the factors that trigger a prescription drug to be subject to Prior Authorization, Step Therapy, or Quantity Limits. The factors and evidentiary standards were applied to both M/S and MH/SUD prescription drugs comparably and not more stringently to MH/SUD prescription drugs than to M/S prescription drugs.

Review of Operational Policies and Procedures

For all prescription drugs covered under the pharmacy benefit, the Plan uses the same policies and procedures to create clinical criteria and develop clinical drug policies through a single P&T Committee.

- **Committee Review.** The P&T Committee is comprised of individuals from diverse clinical disciplines including behavioral health. Additional physician specialists with specific expertise are consulted as part of the clinical evaluation of new and existing drugs. To approve clinical drug policies, the established committee follows a standard process. The P&T Committee evaluates FDA-approved product labeling, peer-reviewed medical literature, published clinical practice guidelines, including randomized clinical trials, drug comparison studies, outcomes research data, pharmacoeconomic studies, comparisons of efficacy, side effects, potential for off-label use, and claims data analysis as relevant as part of the review and approval process of medical and clinical policies. The P&T Committee assesses external clinical evidence and nationally recognized evidence-based guidelines and benchmarks, as well as a prescription drug's place in therapy, and its relative safety and efficacy to approve clinical drug policies for select M/S and MH/SUD prescription drugs.
- **Clinical Criteria.** Clinical reviewers and peer clinical reviewers base Prior Authorization clinical coverage benefit determinations on objective, evidence-based clinical drug policies. The criteria utilized to administer the Prior Authorization, Step Therapy, or Quantity Limit requirements are the same for MH/SUD and M/S prescription drugs.
- **Determinations.** The process for administering Prior Authorization, Step Therapy, or Quantity Limits is the same for M/S and MH/SUD prescription drugs. Clinical reviewers (Medical Director or healthcare professional) consult clinical drug policies when making clinical coverage benefit determinations. The clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical drug policies in the case review to assess whether a prescription drug should be covered. The Prior Authorization, Step Therapy, or Quantity Limit request is approved based on whether the member's clinical condition meets criteria for coverage as determined by the application of clinical drug policy. Only qualified clinical reviewers (e.g., physicians or pharmacists) can issue adverse benefit determinations. If an adverse benefit determination is issued, then the adverse benefit determination and appeal rights are communicated to the member and provider, as applicable.
- **Adverse Benefit Determination.** For prescription drugs, an adverse benefit determination is an administrative or clinical review decision resulting in a reduction or termination, non-coverage, or non-certification of a prescription

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drug. Adverse benefit determinations are recorded as clinical denials when they are based on clinical drug policies and member clinical information and are recorded as administrative denials when member eligibility and benefit coverage cannot be confirmed, or benefits are exhausted.

In Operation

The Plan compared the shared strategies, processes, factors, evidentiary standards, and source information used to determine which M/S and MH/SUD prescription drugs are subject to Prior Authorization, Step Therapy, or Quantity Limits and how Prior Authorization, Step Therapy, or Quantity Limits are administered “in operation.”

The Plan requires members or providers to submit requests for approval of M/S and MH/SUD prescription drugs. Clinical reviews included confirmation of member eligibility and benefit availability for the requested prescription. Clinical reviewers applied benefit plan documents and clinical drug policies to member clinical information to make a benefit determination. Only qualified peer clinical reviewers issued adverse benefit determinations. The Plan communicated all adverse benefit determinations for M/S and MH/SUD prescription drugs that did not meet applicable clinical drug policies consistent with state, federal, and accreditation requirements, including appeal rights, as applicable.

The Plan reviewed the percentage of M/S and MH/SUD prescription drugs subject to various NQTLs on a tri-annual basis. The results are reviewed with the UM Committee to determine if any changes should be made in the NQTLs. The UM Committee is comprised of internal clinicians who review clinical guidelines and recommend changes before going to the P&T Committee.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The findings of the analyses confirmed the strategies, processes, factors, evidentiary standards, and source information used to subject certain MH/SUD prescription drugs to Prior Authorization, Step Therapy, or Quantity Limits were comparable to, and applied no more stringently than, the strategies, processes, factors, evidentiary standards, and source information used to subject certain M/S prescription drugs to Prior Authorization, Step Therapy, or Quantity Limits “as written.”

Both M/S and MH/SUD utilize FDA-approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmaco-economic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off-label use, and claims data to develop prescription drug clinical policies.

In addition, both M/S and MH/SUD utilize the same generally accepted types of data, evidentiary sources, and trend analysis in order to create and maintain a Prior Authorization, Step Therapy, or Quantity Limit requirement.

The findings of the prescription drug Prior Authorization, Step Therapy, or Quantity Limits outcomes analysis for each Plan (see data below) indicated the percentage of prescription drugs subject to Prior Authorization, Step Therapy, and/or Quantity Limits for MH/SUD prescription drugs were comparable to the percentage of prescription drugs subject to Prior Authorization, Step Therapy, and/or Quantity Limits for M/S prescription drugs. Data is for (January, May, and September 2022). The Plan notes that the U.S. Department of Labor has indicated generally that outcomes data are not dispositive of parity compliance.

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The following are results of each analysis in 2022:

- January 2022 – 30.6% (182) of MH/SUD drugs are subject to Prior Authorization, Step Therapy, and/or Quantity Limits, while 19.6% (1,513) of M/S drugs are subject to these programs
- May 2022 – 32.5% (197) of MH/SUD drugs are subject to Prior Authorization, Step Therapy, and/or Quantity Limits, while 19.8% (1,532) of M/S drugs are subject to these programs
- September 2022 – 32.7% (201) of MH/SUD drugs are subject to Prior Authorization, Step Therapy, and/or Quantity Limits, while 20.4% (1,577) of M/S drugs are subject to these programs

Conclusions

The Plan reviewed the M/S and MH/SUD processes and noted the Plan uses a single P&T committee which follows a standard process to create clinical criteria and develop clinical drug policies for M/S and MH/SUD prescription drugs. From review of the Prior Authorization Step Therapy, or Quantity Limit policies and procedures, the Plan concluded the methodology used to determine which MH/SUD prescription drugs are subject to Prior Authorization Step Therapy, or Quantity Limits “as written” were comparable to, and applied no more stringently than, the methodology used to determine which M/S prescription drugs are subject to Prior Authorization, Step Therapy, or Quantity Limits “as written.” Additionally, the Plan concluded how Prior Authorization, Step Therapy, or Quantity Limits is applied to MH/SUD prescription drugs was comparable to, and applied no more stringently than, how Prior Authorization, Step Therapy, or Quantity Limits was applied to M/S prescription drugs “as written.”

The Plan notes that the percentage of MH/SUD drugs subject to Prior Authorization, Step Therapy, and/or Quantity Limits is higher than the percentage of M/S drugs subject to Prior Authorization, Step Therapy, and/or Quantity Limits. The Plan concluded this was due to the following contributing factors: a smaller pool of MH/SUD products to evaluate, a broader range of strengths for MH/SUD products, and an increased risk of abuse and diversion of MH/SUD products explain the variance. The Plan concluded this does not indicate a parity concern, but rather is an indicator of patient safety in disbursing MH/SUD drugs.

The Plan reviewed the M/S and MH/SUD processes and noted the Plan uses the same policies and procedures to create clinical criteria and develop clinical drug policies for both M/S and MH/SUD prescription drugs. The Plan also reviewed the percentage of M/S and MH/SUD prescription drugs which are subject to Prior Authorization, Step Therapy, or Quantity Limits and concluded the methodology used to determine which MH/SUD prescription drugs are subject to Prior Authorization, Step Therapy, or Quantity Limits and how Prior Authorization, Step Therapy, or Quantity Limits were applied were comparable to, and applied no more stringent than, the methodology used to determine which M/S prescription drugs were subject to Prior Authorization, Step Therapy, or Quantity Limits “in operation.”

Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical/surgical (M/S) benefits. This generally means that financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements, such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage.

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Prior Authorization is defined as: “A required or mandatory clinical assessment for proposed service(s) based on clinical information provided and the terms of the health plan benefits before the service(s) are performed or delivered. Clinical and medical necessity requirements, level of care appropriateness, and the terms of the health plan benefits must be met in order for services to be covered by the member's plan.” The *Optum National Policy Definitions List* defines pre-authorization (aka Prior Authorization) as “a form of prospective utilization review of health care services proposed to be provided to a member.”

Prior Authorization is a component of the Plan’s Utilization Management (UM) program that helps ensure members receive appropriate coverage based on their specific clinical status and health care needs. The process is designed to achieve optimal clinical outcomes by applying objective, evidence-based clinical criteria, and nationally recognized guidelines and best practices.

Prior Authorization for inpatient services commences prior to a service being delivered. Prior Authorization is a UM process that involves applying the benefit plan language and/or clinical criteria to make the most appropriate clinical coverage benefit determination.

This document includes the following information:

- Prior Authorization process for M/S and MH/SUD inpatient services
- Description of the NQTL and application (Step 1)
- Factors used to determine which services are subject to the NQTL (Step 2)
- Evidentiary standards and sources used to define, trigger and/or implicate a factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

This analysis refers to the following attachments:

- *Addendum A* - Identifies the M/S and MH/SUD inpatient services that are subject to Prior Authorization
- *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions* - M/S policy that defines Prior Authorization

- *Optum National Policy Definitions List* - MH/SUD policy that defines Prior Authorization
- *Utilization Management Program Description (UMPD) of United HealthCare Services, Inc. and UnitedHealthcare Insurance Company* - Summarizes the philosophy, structure and standards that govern UHC's medical management, UM and utilization review responsibilities and functions
- *Management of Behavioral Health Benefits Policy* - Describes the mechanisms and processes designed to promote consistency in the management of behavioral health benefits and to ensure that members receive appropriate, high quality behavioral health services in a timely manner
- *Prior Authorization Factor Grid(s) provided for (2023 Prior Auth_Concurrent Rev Factor Grid)* - Details the service categories subject to Prior Authorization and the shared factors and evidentiary standards used as the basis for subjecting M/S and MH/SUD inpatient benefits to Prior Authorization
- *Core Principles and Practices* - MH/SUD policy that outlines the core principles and practices that should be used by personnel in their interactions with members, authorized member representatives, practitioners and facilities, related to the management of behavioral health benefits, coverage determinations and appeals/grievances of non-coverage determinations.
- *Performance Assessment and Incentives* - M/S policy confirming that clinical reviewers are not incented to make denials for financial reasons
- *2023 UnitedHealthcare Provider Administrative Guide* – Informs M/S providers of the Prior Authorization process. The *UnitedHealthcare Provider Administrative Guide* can be accessed on the website <https://www.uhcprovider.com/en/admin-guides.html>
- *September 2023 Optum National Network Manual* - Informs MH/SUD providers of the Prior Authorization process. <https://public.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/optum-network-manual.html>
- *Certificates of Coverage (COC23-INS-2018-LG-GA, COC23-HMO-2018-LG-GA, COC23-INS-2018-SG-GA and COC23-HMO-2018-SG-GA)* - Plan documents that explains covered services, terms, conditions, and limitations of the member's policy
- *Schedule of Benefits (SBN23-Medical-INS-2018-[Charter][Navigate][Nexus+[N]R]-LG-GA, SBN23-Medical-INS-2018-[Choice+Plus][Select+Plus][Doctors+Plus]-LG-GA, SBN23-Medical-INS-2018-[Core][Nexus+OAP]-LG-GA, SBN23-Medical-INS-2018-[Core+Essential][Nexus+OA]-LG-GA, SBN23-Medical-HMO-2018-[Charter][Navigate][Nexus+[N]R]-LG-GA, SBN23-Medical-INS-2018-[Choice+Plus][Select+Plus][Doctors+Plus]-SG-GA, SBN23-Medical-HMO-2018-[CharterBal][NavigateBal][Nexus+[N]RB]-LG-GA, SBN23-Medical-HMO-2018-[CharterPls][NavigatePls][Nexus+[N]RP]-LG-GA, SBN23-Medical-HMO-2018-[Choice][Select][Doctors]-LG-GA, SBN23-Medical-HMO-2018-[Core][Nexus+OAP]-LG-GA, SBN23-Medical-HMO-2018-[Core+Essential][Nexus+OA]-LG-GA, SBN23-Medical-INS-2018-NonDifferential-LG-GA, and SBN23-Medical-HMO-2018-[Choice][Select][Doctors]-SG-GA)* - Plan documents that outlines member responsibilities

The Plan concludes that the Prior Authorization requirements for M/S and MH/SUD are comparable and applied no more stringently for MH/SUD in-network (INN) inpatient benefits, both “as written” and “in operation.”

Process

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Prior Authorization is defined as: “A required or mandatory clinical assessment for proposed service(s) based on clinical information provided and the terms of the health plan benefits before the service(s) are performed or delivered. Clinical and medical necessity requirements, level of care appropriateness, and the terms of the health plan benefits must be met in order for services to be covered by the member's plan.” The *Optum National Policy Definitions List* defines pre-authorization (aka Prior Authorization) as “a form of prospective utilization review of health care services proposed to be provided to a member.”

The Plan structures inpatient Prior Authorization processes to be compliant with all applicable federal and state requirements, as well as the National Committee for Quality Assurance (NCQA) accreditation standards. NCQA confirms that Plan operations and policies identify appropriate timeframes for decisions, requires decision-making by appropriate personnel, and governs

communication of adverse benefit determinations. In addition, Prior Authorization is governed at both the state and federal level, which includes consumer protections such as external review for adverse benefit determinations after internal appeal options are exhausted.

The Plan delegates management of MH/SUD inpatient services, including Prior Authorization, to United Behavioral Health d/b/a Optum Behavioral Health (OBH), its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor.

The Plan has national committees that approve M/S and MH/SUD services to be subject to Prior Authorization. *Addendum A* includes a list of service categories subject to inpatient Prior Authorization. The Plan publishes the services subject to Prior Authorization on the provider portal(s) ([Advance Notification and Clinical Submission Requirements | UHCprovider.com](#) for M/S and [Optum - Provider Express Home](#) for MH/SUD). Members can learn what services are subject to Prior Authorization in their benefit plan document, through [myuhc.com](#), or by contacting customer service.

Prior Authorization Review of M/S inpatient admissions consists of the following:

The Plan requires INN facilities and providers to submit a Prior Authorization request for services on the Prior Authorization list prior to rendering the service. There may be some INN benefits for which the member is responsible for obtaining Prior Authorization. These are identified in the member's benefit plan document (i.e., *Schedule of Benefits*). The INN provider's submission of a request (notification) triggers the Prior Authorization process.

INN providers can submit Prior Authorization requests through the secure provider portal ([www.uhcprovider.com](#)), their connected electronic medical record, by telephone, or by fax (where required). Members may submit Prior Authorization requests by telephone, fax, or mail, in accordance with Plan requirements. Providers and members communicate basic information to create a case. As outlined in the *UnitedHealthcare Care Provider Administrative Guide*, providers must submit advance notification with supporting documentation as soon as possible, but at least two weeks before the planned service, unless otherwise stated.

The Plan confirms receipt of the Prior Authorization request. Non-clinical staff confirm member eligibility and benefit coverage upon receipt of the notification. Non-clinical staff review cases to ensure availability of accurate and thorough case information. Non-clinical staff may approve coverage requests in scenarios where the member's plan documents allow and if a clinical review is not required. Non-clinical staff will also approve a coverage request if the facility's contract does not allow for clinical reviews. Requests that are submitted through the secure provider portal may also be approved based on the benefit plan coverage criteria, member diagnosis, and the clinical information submitted. Non-clinical staff may administratively deny coverage when a member's benefits are exhausted. Non-clinical staff refer coverage requests that they cannot approve or administratively deny to initial clinical reviewers.

First Level Clinical Review/Initial Review. Clinical reviewers (nurses or physicians) consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether the inpatient admission is medically necessary by reviewing the member's clinical information, the applicable clinical criteria or guidelines, and the Plan benefit terms. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs to determine whether the applicable clinical criteria are met or may access clinical information in the provider's electronic medical record (EMR) if the provider has given the Plan access. The clinical reviewer may approve cases that meet applicable clinical criteria.

Second Level Clinical Review/Peer Review. The initial clinical reviewer refers cases to a second level/peer clinical reviewer if the case cannot be approved. Peer clinical reviewers (physician or mid-level practitioner) consult clinical criteria when making clinical coverage benefit determinations. Peer clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history

of related treatment and services, and photographs. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. The peer clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. If a peer clinical reviewer issues an adverse benefit determination, then the Plan communicates the adverse benefit determination and appeal rights and offers a peer-to-peer conversation consistent with state, federal, and accreditation requirements.

Adverse Benefit Determination. For M/S, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when member benefits are exhausted. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials. Modified coverage requests that are approved are recorded as partial denials.

Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based medical clinical policies and use clinical criteria from third-party sources such as InterQual® or MCG® guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that inpatient Prior Authorization determinations are appropriate.

M/S monitors clinical reviewer and peer clinical reviewer application of clinical criteria through an annual inter-rater reliability (IRR) assessment that is provided by InterQual. Clinical reviewers and peer clinical reviewers are required to pass the IRR assessment with a score of 90% or better through three attempts. After a second failed IRR assessment, staff enter a remediation period and are required to review all cases with a supervisor for 30 days, or until 90% is achieved on the assessment. If the clinical reviewer achieves a passing score within the 30-day period, supervisors review a minimum of one case per week for the remainder of the 30-day period.

The Plan also conducts end-to-end case audits that are designed and approved by clinical leadership each year. The end-to-end audits include all stages of a case review, from intake through appeal. These audits are conducted monthly and approximately 1500 cases are reviewed per month. Results are reported to an oversight team. All deficiencies are remediated. Remediation may include corrective actions and/or additional education, as indicated.

The Plan routinely monitors Prior Authorization performance through its clinical performance oversight functions. Outcomes are monitored against timeliness compliance, performance guarantees, and for potential trends, including overall utilization.

The Plan's National Medical Care Management Committee (NMCMC) annually reviews overall UM program outcomes, to confirm overall utilization is appropriate. The NMCMC is comprised of the Chief Medical Officer, and representatives from clinical policy, clinical advocacy and grievances, business standardization and advancement, regional chief medical officers, inpatient care management, lines of business, medical policy, clinical operations, and Optum Behavioral Health. The Chair of the NMCMC must be an executive leader and licensed physician.

As of April 1, 2023, the Utilization Management Program Committee (UMPC) began overseeing the M/S UM program. The UMPC is responsible for the development and maintenance of the M/S Prior Authorization processes. The UMPC ensures that the UM program considers the factors and evidentiary standards for applying UM. The UMPC is comprised of:

- Chief Medical Officer, Medical Management (Co-Chair)
- Senior Vice President, Clinical Advancement (Co-Chair)
- Chief Medical Officer, UnitedHealthcare
- Senior Vice President, Clinical Appeals & Grievances
- Chief Medical Officer, Clinical Policy
- Chief Medical Officer, UnitedHealthcare Employer & Individual
- Chief Medical Officer, UnitedHealthcare Medicare & Retirement

- Chief Medical Officer, Community & State
- Chief Medical Officer, UnitedHealthcare Individual & Family Plans
- Vice President, Clinical Transformation & Affordability
- Senior Director, Mental Health Parity
- Vice President, Utilization Management Strategy & Implementation

One of the chairs must be an executive leader and a licensed physician. UMPC meets at least six times per year but may meet more frequently if needed.

Per the M/S policy entitled *Performance Assessment and Incentives*, at no time are initial clinical reviewers or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons.

M/S generally structures UM processes to comply with federal Employee Retirement Income Security Act of 1974 (ERISA) requirements, NCQA UM standards, and state law where applicable.

Prior Authorization review of MH/SUD inpatient admissions consists of the following:

The Plan delegates management of MH/SUD inpatient services, including Prior Authorization, to United Behavioral Health d/b/a OBH, its delegated MH/SUD MBHO vendor.

The Plan requires INN providers and facilities to submit a Prior Authorization request for services on the Prior Authorization list prior to rendering the service. There may be some INN benefits for which the member is responsible for obtaining Prior Authorization. These are identified in the member's benefit plan document (i.e., *Schedule of Benefits*). The INN provider's submission of a request (notification) triggers the inpatient Prior Authorization process.

INN providers may submit Prior Authorization requests through the secure provider portal (www.providerexpress.com), by telephone, or by fax (where required). Providers communicate basic information to create a case. As outlined in the *Optum National Network Manual*, inpatient behavioral health services require an initial Prior Authorization or notification in advance of the service.

As described in the *Management of Behavioral Health Benefits Policy*, the Plan confirms receipt of the Prior Authorization request. Non-clinical staff confirm member eligibility and benefit coverage. Non-clinical staff may approve coverage requests that do not require clinical evaluation or interpretation based on the member's diagnosis and the clinical information submitted by providers. Non-clinical staff may administratively deny coverage when member benefits are exhausted. Non-clinical staff refer cases that they cannot approve or administratively deny to initial clinical reviewers.

First Level Clinical Review/Initial Review. Clinical decisions are made by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse benefit determinations are made by Medical Directors. Clinical reviewers consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether an inpatient admission is medically necessary by reviewing the member's clinical information, the applicable clinical criteria or guidelines, and the Plan benefit terms. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for certification, related diagnostic results, and history of related treatment and services to determine whether the applicable clinical criteria are met. The clinical reviewer may approve the admission based on their review.

Second Level Clinical Review/Peer Review. The initial clinical reviewer refers cases to a peer clinical reviewer for a peer-to-peer discussion if the case cannot be approved. The requesting provider is offered the opportunity to discuss the case with the peer clinical reviewer, consistent with state, federal, and accreditation requirements before an adverse benefit determination is issued. Only qualified peer clinical reviewers (e.g., Medical Directors) can issue adverse benefit determinations. Peer clinical

reviewers apply clinical criteria to member clinical information to determine coverage for an inpatient admission. If the requesting provider fails to complete the peer-to-peer discussion, the peer clinical reviewer makes a determination based on the information available. If a peer clinical reviewer issues an adverse benefit determination (e.g., the admission is not medically necessary and is not approved), then the Plan timely communicates the adverse benefit determination, including appeal rights, to the member and provider consistent with applicable state, federal, and accreditation requirements.

Adverse Benefit Determination. For MH/SUD, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as a clinical denial when it is based on clinical criteria and member clinical information and is recorded as an administrative denial when member benefits are excluded.

Platinum Designation. The Plan offers a Platinum Designation program to MH/SUD facilities based on facilities' quantitative practice patterns (effectiveness and efficiency benchmarks). The Platinum Designation program's effectiveness and efficiency benchmarks include targeted 30- and 90-day readmission rates, 7- and 30-day follow up after hospitalization, outlier length of stay, and outlier behavioral health episode spend. INN MH/SUD facilities that meet the Platinum Designation are required to notify the Plan of admissions and provide member information. The Plan covers the first 8 to 21 days of a stay depending on the specific level of care without review. The Plan evaluates INN MH/SUD facilities performance annually as described in the *Optum National Network Manual*.

Clinical Criteria. Initial clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based behavioral clinical policies or use clinical criteria from third-party sources such as American Society of Addiction Medicine (ASAM) Criteria®, Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System-Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) and Early Childhood Service Intensity Instrument (ECSII) guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that inpatient Prior Authorization determinations are appropriate.

MH/SUD monitors clinical reviewer and peer clinical reviewer application of clinical criteria through an annual IRR assessment. Clinical reviewers and peer clinical reviewers are required to pass the IRR assessment with a score of 90% or better through three attempts. After a second failed IRR assessment, the reviewer enters a remediation period and is required to review all cases with a supervisor for 30 days, or until 90% is achieved on the assessment. If the clinical reviewer achieves a passing score within the 30-day period, supervisors review a minimum of one case per week for the remainder of the 30-day period.

The Plan also conducts monthly quality audits of individual non-clinical staff, clinical reviewers, and peer clinical reviewers, including staff performing appeal functions. These audits are designed and approved by clinical leadership each year. A minimum of two audits are completed per staff, per month. The results of these real-time audits are shared with supervisors for staff oversight, and all findings are remediated. Remediation may include corrective actions and/or additional education, as warranted.

The Plan routinely monitors Prior Authorization performance through its clinical performance oversight functions. Outcomes are monitored against timeliness requirements, performance guarantees, and for potential trends, including overall utilization.

The Plan's national Clinical Quality & Operations Committee (CQOC) annually reviews UM program outcomes, including inpatient Prior Authorization outcomes, to confirm overall utilization is appropriate. The CQOC is comprised of representatives from sub-committees, and representatives from the clinical quality improvement, UM, care engagement, medical operations, medical policy and standards, clinical operations, appeals, product, legal, compliance, network strategy, provider experience, accreditation, and benefits teams. The Chair of the Clinical Quality & Operations Committee must be an executive leader, board certified in psychiatry or psychiatric subspecialty and a licensed physician.

Prior Authorization – Inpatient In-Network Non-Quantitative Treatment Limitation (NQTL) Analysis
GA – UnitedHealthcare Insurance Company and UnitedHealthcare of Georgia,
Inc.
12/29/2023

Per the MH/SUD policy entitled, *Core Principles and Practices*, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons.

MH/SUD generally structures UM processes to comply with federal ERISA requirements, NCQA UM standards, and state law where applicable.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- Prior Authorization

Benefit Classification(s)

- INN, inpatient

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHC)
- UnitedHealthcare of Georgia, Inc. (UHCGA)

Plan Terms/Source Document(s)

In each of the Plan products, “Medically Necessary” is the Plan term used to guide Prior Authorization decision-making for both M/S and MH/SUD services. “Medically Necessary” is generally defined as follows:

- “Medically Necessary – health care services are all of the following as determined by us or our designee:
 - In accordance with Generally Accepted Standards of Care.
 - Clinically appropriate, in terms of type, frequency, extent, service site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms.
 - Not mainly for your convenience or that of your doctor or other health care provider.
 - Not more costly than an alternative drug, service(s), service site or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.
- Generally Accepted Standards of Care are evidence based independent standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties. Valid, evidence based sources reflecting generally accepted standards of care include credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.
- If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We have the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be determined by us.
- We develop and maintain clinical policies that describe the Generally Accepted Standards of Care scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by us and revised from time to time), are available to Covered Persons through www.myuhc.com or the telephone number on your ID card. They are also available to Physicians and other health care professionals on www.UHCprovider.com”

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Prior Authorization is defined as:

“A required or mandatory clinical assessment for proposed service(s) based on clinical information provided and the terms of the health plan benefits before the service(s) are performed or delivered. Clinical and medical necessity requirements, level of care appropriateness, and the terms of the health plan benefits must be met in order for services to be covered by the member's plan.”

The *Optum National Policy Definitions List* defines pre-authorization (aka Prior Authorization) as “a form of prospective utilization review of health care services proposed to be provided to a member.”

The Plan's *Schedule of Benefits* notify members of the Prior Authorization requirements:

“We require prior authorization for certain Covered Health Care Services. Network providers are responsible for obtaining prior authorization before they provide these services to you.

We recommend that you confirm with us that all Covered Health Care Services have been prior authorized as required. Before receiving these services from a Network provider, you may want to call us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they do not prior authorize as required. You can call us at the telephone number on your ID card.

When you choose to receive certain Covered Health Care Services from out-of-Network providers, you are responsible for obtaining prior authorization before you receive these services. Note that your obligation to obtain prior authorization is also applicable when an out-of-Network provider intends to admit you to a Network facility or to an out-of-Network facility or refers you to other Network or out-of-Network providers. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization. Services for which you are required to obtain prior authorization are shown in the Schedule of Benefits table within each Covered Health Care Service category.

To obtain prior authorization, call the telephone number on your ID card. This call starts the utilization review process.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the Schedule of Benefits table to find out how far in advance you must obtain prior authorization.

For Covered Health Care Services that do not require you to obtain prior authorization, when you choose to receive services from out-of-Network providers, we urge you to confirm with us that the services you plan to receive are Covered Health Care Services. That is because in some instances, certain procedures may not be Medically Necessary or may not otherwise meet the definition of a Covered Health Care Service, and therefore are excluded. In other instances, the same procedure may meet the definition of Covered Health Care Services. By calling before you receive treatment, you can check to see if the service is subject to limitations or exclusions.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those received, our final coverage determination will be changed to account for those differences, and we will only pay Benefits based on the services delivered to you. If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Care Service, you will be responsible for paying all charges and no Benefits will be paid.”

The *2023 UnitedHealthcare Care Provider Administrative Guide* notifies providers of the Prior Authorization requirements. INN providers are required to comply with UM protocols established by the Plan:

“We require prior authorization for all MA benefit plans and some commercial benefit plans. Prior authorization requests allow us to verify if services are medically necessary and covered. After you notify us of a planned service listed on the Advance Notification/Prior Authorization List, we tell you if a clinical coverage review is required, as part of our prior authorization process, and what additional information we need to proceed. We notify you of our coverage decision within the time required by law. Just because we require notification for a service, does not mean it is covered. We determine coverage by the member’s benefit plan.

If there is a conflict or inconsistency between applicable regulations and the notification requirements in this guide, the applicable regulations govern.

Physicians, health care professionals and ancillary care providers are responsible for:

- Providing advance notification or requesting prior authorization for services on the Advance Notification/Prior Authorization List, including for non-emergent air transport services.
- Directing members to use care providers within their network. Members may be required to obtain prior authorization for out-of-network services.

If you perform multiple procedures for a member in one day, and at least one service requires prior authorization, you must obtain Prior authorization for any of the services to be paid.

If you do not follow these requirements, we may deny claims. In that case, you cannot bill the member. Advance notification or prior authorization is valid only for the date of service or date range listed on it. If that specified date of service or date range has passed, you must submit a new request.

Giving us advance notification, or receiving prior authorization from us, is not a guarantee of payment, unless required by law or Medicare guidelines. This includes regulations about care providers on either a sanctions and excluded list, the Medicare preclusion list and/or care providers not included in the Medicare Provider Enrollment Chain and Ownership System (PECOS)* list. Payment of covered services is based on:

- The member’s benefit plan,
- If you are eligible for payment,
- Claim processing requirements, and Your Agreement.

The list of services that require advance notification and prior authorization is the same. The process for providing notification and submitting a prior authorization request is the same. Services that require Prior authorization require a clinical coverage review based on medical necessity.

Advance notification/prior authorization lists are available online. They are subject to change. We will post inform you of changes on UHCprovider.com/networknews > Network Bulletin. Sign up to receive the Network Bulletin by email at UHCprovider.com/subscribe.

If you need a paper copy of the requirements, contact your UnitedHealthcare Network Management representative or provider advocate. We recommend that you submit advance notification with supporting documentation as soon as possible, but at least 2 weeks before the planned service (unless the Advance Notification Requirements states otherwise). Following a facility discharge, advance notification for home health services and durable medical equipment is required within 48 hours after the start of service.”

The *Optum National Network Manual*, September 2023 Edition notifies providers of the Prior Authorization requirements. INN providers are required to comply with UM protocols established by the Plan:

“In most cases, inpatient admissions will be directed only to participating hospitals and attending psychiatrists.

All inpatient and sub-acute level of care admissions require notification or pre-authorization by the network provider or facility. Optum requires notification within one business day after an admission for a facility to request a pre-authorization unless a longer period is required by contract or state specific requirements. This includes, but is not limited to, mental health or substance abuse disorder services delivered as inpatient treatment, partial/day hospitalization or residential treatment.

Network providers are solely responsible for completing prior notification or obtaining preauthorization prior to providing inpatient or sub-acute level of care services. This includes timely provision of information necessary for concurrent review of continued stay or ongoing care requests prior to the delivery of services.”

The role of the Plan’s delegate, United Behavioral Health d/b/a OBH, is discussed in the *UMPD*:

“United Behavioral Health (UBH) performs the review of requests for coverage of behavioral health services (i.e., substance abuse, and mental health requests for services). UBH provides comprehensive behavioral health care delivery for members through a network of behavioral health practitioners, ancillary care providers, hospitals and other facilities.

For mental health, substance-related disorder services, and wraparound services, UBH uses its Clinical Criteria (see below), behavioral clinical policies and best practice guidelines to make coverage determinations. UBH adopts externally-developed clinical criteria, and creates internally-developed Clinical Criteria, where appropriate, based on its assessment of relevant guidance. UBH develops clinical criteria that supersedes its standard set or adopts externally-developed clinical criteria when required to do so by contract or regulation.

- Clinical Criteria (Level of Care Utilization System-LOCUS) – Standardized level of care assessment tool developed by the American Association of Community Psychiatrists used to make clinical determinations and placement decisions for mental health disorder benefits for adults ages 19 and older when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (Child and Adolescent Level of Care/Service Intensity Utilization System-CALOCUS-CASII) - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry (AACAP) and the American Association for Community Psychiatry (AACP) used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children and adolescents ages 6-18 when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (Early Childhood Service Intensity Instrument-ECSII) - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children ages 0-5 when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (State or Contract Specific Level of Care Guidelines) – Criteria used to make medical necessity determinations for mental health disorder benefits when there are explicit mandates or contractual requirements.
- Clinical Criteria (American Society of Addiction Medicine [ASAM]) - Criteria developed by the American Society of Addiction Medicine used to make clinical determinations for substance-related disorder benefits.
- Clinical Criteria (Optum Developed)
 - Optum Behavioral Clinical Policies: Criteria that stem from evaluation of new services or treatments or new applications of existing services or treatments and are used to make clinical determinations regarding proven or unproven services and treatments.

Licensed practitioners conduct all reviews with a focus on measurable outcome goals and objectives for treatment. A senior UBH Medical Director is responsible for directing and implementing behavioral health utilization management programs. A referral is sent to UBH when a member is identified as potentially benefiting from behavioral health services during a “medical event.”

The UBH UM Program is staffed by clinical, non-clinical and administrative personnel. All clinical denials or adverse decisions are made by board certified psychiatrists, or, if the health plans choose, by a panel of other appropriate health care service reviewers. If the health plan chooses to use a panel to make adverse decisions, the panel contains at least one physician who is board certified in psychiatry. When the health care service under review is a mental health or substance abuse service, the adverse decision is made by a licensed physician who is board certified in psychiatry. All potential clinical denials are referred

to a physician who is board certified in psychiatry for final determination. An evaluation of the overall effectiveness of the Behavioral Health UM Program is conducted annually to determine how well resources have been deployed to improve UM activities and the clinical care and service provided to members.”

The Plan’s terms require services to be medically necessary for coverage. INN providers are required to comply with the Plan’s UM protocols including complying with Prior Authorization requirements.

List of M/S and MH/SUD Services Subject to NQTL

Addendum A, attached, lists the M/S and MH/SUD INN inpatient service categories subject to Prior Authorization. Prior Authorization is one component of the UM program that evaluates whether a benefit or service is medically necessary.

- The “Member” tab lists the service categories for which the member is responsible for obtaining authorization for INN services. The “Member” tab includes all products in the scope of the analysis.
- The “Provider” tab lists the service categories for which the provider is responsible for obtaining authorization for INN services. The “Provider” tab applies to all products in the scope of the analysis.

Step 2 – Factors Used to Determine Prior Authorization

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

The Prior Authorization list was originally designed by enterprise clinical leadership. Prior Authorization was applied to new services when they became covered by the Plan and met certain criteria. Examples of Prior Authorization determinants that existed in the business at this time included:

- to monitor and prevent potential overutilization and under-utilization
- manage high-cost and prolonged-duration services
- ensure enrollee safety
- determine the appropriate level of care
- determine whether the service or item is medically necessary

The factors relied upon to determine which INN inpatient services were subjected to Prior Authorization were updated and replaced 2021 with the factors Clinical Appropriateness and Value, as defined below. After this time, all M/S services subject to Prior Authorization must meet Clinical Appropriateness and all MH/SUD services must meet Clinical Appropriateness and Value.

Starting in 2022, any additions or deletions to the Prior Authorization list were reviewed and approved through committees.

The Plan relies on the following factors to determine which INN inpatient benefits will be subject to Prior Authorization. These factors apply to M/S and MH/SUD benefits for the following:

- I. M/S: INN inpatient services
 - II. MH/SUD: INN inpatient services
- Clinical Appropriateness (Qualitative)
 - Whether the application of Prior Authorization promotes optimal clinical outcomes

Applies to M/S and MH/SUD services.

- Value (Quantitative)
 - The cost of the inpatient service exceeding the administrative costs of subjecting the inpatient service to Prior Authorization by at least 1:1. Administrative costs of subjecting the inpatient service to Prior Authorization are determined using the national UM program operating costs, which is comprised of the cost related to staffing.

Administrative costs vary due to differences in the complexities of the requested treatment types, condition(s) treated, and/or clinical guidelines used. The cost of the inpatient service is determined using national inpatient utilization or claims data. The projected benefit cost savings of applying Prior Authorization is reviewed relative to the operating cost of administering Prior Authorization to determine value. Only services that are provided to a minimum of 100 unique individuals are considered (this is the materiality threshold established by the Plan for purposes of the Value analysis).

Applies to M/S and MH/SUD services.

For M/S meeting Clinical Appropriateness is determinative in imposing the limitation. For MH/SUD meeting Clinical Appropriateness and Value is determinative in imposing the limitation. The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL. All Prior Authorization reviews are subject to Clinical Appropriateness and must have medical necessity criteria.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factors used to add services to the Plan's Prior Authorization requirement for INN inpatient services. These evidentiary standards and sources apply benefits for the following:

- I. M/S: INN inpatient services
- II. MH/SUD: INN inpatient services

Factor – Clinical Appropriateness is defined as those inpatient services that are determined by internal medical experts to be in accordance with objective, evidence-based, clinical criteria, and nationally recognized guidelines. The accompanying *Prior Authorization Factor Grid(s)* included with this analysis give details on the service categories subject to Prior Authorization. The *Prior Authorization Factor Grid(s)* detail the shared factors used as the basis for subjecting M/S and MH/SUD INN inpatient benefits to Prior Authorization.

- The Plan's evidentiary standards and sources that trigger and/or define the Clinical Appropriateness factor are:
 - Clinical criteria from nationally recognized third-party sources (e.g., InterQual for M/S services, and ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines for MH/SUD services)
 - Clinical Technology Assessment Committee (CTAC) and Medical Technology and Assessment Committee (MTAC) review
 - Objective, evidence-based medical/behavioral clinical policies, and nationally recognized guidelines approved by professional healthcare associations (e.g., clinical guidance from the American Medical Association, American Psychiatric Association, etc.)

These evidentiary standards and sources apply to M/S and MH/SUD INN inpatient services and are defined in a qualitative manner.

Factor – Value is defined as the cost of the inpatient service exceeding the administrative costs of subjecting the inpatient service to Prior Authorization by at least 1:1. Administrative costs of subjecting the inpatient service to Prior Authorization are determined using the national UM program operating costs, which is comprised of the cost related to staffing. Administrative costs vary due to differences in the complexities of the requested treatment types, condition(s) treated, and/or clinical guidelines used. The cost of the inpatient service is determined using national inpatient utilization or claims data. The

projected benefit cost savings of applying Prior Authorization is reviewed relative to the operating cost of administering Prior Authorization to determine Value. Only services that are provided to a minimum of 100 unique individuals are considered (this is the materiality threshold established by the Plan for purposes of the Value analysis). The accompanying *Prior Authorization Factor Grid(s)* contain the calculated Value for each Prior Authorization service category, for both M/S and MH/SUD, and the internal data used to determine these values.

- The Plan’s evidentiary standard that defines and/or triggers the Value factor:
 - Value is defined as the cost of the inpatient service exceeding the administrative costs of subjecting the service to Prior Authorization by at least 1:1. Only services that are provided to a minimum of 100 unique individuals are considered (this is the materiality threshold established by the Plan for purposes of the value analysis).
- The Plan’s sources used to define the Value factor:
 - National internal claims data
 - National UM program operating costs
 - National UM authorization data

This evidentiary standard and the sources apply to M/S and MH/SUD INN inpatient services and are defined in a quantitative manner.

For M/S meeting Clinical Appropriateness is determinative in imposing the limitation. For MH/SUD meeting Clinical Appropriateness plus Value is determinative in imposing the limitation. The factors are not weighted in that no individual factor carries more importance than another in retaining the NQTL.

The factors and evidentiary standards used as the basis for subjecting MH/SUD INN inpatient benefits to Prior Authorization are comparable to, and applied no more stringently than, the factors and evidentiary standards used as the basis for subjecting M/S INN inpatient benefits to Prior Authorization “as written” and “in operation.”

Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

As Written

The Plan conducted a comparative analysis of the strategies, processes, factors, evidentiary standards, and source information used to determine which M/S and MH/SUD INN inpatient services are subject to Prior Authorization and how Prior Authorization is applied to M/S and MH/SUD INN inpatient services “as written.” The Plan identified the factors and evidentiary standards used as the basis for subjecting M/S and MH/SUD benefits to Prior Authorization.

National internal committees apply the applicable factors and standards described in Steps 2 and 3 to M/S and MH/SUD services when determining whether the services should be included on the Prior Authorization list.

Review of Factors and Evidentiary Standards

The Plan reviewed the factors that trigger an INN inpatient service to be subject to Prior Authorization. The factors and evidentiary standards were applied to M/S and MH/SUD services comparably and not more stringently to MH/SUD services than to M/S services as evidenced by the attached *Prior Authorization Factor Grid(s)*.

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Review of Operational Policies and Procedures

The Plan reviewed M/S and MH/SUD operational policies and procedures, IRR assessment processes, and UM annual oversight to confirm comparability and found MH/SUD policies, procedures, and processes to be comparable and no more stringent than M/S policies, procedures, and processes.

- Medical management operational policies and procedures establish the standards for how the Plan conducts inpatient Prior Authorization. The policies and procedures are consistent with state and federal law and accreditation requirements governing Prior Authorization. Timeframes for decisions, content of adverse benefit determinations, appeal rights, and external review are all governed by state and federal law and accreditation requirements.
- The IRR assessment measures the consistency with which clinical reviewers and peer clinical reviewers apply the Plan's clinical criteria. IRR assessment processes apply to M/S and MH/SUD inpatient services.
- UM oversight monitors and evaluates UM processes by reviewing program outcomes, clinical appeals, IRR assessments, and under- and over-utilization.

Review of Inpatient Prior Authorization Processes

The strategy for applying Prior Authorization to INN inpatient services is comparable for M/S and MH/SUD services and is applied no more stringently to MH/SUD INN inpatient services. The Plan conducted a review of the M/S and MH/SUD Prior Authorization processes to confirm comparability. The review focused on the following aspects of the process for both M/S and MH/SUD:

- Prior Authorization Request. INN M/S and MH/SUD facilities and providers are contractually responsible for submitting Prior Authorization requests. The provider can submit the Prior Authorization request through the secure provider portal, by telephone, or by fax (where required). The member is responsible for obtaining Prior Authorization for certain services that are identified in the member Plan document.
- Timeframe to Submit. *The UnitedHealthcare Administrative Guide* (for M/S) and *Optum National Network Manual* (for MH/SUD) were reviewed for notification timeframes. The timeframes for the provider or member to notify of an inpatient admission were reviewed and determined that MH/SUD was comparable and no more stringent.
 - M/S – As outlined in the *UnitedHealthcare Administrative Guide*, providers must submit advance notification with supporting documentation as soon as possible, but at least two weeks before the planned service, unless otherwise stated.
 - Unplanned or emergency admissions are not subject to Prior Authorization.
 - MH/SUD – As outlined in *Optum National Network Manual*, MH/SUD requires notification within one business day after an inpatient admission to a facility unless a longer period is required by contract or state-specific requirements.
 - Unplanned or emergency services are not subject to Prior Authorization.
- Clinical Reviews. For M/S and MH/SUD inpatient Prior Authorization requests, clinical reviewers may gather more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for certification, related diagnostic results, history of related treatment and services, and photographs. The clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. The clinical reviewer may approve cases that meet applicable clinical criteria.
- Review Time frames. M/S and MH/SUD inpatient Prior Authorization determination timeframes are defined by state, federal, and accreditation requirements. The same determination timeframes apply to M/S and MH/SUD determinations.
- Determinations and Non-Clinical Reviews, First Level Clinical Reviews, and Second Level Peer Clinical Reviews.
 - Non-clinical staff refer coverage requests that they cannot approve or administratively deny to clinical reviewers. Clinical reviewers consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether an inpatient admission is medically necessary. The clinical reviewer may approve the admission based on their review. The clinical reviewer refers cases to a peer clinical reviewer for a peer-to-peer discussion if the case cannot be approved. Only qualified peer clinical reviewers (e.g., Medical Directors) may issue adverse benefit determinations. Peer-to-peer discussions are offered as required.
 - Platinum Designation. Providers that meet the Platinum Designation are required to notify the Plan of admissions and provide member information. The Plan covers the first 13 days of a mental health

inpatient admission and 8 days of a substance use disorder inpatient admission without review.

- **Adverse Benefit Determinations and Peer-to-Peer Conversations.** The Plan offers INN inpatient facilities and providers the opportunity to discuss a potential adverse benefit determination before the Plan issues such determination. This process allows INN inpatient facilities and providers the opportunity to provide additional information and/or modify their request prior to an adverse benefit determination being issued. Only M/S and MH/SUD peer clinical reviewers (e.g., Medical Directors) may issue adverse benefit determinations for coverage of M/S and MH/SUD inpatient services.
- **Notification of Decisions to Providers and Members.** The Plan notifies M/S and MH/SUD INN facilities, providers, and members of approvals and adverse benefit determinations, including applicable appeal rights, consistent with state, federal, and accreditation requirements.
 - **INN inpatient M/S and MH/SUD services:**
 - An adverse benefit determination is recorded as a clinical denial when it is based on clinical criteria and member clinical information and is recorded as an administrative denial when member benefits are exhausted/excluded.
- **Review of Staff Qualifications.** For M/S and MH/SUD, clinical staff qualifications align with the type of clinical review and state, federal, and accreditation requirements (NCQA).
 - M/S is staffed by clinical, non-clinical, and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., nurses, physicians, etc.) and all adverse benefit determinations are made by Medical Directors.
 - MH/SUD is staffed by clinical, non-clinical, and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse determinations are made by Medical Directors.
- **Clinical Criteria.** For M/S and MH/SUD, clinical reviewers and peer clinical reviewers base determinations on the objective, evidence-based, medical/behavioral clinical policies and use clinical criteria from third party sources such as InterQual, MCG®, ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines.

In Operation

The Plan compared the strategies, processes, factors, evidentiary standards, and source information used to determine which M/S and MH/SUD INN inpatient services are subject to Prior Authorization and how Prior Authorization is applied “in operation.”

The Plan required INN M/S and MH/SUD providers to submit requests for approval of inpatient services for which the Plan requires Prior Authorization. The Plan publishes the services subject to Prior Authorization on the provider portal(s) (www.uhcprovider.com for M/S and www.providerexpress.com for MH/SUD). Members can learn what services are subject to Prior Authorization in their benefit plan document (i.e., *Schedule of Benefits*), through myuhc.com, or by contacting customer service. Notification triggered the Prior Authorization process for INN M/S and MH/SUD inpatient admissions.

M/S and MH/SUD inpatient Prior Authorization reviews included confirmation of member eligibility and benefit availability for the requested services. For M/S and MH/SUD INN inpatient services, non-clinical staff approved coverage for inpatient admissions that did not require clinical review or interpretation and where member's plan documents allowed. Non-clinical staff also approved coverage requests if the facility's contract did not allow for clinical reviews.

M/S and MH/SUD inpatient cases that were not administratively approved in initial administrative review were referred to a clinical reviewer for further research and evaluation. The M/S and MH/SUD clinical reviewers applied benefit plan documents and medical necessity criteria to member clinical information. M/S and MH/SUD clinical reviewers requested additional clinical information if they were unable to approve cases based on the available member clinical information. The clinical reviewers approved the admission based on their review when clinical criteria were met.

If the requested clinical information was not received or if the case could not be approved, M/S and MH/SUD clinical reviewers referred cases to a peer clinical reviewer. The Plan offered peer-to-peer conversations so the INN provider could provide additional clinical information prior to issuance of an adverse benefit determination. Only qualified peer clinical reviewers

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issued M/S and MH/SUD adverse benefit determinations.

The Plan communicated all adverse benefit determinations for M/S and MH/SUD inpatient cases that did not meet applicable clinical criteria consistent with state, federal, and accreditation requirements, including appeal rights, as applicable.

The Plan monitored M/S and MH/SUD clinical and peer clinical reviewers' application of clinical criteria through annual IRR assessments. The Plan also conducted quality audits of cases. The Plan routinely monitors Prior Authorization performance through its clinical performance oversight functions. In addition to comparing these "in operation" processes, the Plan reviewed medical necessity approval and denial rates, internal appeals outcomes, and external appeals outcomes related to Prior Authorization determinations for M/S and MH/SUD INN inpatient services. The results of these analyses are discussed in greater detail in Step 5.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The findings of the Plan's comparative analyses confirmed the strategies, processes, factors, evidentiary standards, and source information used to determine the MH/SUD INN inpatient services subject to Prior Authorization were comparable to, and applied no more stringently than, the strategies, processes, factors, evidentiary standards, and source information used to determine the M/S INN inpatient services subject to Prior Authorization "as written." For M/S and MH/SUD INN inpatient benefits, the *Prior Authorization Factor Grid* included with this analysis detail the shared factors used as the basis for subjecting M/S and MH/SUD INN inpatient benefits to Prior Authorization, as described above.

The Plan found the factors used to determine the MH/SUD INN inpatient services subject to Prior Authorization were comparable to, and applied no more stringently than, the factors used to determine the M/S INN inpatient services subject to Prior Authorization. Beginning in 2022, INN M/S and MH/SUD inpatient services that met the Clinical Appropriateness plus the Value factor were subject to Prior Authorization review "in operation." Certain MH/SUD facilities that attained Platinum Designation were exempt from inpatient Prior Authorization.

The Plan used comparable processes to conduct Prior Authorization review of INN M/S and MH/SUD inpatient admissions. The Plan required M/S and MH/SUD INN facilities and providers to timely submit Prior Authorization requests. The Plan used qualified staff to confirm member eligibility and benefit availability, and to request additional information if necessary. The Plan issued approvals for M/S and MH/SUD inpatient admissions that met applicable clinical criteria or guidelines. Only qualified M/S and MH/SUD peer clinical reviewers issued adverse benefit determinations. The Plan gave INN facilities and providers the opportunity to discuss potential adverse benefit determinations with qualified peer clinical reviewers prior to issuing adverse benefit determinations. This afforded INN providers the opportunity to provide additional information or alter the initial request.

The Plan operated monitoring and oversight programs to ensure that clinical reviewers and peer clinical reviewers rendered appropriate determinations. Both M/S and MH/SUD required clinical reviewers, including peer clinical reviewers, to successfully complete the annual IRR assessment. Clinical reviewers were required to pass the IRR assessment with a score of 90% or better to render UM decisions independently. The 2022 IRR M/S results were 97% and MH/SUD results were 96%, demonstrating that M/S and MH/SUD clinical reviewers comparably applied medical necessity criteria when making utilization review determinations.

INN inpatient medical necessity approval and denial rates and appeals outcomes data from 01/01/2022-12/31/2022 were evaluated where a minimum threshold of 100 cases were available to ensure a valid data set for analysis.

The findings of a comparative analysis for each Plan product (see data below) indicated the Prior Authorization process for MH/SUD INN inpatient services was comparable to the Prior Authorization process for M/S INN inpatient services.

For UnitedHealthcare Insurance Company (UHC) M/S had a clinical denial rate of 23.26% and MH/SUD had a clinical denial rate of 2.18%. The denial rates did not reflect any material differences in Prior Authorization processes.

For UnitedHealthcare of Georgia M/S had a clinical denial rate of 21.71% and MH/SUD had a clinical denial rate of 0.00%. The denial rates did not reflect any material differences in Prior Authorization processes.

The Plan notes the UM outcomes data do not reflect material differences in Prior Authorization processes for M/S or MH/SUD benefit coverage determinations. Similarly, the appeals data do not reflect that members face a materially different or more stringent review process.

The following definitions are applicable to the charts below:

- Total # of Requests Received: the aggregate number of INN inpatient prior authorization requests received
- Total # of Requests Approved: the aggregate number of INN inpatient prior authorization requests approved
- Total # of Requests Clinically Denied: the aggregate number of INN inpatient prior authorization requests that were denied for clinical reasons (request did not meet medical necessity)
- Approval Rate %: (Requests Approved / Requests Received)
- Clinical Denial Rate %: (Total number of Requests Clinically Denied / Total number of Requests Received)
- Total # of Clinical Denials reviewed upon appeal: Total (internal & external): the aggregate number of INN inpatient prior authorization clinical internal and external appeals received
- Total # of Clinical Denials Overturned upon appeal: Total (internal & external): the aggregate number of INN inpatient prior authorization clinical internal and external appeals overturned
- Clinical Denial Overturn Rate %: Total (Internal & External): percent of INN inpatient prior authorization clinical internal and external appeals overturned (Total # of Clinical Denials Overturned upon internal and external appeal/Total # of Clinical Denials reviewed upon internal and external appeal)
- Total # of Clinical Denials Upheld: Total (Internal & External): the aggregate number of INN inpatient prior authorization clinical internal and external appeals upheld
- Clinical Denial Uphold Rate %: Total (Internal & External): percent of INN inpatient prior authorization clinical internal and external appeals upheld (Total # of Clinical Denials Upheld upon internal and external appeal/Total # of Clinical Denials reviewed upon internal and external appeal)
- Total # of Clinical Denials reviewed upon internal appeal only: the aggregate number of INN inpatient prior authorization clinical internal appeals received
- Total # of Clinical Denials Overturned upon internal appeal only: the aggregate number of INN inpatient prior authorization clinical internal appeals overturned
- Clinical Denial Overturn Rate %, internal appeal only: percent of INN inpatient prior authorization clinical internal appeals overturned (Total # of Clinical Denials Overturned upon internal appeal/Total # of Clinical Denials reviewed upon internal appeal)
- Total # of Clinical Denials Upheld upon internal appeal: the aggregate number of INN inpatient prior authorization clinical internal appeals upheld
- Clinical Denial Uphold Rate %, internal appeal only: percent of INN inpatient prior authorization clinical internal appeals upheld (Total # of Clinical Denials Upheld upon internal appeal/Total # of Clinical Denials reviewed upon internal appeal)
- Total # of Clinical Denials reviewed upon external appeal only: the aggregate number of INN inpatient prior authorization clinical external appeals received
- Total # of Clinical Denials Overturned upon external appeal only: the aggregate number of INN inpatient prior authorization clinical external appeals overturned
- Clinical Overturn Rate %, external appeal only: percent of INN inpatient prior authorization clinical external appeals overturned (Total # of Clinical Denials Overturned upon external appeal/Total # of Clinical Denials reviewed upon external appeal)

external appeal)

- Total # of Clinical Denials Upheld upon external appeal: the aggregate number of INN inpatient prior authorization clinical external appeals upheld
- Clinical Uphold Denial Rate %, external appeal only: percent of INN inpatient prior authorization clinical external appeals upheld (Total # of Clinical Denials Upheld upon external appeal/Total # of Clinical Denials reviewed upon external appeal)

UHC

Outcomes Data Prior Authorization Review Analysis:	In-Network Inpatient	
	M/S	MH/SUD
Total # of Requests Received	1,290	367
Total # of Requests Approved	990	356
Total # of Requests Clinically Denied	300	8
Approval Rate %	76.74%	97.00%
Clinical Denial Rate %	23.26%	2.18%
Total # of Clinical Denials reviewed upon appeal-Total (Internal & External)	9	1
Total # of Clinical Denials Overturned upon appeal--Total (Internal & External)	4	0
Clinical Denial Overturn Rate %- Total (Internal & External)	44.44%	0.00%
Total # of Clinical Denials Upheld-Total (Internal & External)	5	1
Clinical Denial Uphold Rate %--Total (Internal & External)	55.56%	100.00%
Total # of Clinical Denials reviewed upon internal appeal only	9	1
Total # of Clinical Denials Overturned upon internal appeal only	4	0
Clinical Denial Overturn Rate %, internal appeal only	44.44%	0.00%
Total # of Clinical Denials Upheld upon internal appeal	5	1
Clinical Denial Uphold Rate %, internal appeal only	55.56%	100.00%
Total # of Clinical Denials reviewed upon external appeal only	0	0
Total # of Clinical Denials Overturned upon external appeal only	0	0
Clinical Overturn Rate %, external appeal only	-	-
Total # of Clinical Denials Upheld upon external appeal	0	0
Clinical Uphold Denial Rate %, external appeal only	-	-

UHC GA

Outcomes Data Prior Authorization Review Analysis:	In-Network Inpatient	
	M/S	MH/SUD
Total # of Requests Received	129	54
Total # of Requests Approved	101	54
Total # of Requests Clinically Denied	28	0
Approval Rate %	78.29%	100.00%
Clinical Denial Rate %	21.71%	0.00%
Total # of Clinical Denials reviewed upon appeal--Total (Internal & External)	3	0
Total # of Clinical Denials Overturned upon appeal--Total (Internal & External)	2	0
Clinical Denial Overturn Rate %- Total (Internal & External)	66.67%	-
Total # of Clinical Denials Upheld--Total (Internal & External)	1	0
Clinical Denial Uphold Rate %--Total (Internal & External)	33.33%	-
Total # of Clinical Denials reviewed upon internal appeal only	3	0
Total # of Clinical Denials Overturned upon internal appeal only	2	0
Clinical Denial Overturn Rate %, internal appeal only	66.67%	-
Total # of Clinical Denials Upheld upon internal appeal	1	0
Clinical Denial Uphold Rate %, internal appeal only	33.33%	-
Total # of Clinical Denials reviewed upon external appeal only	0	0
Total # of Clinical Denials Overturned upon external appeal only	0	0
Clinical Overturn Rate %, external appeal only	-	-
Total # of Clinical Denials Upheld upon external appeal	0	0
Clinical Uphold Denial Rate %, external appeal only	-	-

Conclusions

The Plan reviewed the M/S and MH/SUD Prior Authorization operational policies and procedures and concluded the methodology used to determine which MH/SUD INN inpatient services are subject to Prior Authorization “as written” were comparable to, and applied no more stringently than, the methodology used to determine which M/S INN inpatient services are subject to Prior Authorization “as written.” Additionally, the Plan concluded that how Prior Authorization is applied to MH/SUD INN inpatient services was comparable to, and applied no more stringently than, how Prior Authorization is applied to M/S INN inpatient services “as written.”

The Plan reviewed the M/S and MH/SUD processes including responsibility for submission, timeframes for submission and review, notification to members and providers, clinical standards for review, staff qualifications, outcomes data, and IRR assessment results and concluded how the Plan conducts Prior Authorization for MH/SUD INN inpatient services “in operation” was comparable to, and applied no more stringently than, how the Plan conducts Prior Authorization for M/S INN inpatient services “in operation.”

Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical/surgical (M/S) benefits. This generally means that financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements, such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage.

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth the findings and conclusions both “as written” and “in operation” (Step 5).

Specific NQTL

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Prior Authorization is defined as: “A required or mandatory clinical assessment for proposed service(s) based on clinical information provided and the terms of the health plan benefits before the service(s) are performed or delivered. Clinical and medical necessity requirements, level of care appropriateness, and the terms of the health plan benefits must be met in order for services to be covered by the member’s plan.” The *Optum National Policy Definitions List* defines pre-authorization (aka Prior Authorization) as “a form of prospective utilization review of health care services proposed to be provided to a member.”

Prior Authorization is a component of the Plan’s Utilization Management (UM) program that helps ensure members receive appropriate coverage based on their specific clinical status and health care needs. The process is designed to achieve optimal clinical outcomes by applying objective, evidence-based clinical criteria and nationally recognized guidelines and best practices.

Prior Authorization for outpatient services commences prior to a service being delivered. Prior Authorization is a UM process that involves applying the benefit plan language and/or clinical criteria to make the most appropriate clinical coverage benefit determination.

This document includes the following information:

- Prior Authorization process for M/S and MH/SUD outpatient services
- Description of the NQTL and application (Step 1)
- Factors used to determine which services are subject to the NQTL (Step 2)
- Evidentiary standards and sources used to define, trigger and/or implicate a factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

This analysis refers to the following attachments:

- *Addendum A* - Identifies the M/S and MH/SUD outpatient services that are subject to Prior Authorization
- *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions* - M/S policy that defines Prior Authorization
- *Optum National Policy Definitions List* - MH/SUD policy that defines Prior Authorization

- *Utilization Management Program Description (UMPD) of United HealthCare Services, Inc. and UnitedHealthcare Insurance Company* - Summarizes the philosophy, structure and standards that govern UHC's medical management, UM and utilization review responsibilities and functions
- *Management of Behavioral Health Benefits Policy* - Describes the mechanisms and processes designed to promote consistency in the management of behavioral health benefits and to ensure that members receive appropriate, high quality behavioral health services in a timely manner
- *Prior Authorization Factor Grid(s) provided for (2023 Prior Auth_Concurrent Rev Factor Grid)* - Details the service categories subject to Prior Authorization and the shared factors and evidentiary standards used as the basis for subjecting M/S and MH/SUD outpatient benefits to Prior Authorization
- *Core Principles and Practices* - MH/SUD policy that outlines the core principles and practices that should be used by personnel in their interactions with members, authorized member representatives, practitioners and facilities, related to the management of behavioral health benefits, coverage determinations and appeals/grievances of non-coverage determinations.
- *Performance Assessment and Incentives* - M/S policy confirming that clinical reviewers are not incented to make denials for financial reasons
- *2023 UnitedHealthcare Provider Administrative Guide* – Informs M/S providers of the Prior Authorization process. The *UnitedHealthcare Provider Administrative Guide* can be accessed on the website <https://www.uhcprovider.com/en/admin-guides.html>
- *September 2023 Optum National Network Manual* - Informs MH/SUD providers of the Prior Authorization process. <https://public.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/optum-network-manual.html>
- *Certificates of Coverage (COC23-INS-2018-LG-GA, COC23-HMO-2018-LG-GA, COC23-INS-2018-SG-GA and COC23-HMO-2018-SG-GA)* - Plan documents that explains covered services, terms, conditions, and limitations of the member's policy
- *Schedule of Benefits (SBN23-Medical-INS-2018-[Charter][Navigate][Nexus+[N]R]-LG-GA, SBN23-Medical-INS-2018-[Choice+Plus][Select+Plus][Doctors+Plus]-LG-GA, SBN23-Medical-INS-2018-[Core][Nexus+OAP]-LG-GA, SBN23-Medical-INS-2018-[Core+Essential][Nexus+OA]-LG-GA, SBN23-Medical-HMO-2018-[Charter][Navigate][Nexus+[N]R]-LG-GA, SBN23-Medical-INS-2018-[Choice+Plus][Select+Plus][Doctors+Plus]-SG-GA, SBN23-Medical-HMO-2018-[CharterBal][NavigateBal][Nexus+[N]RB]-LG-GA, SBN23-Medical-HMO-2018-[CharterPls][NavigatePls][Nexus+[N]RP]-LG-GA, SBN23-Medical-HMO-2018-[Choice][Select][Doctors]-LG-GA, SBN23-Medical-HMO-2018-[Core][Nexus+OAP]-LG-GA, SBN23-Medical-HMO-2018-[Core+Essential][Nexus+OA]-LG-GA, SBN23-Medical-INS-2018-NonDifferential-LG-GA, and SBN23-Medical-HMO-2018-[Choice][Select][Doctors]-SG-GA)* - Plan documents that outlines member responsibilities

The Plan concludes that the Prior Authorization requirements for M/S and MH/SUD are comparable and applied no more stringently for MH/SUD in-network (INN) outpatient benefits both "as written" and "in operation."

Process

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Prior Authorization is defined as: "A required or mandatory clinical assessment for proposed service(s) based on clinical information provided and the terms of the health plan benefits before the service(s) are performed or delivered. Clinical and medical necessity requirements, level of care appropriateness, and the terms of the health plan benefits must be met in order for services to be covered by the member's plan." The *Optum National Policy Definitions List* defines pre-authorization (aka Prior Authorization) as "a form of prospective utilization review of health care services proposed to be provided to a member."

The Plan structures outpatient Prior Authorization processes to be compliant with all applicable federal and state requirements, as well as the National Committee for Quality Assurance (NCQA) accreditation standards. NCQA confirms that Plan operations and policies identify appropriate timeframes for decisions, requires decision-making by appropriate personnel, and governs communication of adverse benefit determinations. In addition, Prior Authorization is governed at both the state and federal level, which includes consumer protections such as external review for adverse benefit determinations after

internal appeals options are exhausted.

The Plan delegates management of MH/SUD outpatient services, including Prior Authorization, to United Behavioral Health d/b/a Optum Behavioral Health (OBH), its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor.

The Plan has national committees that approve M/S and MH/SUD outpatient services to be subject to Prior Authorization. Additionally, the Plan has a standard process for assessing the services that are subjected to Prior Authorization and whether they should be retained or removed from the Prior Authorization list. *Addendum A* includes the list of service categories subject to Prior Authorization. The Plan publishes the services subject to Prior Authorization on the provider portal(s) ([Advance Notification and Clinical Submission Requirements | UHCprovider.com](#) for M/S and [Optum - Provider Express Home](#) for MH/SUD). Members can learn what services are subject to Prior Authorization in their benefit plan document, through <https://member.uhc.com/myuhc>, myuhc.com, or by contacting customer service.

Prior Authorization review of M/S outpatient services consists of the following:

The Plan requires INN providers to submit a Prior Authorization request for services on the Prior Authorization list prior to rendering the service. There may be some INN benefits for which the member is responsible for obtaining Prior Authorization. These are identified in the member's benefit plan document (i.e., *Schedule of Benefits*). The INN provider's submission of a request (notification) triggers the Prior Authorization process.

INN providers may submit Prior Authorization requests through the secure provider portal (www.uhcprovider.com), their connected electronic medical record, by telephone, or by fax (where required). Members may submit Prior Authorization requests by phone, fax, or mail, in accordance with Plan requirements. Providers and members communicate basic information to create a case. As outlined in the *UnitedHealthcare Care Provider Administrative Guide*, providers must submit advance notification with supporting documentation as soon as possible, but at least two weeks before the planned service, unless otherwise stated.

The Plan confirms receipt of the Prior Authorization request. Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. Non-clinical staff review cases to ensure availability of accurate and thorough case information. Non-clinical staff may approve coverage requests in scenarios where the member's plan documents allow and if a clinical review is not required. Requests that are submitted through the secure provider portal may also be approved based on the benefit plan coverage criteria, member diagnosis, and the clinical information submitted. Non-clinical staff may administratively deny coverage when a member's benefits are exhausted. Non-clinical staff refer cases that they cannot approve or administratively deny to the initial clinical reviewers for medical necessity review.

First Level Clinical Review/Initial Review. Clinical reviewers (nurses) consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs to determine whether the applicable clinical criteria are met. The clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. The clinical reviewer can approve cases that meet applicable clinical criteria.

Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Peer clinical reviewers (physician or mid-level practitioner) consult clinical criteria when making clinical coverage benefit determinations. Peer clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs. The peer clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If a peer clinical reviewer issues an adverse benefit determination, then

the Plan communicates the adverse benefit determination, including appeal rights, and offers a peer-to-peer conversation consistent with state, federal, and accreditation requirements.

Adverse Benefit Determination. For M/S an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when member benefits are exhausted. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials. Modified coverage requests that are approved are recorded as partial denials.

Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based, medical clinical policies or use clinical criteria from third-party sources such as InterQual® or MCG® guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that outpatient Prior Authorization determinations are appropriate.

M/S monitors clinical reviewer and peer clinical reviewer application of clinical criteria through an annual inter-rater reliability (IRR) assessment that is provided by InterQual. Clinical reviewers and peer clinical reviewers are required to pass the IRR assessment with a score of 90% or better through three attempts. After a second failed IRR assessment, staff enter a remediation period and are required to review all cases with a supervisor for 30 days, or until 90% is achieved on the assessment. If the clinical reviewer achieves a passing score within the 30-day period, supervisors review a minimum of one case per week for the remainder of the 30-day period.

The Plan also conducts end-to-end case audits that are designed and approved by clinical leadership each year. The end-to-end audits include all stages of a case review, from intake through appeal. These audits are conducted monthly and approximately 1500 cases are reviewed per month. Results are reported to an oversight team. All deficiencies are remediated. Remediation may include corrective actions and/or additional education, as indicated.

The Plan routinely monitors Prior Authorization performance through its clinical performance oversight functions. Outcomes are monitored against timeliness compliance, performance guarantees, and for potential trends, including overall utilization.

The Plan's National Medical Care Management Committee (NMCMC) annually reviews overall UM program outcomes, to confirm overall utilization is appropriate. The NMCMC is comprised of the Chief Medical Officer, and representatives from clinical policy, clinical advocacy and grievances, business standardization and advancement, regional chief medical officers, inpatient care management, lines of business, medical policy, clinical operations, and Optum Behavioral Health. The Chair of the NMCMC must be an executive leader and licensed physician.

As of April 1, 2023, the Utilization Management Program Committee (UMPC) began overseeing the M/S UM program. The UMPC is responsible for the development and maintenance of the M/S Prior Authorization processes. The UMPC ensures that the UM program considers the factors and evidentiary standards for applying UM. The UMPC is comprised of:

- Chief Medical Officer, Medical Management (Co-Chair)
- Senior Vice President, Clinical Advancement (Co-Chair)
- Chief Medical Officer, UnitedHealthcare
- Senior Vice President, Clinical Appeals & Grievances
- Chief Medical Officer, Clinical Policy
- Chief Medical Officer, UnitedHealthcare Employer & Individual
- Chief Medical Officer, UnitedHealthcare Medicare & Retirement
- Chief Medical Officer, Community & State
- Chief Medical Officer, UnitedHealthcare Individual & Family Plans
- Vice President, Clinical Transformation & Affordability

- Senior Director, Mental Health Parity
- Vice President, Utilization Management Strategy & Implementation

One of the chairs must be an executive leader and a licensed physician. UMPC meets at least six times per year but may meet more frequently if needed.

Per the M/S policy entitled, *Performance Assessment and Incentives*, at no time are initial or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons.

M/S generally structures UM processes to comply with federal Employee Retirement Income Security Act of 1974 (ERISA) requirements, NCQA UM standards, and state law where applicable.

Prior Authorization review of MH/SUD outpatient services consists of the following:

The Plan delegates management of MH/SUD outpatient services, including Prior Authorization, to United Behavioral Health d/b/a OBH, its delegated MH/SUD MBHO vendor.

The Plan requires INN providers to submit a Prior Authorization request for services on the Prior Authorization list prior to rendering the service. There may be some INN benefits for which the member is responsible for obtaining Prior Authorization. These are identified in the member's benefit plan document (i.e., *Schedule of Benefits*).

INN providers may submit Prior Authorization requests through the secure provider portal (www.providerexpress.com), by telephone, or by fax (where required). Providers and members communicate basic information to create a case. As outlined in the *Optum National Network Manual*, most routine outpatient behavioral health services do not require an initial pre-authorization or notification in advance of the service. The INN provider's submission of a request (notification) triggers the Prior Authorization process.

As described in the *Management of Behavioral Health Benefits Policy*, the Plan confirms receipt of the Prior Authorization request. Non-clinical staff confirm member eligibility and benefit plan coverage. Non-clinical staff may approve cases that do not require clinical evaluation or interpretation based on the member's diagnosis and the clinical information submitted by providers. Non-clinical staff may administratively deny coverage when member benefits are exhausted. Non-clinical staff refer cases that they cannot approve or administratively deny to the initial clinical reviewers.

First Level Clinical Review/Initial Review. Clinical decisions are made by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse benefit determinations are made by Medical Directors or psychologists. Clinical reviewers consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether a service is medically necessary by reviewing the member's clinical information, the applicable clinical criteria or guidelines, and the Plan benefit terms. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for certification, related diagnostic results, and history of related treatment and services. The clinical reviewer may approve cases that meet applicable clinical criteria.

Second Level Clinical Review/Peer Review. The initial clinical reviewer refers cases to a peer clinical reviewer for a peer-to-peer discussion if the case cannot be approved. The requesting provider is offered the opportunity to discuss the case with the peer clinical reviewer, consistent with state, federal, and accreditation requirements, before an adverse benefit determination is issued. Only qualified peer clinical reviewers (e.g., Medical Directors or psychologists) can issue adverse benefit determinations. Peer clinical reviewers apply clinical criteria to member clinical information to determine coverage. If the requesting provider fails to complete the peer-to-peer discussion, the peer clinical reviewer makes a determination based on the information available. If a peer clinical reviewer issues an adverse benefit determination (e.g., the number of treatments are not authorized), then the Plan timely communicates the adverse benefit determination including appeal rights, to the member and provider consistent with applicable state, federal, and accreditation requirements.

Adverse Benefit Determination. For MH/SUD, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as a clinical denial when it is based on clinical criteria and member clinical information and is recorded as an administrative denial when member benefits are excluded.

Intensive Outpatient Program (IOP) Practice Management. The Plan identifies INN MH/SUD IOP facilities and clinics that demonstrate effective performance based on readmission rates, lengths of stay, and post-discharge outcomes for inclusion in Practice Management. INN MH/SUD facilities or clinics that meet these performance criteria do not have to obtain Prior Authorization for IOP services. Instead, the facilities submit claims post-service, which the Plan pays.

Platinum Designation. The Plan offers a Platinum Designation program to MH/SUD providers based on facilities' quantitative practice patterns (effectiveness and efficiency benchmarks). The Platinum Designation program's effectiveness and efficiency benchmarks include targeted 30- and 90-day readmission rates, 7- and 30-day follow up after hospitalization, outlier length of stay, and outlier behavioral health episode spend. INN MH/SUD facilities that meet the Platinum Designation are required to notify the Plan of admissions to Partial Hospitalization Program (PHP) and provide member information. The Plan covers the first 17 days of admission to PHP without review. Facilities notify the Plan if additional days are needed. The Plan evaluates INN MH/SUD facilities' performance annually as described in the *Optum National Network Manual*.

Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity clinical coverage determinations on objective, evidence-based behavioral clinical policies or use clinical criteria from third-party sources such as American Society of Addiction Medicine (ASAM) Criteria®, Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System-Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) and Early Childhood Service Intensity Instrument (ECSII) guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that outpatient Prior Authorization determinations are appropriate.

MH/SUD monitors clinical reviewer and peer clinical reviewer application of clinical criteria through an annual IRR assessment. Clinical reviewers and peer clinical reviewers are required to pass the IRR assessment with a score of 90% or better through three attempts. After a second failed IRR assessment, the reviewer enters a remediation period and is required to review all cases with a supervisor for 30 days, or until 90% is achieved on the assessment. If the clinical reviewer achieves a passing score within the 30-day period, supervisors review a minimum of one case per week for the remainder of the 30-day period.

The Plan also conducts monthly quality audits of individual non-clinical staff, clinical reviewers, and peer clinical reviewers, including staff performing appeal functions. These audits are designed and approved by clinical leadership each year. A minimum of two audits are completed per staff, per month. The results of these real-time audits are shared with supervisors for staff oversight, and all findings are remediated. Remediation may include corrective actions and/or additional education, as indicated.

The Plan routinely monitors Prior Authorization performance through its clinical performance oversight functions. Outcomes are monitored against timeliness compliance, performance guarantees, and for potential trends, including overall utilization.

The Plan's national Clinical Quality & Operations Committee (CQOC) annually reviews overall UM program outcomes, including outpatient Prior Authorization outcomes, to confirm overall utilization is appropriate. The national CQOC is comprised of representatives from sub-committees, and representatives from the clinical quality improvement, UM, care engagement, medical operations, medical policy and standards, clinical operations, appeals, product, legal, compliance, network strategy, provider experience, accreditation, and benefits teams. The Chair of the CQOC must be an executive leader, board certified in psychiatry or psychiatric subspecialty and a licensed physician.

Per the MH/SUD policy entitled, *Core Principles and Practices*, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse clinical coverage benefit determinations (clinical denials) for financial reasons. MH/SUD generally structures UM processes to comply with federal ERISA requirements, NCQA UM standards, and state law where applicable.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- Prior Authorization

Benefit Classification(s)

- INN, outpatient

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHIC)
- UnitedHealthcare of Georgia, Inc. (UHCGA)

Plan Terms/Source Document(s)

In each of the Plan products, “Medically Necessary” is the Plan term used to guide Prior Authorization decision-making for both M/S and MH/SUD services. “Medically Necessary” is generally defined as follows:

- “Medically Necessary – health care services are all of the following as determined by us or our designee:
 - In accordance with Generally Accepted Standards of Care.
 - Clinically appropriate, in terms of type, frequency, extent, service site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms.
 - Not mainly for your convenience or that of your doctor or other health care provider.
 - Not more costly than an alternative drug, service(s), service site or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

Generally Accepted Standards of Care are evidence based independent standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties. Valid, evidence based sources reflecting generally accepted standards of care include credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We have the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be determined by us.

We develop and maintain clinical policies that describe the Generally Accepted Standards of Care scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by us and revised from time to time), are available to Covered Persons through www.myuhc.com or the telephone number on your ID card. They are also available to Physicians and other health care professionals on www.UHCprovider.com.

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Prior Authorization

is defined as:

“A required or mandatory clinical assessment for proposed service(s) based on clinical information provided and the terms of the health plan benefits before the service(s) are performed or delivered. Clinical and medical necessity requirements, level of care appropriateness, and the terms of the health plan benefits must be met in order for services to be covered by the member's plan.”

The *Optum National Policy Definitions List* defines pre-authorization (aka Prior Authorization) as “a form of prospective utilization review of health care services proposed to be provided to a member.”

The Plan's *Schedule of Benefits* notify members of the Prior Authorization requirements:

“We require prior authorization for certain Covered Health Care Services. Network providers are responsible for obtaining prior authorization before they provide these services to you.

We recommend that you confirm with us that all Covered Health Care Services have been prior authorized as required. Before receiving these services from a Network provider, you may want to call us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they do not prior authorize as required. You can call us at the telephone number on your ID card.

When you choose to receive certain Covered Health Care Services from out-of-Network providers, you are responsible for obtaining prior authorization before you receive these services. Note that your obligation to obtain prior authorization is also applicable when an out-of-Network provider intends to admit you to a Network facility or to an out-of-Network facility or refers you to other Network or out-of-Network providers. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization. Services for which you are required to obtain prior authorization are shown in the Schedule of Benefits table within each Covered Health Care Service category.

To obtain prior authorization, call the telephone number on your ID card. This call starts the utilization review process.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the Schedule of Benefits table to find out how far in advance you must obtain prior authorization.

For Covered Health Care Services that do not require you to obtain prior authorization, when you choose to receive services from out-of-Network providers, we urge you to confirm with us that the services you plan to receive are Covered Health Care Services. That is because in some instances, certain procedures may not be Medically Necessary or may not otherwise meet the definition of a Covered Health Care Service, and therefore are excluded. In other instances, the same procedure may meet the definition of Covered Health Care Services. By calling before you receive treatment, you can check to see if the service is subject to limitations or exclusions.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those received, our final coverage determination will be changed to account for those differences, and we will only pay Benefits based on the services delivered to you. If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Care Service, you will be responsible for paying all charges and no Benefits will be paid.”

The *2023 UnitedHealthcare Care Provider Administrative Guide* notifies providers of the Prior Authorization requirements. INN providers are required to comply with UM protocols established by the Plan:

“We require prior authorization for all MA benefit plans and some commercial benefit plans. Prior authorization requests allow us to verify if services are medically necessary and covered. After you notify us of a planned service listed on the Advance Notification/Prior Authorization List, we tell you if a clinical coverage review is required, as part of our prior authorization process, and what additional information we need to proceed. We notify you of our coverage decision within the time required by law. Just because we require notification for a service, does not mean it is covered. We determine coverage by the member’s benefit plan.

If there is a conflict or inconsistency between applicable regulations and the notification requirements in this guide, the applicable regulations govern.

Physicians, health care professionals and ancillary care providers are responsible for:

- Providing advance notification or requesting prior authorization for services on the Advance Notification/Prior Authorization List, including
- for non-emergent air transport services.
- Directing members to use care providers within their network. Members may be required to obtain prior authorization for out-of-network services.

If you perform multiple procedures for a member in one day, and at least one service requires prior authorization, you must obtain Prior authorization for any of the services to be paid.

If you do not follow these requirements, we may deny claims. In that case, you cannot bill the member. Advance notification or prior authorization is valid only for the date of service or date range listed on it. If that specified date of service or date range has passed, you must submit a new request.

Giving us advance notification, or receiving prior authorization from us, is not a guarantee of payment, unless required by law or Medicare guidelines. This includes regulations about care providers on either a sanctions and excluded list, the Medicare preclusion list and/or care providers not included in the Medicare Provider Enrollment Chain and Ownership System (PECOS)* list. Payment of covered services is based on:

- The member’s benefit plan,
- If you are eligible for payment,
- Claim processing requirements, and Your Agreement.

The list of services that require advance notification and prior authorization is the same. The process for providing notification and submitting a prior authorization request is the same. Services that require Prior authorization require a clinical coverage review based on medical necessity.

Advance notification/prior authorization lists are available online. They are subject to change. We will post inform you of changes on UHCprovider.com/networknews > Network Bulletin. Sign up to receive the Network Bulletin by email at UHCprovider.com/subscribe.

If you need a paper copy of the requirements, contact your UnitedHealthcare Network Management representative or provider advocate. We recommend that you submit advance notification with supporting documentation as soon as possible, but at least 2 weeks before the planned service (unless the Advance Notification Requirements states otherwise). Following a facility discharge, advance notification for home health services and durable medical equipment is required within 48 hours after the start of service.”

The *Optum National Network Manual*, September 2023 Edition notifies providers of the Prior Authorization requirements. INN providers are required to comply with UM protocols established by the Plan:

“In accordance with the Agreement and many Benefit Plans, most routine outpatient behavioral health services do not require an initial pre-authorization or notification. Some non-routine outpatient services require ongoing authorization prior to providing services. These may include, but are not limited to, the following:

- Outpatient Electro-Convulsive Treatment
- Applied Behavioral Analysis (ABA) for the treatment of Autism
- Transcranial Magnetic Stimulation (TMS) (for MDs only)
- Psychological Testing

Authorization for some non-routine services may be requested online:

- ABA services: Provider Express > Autism Corner: Autism/ABA Information
 - ABA Assessment Portal (electronic authorization request submissions)
 - ABA Treatment Request Documents (please review webpage for specific forms)
- Psychological/Neuropsychological Testing: Provider Express > Clinical Resources > Forms > Psychological Testing Request Forms:
 - Optum Psychological and Neuropsychological Testing Request Form
- Transcranial Magnetic Stimulation (TMS) & Electroconvulsive Therapy (ECT) (electronic submission)
 - TMS & ECT Authorization Request Form (electronic submission)

For authorization of other non-routine outpatient services, call the number on the Member's ID Card. For more information refer to the "Psychological Testing" section below.

Authorizations for non-routine outpatient services are specific to the requesting Clinician. The Clinician will receive a copy of this authorization. When a written authorization lists a range of CPT and/or HCPCS codes, payment for any specific code is subject to ongoing medical necessity review.

Psychological testing must be pre-authorized separately for both outpatient and inpatient services. Psychological testing is considered after a standard evaluation (including clinical interview, direct observation and collateral input, as indicated) has been completed and one of the following circumstances exists:

- There are significant diagnostic questions remaining that can only be clarified through testing
- There are questions about the appropriate treatment course for a patient, or a patient has not responded to standard treatment with no clear explanation, and testing would have a timely effect on the treatment plan
- There is reason to suspect, based on the initial assessment, the presence of cognitive, intellectual and/or neurological deficits or impairment that may affect functioning or interfere with the patient's ability to participate in or benefit from treatment, and testing will verify the presence or absence of such deficits or dysfunction

In some cases where a member in need of testing has already received sufficient evaluation to conclude testing is necessary, it is permissible to conduct the initial interview intake on the same day of service as testing.

Generally, psychological testing solely for purposes of education or school evaluations, learning disorders, legal and/or administrative requirements is not covered. Also not covered are tests performed routinely as part of an assessment. We recommend that you contact Optum pre-service to determine authorization requirements and procedures."

The role of the Plan's delegate, United Behavioral Health d/b/a OBH, is discussed in the UMPD:

"United Behavioral Health (UBH) performs the review of requests for coverage of behavioral health services (i.e., substance abuse, and mental health requests for services). UBH provides comprehensive behavioral health care delivery for members through a network of behavioral health practitioners, ancillary care providers, hospitals and other facilities.

For mental health, substance-related disorder services, and wraparound services, UBH uses its Clinical Criteria (see below), behavioral clinical policies and best practice guidelines to make coverage determinations. UBH adopts externally-developed clinical criteria, and creates internally-developed Clinical Criteria, where appropriate, based on its assessment of relevant guidance. UBH develops clinical criteria that supersedes its standard set or adopts externally-developed clinical criteria when required to do so by contract or regulation.

- Clinical Criteria (Level of Care Utilization System-LOCUS) – Standardized level of care assessment tool developed by the American Association of Community Psychiatrists used to make clinical determinations and placement decisions for mental health disorder benefits for adults ages 19 and older when State or Contract

Specific Level of Care Guidelines do not apply.

- Clinical Criteria (Child and Adolescent Level of Care/Service Intensity Utilization System-CALOCUS-CASII) - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry (AACAP) and the American Association for Community Psychiatry (AAPC) used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children and adolescents ages 6-18 when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (Early Childhood Service Intensity Instrument-ECSII) - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children ages 0-5 when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (State or Contract Specific Level of Care Guidelines) – Criteria used to make medical necessity determinations for mental health disorder benefits when there are explicit mandates or contractual requirements.
- Clinical Criteria (American Society of Addiction Medicine [ASAM]) - Criteria developed by the American Society of Addiction Medicine used to make clinical determinations for substance-related disorder benefits.
- Clinical Criteria (Optum Developed)
 - Optum Behavioral Clinical Policies: Criteria that stem from evaluation of new services or treatments or new applications of existing services or treatments and are used to make clinical determinations regarding proven or unproven services and treatments.

Licensed practitioners conduct all reviews with a focus on measurable outcome goals and objectives for treatment. A senior UBH Medical Director is responsible for directing and implementing behavioral health utilization management programs. A referral is sent to UBH when a member is identified as potentially benefiting from behavioral health services during a “medical event.”

The UBH UM Program is staffed by clinical, non-clinical and administrative personnel. All clinical denials or adverse decisions are made by board certified psychiatrists, or, if the health plans choose, by a panel of other appropriate health care service reviewers. If the health plan chooses to use a panel to make adverse decisions, the panel contains at least one physician who is board certified in psychiatry. When the health care service under review is a mental health or substance abuse service, the adverse decision is made by a licensed physician who is board certified in psychiatry. All potential clinical denials are referred to a physician who is board certified in psychiatry for final determination. An evaluation of the overall effectiveness of the Behavioral Health UM Program is conducted annually to determine how well resources have been deployed to improve UM activities and the clinical care and service provided to members.”

The Plan’s terms require services to be medically necessary for coverage.

List of M/S and MH/SUD Services Subject to NQTL

Addendum A, attached, lists the M/S and MH/SUD INN outpatient service categories subject to Prior Authorization requirements. Prior Authorization is one component of the UM program that evaluates whether a benefit or service is medically necessary.

- The “Member”- tab lists the service categories for which the member is responsible for obtaining authorization for INN services. The “Member” tab includes all products in the scope of the analysis.
- The “Provider” tab lists the service categories for which the provider is responsible for obtaining authorization for INN services. The “Provider” tab applies to all products in the scope of the analysis.

Step 2 – Factors Used in the Design and Application of the NQTL

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

The Prior Authorization list was originally designed by enterprise clinical leadership. Prior Authorization was applied to new services when they became covered by the Plan and met certain criteria. Examples of Prior Authorization determinants that existed in the business at the time included:

- to monitor and prevent potential overutilization and under-utilization

- manage high-cost and prolonged-duration services
- ensure enrollee safety
- determine the appropriate level of care
- determine whether the service or item is medically necessary

The factors relied upon to determine which INN outpatient services by category were subjected to Prior Authorization were updated and replaced in 2021 with the factors Clinical Appropriateness, Value, and Variation as defined below. After this time, all M/S services subject to Prior Authorization must meet Clinical Appropriateness and all MH/SUD services subject to Prior Authorization must meet Clinical Appropriateness and at least one of the other factors.

Starting in 2022, any additions or deletions to the Prior Authorization list were reviewed and approved through committees.

The Plan relies on the following factors to determine which INN outpatient services are added to the Prior Authorization list. These factors apply to M/S and MH/SUD benefits for the following:

- I. M/S INN outpatient services
- II. MH/SUD INN outpatient services

- Clinical Appropriateness (Qualitative)
 - Whether the application of Prior Authorization promotes optimal clinical outcomes

Applies to M/S and MH/SUD services.

- Value (Quantitative)
 - The cost of the outpatient service exceeding the administrative costs of subjecting the outpatient service to Prior Authorization review by at least 1:1. Administrative costs of subjecting the outpatient service to Prior Authorization review are determined using the national UM program operating costs, which is comprised of the cost related to staffing. Administrative costs vary due to differences in the complexities of the requested treatment types, condition(s) treated, and/or clinical guidelines used. The cost of the outpatient service is determined using national outpatient utilization or claims data. The projected benefit cost savings of applying Prior Authorization is reviewed relative to the operating cost of administering Prior Authorization to determine value. Only services that are provided to a minimum of 100 unique individuals are considered (this is the materiality threshold established by the Plan for purposes of the Value analysis).

Applies to M/S and MH/SUD services.

- Variation (Quantitative)
 - Cost per episode of service (service units multiplied by unit cost) that trigger 2x the mean of other outpatient services. Consideration of this factor includes a review of national internal claims data for service-specific costs and calculating for M/S and MH/SUD, respectively, an overall mean of the service-specific average cost per patient. For any given M/S or MH/SUD service, if the average allowed cost per patient's episode of care is twice the average cost per patient's episode of care across all other M/S or MH/SUD outpatient services, Prior Authorization is applied. Only services that are provided to a minimum of 20 unique individuals are considered (this is the materiality threshold established by the Plan for the purposes of the Variation analysis)

Applies to M/S and MH/SUD services.

For M/S meeting Clinical Appropriateness is determinative in imposing the limitation. For MH/SUD meeting Clinical Appropriateness plus Value and/or Variation is determinative in imposing the limitation. The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL.

In 2023, to further refine how decisions are made to subject INN outpatient services to Prior Authorization, the enterprise

adopted factors to be assessed when considering whether to remove or retain services on the enterprise Prior Authorization list. These changes were implemented September 2023. The assessment first considered the factors for removal of the service from the Prior Authorization list. If the service met a removal factor, the Plan then assessed if the service met a retention factor. Services that met a retention factor were retained on the Prior Authorization list. Services that did not meet a removal factor remained on the Prior Authorization list based on the original add factors.

The Plan relies on the following factors to determine which INN outpatient benefits are removed from the Prior Authorization list. These factors apply to M/S and MH/SUD benefits for the following:

- I. M/S: INN outpatient services
 - II. MH/SUD: INN outpatient services
- Low Value (Quantitative)
 - Defined as services that do not result in a minimum savings of at least \$50 per review

Applies to M/S and MH/SUD services.
 - Consistency (Quantitative)
 - Defined as consistent adherence to evidence-based guidelines as evidenced by adverse determination rate (ADR) of less than 5%

Applies to M/S and MH/SUD services.
 - Low Volume (Quantitative)
 - Defined as services with fewer than 100 authorizations per year

Applies to M/S and MH/SUD services.

Please note that if the primary code within a code family meets the requirements for removal, the family of codes will be addressed in a similar fashion per medical policy and clinical practice patterns.

The Plan then relies on the following factors to determine which INN outpatient benefits are retained on the Prior Authorization list. These factors apply to M/S and MH/SUD benefits for the following:

- I. M/S: INN outpatient services
 - II. MH/SUD: INN outpatient services
- Services that are experimental, investigational, or unproven (EIU) (Qualitative)
 - Defined as services that are classified as experimental, investigation or unproved based on medical/behavioral clinical policy

Applies to M/S and MH/SUD services.
 - Patient Safety (Qualitative)
 - As defined by the World Health Organization as “the absence of preventable harm to a patient and reduction of risk of unnecessary harm associated with health care to an acceptable minimum.”

Applies to M/S and MH/SUD services.
 - Level of Care (Quantitative)
 - Defined as Site of Service/Site of Care, and where the volume is greater than 100 requests per year

Applies to M/S and MH/SUD services.

- High-Cost Drugs and Services that are greater than \$100,000 (Quantitative)
 - Defined as services where the allowed amount is greater than \$100,000 per treated patient, per year

Applies to M/S and MH/SUD services.

For M/S meeting Clinical Appropriateness is determinative in imposing the limitation. For MH/SUD meeting Clinical Appropriateness plus Value and/or Variation is determinative in imposing the limitation. If the service met a removal factor, the Plan then assessed if the service met a retention factor. Services that met a retention factor were retained on the Prior Authorization list. Meeting any one of the factors is determinative in retaining the limitation. The factors are not weighted in that no individual factor carries more value than another in retaining the NQTL.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factors used to add services to the Plan's Prior Authorization list for INN outpatient services. These evidentiary standards and sources apply to benefits for the following:

- I. M/S INN outpatient services
- II. MH/SUD INN outpatient services

Factor – Clinical Appropriateness is defined as those outpatient services that are determined by internal medical experts to be in accordance with objective, evidence-based clinical criteria, and nationally recognized guidelines. The accompanying *Prior Authorization Factor Grid(s)* included with this analysis give details on the service categories subject to Prior Authorization. The *Prior Authorization Factor Grid(s)* detail the shared factors used as the basis for subjecting M/S and MH/SUD INN outpatient benefits to Prior Authorization.

- The Plan's evidentiary standards and sources that define and/or trigger the Clinical Appropriateness factor are:
 - Clinical criteria from nationally recognized, third-party sources (e.g., InterQual or MCG for M/S services, and ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines for MH/SUD services)
 - Clinical Technology Assessment Committee (CTAC) and Medical Technology and Assessment Committee (MTAC) review
 - Objective, evidence-based medical/behavioral clinical policies and nationally recognized guidelines approved by professional healthcare associations (e.g., clinical guidance from the American Medical Association, American Psychiatric Association, etc.)

These evidentiary standards and sources apply to M/S and MH/SUD INN outpatient services and are defined in a qualitative manner.

Factor – Value is defined as the cost of the outpatient service exceeding the administrative costs of subjecting the outpatient service to Prior Authorization by at least 1:1. Administrative costs of subjecting the outpatient service to Prior Authorization are determined using the national UM program operating costs, which is comprised of the cost related to staffing. Administrative costs vary due to differences in the complexities of the requested treatment types, condition(s) treated, and/or clinical guidelines used. The cost of the outpatient service is determined using national outpatient utilization or claims data. The projected benefit cost savings of applying Prior Authorization is reviewed relative to the operating cost of administering Prior Authorization to determine Value. Only services that are provided to a minimum of 100 unique individuals are considered (this is the materiality threshold established by the Plan for purposes of the Value analysis). The accompanying *Prior Authorization*

Factor Grid(s) contain the calculated Value for each Prior Authorization service category, for both M/S and MH/SUD, and the internal data used to determine these values.

- The Plan's evidentiary standard that defines and/or triggers the Value factor:
 - Value is defined as the cost of the outpatient service exceeding the administrative costs of subjecting the service to Prior Authorization by at least 1:1. Only services that are provided to a minimum of 100 unique individuals are considered (this is the materiality threshold established by the Plan for purposes of the Value analysis).
- The Plan's sources used to define the Value factor:
 - National internal claims data
 - National UM program operating costs
 - National UM authorization data

This evidentiary standard and sources apply to M/S and MH/SUD INN outpatient services and are defined in a quantitative manner.

Factor – Variation is defined as cost per episode of service (service units multiplied by unit cost) that trigger 2x the mean of other outpatient services. Consideration of this factor includes a review of national internal claims data for service-specific costs and calculating for M/S and MH/SUD, respectively, an overall mean of the service-specific average cost per patient. For any given M/S or MH/SUD service, if the average allowed cost per patient's episode of care is twice the average cost per patient's episode of care across all other M/S or MH/SUD outpatient services, Prior Authorization is applied. Only services that are provided to a minimum of 20 unique individuals are considered (this is the materiality threshold established by the Plan for the purposes of the Variation analysis). The accompanying *Prior Authorization Factor Grid(s)* reflect whether each category of M/S and MH/SUD INN outpatient service meets the Variation identified criteria, and contains the internal data used in the determination.

- The Plan's evidentiary standard that defines and/or triggers the Variation factor:
 - Variation is defined as cost per episode of service (service units multiplied by unit cost) that trigger 2x the mean of other outpatient services. Only services that are provided to a minimum of 20 unique individuals are considered (this is the materiality threshold established by the Plan for purposes of the Variation analysis).
- The Plan's source used to define the Variation factor:
 - National internal claims data

The evidentiary standard and source applies to M/S and MH/SUD INN outpatient services and are defined in a quantitative manner.

For M/S meeting Clinical Appropriateness is determinative in imposing the limitation. For MH/SUD meeting Clinical Appropriateness plus Value and/or Variation is determinative in imposing the limitation. The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL.

In 2023, to further refine how decisions are made to subject INN outpatient services to Prior Authorization, the enterprise adopted factors to be assessed when considering whether to remove or retain services on the enterprise Prior Authorization list. These changes were implemented September 2023. The assessment first considered the factors for removal of the service from the Prior Authorization list. If the service met a removal factor, the Plan then assessed if the service met a retention factor. Services that met a retention factor were retained on the Prior Authorization list. Services that did not meet a removal factor remained on the Prior Authorization list based on the original add factors.

The Plan relies on the following factors to determine which INN outpatient benefits are removed from the Prior Authorization list. These factors apply to M/S and MH/SUD and M/S benefits for the following:

- I. M/S: INN outpatient services

II. MH/SUD: INN outpatient services

Factor - Low Value is defined as services that do not result in a minimum savings of at least \$50 per review

- The Plan's evidentiary standard that defines and/or triggers the Low Value factor:
 - Low Value is defined as services that do not result in a minimum savings of at least \$50 per review
- The Plan's sources used to define the Low Value factor:
 - National internal claims data
 - National UM program operating costs
 - National UM authorization data

The evidentiary standard and the sources apply to M/S and MH/SUD INN outpatient services and are defined in a quantitative manner.

Factor - Consistency is defined as consistent adherence to evidence-based guidelines as evidenced by ADR of less than 5%

- The Plan's evidentiary standard that defines and/or triggers the Consistency factor:
 - Consistency is defined as consistent adherence to evidence-based guidelines as evidenced by ADR of less than 5%
- The Plan's source used to define the Consistency factor:
 - National internal UM outcomes data

The evidentiary standard and the source apply to M/S and MH/SUD INN outpatient services and are defined in a quantitative manner.

Factor - Low Volume is defined as services with fewer than 100 authorizations per year

- The Plan's evidentiary standard that defines and/or triggers the Low Volume factor:
 - Low Volume is defined as services with fewer than 100 authorizations per year
- The Plan's source used to define the Low Volume factor:
 - National internal UM outcomes data

The evidentiary standard and the source apply to M/S and MH/SUD INN outpatient services and are defined in a quantitative manner.

The Plan then relies on the following factors to determine which INN outpatient benefits are retained on the Prior Authorization list. These factors apply to M/S and MH/SUD and M/S benefits for the following:

- I. M/S: INN outpatient services
- II. MH/SUD: INN outpatient services

Factor - Services that are EIU is defined as services that are classified as experimental, investigation or unproved based on medical/behavioral clinical policy

- The Plan's evidentiary standard that defines and/or triggers the Services that are EIU factor:
 - Services that are classified as experimental, investigation or unproved based on medical policy
- The Plan's source used to define the Services that are EIU factor:
 - Medical/behavioral clinical policies

The evidentiary standard and the source apply to M/S and MH/SUD INN outpatient services and are defined in a qualitative manner.

Factor - Patient Safety is defined as “the absence of preventable harm to a patient and reduction of risk of unnecessary harm associated with health care to an acceptable minimum” by the World Health Organization.

- The Plan’s evidentiary standards that define and/or trigger the Patient Safety factor:
 - Professional judgment of members of the Utilization Management Program Committee
 - Clinical criteria from nationally recognized third-party sources (e.g., InterQual for M/S services, and ASAM, LOCUS, CALOCUS-CASII and ECSII guidelines for MH/SUD services)
 - Objective, evidence-based medical/behavioral clinical policies and nationally recognized guidelines approved by professional healthcare associations (e.g., clinical guidance from the American Medical Association, American Psychiatric Association, etc.)
- The Plan’s sources used to define the Patient Safety factor:
 - Professional judgment of members of the Utilization Management Program Committee
 - Clinical criteria from nationally recognized third-party sources (e.g., InterQual for M/S services, and ASAM, LOCUS, CALOCUS-CASII and ECSII guidelines for MH/SUD services)
 - Objective, evidence-based medical/behavioral clinical policies and nationally recognized guidelines approved by professional healthcare associations (e.g., clinical guidance from the American Medical Association, American Psychiatric Association, etc.)

These evidentiary standards and the sources apply to M/S and MH/SUD INN outpatient services and are defined in a qualitative manner.

Factor - Level of Care is defined as Site of Service/Site of Care, and where the volume is greater than 100 requests per year.

- The Plan’s evidentiary standards that define and/or trigger the Level of Care factor:
 - National internal UM outcomes data
 - National internal claims data
 - Place of service
- The Plan’s sources used to define the Level of Care factor:
 - National internal UM outcomes data
 - National internal claims data
 - Place of service

These evidentiary standards and the sources apply to M/S and MH/SUD INN outpatient services and are defined in a quantitative manner.

Factor - High-Cost Drugs and Services that are greater than \$100,000 is defined as services where the allowed amount is greater than \$100,000 per treated patient, per year.

- The Plan’s evidentiary standard that defines and/or triggers the High-Cost Drugs and Services that are greater than \$100,000 factor:
 - National internal claims data
- The Plan’s source used to define the High-Cost Drugs and Services that are greater than \$100,000 factor:
 - National internal claims data

The evidentiary standard and the source applies to M/S and MH/SUD INN outpatient services and are defined in a quantitative manner.

If the service met a removal factor, the Plan then assessed if the service met a retention factor. Services that met a retention factor were retained on the Prior Authorization list. Meeting any one of the factors is determinative in retaining the limitation. The factors are not weighted in that no individual factor carries more value than another in retaining the NQTL.

The factors and evidentiary standards used as the basis for subjecting MH/SUD INN outpatient benefits to Prior Authorization are comparable to, and applied no more stringently than, the factors and evidentiary standards used as the basis for subjecting M/S INN outpatient benefits to Prior Authorization “as written” and “in operation.”

Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

As Written

The Plan conducted a comparative analysis of the strategies, processes, factors, evidentiary standards, and source information used to determine which M/S and MH/SUD INN outpatient services are subject to Prior Authorization and how Prior Authorization is applied to M/S and MH/SUD INN outpatient services “as written.” The Plan identified the factors and evidentiary standards used as the basis for subjecting M/S and MH/SUD INN outpatient benefits to Prior Authorization.

National internal committees apply the applicable factors and standards described in Steps 2 and 3 to M/S and MH/SUD services when determining whether the services should be subjected to Prior Authorization.

Review of Factors and Evidentiary Standards

The Plan reviewed the factors that trigger an INN outpatient service to be added to, removed from, or retained on the Prior Authorization list. The factors and evidentiary standards were applied to M/S and MH/SUD services comparably and not more stringently to MH/SUD services than to M/S services as evidenced by the attached *Prior Authorization Factor Grid(s)*.

Review of Operational Policies and Procedures

The Plan reviewed M/S and MH/SUD operational policies and procedures, IRR assessment processes, and UM annual oversight to confirm comparability and found MH/SUD policies, procedures, and process to be comparable and no more stringent than M/S policies, procedures, and processes.

- Medical management operational policies and procedures establish the standards for how the Plan conducts outpatient Prior Authorization. The policies and procedures are consistent with state and federal law and accreditation requirements governing Prior Authorization. Timeframes for decisions, content of adverse benefit determinations, appeal rights and external review are all governed by state and federal law and accreditation requirements.
- The IRR assessment measures the consistency with which clinical reviewers and peer clinical reviewers apply the Plan's clinical criteria. IRR assessment processes apply to M/S and MH/SUD outpatient services.
- UM oversight monitors and evaluates UM processes by reviewing program outcomes, clinical appeals, IRR assessments, and under- and over-utilization.

Review of Outpatient Prior Authorization Processes

The strategy for applying Prior Authorization to INN outpatient services is comparable for M/S and MH/SUD services and is applied no more stringently to MH/SUD INN outpatient services. The Plan conducted a review of the M/S and MH/SUD Prior Authorization processes to confirm comparability. The review focused on the following aspects of the process for both M/S

and MH/SUD:

- **Prior Authorization Request.** INN M/S and MH/SUD providers are contractually responsible for submitting Prior Authorization requests. The provider can submit the Prior Authorization request through the secure provider portal, by telephone, or by fax (where required). The member is responsible for obtaining Prior Authorization for certain services that are identified in the Plan document.
- **Timeframe to Submit.** The timeframes for the provider or member to submit the Prior Authorization request were reviewed and it was determined that MH/SUD was comparable and no more stringent. INN providers must submit Prior Authorization requests for M/S outpatient services at least two weeks before the planned service. INN providers must submit Prior Authorization requests for MH/SUD outpatient services any time prior to receiving services.
- **Clinical Reviews.** For M/S and MH/SUD outpatient Prior Authorization requests, clinical reviewers may gather more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for certification, related diagnostic results, history of related treatment and services, and photographs. The clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. The clinical reviewer may approve cases that meet applicable clinical criteria.
- **Review Timeframes.** M/S and MH/SUD outpatient Prior Authorization determination timeframes are defined by state, federal and accreditation requirements for both urgent and non-urgent outpatient services. The same determination timeframes apply to M/S and MH/SUD determinations.
- **Determinations and Non-Clinical Reviews, First Level Clinical Reviews, and Second Level/ Peer Clinical Reviews.** For M/S and MH/SUD outpatient Prior Authorization, non-clinical staff may approve cases that do not require clinical evaluation or interpretation. Non-clinical staff may administratively deny cases when member benefits are exhausted/excluded. M/S INN outpatient cases that are submitted through the provider portal may also be approved based on the member diagnosis and the clinical information submitted.
 - Non-clinical staff refer coverage requests that they cannot approve or administratively deny to clinical reviewers. Clinical reviewers consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether an outpatient service is medically necessary. The clinical reviewer may approve the service based on their review. The clinical reviewer refers cases to a peer clinical reviewer for a peer-to-peer discussion if the case cannot be approved. Only qualified peer clinical reviewers (e.g., Medical Directors) may issue adverse benefit determinations. Peer-to-peer discussions are offered as required. For MH/SUD INN outpatient Prior Authorization there are programs through which providers who would otherwise need to request Prior Authorization are not required to do so.
- **Adverse Benefit Determination and Peer to Peer Conversations.** The Plan offers INN outpatient providers the opportunity to discuss a potential adverse benefit determination before the Plan issues such determination. This process allows INN outpatient providers the opportunity to provide additional information prior to an adverse benefit determination being issued.
 - INN outpatient M/S and MH/SUD services
 - An adverse benefit determination is recorded as a clinical denial when it is based on clinical criteria and member clinical information and is recorded as an administrative denial when member benefits are exhausted/excluded.
- **Notification of Decisions to Providers and Members.** The Plan notifies M/S and MH/SUD INN providers and members of approvals and adverse benefit determinations, including applicable appeal rights, consistent with state, federal, and accreditation requirements.
- **Review of Staff Qualifications.** For M/S and MH/SUD, clinical staff qualifications align with the type of clinical review and state, federal, and accreditation requirements (NCQA).
 - M/S is staffed by clinical, non-clinical, and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., nurses, physicians, etc.) and all adverse benefit determinations are made by a physician or other appropriate health care professionals.
 - MH/SUD is staffed by clinical, non-clinical, and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse benefit determinations are made by Medical Directors or psychologists.
- **Clinical Criteria.** For M/S and MH/SUD, clinical reviewers and peer clinical reviewers base determinations on the

objective, evidence-based medical/behavioral clinical policies and use clinical criteria from third party sources such as InterQual, MCG, ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines.

In Operation

The Plan compared the strategies, processes, factors, evidentiary standards, and source information used to determine which M/S and MH/SUD INN outpatient services are subject to Prior Authorization and how Prior Authorization is applied “in operation.”

The Plan required INN M/S and MH/SUD providers to submit requests for approval of outpatient services for which the Plan requires Prior Authorization. The Plan publishes the services subject to Prior Authorization on the provider portal(s) (www.uhcprovider.com for M/S and www.providerexpress.com for MH/SUD). Members can learn what services are subject to Prior Authorization in their benefit plan document (i.e., *Schedule of Benefits*), through myuhc.com, or by contacting customer service. Notification triggered the Prior Authorization process for INN M/S and MH/SUD outpatient services.

M/S and MH/SUD outpatient Prior Authorization reviews included confirmation of member eligibility and benefit availability for the requested services. For M/S and MH/SUD INN outpatient services, non-clinical staff approved coverage for outpatient services that did not require clinical review or interpretation.

M/S and MH/SUD outpatient cases that were not administratively approved in initial review were referred to a clinical reviewer for further research and evaluation. The M/S and MH/SUD clinical reviewers applied benefit plan documents and medical necessity criteria to member clinical information. M/S and MH/SUD clinical reviewers could request additional clinical information if they were unable to approve cases based on the available member clinical information. The clinical reviewers may approve services based on their review.

If the requested clinical information was not received or if the case could not be approved, M/S and MH/SUD clinical reviewers referred cases to a peer clinical reviewer. The Plan offered peer-to-peer conversations so the INN provider could provide additional clinical information prior to issuance of an adverse benefit determination. Only qualified peer clinical reviewers issued M/S and MH/SUD adverse benefit determinations.

The Plan communicated all adverse benefit determinations for M/S and MH/SUD outpatient cases that did not meet applicable clinical criteria consistent with state, federal, and accreditation requirements, including appeal rights, as applicable.

The Plan monitors M/S and MH/SUD clinical and peer clinical reviewers' application of clinical criteria through annual IRR assessments. The Plan also conducts monthly quality audits of individual non-clinical staff, clinical reviewers, and peer clinical reviewers, including staff performing appeal functions. The Plan routinely monitors Prior Authorization performance through its clinical performance oversight functions. In addition to comparing these “in operation” processes, the Plan reviewed medical necessity approval and denial rates, internal appeals outcomes, and external appeals outcomes related to Prior Authorization determinations for M/S and MH/SUD INN outpatient services. The results of these analyses are discussed in greater detail in Step 5.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan's or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The findings of the Plan's comparative analyses confirmed the strategies, processes, factors, evidentiary standards, and source information used to determine the MH/SUD INN outpatient services subject to Prior Authorization were comparable to, and applied no more stringently than, the strategies, processes, factors, evidentiary standards, and source information used to

determine the M/S INN outpatient services subject to Prior Authorization “as written.” For M/S and MH/SUD INN outpatient benefits, the *Prior Authorization Factor Grid(s)* included with this analysis detail the shared factors used as the basis for adding, removing, or retaining M/S and MH/SUD INN outpatient services on the Prior Authorization list, as described above.

The Plan found the factors used to add, remove, or retain MH/SUD INN outpatient services on the Prior Authorization list were comparable to, and applied no more stringently than, the factors used to add, remove, or retain M/S INN outpatient services on the Prior Authorization list. INN M/S and MH/SUD outpatient services that met the applicable factor(s) were subject to Prior Authorization “in operation.”

The Plan used comparable processes to conduct outpatient Prior Authorization review of INN M/S and MH/SUD providers’ requests. The Plan required M/S and MH/SUD INN providers to timely submit Prior Authorization requests. The Plan used qualified staff to confirm member eligibility and benefit availability, and to request additional information if necessary. The Plan issued approvals for M/S and MH/SUD outpatient services that met applicable clinical criteria or guidelines. Only qualified M/S and MH/SUD peer clinical reviewers issued adverse benefit determinations. The Plan gave INN providers the opportunity to discuss potential adverse benefit determinations with qualified peer clinical reviewers prior to issuing adverse benefit determinations. This afforded INN providers the opportunity to provide additional information.

The Plan operated monitoring and oversight programs to ensure that clinical reviewers and peer clinical reviewers rendered appropriate determinations. Both M/S and MH/SUD required clinical reviewers, including peer clinical reviewers, to successfully complete the annual IRR assessment. Clinical reviewers were required to pass the IRR assessment with a score of 90% or better to render UM decisions independently. The 2022 IRR M/S results were 97% and MH/SUD results were 96%, demonstrating that M/S and MH/SUD clinical reviewers comparably applied medical necessity criteria when making utilization review determinations.

INN outpatient medical necessity approval and denial rates and appeals outcomes data from 01/01/2022-12/31/2022 were evaluated where a minimum threshold of 100 cases were available to ensure a valid data set for analysis.

The findings of a comparative analysis for each Plan product (see data below) indicated the Prior Authorization process for MH/SUD INN outpatient services was comparable to the Prior Authorization process for INN M/S outpatient services.

For UnitedHealthcare Insurance Company (UHC), M/S had a clinical denial rate of 12.89% and MH/SUD had a clinical denial rate of 3.62%. The denial rates did not reflect any material differences in Prior Authorization processes .

For UnitedHealthcare of Georgia (UHCGA), M/S had a clinical denial rate of 11.85% and MH/SUD had a clinical denial rate of 2.84%. The denial rates did not reflect any material differences in Prior Authorization processes .

The Plan notes the UM outcomes data do not reflect material differences in Prior Authorization processes for M/S or MH/SUD benefit coverage determinations. Similarly, the appeals data do not reflect that members face a materially different or more stringent review process for MH/SUD benefit coverage determinations.

The following definitions are applicable to the charts below:

- Total # of Requests Received: the aggregate number of INN outpatient Prior Authorization requests received
- Total # of Requests Approved: the aggregate number of INN outpatient Prior Authorization requests approved
- Total # of Requests Clinically Denied: the aggregate number of INN outpatient Prior Authorization requests that were denied for clinical reasons (request did not meet medical necessity). This does not include requests that were denied administratively
- Approval Rate %: (Requests Approved / Requests Received)
- Clinical Denial Rate %: (Total number of Requests Clinically Denied / Total number of Requests Received)
- Total # of Clinical Denials reviewed upon appeal: Total (internal & external): the aggregate number of INN outpatient Prior Authorization clinical internal and external appeals received
- Total # of Clinical Denials Overturned upon appeal: Total (internal & external): the aggregate number of INN outpatient

Prior Authorization clinical internal and external appeals overturned

- Clinical Denial Overturn Rate %: Total (Internal & External): percent of INN outpatient Prior Authorization clinical internal and external appeals overturned (Total # of Clinical Denials Overturned upon internal and external appeal/Total # of Clinical Denials reviewed upon internal and external appeal)
- Total # of Clinical Denials Upheld: Total (Internal & External): the aggregate number of INN outpatient Prior Authorization clinical internal and external appeals upheld
- Clinical Denial Uphold Rate %: Total (Internal & External): percent of INN outpatient Prior Authorization clinical internal and external appeals upheld (Total # of Clinical Denials Upheld upon internal and external appeal/Total # of Clinical Denials reviewed upon internal and external appeal)
- Total # of Clinical Denials reviewed upon internal appeal only: the aggregate number of INN outpatient Prior Authorization clinical internal appeals received
- Total # of Clinical Denials Overturned upon internal appeal only: the aggregate number of INN outpatient Prior Authorization clinical internal appeals overturned
- Clinical Denial Overturn Rate %, internal appeal only: percent of INN outpatient Prior Authorization clinical internal appeals overturned (Total # of Clinical Denials Overturned upon internal appeal/Total # of Clinical Denials reviewed upon internal appeal)
- Total # of Clinical Denials Upheld upon internal appeal: the aggregate number of INN outpatient Prior Authorization clinical internal appeals upheld
- Clinical Denial Uphold Rate %, internal appeal only: percent of INN outpatient Prior Authorization clinical internal appeals upheld (Total # of Clinical Denials Upheld upon internal appeal/Total # of Clinical Denials reviewed upon internal appeal)
- Total # of Clinical Denials reviewed upon external appeal only: the aggregate number of INN outpatient Prior Authorization clinical external appeals received
- Total # of Clinical Denials Overturned upon external appeal only: the aggregate number of INN outpatient Prior Authorization clinical external appeals overturned
- Clinical Overturn Rate %, external appeal only: percent of INN outpatient Prior Authorization clinical external appeals overturned (Total # of Clinical Denials Overturned upon external appeal/Total # of Clinical Denials reviewed upon external appeal)
- Total # of Clinical Denials Upheld upon external appeal: the aggregate number of INN outpatient Prior Authorization clinical external appeals upheld
- Clinical Uphold Denial Rate %, external appeal only: percent of INN outpatient Prior Authorization clinical external appeals upheld (Total # of Clinical Denials Upheld upon external appeal/Total # of Clinical Denials reviewed upon external appeal)

UHC

Outcomes Data Prior Authorization Review Analysis:	In-Network Outpatient	
	M/S	MH/SUD
Total # of Requests Received	34,184	1,299
Total # of Requests Approved	29,773	1,245
Total # of Requests Clinically Denied	4,408	47
Approval Rate %	87.10%	95.84%
Clinical Denial Rate %	12.89%	3.62%
Total # of Clinical Denials reviewed upon appeal-Total (Internal & External)	231	4
Total # of Clinical Denials Overturned upon appeal--Total (Internal & External)	119	3
Clinical Denial Overturn Rate %- Total (Internal & External)	51.52%	75.00%
Total # of Clinical Denials Upheld-Total (Internal & External)	112	1
Clinical Denial Uphold Rate %--Total (Internal & External)	48.48%	25.00%
Total # of Clinical Denials reviewed upon internal appeal only	229	4
Total # of Clinical Denials Overturned upon internal appeal only	118	3
Clinical Denial Overturn Rate %, internal appeal only	51.53%	75.00%
Total # of Clinical Denials Upheld upon internal appeal	111	1
Clinical Denial Uphold Rate %, internal appeal only	48.47%	25.00%
Total # of Clinical Denials reviewed upon external appeal only	2	0
Total # of Clinical Denials Overturned upon external appeal only	1	0
Clinical Overturn Rate %, external appeal only	50.00%	-
Total # of Clinical Denials Upheld upon external appeal	1	0
Clinical Uphold Denial Rate %, external appeal only	50.00%	-

UHCGA

Outcomes Data Prior Authorization Review Analysis:	In-Network Outpatient	
	M/S	MH/SUD
Total # of Requests Received	4,336	211
Total # of Requests Approved	3,812	205
Total # of Requests Clinically Denied	514	6
Approval Rate %	87.92%	97.16%
Clinical Denial Rate %	11.85%	2.84%
Total # of Clinical Denials reviewed upon appeal-Total (Internal & External)	27	2
Total # of Clinical Denials Overturned upon appeal--Total (Internal & External)	19	0
Clinical Denial Overturn Rate %- Total (Internal & External)	70.37%	0.00%
Total # of Clinical Denials Upheld-Total (Internal & External)	8	2
Clinical Denial Uphold Rate %--Total (Internal & External)	29.63%	100.00%
Total # of Clinical Denials reviewed upon internal appeal only	27	2
Total # of Clinical Denials Overturned upon internal appeal only	19	0
Clinical Denial Overturn Rate %, internal appeal only	70.37%	0.00%
Total # of Clinical Denials Upheld upon internal appeal	8	2
Clinical Denial Uphold Rate %, internal appeal only	29.63%	100.00%
Total # of Clinical Denials reviewed upon external appeal only	0	0
Total # of Clinical Denials Overturned upon external appeal only	0	0
Clinical Overturn Rate %, external appeal only	-	-
Total # of Clinical Denials Upheld upon external appeal	0	0
Clinical Uphold Denial Rate %, external appeal only	-	-

Conclusions

The Plan reviewed the M/S and MH/SUD Prior Authorization policies and procedures and concluded the methodology used to

determine which MH/SUD INN outpatient services are subject to Prior Authorization “as written” were comparable to, and applied no more stringently than, the methodology used to determine which M/S INN outpatient services are subject to Prior Authorization “as written.” Additionally, the Plan concluded that how Prior Authorization is applied to MH/SUD INN outpatient services was comparable to, and applied no more stringently than, how Prior Authorization is applied to M/S INN outpatient services “as written.”

The Plan reviewed the M/S and MH/SUD processes including responsibility for submission, timeframes for submission and review, notification to members and providers, clinical standards for review, staff qualifications, outcomes data, and IRR assessment results and concluded how the Plan conducts Prior Authorization for MH/SUD INN outpatient services “in operation” was comparable to, and applied no more stringently than, how the Plan conducts Prior Authorization for M/S INN outpatient services “in operation.”

Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical/surgical (M/S) benefits. This generally means that the financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements, such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage.

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Prior Authorization is defined as: “A required or mandatory clinical assessment for proposed service(s) based on clinical information provided and the terms of the health plan benefits before the service(s) are performed or delivered. Clinical and medical necessity requirements, level of care appropriateness, and the terms of the health plan benefits must be met in order for services to be covered by the member’s plan.” The *Optum National Policy Definitions List* defines pre-authorization (aka Prior Authorization) as “a form of prospective utilization review of health care services proposed to be provided to a member.”

Prior Authorization is a component of the Plan’s Utilization Management (UM) program that helps ensure members receive appropriate coverage based on their specific clinical status and health care needs. The process is designed to achieve optimal clinical outcomes by applying objective, evidence-based clinical criteria, and nationally recognized guidelines and best practices.

Prior Authorization for inpatient services commences prior to a service being delivered. Prior Authorization is a UM process that involves applying the benefit plan language and/or clinical criteria to make the most appropriate clinical coverage benefit determination.

This document includes the following information:

- Prior Authorization process for M/S and MH/SUD inpatient services
- Description of the NQTL and application (Step 1)
- Factors used to determine which services are subject to the NQTL (Step 2)
- Evidentiary standards and sources used to define, trigger and/or implicate a factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

This analysis refers to the following attachments:

- *Addendum A* - Identifies the M/S and MH/SUD inpatient services that are subject to Prior Authorization
- *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions* - M/S policy that

defines Prior Authorization

- *Optum National Policy Definitions List* - MH/SUD policy that defines Prior Authorization
- *Utilization Management Program Description (UMPD) of United HealthCare Services, Inc. and UnitedHealthcare Insurance Company* - Summarizes the philosophy, structure and standards that govern UHC's medical management, UM and utilization review responsibilities and functions
- *Management of Behavioral Health Benefits Policy* - Describes the mechanisms and processes designed to promote consistency in the management of behavioral health benefits and to ensure that members receive appropriate, high quality behavioral health services in a timely manner
- *Prior Authorization Factor Grid(s)* provided for (*2023 Prior Auth_Concurrent Rev Factor Grid*) - Details the service categories subject to Prior Authorization and the shared factors and evidentiary standards used as the basis for subjecting M/S and MH/SUD inpatient benefits to Prior Authorization
- *Core Principles and Practices* - MH/SUD policy that outlines the core principles and practices that should be used by personnel in their interactions with members, authorized member representatives, practitioners and facilities, related to the management of behavioral health benefits, coverage determinations and appeals/grievances of non-coverage determinations.
- *Performance Assessment and Incentives* - M/S policy confirming that clinical reviewers are not incented to make denials for financial reasons
- *Certificates of Coverage (COC23-INS-2018-LG-GA, COC23-HMO-2018-LG-GA, COC23-INS-2018-SG-GA and COC23-HMO-2018-SG-GA)* - Plan documents that explains covered services, terms, conditions, and limitations of the member's policy
- *Schedule of Benefits (SBN23-Medical-INS-2018-[Charter][Navigate][Nexus+[N]R]-LG-GA, SBN23-Medical-INS-2018-[Choice+Plus][Select+Plus][Doctors+Plus]-LG-GA, SBN23-Medical-INS-2018-[Core][Nexus+OAP]-LG-GA, SBN23-Medical-INS-2018-[Core+Essential][Nexus+OA]-LG-GA, SBN23-Medical-HMO-2018-[Charter][Navigate][Nexus+[N]R]-LG-GA, SBN23-Medical-INS-2018-[Choice+Plus][Select+Plus][Doctors+Plus]-SG-GA, SBN23-Medical-HMO-2018-[CharterBal][NavigateBal][Nexus+[N]RB]-LG-GA, SBN23-Medical-HMO-2018-[CharterPls][NavigatePls][Nexus+[N]RP]-LG-GA, SBN23-Medical-HMO-2018-[Choice][Select][Doctors]-LG-GA, SBN23-Medical-HMO-2018-[Core][Nexus+OAP]-LG-GA, SBN23-Medical-HMO-2018-[Core+Essential][Nexus+OA]-LG-GA, SBN23-Medical-INS-2018-NonDifferential-LG-GA, and SBN23-Medical-HMO-2018-[Choice][Select][Doctors]-SG-GA)* - Plan documents that outlines member responsibilities

The Plan concludes that the Prior Authorization requirements for M/S and MH/SUD are comparable and applied no more stringently for MH/SUD for out-of-network (OON) inpatient benefits, both “as written” and “in operation.”

Process

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Prior Authorization is defined as: “A required or mandatory clinical assessment for proposed service(s) based on clinical information provided and the terms of the health plan benefits before the service(s) are performed or delivered. Clinical and medical necessity requirements, level of care appropriateness, and the terms of the health plan benefits must be met in order for services to be covered by the member's plan.” The *Optum National Policy Definitions List* defines pre-authorization (aka Prior Authorization) as “a form of prospective utilization review of health care services proposed to be provided to a member.”

The Plan structures inpatient Prior Authorization processes to be compliant with all applicable federal and state requirements, as well as the National Committee for Quality Assurance (NCQA) accreditation standards. NCQA confirms that Plan operations and policies identify appropriate timeframes for decisions, requires decision-making by appropriate personnel, and governs communication of adverse benefit determinations. Prior Authorization is governed at both the state and federal level, which includes consumer protections such as external review for adverse benefit determinations after internal appeals options are exhausted.

The Plan delegates management of MH/SUD inpatient services, including Prior Authorization, to United Behavioral Health d/b/a Optum Behavioral Health (OBH), its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor.

The Plan has national committees that approve M/S and MH/SUD services to be subject to Prior Authorization. *Addendum A* includes a list of service categories subject to inpatient Prior Authorization. Members can learn what services are subject to Prior Authorization in their benefit plan document, through myuhc.com, or by contacting customer service.

Prior Authorization review of M/S inpatient admissions consists of the following:

Members are responsible for obtaining Prior Authorization for services rendered by OON facilities and providers. The member's benefit plan document (i.e., *Schedule of Benefits*) identify the services for which the member is responsible for obtaining Prior Authorization and the required timeframe(s). The member or OON provider's submission of a request (notification) triggers the Prior Authorization process.

Members may submit Prior Authorization requests by phone, fax, or mail, in accordance with Plan requirements. OON providers may submit Prior Authorization requests on behalf of the member by phone or by fax (where required). Members or providers communicate basic information to create a case.

The Plan confirms receipt of the Prior Authorization request. Non-clinical staff confirm member eligibility and benefit coverage upon receipt of the notification. Non-clinical staff review cases to ensure availability of accurate and thorough case information. Non-clinical staff may approve coverage requests in scenarios where the member's plan documents allow and if a clinical review is not required. Non-clinical staff may administratively deny coverage when a member's benefits are exhausted. Non-clinical staff refer coverage requests that they cannot approve or administratively deny to the initial clinical reviewers.

First Level Clinical Review/Initial Review. Clinical reviewers (nurses or physicians) consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether the inpatient admission is medically necessary by reviewing the member's clinical information, the applicable clinical criteria or guidelines, and the Plan benefit terms. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs to determine whether the applicable clinical criteria are met. The clinical reviewer may approve cases that meet applicable clinical criteria.

Second Level Clinical Review/Peer Review. The initial clinical reviewer refers cases to a second level/peer clinical reviewer if the case cannot be approved. Peer clinical reviewers (physician or mid-level practitioner) consult clinical criteria when making clinical coverage benefit determinations. Peer clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. The peer clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. If a peer clinical reviewer issues an adverse benefit determination, then the Plan communicates the adverse benefit determination, including appeal rights, and offers a peer-to-peer conversation consistent with state, federal, and accreditation requirements.

Adverse Benefit Determination. For M/S, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when member benefits are exhausted. Based on individual state requirements, cases may be cancelled if the member is not eligible for

benefits. Cancelled cases are not considered administrative or clinical denials. Modified coverage requests that are approved are recorded as partial denials.

Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based medical clinical policies and use clinical criteria from third-party sources such as InterQual® or MCG® guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that inpatient Prior Authorization determinations are appropriate.

M/S monitors clinical reviewer and peer clinical reviewer application of clinical criteria through an annual inter-rater reliability (IRR) assessment that is provided by InterQual. Clinical reviewers and peer clinical reviewers are required to pass the IRR assessment with a score of 90% or better through three attempts. After a second failed IRR assessment, staff enter a remediation period and are required to review all cases with a supervisor for 30 days, or until 90% is achieved on the assessment. If the clinical reviewer achieves a passing score within the 30-day period, supervisors review a minimum of one case per week for the remainder of the 30-day period.

The Plan also conducts end-to-end case audits that are designed and approved by clinical leadership each year. The end-to-end audits include all stages of a case review, from intake through appeal. These audits are conducted monthly and approximately 1500 cases are reviewed per month. Results are reported to an oversight team. All deficiencies are remediated. Remediation may include corrective actions and/or additional education, as indicated.

The Plan routinely monitors Prior Authorization performance through its clinical performance oversight functions. Outcomes are monitored against timeliness compliance, performance guarantees, and for potential trends, including overall utilization.

The Plan's National Medical Care Management Committee (NMCMC) annually reviews overall UM program outcomes, to confirm overall utilization is appropriate. The NMCMC is comprised of the Chief Medical Officer, and representatives from clinical policy, clinical advocacy and grievances, business standardization and advancement, regional chief medical officers, inpatient care management, lines of business, medical policy, clinical operations, and Optum Behavioral Health. The Chair of the NMCMC must be an executive leader and licensed physician.

As of April 1, 2023, the Utilization Management Program Committee (UMPC) began overseeing the M/S UM program. The UMPC is responsible for the development and maintenance of the M/S Prior Authorization processes. The UMPC ensures that the UM program considers the factors and evidentiary standards for applying UM. The UMPC is comprised of:

- Chief Medical Officer, Medical Management (Co-Chair)
- Senior Vice President, Clinical Advancement (Co-Chair)
- Chief Medical Officer, UnitedHealthcare
- Senior Vice President, Clinical Appeals & Grievances
- Chief Medical Officer, Clinical Policy
- Chief Medical Officer, UnitedHealthcare Employer & Individual
- Chief Medical Officer, UnitedHealthcare Medicare & Retirement
- Chief Medical Officer, Community & State
- Chief Medical Officer, UnitedHealthcare Individual & Family Plans
- Vice President, Clinical Transformation & Affordability
- Senior Director, Mental Health Parity
- Vice President, Utilization Management Strategy & Implementation

One of the chairs must be an executive leader and a licensed physician. UMPC meets at least six times per year but may meet more frequently if needed.

Per the M/S policy entitled, *Performance Assessment and Incentives*, at no time are initial or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons.

M/S generally structures UM processes to comply with federal Employee Retirement Income Security Act of 1974 (ERISA) requirements, NCQA UM standards, and state law where applicable.

Prior Authorization review of MH/SUD inpatient admissions consists of the following:

The Plan delegates management of MH/SUD inpatient services, including Prior Authorization, to United Behavioral Health d/b/a OBH, its delegated MH/SUD MBHO vendor.

Members are responsible for ensuring Prior Authorization is obtained by the OON provider administering the service. The OON provider must provide clinical information on the member's behalf. The member's benefit plan document (i.e., *Schedule of Benefits*) identifies the services for which the member is responsible for ensuring Prior Authorization is obtained. As outlined in the Plan document, OON providers must submit the Prior Authorization request before inpatient MH/SUD services are received. OON provider's submission of a request (notification) triggers the Prior Authorization process.

OON providers may submit Prior Authorization requests on behalf of the member by telephone, or by fax (where required). Providers communicate basic information to create a case.

As described in the *Management of Behavioral Health Benefits Policy*, the Plan confirms receipt of the Prior Authorization request. Non-clinical staff confirm member eligibility and benefit coverage. Non-clinical staff may approve coverage requests that do not require clinical evaluation or interpretation based on the member's diagnosis and the clinical information submitted by providers. Non-clinical staff may administratively deny coverage when member benefits are exhausted. Non-clinical staff refer cases that they cannot approve or administratively deny to the initial clinical reviewers.

First Level Clinical Review/Initial Review. Clinical decisions are made by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse benefit determinations are made by Medical Directors. Clinical reviewers consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether an inpatient admission is medically necessary by reviewing the member's clinical information, the applicable clinical criteria or guidelines, and the Plan benefit terms. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for certification, related diagnostic results, and history of related treatment and services to determine whether the applicable clinical criteria are met. The clinical reviewer may approve the admission based on their review.

Second Level Clinical Review/Peer Review. The initial clinical reviewer refers cases to a peer clinical reviewer for a peer-to-peer discussion if the case cannot be approved. The requesting provider is offered the opportunity to discuss the case with the peer clinical reviewer, consistent with state, federal, and accreditation requirements before an adverse benefit determination is issued. Only qualified peer clinical reviewers (e.g., Medical Directors) can issue adverse benefit determinations. Peer clinical reviewers apply clinical criteria to member clinical information to determine coverage for an inpatient admission. If the requesting provider fails to complete the peer-to-peer discussion, the peer clinical reviewer makes a determination based on the information available. If a peer clinical reviewer issues an adverse benefit determination (e.g., the admission is not medically necessary and is not approved), then the Plan timely communicates the adverse benefit determination, including appeal rights, to the member and provider consistent with applicable state, federal, and accreditation requirements.

Adverse Benefit Determination. For MH/SUD, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as a clinical denial when it is based on clinical criteria and member clinical information and is recorded as an administrative denial when member benefits are excluded.

Clinical Criteria. Initial clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based behavioral clinical policies or use clinical criteria from third-party sources such as American Society of Addiction Medicine (ASAM) Criteria®, Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System-Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) and Early Childhood Service Intensity Instrument (ECSII) guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that inpatient Prior Authorization determinations are appropriate.

MH/SUD monitors clinical reviewer and peer clinical reviewer application of clinical criteria through an annual IRR assessment. Clinical reviewers and peer clinical reviewers are required to pass the IRR assessment with a score of 90% or better through three attempts. After a second failed IRR assessment, the reviewer enters a remediation period and is required to review all cases with a supervisor for 30 days, or until 90% is achieved on the assessment. If the clinical reviewer achieves a passing score within the 30-day period, supervisors review a minimum of one case per week for the remainder of the 30-day period.

The Plan also conducts monthly quality audits of individual non-clinical staff, clinical reviewers, and peer clinical reviewers, including staff performing appeal functions. These audits are designed and approved by clinical leadership each year. A minimum of two audits are completed per staff, per month. The results of these real-time audits are shared with supervisors for staff oversight, and all findings are remediated. Remediation may include corrective actions and/or additional education, as indicated.

The Plan routinely monitors Prior Authorization performance through its clinical performance oversight functions. Outcomes are monitored against timeliness requirements, performance guarantees, and for potential trends, including overall utilization.

The Plan's national Clinical Quality & Operations Committee (CQOC) annually reviews UM program outcomes, including inpatient Prior Authorization outcomes, to confirm overall utilization is appropriate. The CQOC is comprised of representatives from sub-committees, and representatives from the clinical quality improvement, UM, care engagement, medical operations, medical policy and standards, clinical operations, appeals, product, legal, compliance, network strategy, provider experience, accreditation, and benefits teams. The Chair of the Clinical Quality & Operations Committee must be an executive leader, board certified in psychiatry or psychiatric subspecialty and a licensed physician.

Per the MH/SUD policy entitled, *Core Principles and Practices*, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons.

MH/SUD generally structures UM processes to comply with federal ERISA requirements, NCQA UM standards, and state law where applicable.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- Prior Authorization

Benefit Classification(s)

- OON, inpatient

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHIC)
- UnitedHealthcare of Georgia, Inc. (UHCGA)

Plan Terms/Source Document(s)

In each of the Plan products, “Medically Necessary” is the Plan term used to guide Prior Authorization decision-making for both M/S and MH/SUD services. “Medically Necessary” is generally defined as follows:

- “Medically Necessary – health care services are all of the following as determined by us or our designee:
 - In accordance with Generally Accepted Standards of Care.
 - Clinically appropriate, in terms of type, frequency, extent, service site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms.
 - Not mainly for your convenience or that of your doctor or other health care provider.
 - Not more costly than an alternative drug, service(s), service site or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.
- Generally Accepted Standards of Care are evidence based independent standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties. Valid, evidence based sources reflecting generally accepted standards of care include credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.
- If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We have the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be determined by us.
- We develop and maintain clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by us and revised from time to time), are available to Covered Persons through www.myuhc.com or the telephone number on your ID card. They are also available to Physicians and other health care professionals on www.UHCprovider.com”

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Prior Authorization is defined as:

“A required or mandatory clinical assessment for proposed service(s) based on clinical information provided and the terms of the health plan benefits before the service(s) are performed or delivered. Clinical and medical necessity requirements, level of care appropriateness, and the terms of the health plan benefits must be met in order for services to be covered by the member’s plan.”

The *Optum National Policy Definitions List* defines pre-authorization (aka Prior Authorization) as “a form of prospective utilization review of health care services proposed to be provided to a member.”

The Plan’s *Schedule of Benefits* notify members of the Prior Authorization requirements:

“We require prior authorization for certain Covered Health Care Services. Network providers are responsible for obtaining prior authorization before they provide these services to you.

We recommend that you confirm with us that all Covered Health Care Services have been prior authorized as required. Before receiving these services from a Network provider, you may want to call us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities

and Network providers cannot bill you for services they do not prior authorize as required. You can call us at the telephone number on your ID card.

When you choose to receive certain Covered Health Care Services from out-of-Network providers, you are responsible for obtaining prior authorization before you receive these services. Note that your obligation to obtain prior authorization is also applicable when an out-of-Network provider intends to admit you to a Network facility or to an out-of-Network facility or refers you to other Network or out-of-Network providers. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization. Services for which you are required to obtain prior authorization are shown in the Schedule of Benefits table within each Covered Health Care Service category.

To obtain prior authorization, call the telephone number on your ID card. This call starts the utilization review process.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the Schedule of Benefits table to find out how far in advance you must obtain prior authorization.

For Covered Health Care Services that do not require you to obtain prior authorization, when you choose to receive services from out-of-Network providers, we urge you to confirm with us that the services you plan to receive are Covered Health Care Services. That is because in some instances, certain procedures may not be Medically Necessary or may not otherwise meet the definition of a Covered Health Care Service, and therefore are excluded. In other instances, the same procedure may meet the definition of Covered Health Care Services. By calling before you receive treatment, you can check to see if the service is subject to limitations or exclusions.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those received, our final coverage determination will be changed to account for those differences, and we will only pay Benefits based on the services delivered to you. If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Care Service, you will be responsible for paying all charges and no Benefits will be paid.”

The role of the Plan’s delegate, United Behavioral Health d/b/a OBH, is discussed in the *UMPD*:

“United Behavioral Health (UBH) performs the review of requests for coverage of behavioral health services (i.e., substance abuse, and mental health requests for services). UBH provides comprehensive behavioral health care delivery for members through a network of behavioral health practitioners, ancillary care providers, hospitals and other facilities.

For mental health, substance-related disorder services, and wraparound services, UBH uses its Clinical Criteria (see below), behavioral clinical policies and best practice guidelines to make coverage determinations. UBH adopts externally-developed clinical criteria, and creates internally-developed Clinical Criteria, where appropriate, based on its assessment of relevant guidance. UBH develops clinical criteria that supersedes its standard set or adopts externally-developed clinical criteria when required to do so by contract or regulation.

- Clinical Criteria (Level of Care Utilization System-LOCUS) – Standardized level of care assessment tool developed by the American Association of Community Psychiatrists used to make clinical determinations and placement decisions for mental health disorder benefits for adults ages 19 and older when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (Child and Adolescent Level of Care/Service Intensity Utilization System-CALOCUS-CASII) - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry (AACAP)

and the American Association for Community Psychiatry (AAP) used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children and adolescents ages 6-18 when State or Contract Specific Level of Care Guidelines do not apply.

- Clinical Criteria (Early Childhood Service Intensity Instrument-ECSII) - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children ages 0-5 when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (State or Contract Specific Level of Care Guidelines) – Criteria used to make medical necessity determinations for mental health disorder benefits when there are explicit mandates or contractual requirements.
- Clinical Criteria (American Society of Addiction Medicine [ASAM]) - Criteria developed by the American Society of Addiction Medicine used to make clinical determinations for substance-related disorder benefits.
- Clinical Criteria (Optum Developed)
 - Optum Behavioral Clinical Policies: Criteria that stem from evaluation of new services or treatments or new applications of existing services or treatments and are used to make clinical determinations regarding proven or unproven services and treatments.

Licensed practitioners conduct all reviews with a focus on measurable outcome goals and objectives for treatment. A senior UBH Medical Director is responsible for directing and implementing behavioral health utilization management programs. A referral is sent to UBH when a member is identified as potentially benefiting from behavioral health services during a “medical event.”

The UBH UM Program is staffed by clinical, non-clinical and administrative personnel. All clinical denials or adverse decisions are made by board certified psychiatrists, or, if the health plans choose, by a panel of other appropriate health care service reviewers. If the health plan chooses to use a panel to make adverse decisions, the panel contains at least one physician who is board certified in psychiatry. When the health care service under review is a mental health or substance abuse service, the adverse decision is made by a licensed physician who is board certified in psychiatry. All potential clinical denials are referred to a physician who is board certified in psychiatry for final determination. An evaluation of the overall effectiveness of the Behavioral Health UM Program is conducted annually to determine how well resources have been deployed to improve UM activities and the clinical care and service provided to members.”

The Plan’s terms require services to be medically necessary for coverage.

List of M/S and MH/SUD Services Subject to NQTL

Addendum A, attached, lists the M/S and MH/SUD OON inpatient service categories subject to Prior Authorization. Prior Authorization is one component of the UM program that evaluates whether a benefit or service is medically necessary.

- The “Member” tab lists the service categories for which the member is responsible for obtaining authorization for OON services. The “Member” tab includes all products in the scope of the analysis.
- The “Provider” tab lists the service categories for which the provider is responsible for obtaining authorization for in-network services. The “Provider” tab applies to all products in the scope of the analysis.

Step 2 – Factors Used to Determine the Listed Services are Subject to Prior Authorization

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

The Prior Authorization list was originally designed by enterprise clinical leadership. Prior Authorization was applied to new services when they became covered by the Plan and met certain criteria. Examples of Prior Authorization determinants that existed in the business at this time included:

- to monitor and prevent potential overutilization and under-utilization

- manage high-cost and prolonged-duration services
- ensure enrollee safety
- determine the appropriate level of care
- determine whether the service or item is medically necessary

The factors relied upon to determine which OON inpatient services were subjected to Prior Authorization were updated and replaced 2021 with the factors Clinical Appropriateness and Value, as defined below. After this time, all M/S services subject to Prior Authorization must meet Clinical Appropriateness and all MH/SUD services subject to Prior Authorization must meet Clinical Appropriateness and Value.

Starting in 2022, any additions or deletions to the Prior Authorization list were reviewed and approved through committees.

The Plan relies on the following factors to determine which OON inpatient benefits will be subject to Prior Authorization. These factors apply to M/S and MH/SUD benefits for the following:

- I. M/S: OON inpatient services
- II. MH/SUD: OON inpatient services

- Clinical Appropriateness (Qualitative)
 - Whether the application of Prior Authorization promotes optimal clinical outcomes

Applies to M/S and MH/SUD services.

- Value (Quantitative)
 - The cost of the inpatient service exceeding the administrative costs of subjecting the inpatient service to Prior Authorization by at least 1:1. Administrative costs of subjecting the inpatient service to Prior Authorization are determined using the national UM program operating costs, which is comprised of the cost related to staffing. Administrative costs vary due to differences in the complexities of the requested treatment types, condition(s) treated, and/or clinical guidelines used. The cost of the inpatient service is determined using national inpatient utilization or claims data. The projected benefit cost savings of applying Prior Authorization is reviewed relative to the operating cost of administering Prior Authorization to determine value. Only services that are provided to a minimum of 100 unique individuals are considered (this is the materiality threshold established by the Plan for purposes of the Value analysis).

Applies to M/S and MH/SUD services.

For M/S meeting Clinical Appropriateness is determinative in imposing the limitation. For MH/SUD meeting Clinical Appropriateness and Value is determinative in imposing the limitation. The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL. All Prior Authorization reviews are subject to Clinical Appropriateness and must have medical necessity criteria.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factors used to add services to the Plan's Prior Authorization requirement for OON inpatient services. These evidentiary standards and sources apply to

benefits for the following:

- I. M/S: OON inpatient services
- II. MH/SUD: OON inpatient services

Factor – Clinical Appropriateness is defined as those inpatient services that are determined by internal medical experts to be in accordance with objective, evidence-based clinical criteria, and nationally recognized guidelines. The accompanying *Prior Authorization Factor Grid(s)* included with this analysis gives details on the specific service categories subject to Prior Authorization. The *Prior Authorization Factor Grid(s)* detail the shared factors used as the basis for subjecting M/S and MH/SUD OON inpatient benefits to Prior Authorization.

- The Plan's evidentiary standards and sources that trigger and/or define the Clinical Appropriateness factor are:
 - Clinical criteria from nationally recognized third-party sources (e.g., InterQual for M/S services, and ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines for MH/SUD services)
 - Clinical Technology and Assessment Committee (CTAC) and Medical Technology and Assessment Committee (MTAC) review
 - Objective, evidence-based medical/behavioral clinical policies, and nationally recognized guidelines approved by professional healthcare associations (e.g., clinical guidance from the American Medical Association, American Psychiatric Association, etc.)

These evidentiary standards and sources apply to M/S and MH/SUD services and are defined in a qualitative manner.

Factor – Value is defined as the cost of the inpatient service exceeding the administrative costs of subjecting the inpatient service to Prior Authorization by at least 1:1. Administrative costs of subjecting the inpatient service to Prior Authorization are determined using the national UM program operating costs, which is comprised of the cost related to staffing. Administrative costs vary due to differences in the complexities of the requested treatment types, condition(s) treated, and/or clinical guidelines used. The cost of the inpatient service is determined using national inpatient utilization or claims data. The projected benefit cost savings of applying Prior Authorization is reviewed relative to the operating cost of administering Prior Authorization to determine value. Only services that are provided to a minimum of 100 unique individuals are considered (this is the materiality threshold established by the Plan for purposes of the Value analysis). The accompanying *Prior Authorization Factor Grid(s)* contain the calculated value for each Prior Authorization service category, for both M/S and MH/SUD, and the internal data used to determine these values.

- The Plan's evidentiary standard that defines and/or triggers the Value factor:
 - Value is defined as the cost of the inpatient service exceeding the administrative costs of subjecting the service to Prior Authorization by at least 1:1. Only services that are provided to a minimum of 100 unique individuals are considered (this is the materiality threshold established by the Plan for purposes of the value analysis).
- The Plan's sources used to define the Value factor:
 - National internal claims data
 - National UM program operating costs
 - National UM authorization data

This evidentiary standard and the sources apply to M/S and MH/SUD OON inpatient services and are defined in a quantitative manner.

For M/S meeting Clinical Appropriateness is determinative in imposing the limitation. For MH/SUD meeting Clinical

Appropriateness and Value is determinative in imposing the limitation. The factors are not weighted in that no individual factor carries more importance than another in retaining the NQTL.

The factors and evidentiary standards used as the basis for subjecting MH/SUD OON inpatient benefits to Prior Authorization are comparable to, and applied no more stringently than, the factors and evidentiary standards used as the basis for subjecting M/S OON inpatient benefits to Prior Authorization “as written” and “in operation.”

Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

As Written

The Plan conducted a comparative analysis of the strategies, processes, factors, evidentiary standards, and source information used to determine which M/S and MH/SUD OON inpatient services are subject to Prior Authorization and how Prior Authorization is applied to M/S and MH/SUD OON inpatient services “as written.” The Plan identified the factors and evidentiary standards used as the basis for subjecting M/S and MH/SUD benefits to Prior Authorization.

National internal committees apply the applicable factors and standards described in Steps 2 and 3 to M/S and MH/SUD services when determining whether the services should be included on the Prior Authorization list.

Review of Factors and Evidentiary Standards

The Plan reviewed the factors that trigger an OON inpatient service to be subject to Prior Authorization. The factors and evidentiary standards were applied to M/S and MH/SUD services comparably and not more stringently to MH/SUD services than to M/S services as evidenced by the attached *Prior Authorization Factor Grid(s)*.

Review of Operational Policies and Procedures

The Plan reviewed M/S and MH/SUD operational policies and procedures, IRR assessment processes, and UM annual oversight to confirm comparability and found MH/SUD policies, procedures, and processes to be comparable and no more stringent than M/S policies, procedures, and processes.

- Medical management operational policies and procedures establish the standards for how the Plan conducts inpatient Prior Authorization. The policies and procedures are consistent with state and federal law and accreditation requirements governing Prior Authorization. Timeframes for decisions, content of adverse benefit determinations, appeal rights, and external review are all governed by state and federal law and accreditation requirements.
- The IRR assessment measures the consistency with which clinical reviewers and peer clinical reviewers apply the Plan's clinical criteria. IRR assessment processes apply to M/S and MH/SUD inpatient services.
- UM oversight monitors and evaluates UM processes by reviewing program outcomes, clinical appeals, IRR assessments, and under- and over-utilization.

Review of Inpatient Prior Authorization Processes

The strategy for applying Prior Authorization to OON inpatient services is comparable for M/S and MH/SUD services and is applied no more stringently to MH/SUD OON inpatient services. The Plan conducted a review of the M/S and MH/SUD Prior Authorization processes to confirm comparability. The review focused on the following aspects of the process for both M/S and MH/SUD:

- Prior Authorization Request. For M/S and MH/SUD OON services, the member is responsible for ensuring the OON

provider or facility submits Prior Authorization requests. For M/S services, the member can contact the telephone number on their member ID card, mail, or fax to request a Prior Authorization. For M/S and MH/SUD the OON provider can request Prior Authorization on behalf of the member or submit clinical information via telephone or fax (where required).

- Timeframe to Submit. The timeframes for the member or OON provider on behalf of the member to submit the Prior Authorization request were reviewed and it was determined that MH/SUD was no more stringent.
 - M/S – Per the member’s Plan documents, the timeframes vary depending upon the services requested from as soon as possible to six months prior to the OON service.
 - Unplanned or emergency services are not subject to Prior Authorization
 - MH/SUD – Per the member’s Plan documents, the Prior Authorization should be requested before OON services are received.
 - Unplanned or emergency services are not subject to Prior Authorization
- Clinical Reviews. For M/S and MH/SUD inpatient Prior Authorization requests, clinical reviewers may gather more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for certification, related diagnostic results, history of related treatment and services, and photographs. The clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. The clinical reviewer may approve cases that meet applicable clinical criteria.
- Review Timeframes. M/S and MH/SUD inpatient Prior Authorization determination timeframes are defined by state, federal, and accreditation requirements for both urgent and non-urgent services. The same determination timeframes apply to M/S and MH/SUD determinations.
- Determinations and Non-Clinical Reviews, First Level Clinical Reviews, and Second Level Peer Clinical Reviews.
 - Non-clinical staff refer coverage requests that they cannot approve or administratively deny to clinical reviewers. Clinical reviewers consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether an inpatient admission is medically necessary. The clinical reviewer may approve the admission based on their review. The clinical reviewer refers cases to a peer clinical reviewer for a peer-to-peer discussion if the case cannot be approved. Only qualified peer clinical reviewers (e.g., Medical Directors) may issue adverse benefit determinations. Peer-to-peer discussions are offered as required.
- Adverse Benefit Determinations and Peer-to-Peer Conversations. The Plan offers OON inpatient facilities and providers the opportunity to discuss a potential adverse benefit determination before the Plan issues such determination. This process allows OON inpatient facilities and providers the opportunity to provide additional information and/or modify their request prior to an adverse benefit determination being issued. Only M/S and MH/SUD peer clinical reviewers (e.g., Medical Director) may issue adverse benefit determinations for coverage of M/S and MH/SUD inpatient services.
- Notification of Decisions to Providers and Members. The Plan notifies M/S and MH/SUD OON facilities, providers, and members of approvals and adverse benefit determinations, including applicable appeal rights, consistent with state, federal, and accreditation requirements.
 - OON inpatient M/S and MH/SUD services:
 - An adverse benefit determination is recorded as a clinical denial when it is based on clinical criteria and member clinical information and is recorded as an administrative denial when member benefits are exhausted.
- Review of Staff Qualifications For M/S and MH/SUD, clinical staff qualifications align with the type of clinical review and state, federal, and accreditation requirements (NCQA).
 - M/S is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., nurses, physicians, etc.) and all adverse determinations are made by Medical Directors.
 - MH/SUD is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., physicians, psychologists, nurses, licensed master’s level behavioral health clinicians, etc.) and all adverse determinations are made by Medical Directors.
- Clinical Criteria. For M/S and MH/SUD, clinical reviewers and peer clinical reviewers base determinations on the

objective, evidence-based, medical/behavioral clinical policies and use clinical criteria from third party sources such as InterQual®, MCG®, ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines.

In Operation

The Plan compared the strategies, processes, factors, evidentiary standards, and source information used to determine which M/S and MH/SUD OON inpatient services are subject to Prior Authorization and how Prior Authorization is applied “in operation.”

M/S and MH/SUD members, or OON providers on the members behalf, submit requests for approval of inpatient services for which the Plan requires Prior Authorization. Members can learn what services are subject to Prior Authorization in their benefit plan document (i.e., *Schedule of Benefits*) or by contacting customer service. Notification triggered the Prior Authorization process for OON M/S and MH/SUD inpatient admissions.

M/S and MH/SUD inpatient Prior Authorization reviews included confirmation of member eligibility and benefit availability for the requested services. For M/S and MH/SUD OON inpatient services, non-clinical staff approved coverage for inpatient admissions that did not require clinical review or interpretation and where member plan documents allowed.

M/S and MH/SUD inpatient cases that were not administratively approved in initial review were referred to a clinical reviewer for further research and evaluation. The M/S and MH/SUD clinical reviewers applied benefit plan documents and medical necessity criteria to member clinical information. M/S and MH/SUD clinical reviewers requested additional clinical information if they were unable to approve cases based on the available member clinical information. The clinical reviewers approved the admission based on their review when clinical criteria were met.

If the requested clinical information was not received or if the case could not be approved, M/S and MH/SUD clinical reviewers referred cases to a peer clinical reviewer. The Plan offered peer-to-peer conversations so the OON provider could provide additional clinical information prior to issuance of an adverse benefit determination. Only qualified peer clinical reviewers issued M/S and MH/SUD adverse benefit determinations.

The Plan communicated all adverse benefit determinations for M/S and MH/SUD inpatient cases that did not meet applicable clinical criteria consistent with state, federal, and accreditation requirements, including appeal rights, as applicable.

The Plan monitored M/S and MH/SUD clinical and peer clinical reviewers’ application of clinical criteria through annual IRR assessments. The Plan also conducted quality audits of cases. The Plan routinely monitors Prior Authorization performance through its clinical performance oversight functions. In addition to comparing these “in operation” processes, the Plan reviewed medical necessity approval and denial rates, internal appeals outcomes, and external appeals outcomes related to Prior Authorization determinations for M/S and MH/SUD OON inpatient services. The results of these analyses are discussed in greater detail in Step 5.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan or issuer’s findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The findings of the Plan’s comparative analysis confirmed the strategies, processes, factors, evidentiary standards, and source information used to determine the MH/SUD OON inpatient services subject to Prior Authorization were comparable to, and applied no more stringently than, the strategies, processes, factors, evidentiary standards, and source information used to

determine the M/S OON inpatient services subject to Prior Authorization “as written.” For M/S and MH/SUD OON inpatient benefits, the *Prior Authorization Factor Grid(s)* included with this analysis detail the shared factors used as the basis for subjecting M/S and MH/SUD OON inpatient benefits to Prior Authorization, as described above.

The Plan found the factors used to determine the MH/SUD OON inpatient services subject to Prior Authorization were comparable to, and applied no more stringently than, the factors used to determine the M/S OON inpatient services subject to Prior Authorization. Beginning in 2022, OON M/S and MH/SUD inpatient services that met the Clinical Appropriateness plus the Value factor were subject to Prior Authorization review “in operation.”

The Plan used comparable processes to conduct Prior Authorization review of OON M/S and MH/SUD inpatient admissions. The Plan required members, or OON providers on behalf of the member, to timely submit Prior Authorization requests. The Plan used qualified staff to confirm member eligibility and benefit availability, and to request additional information if necessary. The Plan issued approvals for M/S and MH/SUD inpatient services that met applicable clinical criteria or guidelines. Only qualified M/S and MH/SUD peer clinical reviewers issued adverse benefit determinations. The Plan gave OON facilities and providers the opportunity to discuss potential adverse benefit determinations with qualified peer clinical reviewers prior to issuing adverse benefit determinations. This afforded OON providers the opportunity to provide additional information or alter the initial request.

The Plan operated monitoring and oversight programs to ensure that clinical reviewers and peer clinical reviewers rendered appropriate determinations. Both M/S and MH/SUD required clinical reviewers, including peer clinical reviewers, to successfully complete the annual IRR assessment. Clinical reviewers were required to pass the IRR assessment with a score of 90% or better to render UM decisions independently. The 2022 IRR M/S results were 97% and MH/SUD results were 96%, demonstrating that M/S and MH/SUD clinical reviewers comparably applied medical necessity criteria when making utilization review determinations.

OON inpatient medical necessity approval and denial rates and appeals outcomes data from 01/01/2022-12/31/2022 were evaluated where a minimum threshold of 100 cases were available to ensure a valid data set for analysis.

The findings of a comparative analysis for each Plan product (see data below) indicated the Prior Authorization process for MH/SUD OON inpatient services was comparable to the Prior Authorization process for M/S OON inpatient services.

For UnitedHealthcare Insurance Company (UHC), M/S had a clinical denial rate of 15.83% and MH/SUD had a clinical denial rate of 5.85%. The denial rates did not reflect any material differences in Prior Authorization processes .

The Plan notes the UM outcomes data do not reflect material differences in Prior Authorization processes for M/S or MH/SUD benefit coverage determinations. Similarly, the appeals data do not reflect that members face a materially different or more stringent review process.

There is an insufficient number of MH/SUD OON inpatient cases from 01/01/2022-12/31/2022 to support an analysis of clinical outcomes data for UnitedHealthcare of Georgia, Inc. (UHCGA)

The following definitions are applicable to the charts below:

- Total # of Requests Received: the aggregate number of OON inpatient Prior Authorization requests received
- Total # of Requests Approved: the aggregate number of OON inpatient Prior Authorization requests approved
- Total # of Requests Clinically Denied: the aggregate number of OON inpatient Prior Authorization requests that were denied for clinical reasons (request did not meet medical necessity)
- Approval Rate %: (Requests Approved / Requests Received)
- Clinical Denial Rate %: (Total number of Requests Clinically Denied / Total number of Requests Received)

- Total # of Clinical Denials reviewed upon appeal: Total (internal & external): the aggregate number of OON inpatient Prior Authorization clinical internal and external appeals received
- Total # of Clinical Denials Overturned upon appeal: Total (internal & external): the aggregate number of OON inpatient Prior Authorization clinical internal and external appeals overturned
- Clinical Denial Overturn Rate %: Total (Internal & External): percent of OON inpatient Prior Authorization clinical internal and external appeals overturned (Total # of Clinical Denials Overturned upon internal and external appeal/Total # of Clinical Denials reviewed upon internal and external appeal)
- Total # of Clinical Denials Upheld: Total (Internal & External): the aggregate number of OON inpatient Prior Authorization clinical internal and external appeals upheld
- Clinical Denial Uphold Rate %: Total (Internal & External): percent of OON inpatient Prior Authorization clinical internal and external appeals upheld (Total # of Clinical Denials Upheld upon internal and external appeal/Total # of Clinical Denials reviewed upon internal and external appeal)
- Total # of Clinical Denials reviewed upon internal appeal only: the aggregate number of OON inpatient Prior Authorization clinical internal appeals received
- Total # of Clinical Denials Overturned upon internal appeal only: the aggregate number of OON inpatient Prior Authorization clinical internal appeals overturned
- Clinical Denial Overturn Rate %, internal appeal only: percent of OON inpatient Prior Authorization clinical internal appeals overturned (Total # of Clinical Denials Overturned upon internal appeal/Total # of Clinical Denials reviewed upon internal appeal)
- Total # of Clinical Denials Upheld upon internal appeal: the aggregate number of OON inpatient Prior Authorization clinical internal appeals upheld
- Clinical Denial Uphold Rate %, internal appeal only: percent of OON inpatient Prior Authorization clinical internal appeals upheld (Total # of Clinical Denials Upheld upon internal appeal/Total # of Clinical Denials reviewed upon internal appeal)
- Total # of Clinical Denials reviewed upon external appeal only: the aggregate number of OON inpatient Prior Authorization clinical external appeals received
- Total # of Clinical Denials Overturned upon external appeal only: the aggregate number of OON inpatient Prior Authorization clinical external appeals overturned
- Clinical Overturn Rate %, external appeal only: percent of OON inpatient Prior Authorization clinical external appeals overturned (Total # of Clinical Denials Overturned upon external appeal/Total # of Clinical Denials reviewed upon external appeal)
- Total # of Clinical Denials Upheld upon external appeal: the aggregate number of OON inpatient Prior Authorization clinical external appeals upheld
- Clinical Uphold Denial Rate %, external appeal only: percent of OON inpatient Prior Authorization clinical external appeals upheld (Total # of Clinical Denials Upheld upon external appeal/Total # of Clinical Denials reviewed upon external appeal)

Prior Authorization – Inpatient Out-of-Network Non-Quantitative Treatment Limitation (NQTL) Analysis
GA – UnitedHealthcare Insurance Company and UnitedHealthcare of Georgia,
Inc.
12/29/2023

UHIC

Outcomes Data Prior Authorization Review Analysis:	Out-of-Network Inpatient	
	M/S	MH/SUD
Total # of Requests Received	120	188
Total # of Requests Approved	101	170
Total # of Requests Clinically Denied	19	11
Approval Rate %	84.17%	90.43%
Clinical Denial Rate %	15.83%	5.85%
Total # of Clinical Denials reviewed upon appeal-Total (Internal & External)	0	3
Total # of Clinical Denials Overturned upon appeal--Total (Internal & External)	0	0
Clinical Denial Overturn Rate %- Total (Internal & External)	-	0.00%
Total # of Clinical Denials Upheld-Total (Internal & External)	0	3
Clinical Denial Uphold Rate %--Total (Internal & External)	-	100.00%
Total # of Clinical Denials reviewed upon internal appeal only	0	2
Total # of Clinical Denials Overturned upon internal appeal only	0	0
Clinical Denial Overturn Rate %, internal appeal only	-	0.00%
Total # of Clinical Denials Upheld upon internal appeal	0	2
Clinical Denial Uphold Rate %, internal appeal only	-	100.00%
Total # of Clinical Denials reviewed upon external appeal only	0	1
Total # of Clinical Denials Overturned upon external appeal only	0	0
Clinical Overturn Rate %, external appeal only	-	0.00%
Total # of Clinical Denials Upheld upon external appeal	0	1
Clinical Uphold Denial Rate %, external appeal only	-	100.00%

UHC GA

Outcomes Data Prior Authorization Review Analysis:	Out-of-Network Inpatient	
	M/S	MH/SUD
Total # of Requests Received	16	21
Total # of Requests Approved	14	19
Total # of Requests Clinically Denied	2	1
Approval Rate %	87.50%	90.48%
Clinical Denial Rate %	12.50%	4.76%
Total # of Clinical Denials reviewed upon appeal-Total (Internal & External)	0	0
Total # of Clinical Denials Overturned upon appeal--Total (Internal & External)	0	0
Clinical Denial Overturn Rate %- Total (Internal & External)	-	-
Total # of Clinical Denials Upheld-Total (Internal & External)	0	0
Clinical Denial Uphold Rate %--Total (Internal & External)	-	-
Total # of Clinical Denials reviewed upon internal appeal only	0	0
Total # of Clinical Denials Overturned upon internal appeal only	0	0
Clinical Denial Overturn Rate %, internal appeal only	-	-
Total # of Clinical Denials Upheld upon internal appeal	0	0
Clinical Denial Uphold Rate %, internal appeal only	-	-
Total # of Clinical Denials reviewed upon external appeal only	0	0
Total # of Clinical Denials Overturned upon external appeal only	0	0
Clinical Overturn Rate %, external appeal only	-	-
Total # of Clinical Denials Upheld upon external appeal	0	0
Clinical Uphold Denial Rate %, external appeal only	-	-

Conclusions

The Plan reviewed the M/S and MH/SUD Prior Authorization operational policies and procedures and concluded the methodology used to determine which MH/SUD OON inpatient services are subject to Prior Authorization “as written” were comparable to, and applied no more stringently than, the methodology used to determine which M/S OON inpatient services

are subject to Prior Authorization “as written.” Additionally, the Plan concluded that how Prior Authorization is applied to MH/SUD OON inpatient services was comparable to, and applied no more stringently than, how Prior Authorization is applied to M/S OON inpatient services “as written.”

The Plan reviewed the M/S and MH/SUD processes including responsibility for submission, timeframes for submission and review, notification to members and providers, clinical standards for review, staff qualifications, outcomes data, and IRR assessment results and concluded how the Plan conducts Prior Authorization for MH/SUD OON inpatient services “in operation” was comparable to, and applied no more stringently than, how the Plan conducts Prior Authorization for M/S OON inpatient services “in operation.”

Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical/surgical (M/S) benefits. This generally means that the financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements, such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage.

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth the findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Prior Authorization is defined as: “A required or mandatory clinical assessment for proposed service(s) based on clinical information provided and the terms of the health plan benefits before the service(s) are performed or delivered. Clinical and medical necessity requirements, level of care appropriateness, and the terms of the health plan benefits must be met in order for services to be covered by the member's plan.” The *Optum National Policy Definitions List* defines pre-authorization (aka Prior Authorization) as “a form of prospective utilization review of health care services proposed to be provided to a member.”

Prior Authorization is a component of the Plan’s Utilization Management (UM) program that helps ensure members receive appropriate coverage based on their specific clinical status and health care needs. The process is designed to achieve optimal clinical outcomes by applying objective, evidence-based clinical criteria and nationally recognized guidelines and best practices.

Prior Authorization for outpatient services commences prior to a service being delivered. Prior Authorization is a UM process that involves applying the benefit plan language and/or clinical criteria to make the most appropriate clinical coverage benefit determination.

This document includes the following information:

- Prior Authorization process for M/S and MH/SUD outpatient services
- Description of the NQTL and application (Step 1)
- Factors used to determine which services are subject to the NQTL (Step 2)
- Evidentiary standards and sources used to define, trigger and/or implicate a factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

This analysis refers to the following attachments:

- *Addendum A* – Identifies the M/S and MH/SUD outpatient services that are subject to Prior Authorization
- *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions* - M/S policy that defines Prior Authorization
- *Optum National Policy Definitions List* - MH/SUD policy that defines Prior Authorization
- *Utilization Management Program Description (UMPD) of United HealthCare Services, Inc. and UnitedHealthcare*

Insurance Company - Summarizes the philosophy, structure and standards that govern UHC's medical management, UM and utilization review responsibilities and functions

- *Management of Behavioral Health Benefits Policy* - Describes the mechanisms and processes designed to promote consistency in the management of behavioral health benefits and to ensure that members receive appropriate, high quality behavioral health services in a timely manner
- *Prior Authorization Factor Grid(s)* (provided for (2023 Prior Auth_Concurrent Rev Factor Grid)- Details the service categories subject to Prior Authorization and the shared factors and evidentiary standards used as the basis for subjecting M/S and MH/SUD outpatient benefits to Prior Authorization
- *Core Principles and Practices* - MH/SUD policy that outlines the core principles and practices that should be used by personnel in their interactions with members, authorized member representatives, practitioners and facilities, related to the management of behavioral health benefits, coverage determinations and appeals/grievances of non-coverage determinations.
- *Performance Assessment and Incentives* - M/S policy confirming that clinical reviewers are not incented to make denials for financial reasons
- *2023 UnitedHealthcare Provider Administrative Guide* – Informs M/S providers of the Prior Authorization process
- *Certificates of Coverage (COC23-INS-2018-LG-GA, COC23-INS-2018-SG-GA)* - Plan documents that explains covered services, terms, conditions, and limitations of the member's policy
- *Schedule of Benefits (SBN23-Medical-INS-2018-[Charter][Navigate][Nexus+[N]R]-LG-GA, SBN23-Medical-INS-2018-[Choice+Plus][Select+Plus][Doctors+Plus]-LG-GA, SBN23-Medical-INS-2018-[Core][Nexus+OAP]-LG-GA, SBN23-Medical-INS-2018-[Core+Essential][Nexus+OA]-LG-GA, SBN23-Medical-INS-2018-Choice+Plus][Select+Plus][Doctors+Plus]-SG-GA)*. Plan documents that outlines member responsibilities

The Plan concludes that the Prior Authorization requirements for M/S and MH/SUD are comparable and applied no more stringently for MH/SUD out-of-network (OON) outpatient benefits both "as written" and "in operation."

Process

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Prior Authorization is defined as: "A required or mandatory clinical assessment for proposed service(s) based on clinical information provided and the terms of the health plan benefits before the service(s) are performed or delivered. Clinical and medical necessity requirements, level of care appropriateness, and the terms of the health plan benefits must be met in order for services to be covered by the member's plan." The *Optum National Policy Definitions List* defines pre-authorization (aka Prior Authorization) as "a form of prospective utilization review of health care services proposed to be provided to a member."

The Plan structures outpatient Prior Authorization processes to be compliant with all applicable federal and state requirements, as well as the National Committee for Quality Assurance (NCQA) accreditation standards. NCQA confirms that Plan operations and policies identify appropriate timeframes for decisions, requires decision-making by appropriate personnel, and governs communication of adverse benefit determinations. In addition, Prior Authorization is governed at both the state and federal level, which includes consumer protections such as external review for adverse benefit determinations after internal appeals options are exhausted.

The Plan delegates management of MH/SUD outpatient services, including Prior Authorization, to United Behavioral Health d/b/a Optum Behavioral Health (OBH), its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor.

The Plan has national committees that approve M/S and MH/SUD outpatient services to be subject to Prior Authorization. Additionally, the Plan has a standard process for assessing the services that are subjected to Prior Authorization and whether they should be retained or removed from the Prior Authorization list. *Addendum A* includes the list of services categories subject to Prior Authorization. The Plan publishes the services subject to Prior Authorization on the provider portal(s) ([Advance Notification and Clinical Submission Requirements | UHCprovider.com](#) for M/S and [Optum - Provider Express Home](#) for MH/SUD). Members can learn what services are subject to Prior Authorization in their benefit plan document, through

<https://member.uhc.com/myuhc>, myuhc.com, or by contacting customer service.

Prior Authorization review of M/S outpatient services consists of the following:

Members are responsible for obtaining Prior Authorization for services rendered by OON providers. The member's benefit plan document (i.e., *Schedule of Benefits*) identifies the services for which the member is responsible for obtaining Prior Authorization and the required timeframe(s). The member or OON provider's submission of a request (notification) triggers the Prior Authorization process.

Members may submit Prior Authorization requests by phone, fax, or mail, in accordance with Plan requirements. OON providers may submit Prior Authorization requests on behalf of the member by phone, online or by fax (where required). Members or providers communicate basic information to create a case.

The Plan confirms receipt of the Prior Authorization request. Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. Non-clinical staff review cases to ensure availability of accurate and thorough case information. Non-clinical staff may approve coverage requests in scenarios where the member's plan documents allow and if a clinical review is not required. Non-clinical staff may administratively deny coverage when a member's benefits are exhausted. Non-clinical staff refer cases that they cannot approve or administratively deny to clinical reviewers.

First Level Clinical Review/Initial Review. Clinical reviewers (nurses) consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs. The clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. The clinical reviewer can approve cases that meet applicable clinical criteria.

Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Peer clinical reviewers (physician or mid-level practitioner) consult clinical criteria when making clinical coverage benefit determinations. Peer clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs. The peer clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If a peer clinical reviewer issues an adverse benefit determination, then the Plan communicates the adverse benefit determination, including appeal rights, and offers a peer-to-peer conversation consistent with state, federal, and accreditation requirements.

Adverse Benefit Determination. For M/S an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when member benefits are exhausted. Modified coverage requests that are approved are recorded as partial denials.

Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based medical clinical policies and use clinical criteria from third-party sources such as InterQual® or MCG® guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that outpatient Prior Authorization determinations are appropriate.

M/S monitors clinical reviewer and peer clinical reviewer application of clinical criteria through an annual inter-rater reliability (IRR) assessment that is provided by InterQual. Clinical reviewers and peer clinical reviewers are required to pass the IRR assessment with a score of 90% or better through three attempts. After a second failed IRR assessment, staff enter a

remediation period and are required to review all cases with a supervisor for 30 days, or until 90% is achieved on the assessment. If the clinical reviewer achieves a passing score within the 30-day period, supervisors review a minimum of one case per week for the remainder of the 30-day period.

The Plan also conducts end-to-end case audits that are designed and approved by clinical leadership each year. The end-to-end audits include all stages of a case review, from intake through appeal. These audits are conducted monthly and approximately 1500 cases are reviewed per month. Results are reported to an oversight team. All deficiencies are remediated. Remediation may include corrective actions and/or additional education, as indicated.

The Plan routinely monitors Prior Authorization performance through its clinical performance oversight functions. Outcomes are monitored against timeliness compliance, performance guarantees, and for potential trends, including overall utilization.

The Plan's National Medical Care Management Committee (NMCMC) annually reviews overall UM program outcomes, to confirm overall utilization is appropriate. The NMCMC is comprised of the Chief Medical Officer, and representatives from clinical policy, clinical advocacy and grievances, business standardization and advancement, regional chief medical officers, inpatient care management, lines of business, medical policy, clinical operations, and Optum Behavioral Health. The Chair of the NMCMC must be an executive leader and licensed physician.

As of April 1, 2023, the Utilization Management Program Committee (UMPC) began overseeing the M/S UM program. The UMPC is responsible for the development and maintenance of the M/S Prior Authorization processes. The UMPC ensures that the UM program considers the factors and evidentiary standards for applying UM. The UMPC is comprised of:

- Chief Medical Officer, Medical Management (Co-Chair)
- Senior Vice President, Clinical Advancement (Co-Chair)
- Chief Medical Officer, UnitedHealthcare
- Senior Vice President, Clinical Appeals & Grievances
- Chief Medical Officer, Clinical Policy
- Chief Medical Officer, UnitedHealthcare Employer & Individual
- Chief Medical Officer, UnitedHealthcare Medicare & Retirement
- Chief Medical Officer, Community & State
- Chief Medical Officer, UnitedHealthcare Individual & Family Plans
- Vice President, Clinical Transformation & Affordability
- Senior Director, Mental Health Parity
- Vice President, Utilization Management Strategy & Implementation

One of the chairs must be an executive leader and a licensed physician. UMPC meets at least six times per year but may meet more frequently if needed.

Per the M/S policy entitled, *Performance Assessment and Incentives*, at no time are initial or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons.

M/S generally structures UM processes to comply with federal Employee Retirement Income Security Act of 1974 (ERISA) requirements, NCQA UM standards, and state law where applicable.

Prior Authorization review of MH/SUD outpatient services consists of the following:

The Plan delegates management of MH/SUD outpatient services, including Prior Authorization, to United Behavioral Health d/b/a OBH, its delegated MH/SUD MBHO vendor.

Members are responsible for ensuring Prior Authorization is obtained by the OON provider administering the service. The OON

provider must provide clinical information on the member's behalf. The member's benefit plan document (i.e., *Schedule of Benefits*) identifies the services for which the member is responsible for ensuring Prior Authorization is obtained. As outlined in the Plan document, OON providers must submit the Prior Authorization request before outpatient MH/SUD services are received.

OON providers may submit Prior Authorization requests on behalf of the member by telephone, online (for certain services) or by fax (where required). Providers communicate basic information to create a case. OON provider's submission of a request (notification) triggers the Prior Authorization process.

As described in the *Management of Behavioral Health Benefits Policy*, the Plan confirms receipt of the Prior Authorization request. Non-clinical staff confirm member eligibility and benefit coverage. Non-clinical staff may administratively deny coverage when member benefits are exhausted. Non-clinical staff may approve coverage requests that do not require clinical evaluation or interpretation based on the member's diagnosis and the clinical information submitted by providers. Non-clinical staff refer cases that they cannot approve or administratively deny to the initial clinical reviewers.

First Level Clinical Review/Initial Review. Clinical decisions are made by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse benefit determinations are made by Medical Directors or psychologists. Clinical reviewers consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether a service is medically necessary by reviewing the member's clinical information, the applicable clinical criteria or guidelines, and the Plan benefit terms. Clinical reviewers may request additional clinical information including, but not limited to, office or facility medical records, consultations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for certification, related diagnostic results, and history of related treatment and services. The clinical reviewer may approve cases that meet applicable clinical criteria.

Second Level Clinical Review/Peer Review. The initial clinical reviewer refers cases to a peer clinical reviewer for a peer-to-peer discussion if the case cannot be approved. The requesting provider is offered the opportunity to discuss the case with the peer clinical reviewer, consistent with state, federal, and accreditation requirements before an adverse benefit determination is issued. Only qualified peer clinical reviewers (e.g., Medical Directors or psychologists) can issue adverse benefit determinations. Peer clinical reviewers apply clinical criteria to member clinical information to determine coverage. If the requesting provider fails to complete the peer-to-peer discussion, the peer clinical reviewer makes a determination based on the information available. If a peer clinical reviewer issues an adverse benefit determination (e.g., number of treatments are not authorized), then the Plan timely communicates the adverse benefit determination, including appeal rights, to the member and provider consistent with applicable state, federal, and accreditation requirements.

Adverse Benefit Determination. For MH/SUD, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as a clinical denial when it is based on clinical criteria and member clinical information and is recorded as an administrative denial when member benefits are excluded.

Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity clinical coverage determinations on objective, evidence-based behavioral clinical policies or use clinical criteria from third-party sources such as American Society of Addiction Medicine (ASAM) Criteria®, Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System-Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) and Early Childhood Service Intensity Instrument (ECSII) guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that outpatient Prior Authorization determinations are appropriate.

MH/SUD monitors clinical reviewer and peer clinical reviewer application of clinical criteria through an annual IRR assessment. Clinical reviewers and peer clinical reviewers are required to pass the IRR assessment with a score of 90% or better through three attempts. After a second failed IRR assessment, the reviewer enters a remediation period and is required to review all

cases with a supervisor for 30 days, or until 90% is achieved on the assessment. If the clinical reviewer achieves a passing score within the 30-day period, supervisors review a minimum of one case per week for the remainder of the 30-day period.

The Plan also conducts monthly quality audits of individual non-clinical staff, clinical reviewers, and peer clinical reviewers, including staff performing appeal functions. These audits are designed and approved by clinical leadership each year. A minimum of two audits are completed per staff, per month. The results of these real-time audits are shared with supervisors for staff oversight, and all findings are remediated. Remediation may include corrective actions and/or additional education, as indicated.

The Plan routinely monitors Prior Authorization performance through its clinical performance oversight functions. Outcomes are monitored against timeliness compliance, performance guarantees, and for potential trends, including overall utilization.

The Plan's national Clinical Quality & Operations Committee (CQOC) annually reviews overall UM program outcomes, including outpatient Prior Authorization outcomes, to confirm overall utilization is appropriate. The national CQOC is comprised of representatives from sub-committees, and representatives from the clinical quality improvement, UM, care engagement, medical operations, medical policy and standards, clinical operations, appeals, product, legal, compliance, network strategy, provider experience, accreditation, and benefits teams. The Chair of the CQOC must be an executive leader, board certified in psychiatry or psychiatric subspecialty and a licensed physician.

Per the MH/SUD policy entitled, *Core Principles and Practices*, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse clinical coverage benefit determinations (clinical denials) for financial reasons.

MH/SUD generally structures UM processes to comply with federal ERISA requirements, NCQA UM standards, and state law where applicable.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- Prior Authorization

Benefit Classification(s)

- OON, outpatient

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHIC)

Plan Terms/Source Document(s)

In each of the Plan products, "Medically Necessary" is the Plan term used to guide Prior Authorization decision-making for both M/S and MH/SUD services. "Medically Necessary" is generally defined as follows:

- Medically Necessary – health care services are all of the following as determined by us or our designee:
 - In accordance with Generally Accepted Standards of Care.
 - Clinically appropriate, in terms of type, frequency, extent, service site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms.
 - Not mainly for your convenience or that of your doctor or other health care provider.
 - Not more costly than an alternative drug, service(s), service site or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.
- Generally Accepted Standards of Care are evidence based independent standards of care and clinical practice that are

generally recognized by health care providers practicing in relevant clinical specialties. Valid, evidence based sources reflecting generally accepted standards of care include credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

- If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We have the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be determined by us.
- We develop and maintain clinical policies that describe the Generally Accepted Standards of Care scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by us and revised from time to time), are available to Covered Persons through www.myuhc.com or the telephone number on your ID card. They are also available to Physicians and other health care professionals on www.UHCprovider.com.”

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions*, Prior Authorization is defined as:

“A required or mandatory clinical assessment for proposed service(s) based on clinical information provided and the terms of the health plan benefits before the service(s) are performed or delivered. Clinical and medical necessity requirements, level of care appropriateness, and the terms of the health plan benefits must be met in order for services to be covered by the member's plan.”

The *Optum National Policy Definitions List* defines pre-authorization (aka Prior Authorization) as “a form of prospective utilization review of health care services proposed to be provided to a member.”

The Plan's *Schedule of Benefits* notify members of the Prior Authorization requirements:

“We require prior authorization for certain Covered Health Care Services. Network providers are responsible for obtaining prior authorization before they provide these services to you.

We recommend that you confirm with us that all Covered Health Care Services have been prior authorized as required. Before receiving these services from a Network provider, you may want to call us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they do not prior authorize as required. You can call us at the telephone number on your ID card.

When you choose to receive certain Covered Health Care Services from out-of-Network providers, you are responsible for obtaining prior authorization before you receive these services. Note that your obligation to obtain prior authorization is also applicable when an out-of-Network provider intends to admit you to a Network facility or to an out-of-Network facility or refers you to other Network or out-of-Network providers. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization. Services for which you are required to obtain prior authorization are shown in the Schedule of Benefits table within each Covered Health Care Service category.

To obtain prior authorization, call the telephone number on your ID card. This call starts the utilization review process.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the Schedule of Benefits table to find out how far in advance you must obtain prior authorization.

For Covered Health Care Services that do not require you to obtain prior authorization, when you choose to receive services from out-of-Network providers, we urge you to confirm with us that the services you plan to receive are Covered Health Care Services. That is because in some instances, certain procedures may not be Medically Necessary or may not otherwise meet the definition of a Covered Health Care Service, and therefore are excluded. In other instances, the same procedure may meet the definition of Covered Health Care Services. By calling before you receive treatment, you can check to see if the service is subject to limitations or exclusions.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those received, our final coverage determination will be changed to account for those differences, and we will only pay Benefits based on the services delivered to you. If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Care Service, you will be responsible for paying all charges and no Benefits will be paid.”

The role of the Plan’s delegate, United Behavioral Health d/b/a OBH, is discussed in the UMPD:

“United Behavioral Health (UBH) performs the review of requests for coverage of behavioral health services (i.e., substance abuse, and mental health requests for services). UBH provides comprehensive behavioral health care delivery for members through a network of behavioral health practitioners, ancillary care providers, hospitals and other facilities.

For mental health, substance-related disorder services, and wraparound services, UBH uses its Clinical Criteria (see below), behavioral clinical policies and best practice guidelines to make coverage determinations. UBH adopts externally-developed clinical criteria, and creates internally-developed Clinical Criteria, where appropriate, based on its assessment of relevant guidance. UBH develops clinical criteria that supersedes its standard set or adopts externally-developed clinical criteria when required to do so by contract or regulation.

- Clinical Criteria (Level of Care Utilization System-LOCUS) – Standardized level of care assessment tool developed by the American Association of Community Psychiatrists used to make clinical determinations and placement decisions for mental health disorder benefits for adults ages 19 and older when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (Child and Adolescent Level of Care/Service Intensity Utilization System-CALOCUS-CASII) - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry (AACAP) and the American Association for Community Psychiatry (AAPC) used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children and adolescents ages 6-18 when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (Early Childhood Service Intensity Instrument-ECSII) - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children ages 0-5 when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (State or Contract Specific Level of Care Guidelines) – Criteria used to make medical necessity determinations for mental health disorder benefits when there are explicit mandates or contractual requirements.
- Clinical Criteria (American Society of Addiction Medicine [ASAM]) - Criteria developed by the American Society of Addiction Medicine used to make clinical determinations for substance-related disorder benefits.
- Clinical Criteria (Optum Developed)
 - Optum Behavioral Clinical Policies: Criteria that stem from evaluation of new services or treatments or new applications of existing services or treatments and are used to make clinical determinations regarding proven or unproven services and treatments.

Licensed practitioners conduct all reviews with a focus on measurable outcome goals and objectives for treatment. A senior UBH Medical Director is responsible for directing and implementing behavioral health utilization management programs. A referral is sent to UBH when a member is identified as potentially benefiting from behavioral health services during a “medical event.”

The UBH UM Program is staffed by clinical, non-clinical and administrative personnel. All clinical denials or adverse decisions

are made by board certified psychiatrists, or, if the health plans choose, by a panel of other appropriate health care service reviewers. If the health plan chooses to use a panel to make adverse decisions, the panel contains at least one physician who is board certified in psychiatry. When the health care service under review is a mental health or substance abuse service, the adverse decision is made by a licensed physician who is board certified in psychiatry. All potential clinical denials are referred to a physician who is board certified in psychiatry for final determination. An evaluation of the overall effectiveness of the Behavioral Health UM Program is conducted annually to determine how well resources have been deployed to improve UM activities and the clinical care and service provided to members.”

The Plan’s terms require services to be medically necessary for coverage.

List of M/S and MH/SUD Services Subject to NQTL

Addendum A, attached, lists the M/S and MH/SUD OON outpatient service categories subject to Prior Authorization requirements. Prior Authorization is one component of the UM program that evaluates whether a benefit or service is medically necessary.

- The “Member” tab lists the service categories for which the member is responsible for obtaining authorization for OON services. The “Member” tab includes all products in the scope of the analysis
- The “Provider” tab lists the service categories for which the provider is responsible for obtaining authorization for in-network (INN) services. The “Provider” tab applies to all products in the scope of the analysis

Step 2 – Factors Used in the Design and Application of the NQTL

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

The Prior Authorization list was originally designed by enterprise clinical leadership. Prior Authorization was applied to new services when they became covered by the Plan and met certain criteria. Examples of Prior Authorization determinants that existed in the business at this time included:

- to monitor and prevent potential overutilization and under-utilization
- manage high-cost and prolonged-duration services
- ensure enrollee safety
- determine the appropriate level of care
- determine whether the service or item is medically necessary

The factors relied upon to determine which OON outpatient services by category were subjected to Prior Authorization were updated and replaced 2021 with the factors Clinical Appropriateness, Value, and Variation as defined below. After this time, all M/S services subject to Prior Authorization must meet Clinical Appropriateness and all MH/SUD services subject to Prior Authorization must meet Clinical Appropriateness and at least one of the other factors.

Starting in 2022, any additions or deletions to the Prior Authorization list were reviewed and approved through committees.

The Plan relies on the following factors to determine which OON outpatient services are added to the Prior Authorization list. These factors apply to M/S and MH/SUD benefits for the following:

- I. M/S OON outpatient services
 - II. MH/SUD OON outpatient services
- Clinical Appropriateness (Qualitative)
 - Whether the application of Prior Authorization promotes optimal clinical outcomes

Applies to M/S and MH/SUD services

- Value (Quantitative)

- The cost of the outpatient service exceeding the administrative costs of subjecting the outpatient service to Prior Authorization review by at least 1:1. Administrative costs of subjecting the outpatient service to Prior Authorization review are determined using the national UM program operating costs, which is comprised of the cost related to staffing. Administrative costs vary due to differences in the complexities of the requested treatment types, condition(s) treated, and/or clinical guidelines used. The cost of the outpatient service is determined using national outpatient utilization or claims data. The projected benefit cost savings of applying Prior Authorization is reviewed relative to the operating cost of administering Prior Authorization to determine value. Only services that are provided to a minimum of 100 unique individuals are considered (this is the materiality threshold established by the Plan for purposes of the Value analysis)

Applies to M/S and MH/SUD services

- Variation (Quantitative)

- Cost per episode of service (service units multiplied by unit cost) that trigger 2x the mean of other outpatient services. Consideration of this factor includes a review of national internal claims data for service-specific costs and calculating for M/S and MH/SUD, respectively, an overall mean of the service-specific average cost per patient. For any given M/S or MH/SUD service, if the average allowed cost per patient's episode of care is twice the average cost per patient's episode of care across all other M/S or MH/SUD outpatient services, Prior Authorization is applied. Only services that are provided to a minimum of 20 unique individuals are considered (this is the materiality threshold established by the Plan for the purposes of the Variation analysis)

Applies to M/S and MH/SUD services

For M/S meeting Clinical Appropriateness is determinative in imposing the limitation for MH/SUD meeting Clinical Appropriateness plus Value and/or Variation is determinative in imposing the limitation. The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL.

In 2023, to further refine how decisions are made to subject M/S and MH/SUD OON outpatient services to Prior Authorization, the enterprise adopted factors to be assessed when considering whether to remove or retain services on the enterprise Prior Authorization list. These changes were implemented September 2023. The assessment first considered the factors for removal of the service from the Prior Authorization list. If the service met a removal factor, the Plan then assessed if the service met a retention factor. Services that met a retention factor were retained on the Prior Authorization list. Services that did not meet a removal factor remained on the Prior Authorization list based on the original add factors.

The Plan relies on the following factors to determine which OON outpatient benefits are removed from the Prior Authorization list. These factors apply to M/S and MH/SUD and M/S benefits for the following:

- I. M/S: OON outpatient services
- II. MH/SUD: OON outpatient services

- Low Value (Quantitative)

- Does not result in a minimum savings of at least \$50 per review

Applies to M/S and MH/SUD OON outpatient services.

- Consistency (Quantitative)

- Defined as consistent adherence to evidence-based guidelines as evidenced by adverse determination rate (ADR) of less than 5%

Applies to M/S and MH/SUD OON outpatient services.

- Low Volume (Quantitative)
 - Does not have at least 100 authorizations per year

Applies to M/S and MH/SUD OON outpatient services.

Please note that if the primary code within a code family meets the requirements for removal, the family of codes will be addressed in a similar fashion per medical policy and clinical practice patterns.

The Plan then relies on the following factors to determine which OON outpatient benefits are retained on the Prior Authorization list. These factors apply to M/S and MH/SUD and M/S benefits for the following:

- I. M/S: OON outpatient services
 - II. MH/SUD: OON outpatient services
- Services that are experimental, investigational, or unproven (EIU) (Qualitative)
 - Defined as services that are classified as experimental, investigation or unproved based on medical/behavioral clinical policy

Applies to M/S and MH/SUD OON outpatient services.

- Patient Safety (Qualitative)
 - As defined by the World Health Organization as “the absence of preventable harm to a patient and reduction of risk of unnecessary harm associated with health care to an acceptable minimum.”

Applies to M/S and MH/SUD OON outpatient services.

- Level of Care (Quantitative)
 - Defined as Site of Service/Site of Care and where volume is greater than 100 requests per year

Applies to M/S and MH/SUD OON outpatient services.

- High-Cost Drugs and Services that are greater than \$100,000 (Quantitative)
 - Defined as services where the allowed amount is greater than \$100,000 per treated patient, per year

For M/S meeting Clinical Appropriateness is determinative in imposing the limitation. For MH/SUD meeting Clinical Appropriateness plus Value and/or Variation is determinative in imposing the limitation. If the service met a removal factor, the Plan then assessed if the service met a retention factor. Services that met a retention factor were retained on the Prior Authorization list. Meeting any one of the factors is determinative in retaining the limitation. The factors are not weighted in that no individual factor carries more value than another in retaining the NQTL.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factors used to add services to the Plan's Prior Authorization requirement for OON outpatient services. These evidentiary standards and sources apply to benefits for the following:

- I. M/S OON outpatient services
- II. MH/SUD OON outpatient services

Factor – Clinical Appropriateness is defined as those outpatient services that are determined by internal medical experts to be in accordance with objective, evidence-based clinical criteria, and nationally recognized guidelines. The accompanying *Prior Authorization Factor Grid(s)* included with this analysis give details on the service categories subject to Prior Authorization. The *Prior Authorization Factor Grid(s)* detail the shared factors used as the basis for subjecting M/S and MH/SUD OON outpatient benefits to Prior Authorization.

- The Plan’s evidentiary standards and sources that define and/or trigger the Clinical Appropriateness factor are:
 - Clinical criteria from nationally recognized, third-party sources (e.g., InterQual or MCG for M/S services, and ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines for MH/SUD services)
 - Clinical Technology and Assessment Committee (CTAC) and Medical Technology and Assessment Committee (MTAC) review
 - Objective, evidence-based medical/behavioral clinical policies and nationally recognized guidelines approved by professional healthcare associations (e.g., clinical guidance from the American Medical Association, American Psychiatric Association, etc.)

These evidentiary standards and sources apply to M/S and MH/SUD OON outpatient services and are defined in a qualitative manner.

Factor – Value is defined as the cost of the outpatient service exceeding the administrative costs of subjecting the outpatient service to Prior Authorization by at least 1:1. Administrative costs of subjecting the outpatient service to Prior Authorization are determined using the national UM program operating costs, which is comprised of the cost related to staffing. Administrative costs vary due to differences in the complexities of the requested treatment types, condition(s) treated, and/or clinical guidelines used. The cost of the outpatient service is determined using national outpatient utilization or claims data. The projected benefit cost savings of applying Prior Authorization is reviewed relative to the operating cost of administering Prior Authorization to determine Value. Only services that are provided to a minimum of 100 unique individuals are considered (this is the materiality threshold established by the Plan for purposes of the Value analysis). The accompanying *Prior Authorization Factor Grid(s)* contain the calculated Value for each Prior Authorization service category, for both M/S and MH/SUD, and the internal data used to determine these values.

- The Plan’s evidentiary standard that defines and/or triggers the Value factor:
 - Value is defined as the cost of the outpatient service exceeding the administrative costs of subjecting the service to Prior Authorization by at least 1:1. Only services that are provided to a minimum of 100 unique individuals are considered (this is the materiality threshold established by the Plan for purposes of the Value analysis).
- The Plan’s sources used to define the Value factor:
 - National internal claims data
 - National UM program operating costs
 - National UM authorization data

This evidentiary standard and sources apply to M/S and MH/SUD OON outpatient services and are defined in a quantitative manner.

Factor – Variation is defined as cost per episode of service (service units multiplied by unit cost) that trigger 2x the mean of other outpatient services. Consideration of this factor includes a review of national internal claims data for service-specific costs and calculating for M/S and MH/SUD, respectively, an overall mean of the service-specific average cost per patient. For any given M/S or MH/SUD service, if the average allowed cost per patient’s episode of care is twice the average cost per patient’s episode of care across all other M/S or MH/SUD outpatient services, Prior Authorization is applied. Only services that are provided to a minimum of 20 unique individuals are considered (this is the materiality threshold established by the Plan for the purposes of the Variation analysis). The accompanying *Prior Authorization Factor Grid(s)* reflect whether each category of M/S and MH/SUD OON outpatient service meets the Variation identified criteria, and contains the internal data used in the determination.

- The Plan's evidentiary standard that defines and/or triggers the Variation factor:
 - Variation is defined as cost per episode of service (service units multiplied by unit cost) that trigger 2x the mean of other outpatient services. Only services that are provided to a minimum of 20 unique individuals are considered (this is the materiality threshold established by the Plan for purposes of the Variation analysis).
- The Plan's source used to define the Variation factor:
 - National internal claims data

The evidentiary standard and source applies to M/S and MH/SUD OON outpatient services and are defined in a quantitative manner.

For M/S meeting Clinical Appropriateness is determinative in imposing the limitation. For MH/SUD meeting Clinical Appropriateness plus Value and/or Variation is determinative in imposing the limitation. The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL.

In 2023, to further refine how decisions are made to subject M/S and MH/SUD OON outpatient services to Prior Authorization, the enterprise adopted factors to be assessed when considering whether to remove or retain services on the enterprise Prior Authorization list. These changes were implemented September 2023. The assessment first considered the factors for removal of the service from the Prior Authorization list. If the service met a removal factor, the Plan then assessed if the service met a retention factor. Services that met a retention factor were retained on the Prior Authorization list. Services that did not meet a removal factor remained on the Prior Authorization list based on the original add factors.

The Plan relies on the following factors to determine which OON outpatient benefits are removed from the Prior Authorization list. These factors apply to M/S and MH/SUD and M/S benefits for the following:

- I. M/S: OON outpatient services
- II. MH/SUD: OON outpatient services

Factor - Low Value is defined as services that do not result in a minimum savings of at least \$50 per review

- The Plan's evidentiary standard that defines and/or triggers the Low Value factor:
 - Low Value is defined as services that do not result in a minimum savings of at least \$50 per review
- The Plan's sources used to define the Low Value factor:
 - National internal claims data
 - National UM program operating costs
 - National UM authorization data

The evidentiary standard and the sources apply to M/S and MH/SUD OON outpatient services and are defined in a quantitative manner.

Factor - Consistency is defined as consistent adherence to evidence-based guidelines as evidenced by ADR of less than 5%

- The Plan's evidentiary standard that defines and/or triggers the Consistency factor:
 - Consistency is defined as consistent adherence to evidence-based guidelines as evidenced by ADR of less than 5%
- The Plan's source used to define the Consistency factor:
 - National internal UM outcomes data

The evidentiary standard and the source apply to M/S and MH/SUD OON outpatient services and are defined in a

quantitative manner.

Factor - Low Volume is defined as services with fewer than 100 authorizations per year

- The Plan's evidentiary standard that defines and/or triggers the Low Volume factor:
 - Low Volume is defined as services with fewer than 100 authorizations per year
- The Plan's source used to define the Low Volume factor:
 - National internal UM outcomes data

The evidentiary standard and the source apply to M/S and MH/SUD OON outpatient services and are defined in a quantitative manner.

The Plan then relies on the following factors to determine which OON outpatient benefits are retained on the Prior Authorization list. These factors apply to M/S and MH/SUD and M/S benefits for the following:

- I. M/S: OON outpatient services
- II. MH/SUD: OON outpatient services

Factor - Services that are EIU is defined as services that are classified as experimental, investigation or unproved based on medical/behavioral clinical policy

- The Plan's evidentiary standard that triggers and/or defines the Services that are EIU factor:
 - Services that are classified as experimental, investigation or unproved based on medical policy
- The Plan's source used to define the Services that are EIU factor:
 - Medical/behavioral clinical policies

The evidentiary standard and the source apply to M/S and MH/SUD OON outpatient services and are defined in a qualitative manner.

Factor - Patient Safety is defined as "the absence of preventable harm to a patient and reduction of risk of unnecessary harm associated with health care to an acceptable minimum" by the World Health Organization.

- The Plan's evidentiary standards that define and/or trigger the Patient Safety factor:
 - Professional judgment of members of the Utilization Management Program Committee
 - Clinical criteria from nationally recognized third-party sources (e.g., InterQual for M/S services, and ASAM, LOCUS, CALOCUS-CASII and ECSII guidelines for MH/SUD services)
 - Objective, evidence-based medical/behavioral clinical policies and nationally recognized guidelines approved by professional healthcare associations (e.g., clinical guidance from the American Medical Association, American Psychiatric Association, etc.)
- The Plan's sources used to define the Patient Safety factor:
 - Professional judgment of members of the Utilization Management Program Committee
 - Clinical criteria from nationally recognized third-party sources (e.g., InterQual for M/S services, and ASAM, LOCUS, CALOCUS-CASII and ECSII guidelines for MH/SUD services)
 - Objective, evidence-based medical/behavioral clinical policies and nationally recognized guidelines approved by professional healthcare associations (e.g., clinical guidance from the American Medical Association, American Psychiatric Association, etc.)

These evidentiary standards and the sources apply to M/S and MH/SUD OON outpatient services and are defined in a qualitative manner.

Factor - Level of Care is defined as Site of Service/Site of Care, and where the volume is greater than 100 requests per year.

- The Plan's evidentiary standards that define and/or trigger the Level of Care factor:
 - National internal UM outcomes data
 - National internal claims data
 - Place of service
- The Plan's sources used to define the Level of Care factor:
 - National internal UM outcomes data
 - National internal claims data
 - Place of service

These evidentiary standards and the sources apply to M/S and MH/SUD OON outpatient services and are defined in a quantitative manner.

Factor - High-Cost Drugs and Services that are greater than \$100,000 is defined as services where the allowed amount is greater than \$100,000 per treated patient, per year.

- The Plan's evidentiary standard that defines and/or triggers the High-Cost Drugs and Services that are greater than \$100,000 factor:
 - National internal claims data
- The Plan's source used to define the High-Cost Drugs and Services that are greater than \$100,000 factor:
 - National internal claims data

The evidentiary standard and the source applies to M/S and MH/SUD OON outpatient services and are defined in a quantitative manner.

If the service met a removal factor, the Plan then assessed if the service met a retention factor. Services that met a retention factor were retained on the Prior Authorization list. Meeting any one of the factors is determinative in retaining the limitation. The factors are not weighted in that no individual factor carries more value than another in retaining the NQTL.

The factors and evidentiary standards used as the basis for subjecting MH/SUD OON outpatient benefits to Prior Authorization are comparable to, and applied no more stringently than, the factors and evidentiary standards used as the basis for subjecting M/S OON outpatient benefits to Prior Authorization "as written" and "in operation."

Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

As Written

The Plan conducted a comparative analysis of the strategies, processes, factors, evidentiary standards, and source information used to determine which M/S and MH/SUD OON outpatient services are subject to Prior Authorization and how Prior Authorization is applied to M/S and MH/SUD OON outpatient services "as written." The Plan identified the factors and evidentiary standards used as the basis for subjecting M/S and MH/SUD benefits to Prior Authorization.

National internal committees apply the applicable factors and standards described in Steps 2 and 3 to M/S and MH/SUD services when determining whether the services should be subjected to Prior Authorization.

Review of Factors and Evidentiary Standards

The Plan reviewed the factors that trigger an OON outpatient service to be added to, removed from, or retained on the Prior Authorization list. The factors and evidentiary standards were applied to M/S and MH/SUD services comparably and not more stringently to MH/SUD services than to M/S services as evidenced by the attached *Prior Authorization Factor Grid(s)*.

Review of Operational Policies and Procedures

The Plan reviewed M/S and MH/SUD operational policies and procedures, IRR assessment processes, and UM annual oversight to confirm comparability and found MH/SUD policies, procedures, and process to be comparable and no more stringent than M/S policies, procedures, and processes.

- Medical management operational policies and procedures establish the standards for how the Plan conducts outpatient Prior Authorization. The policies and procedures are consistent with state and federal law and accreditation requirements governing Prior Authorization. Timeframes for decisions, content of adverse benefit determinations, appeal rights and external review are all governed by state and federal law and accreditation requirements.
- The IRR measures the consistency with which clinical reviewers and peer clinical reviewers apply the Plan's clinical criteria. IRR assessment processes apply to M/S and MH/SUD outpatient services.
- UM oversight monitors and evaluates UM processes by reviewing program outcomes, clinical appeals, IRR assessments, and under- and over-utilization.

Review of Outpatient Prior Authorization Processes

The strategy for applying Prior Authorization to OON outpatient services is comparable for M/S and MH/SUD services and is applied no more stringently to MH/SUD OON outpatient services. The Plan conducted a review of the M/S and MH/SUD Prior Authorization processes to confirm comparability. The review focused on the following aspects of the process for both M/S and MH/SUD:

- **Prior Authorization Request.** For M/S and MH/SUD OON services, the member is responsible for ensuring the OON provider submits Prior Authorization requests. For M/S services, the member can contact the telephone number on their member ID card, mail, or fax to request a Prior Authorization. For M/S and MH/SUD, the OON provider can request Prior Authorization on behalf of the member, or submit clinical information, via telephone, online form (for certain services) or fax (where required).
- **Timeframe to Submit.** The timeframes for the member, or OON provider on behalf of the member, to submit the Prior Authorization request were reviewed and it was determined that MH/SUD was no more stringent.
 - M/S: Per the member's Plan documents, the timeframes vary depending upon the services requested from as soon as possible to six months prior to the OON service
 - Unplanned or emergency services are not subject to Prior Authorization
 - MH/SUD: Per the member's Plan documents, the Prior Authorization should be requested before OON services are received.
 - Unplanned or emergency services are not subject to Prior Authorization
- **Clinical Reviews.** For M/S and MH/SUD outpatient Prior Authorization requests, clinical reviewers may gather more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for certification, related diagnostic results, history of related treatment and services, and photographs. The clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. The clinical reviewer may approve cases that meet applicable clinical criteria.
- **Review Timeframes.** M/S and MH/SUD outpatient Prior Authorization determination timeframes are defined by state, federal and accreditation requirements for both urgent and non-urgent services. The same determination timeframes apply to M/S and MH/SUD determinations.
- **Determinations and Non-Clinical Reviews, First Level Clinical Reviews, and Second Level/Peer Clinical Reviews.** For M/S and MH/SUD outpatient Prior Authorization, non-clinical staff may approve cases that do not require clinical

evaluation or interpretation. Non-clinical staff may administratively deny cases when member benefits are exhausted.

- Non-clinical staff refer coverage requests that they cannot approve or administratively deny to clinical reviewers. Clinical reviewers consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether an outpatient service is medically necessary. The clinical reviewer may approve the service based on their review. The clinical reviewer refers cases to a peer clinical reviewer for a peer-to-peer discussion if the case cannot be approved. Only qualified peer clinical reviewers (e.g., Medical Directors) may issue adverse benefit determinations. Peer-to-peer discussions are offered as required.
- Adverse Benefit Determination and Peer to Peer Conversations. The Plan offers OON outpatient providers the opportunity to discuss a potential adverse benefit determination before the Plan issues such determination. This process allows OON outpatient MH/SUD facilities and providers the opportunity to provide additional information prior to an adverse benefit determination being issued.
 - OON outpatient M/S and MH/SUD services
 - An adverse benefit determination is recorded as a clinical denial when it is based on clinical criteria and member clinical information and is recorded as an administrative denial when member benefits are exhausted/excluded.
- Notification of Decisions to Providers and Members. The Plan notifies M/S and MH/SUD OON providers and members of approvals and adverse benefit determinations, including applicable appeal rights, consistent with state, federal, and accreditation requirements.
- Review of Staff Qualifications. For M/S and MH/SUD, clinical staff qualifications align with the type of clinical review and with state, federal, and accreditation requirements (NCQA).
 - M/S is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., nurses, physicians, etc.) and all adverse determinations are made by a physician or other appropriate health care professionals.
 - MH/SUD is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse determinations are made by medical directors or psychologists.
- Clinical Criteria. For M/S and MH/SUD, clinical reviewers and peer reviewers base determinations on the objective, evidence-based, medical/behavioral clinical policies and use clinical criteria from third party sources such as InterQual, MCG, ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines.

In Operation

The Plan compared the strategies, processes, factors, evidentiary standards, and source information used to determine which M/S and MH/SUD OON outpatient services are subject to Prior Authorization and how Prior Authorization is applied “in operation.”

M/S and MH/SUD members, or OON providers on the member's behalf submit requests for approval of outpatient services for which the Plan requires Prior Authorization. Members can learn what services are subject to Prior Authorization in their benefit plan document (i.e., *Schedule of Benefits*), or by contacting customer service. Notification triggered the Prior Authorization process for OON M/S and MH/SUD outpatient services.

M/S and MH/SUD outpatient Prior Authorization reviews included confirmation of member eligibility and benefit availability for the requested services. For M/S and MH/SUD OON outpatient services, non-clinical staff approved coverage for outpatient services that did not require clinical review or interpretation.

M/S and MH/SUD outpatient cases that were not administratively approved in initial review, were referred to a clinical reviewer for further research and evaluation. The M/S and MH/SUD clinical reviewers applied benefit plan documents and medical necessity criteria to member clinical information. M/S and MH/SUD clinical reviewers could request additional clinical information if they were unable to approve cases based on the available member clinical information. The clinical reviewers may approve cases based on their review.

If the requested clinical information was not received or if the case could not be approved, M/S and MH/SUD clinical reviewers referred cases to a peer clinical reviewer. The Plan offered peer-to-peer conversations so the OON provider could provide additional clinical information prior to issuance of an adverse benefit determination. Only qualified peer clinical reviewers issued M/S and MH/SUD adverse benefit determinations.

The Plan communicated all adverse benefit determinations for M/S and MH/SUD outpatient cases that did not meet applicable clinical criteria consistent with state, federal, and accreditation requirements, including appeal rights, as applicable.

The Plan monitors M/S and MH/SUD clinical and peer clinical reviewers' application of clinical criteria through annual IRR assessments. The Plan also conducts monthly quality audits of individual non-clinical staff, clinical reviewers, and peer clinical reviewers, including staff performing appeal functions. The Plan routinely monitors Prior Authorization performance through its clinical performance oversight functions. In addition to comparing these "in operation" processes, the Plan reviewed medical necessity approval and denial rates, internal appeals outcomes, and external appeals outcomes related to Prior Authorization determinations for M/S and MH/SUD OON outpatient services. The results of these analyses are discussed in greater detail in Step 5.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan's or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The findings of the Plan's comparative analyses confirmed the strategies, processes, factors, evidentiary standards, and source information used to determine the MH/SUD OON outpatient services subject to Prior Authorization were comparable to, and applied no more stringently than, the strategies, processes, factors, evidentiary standards, and source information used to determine the M/S OON outpatient services subject to Prior Authorization "as written." For M/S and MH/SUD OON outpatient benefits, the *Prior Authorization Factor Grid(s)* included with this analysis detail the shared factors used as the basis for adding, removing, or retaining M/S and MH/SUD OON outpatient services on the Prior Authorization list, as described above.

The Plan found the factors used to add to, remove, or retain MH/SUD OON outpatient services on the Prior Authorization list were comparable to, and applied no more stringently than, the factors used to add to, remove, or retain M/S OON outpatient services on the Prior Authorization list. OON M/S and MH/SUD outpatient services that met the applicable factor(s) were subject to Prior Authorization review "in operation."

The Plan used comparable processes to conduct outpatient Prior Authorization review of member and OON providers' requests. The Plan required members, or OON providers on behalf of the member, to timely submit Prior Authorization requests. The Plan used qualified staff to confirm member eligibility and benefit availability, and to request additional information if necessary. The Plan issued approvals for M/S and MH/SUD outpatient services that met applicable clinical criteria or guidelines. Only qualified M/S and MH/SUD peer clinical reviewers issued adverse benefit determinations. The Plan gave OON providers the opportunity to discuss potential adverse benefit determinations with qualified peer clinical reviewers prior to issuing adverse benefit determinations. This afforded INN MH/SUD providers the opportunity to provide additional information.

The Plan operated monitoring and oversight programs to ensure that clinical reviewers and peer clinical reviewers rendered appropriate determinations. Both M/S and MH/SUD required clinical reviewers, including peer clinical reviewers, to successfully complete the annual IRR assessment. Clinical reviewers were required to pass the IRR assessment with a score of 90% or better to render UM decisions independently. The 2022 IRR M/S results were 97% and MH/SUD results were 96%, demonstrating that M/S and MH/SUD clinical reviewers comparably applied medical necessity criteria when making utilization review determinations.

OON outpatient medical necessity approval and denial rates and appeals outcomes data from 01/01/2022-12/31/2022 were evaluated where a minimum threshold of 100 cases were available to ensure a valid data set for analysis.

The findings of a comparative analysis for each Plan product (see data below) indicated the Prior Authorization process for MH/SUD OON outpatient services was comparable to the Prior Authorization process for OON M/S outpatient services.

For UnitedHealthcare Insurance Company (UHC), M/S had a clinical denial rate of 12.40% and MH/SUD had a clinical denial rate of 4.27%. The denial rates did not reflect any material differences in Prior Authorization processes.

The Plan notes the UM outcomes data do not reflect material differences in Prior Authorization processes for M/S or MH/SUD benefit coverage determinations. Similarly, the appeals data do not reflect that members face a materially different or more stringent review process.

The following definitions are applicable to the charts below:

- Total # of Requests Received: the aggregate number of OON outpatient Prior Authorization requests received
- Total # of Requests Approved: the aggregate number of OON outpatient Prior Authorization requests approved
- Total # of Requests Clinically Denied: the aggregate number of OON outpatient Prior Authorization requests that were denied for clinical reasons (request did not meet medical necessity). This does not include requests there were denied administratively
- Approval Rate %: (Requests Approved / Requests Received)
- Clinical Denial Rate %: (Total number of Requests Clinically Denied / Total number of Requests Received)
- Total # of Clinical Denials reviewed upon appeal: Total (internal & external): the aggregate number of OON outpatient Prior Authorization clinical internal and external appeals received
- Total # of Clinical Denials Overturned upon appeal: Total (internal & external): the aggregate number of OON outpatient Prior Authorization clinical internal and external appeals overturned
- Clinical Denial Overturn Rate %: Total (Internal & External): percent of OON outpatient Prior Authorization clinical internal and external appeals overturned (Total # of Clinical Denials Overturned upon internal and external appeal/Total # of Clinical Denials reviewed upon internal and external appeal)
- Total # of Clinical Denials Upheld: Total (Internal & External): the aggregate number of OON outpatient Prior Authorization clinical internal and external appeals upheld
- Clinical Denial Uphold Rate %: Total (Internal & External): percent of OON outpatient Prior Authorization clinical internal and external appeals upheld (Total # of Clinical Denials Upheld upon internal and external appeal/Total # of Clinical Denials reviewed upon internal and external appeal)
- Total # of Clinical Denials reviewed upon internal appeal only: the aggregate number of OON outpatient Prior Authorization clinical internal appeals received
- Total # of Clinical Denials Overturned upon internal appeal only: the aggregate number of OON outpatient Prior Authorization clinical internal appeals overturned
- Clinical Denial Overturn Rate %, internal appeal only: percent of OON outpatient Prior Authorization clinical internal appeals overturned (Total # of Clinical Denials Overturned upon internal appeal/Total # of Clinical Denials reviewed upon internal appeal)
- Total # of Clinical Denials Upheld upon internal appeal: the aggregate number of OON outpatient Prior Authorization clinical internal appeals upheld
- Clinical Denial Uphold Rate %, internal appeal only: percent of OON outpatient Prior Authorization clinical internal appeals upheld (Total # of Clinical Denials Upheld upon internal appeal/Total # of Clinical Denials reviewed upon internal appeal)
- Total # of Clinical Denials reviewed upon external appeal only: the aggregate number of OON outpatient Prior Authorization clinical external appeals received
- Total # of Clinical Denials Overturned upon external appeal only: the aggregate number of OON outpatient Prior Authorization clinical external appeals overturned

- Clinical Overturn Rate %, external appeal only: percent of OON outpatient Prior Authorization clinical external appeals overturned (Total # of Clinical Denials Overturned upon external appeal/Total # of Clinical Denials reviewed upon external appeal)
- Total # of Clinical Denials Upheld upon external appeal: the aggregate number of OON outpatient Prior Authorization clinical external appeals upheld
- Clinical Uphold Denial Rate %, external appeal only: percent of OON outpatient Prior Authorization clinical external appeals upheld (Total # of Clinical Denials Upheld upon external appeal/Total # of Clinical Denials reviewed upon external appeal)

UHC

Outcomes Data Prior Authorization Review Analysis:	Out-of-Network Outpatient		
	M/S	MH/SUD	
Total # of Requests Received	2,177	468	
Total # of Requests Approved	1,906	441	
Total # of Requests Clinically Denied	270	20	
Approval Rate %	87.55%	94.23%	
Clinical Denial Rate %	12.40%	4.27%	
Total # of Clinical Denials reviewed upon appeal--Total (Internal & External)	8	0	
Total # of Clinical Denials Overturned upon appeal--Total (Internal & External)	6	0	Low volume (of some classifications) is not sufficient for analysis. (quantity of 100 each, is required for a valid sample)
Clinical Denial Overturn Rate %- Total (Internal & External)	75.00%	-	
Total # of Clinical Denials Upheld--Total (Internal & External)	2	0	
Clinical Denial Uphold Rate %--Total (Internal & External)	25.00%	-	
Total # of Clinical Denials reviewed upon internal appeal only	8	0	
Total # of Clinical Denials Overturned upon internal appeal only	6	0	Low volume (of some classifications) is not sufficient for analysis. (quantity of 100 each, is required for a valid sample)
Clinical Denial Overturn Rate %, internal appeal only	75.00%	-	
Total # of Clinical Denials Upheld upon internal appeal	2	0	
Clinical Denial Uphold Rate %, internal appeal only	25.00%	-	
Total # of Clinical Denials reviewed upon external appeal only	0	0	
Total # of Clinical Denials Overturned upon external appeal only	0	0	Low volume (of some classifications) is not sufficient for analysis. (quantity of 100 each, is required for a valid sample)
Clinical Overturn Rate %, external appeal only	-	-	
Total # of Clinical Denials Upheld upon external appeal	0	0	
Clinical Uphold Denial Rate %, external appeal only	-	-	

Conclusions

The Plan reviewed the M/S and MH/SUD Prior Authorization policies and procedures and concluded the methodology used to determine which MH/SUD OON outpatient services are subject to Prior Authorization “as written” were comparable to, and applied no more stringently than, the methodology used to determine which M/S OON outpatient services are subject to Prior Authorization “as written.” Additionally, the Plan concluded that how Prior Authorization is applied to MH/SUD OON outpatient services was comparable to, and applied no more stringently than, how Prior Authorization is applied to M/S OON outpatient services “as written.”

The Plan reviewed the M/S and MH/SUD processes including responsibility for submission, timeframes for submission and review, notification to members and providers, clinical standards for review, staff qualifications, outcomes data, and IRR assessment results and concluded how the Plan conducts Prior Authorization for MH/SUD OON outpatient services “in operation” was comparable to, and applied no more stringently than, how the Plan conducts Prior Authorization for M/S OON outpatient services “in operation.”

Reimbursement Policy-Coding Edits Non-Quantitative Treatment Limitation (NQTL) Analysis

GA – UnitedHealthcare Insurance Company, UnitedHealthcare of Georgia, Inc., UnitedHealthcare Insurance Company of the River Valley
12/29/2023

Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical/surgical (M/S) benefits. This generally means that the financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements, such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage.

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

Per the Plan’s *Certificate of Coverage*, the Plan reviews and determines benefits in accordance with reimbursement policies. Reimbursement policies are developed in accordance with:

- The most recent edition of the Current Procedural Terminology® (CPT), a publication of the American Medical Association (AMA), and/or the Centers for Medicare and Medicaid Services (CMS)
- As reported by generally recognized professionals or publications
- As used for Medicare
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that we accept

Reimbursement policies are applied to provider billings concurrent with the Plan’s Fraud, Waste, Abuse, and Error (FWAE) processes.

In-network (INN) providers adhere to *UnitedHealthcare’s (UHC) Provider Administrative Guide* (M/S) and the *Optum National Network Manual* (MH/SUD), while out-of-network (OON) providers are guided by the member’s Plan documents.

This document includes the following information:

- Process for the development and application of reimbursement policies for both M/S and MH/SUD
- Description of the NQTL and application (Step 1)
- Factors used to develop and apply reimbursement policies for both M/S and MH/SUD (Step 2)
- Evidentiary standards and sources used to define, trigger and/or implicate a factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

This analysis refers to the following attachments:

- *UHC Provider Administrative Guide* - [2023 UnitedHealthcare Care Provider Administrative Guide \(uhcprovider.com\)](https://uhcprovider.com)- Describes requirement to timely submit complete claims with accurate coding

Reimbursement Policy-Coding Edits Non-Quantitative Treatment Limitation (NQTL) Analysis

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- *2023 Optum National Network Manual* - Describes requirement to timely submit complete claims with accurate coding
- *UHC Commercial Reimbursement Policies* (<https://www.uhcprovider.com/en/policies-protocols/commercial-policies/commercial-reimbursement-policies.html>) - General reference resource regarding UnitedHealthcare's reimbursement policies
- *Optum Reimbursement Policies* (<https://www.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/reimbursement-policies.html>) - General reference resource regarding Optum's reimbursement policies
- *Certificates of Coverage* (COC23-INS-2018-LG-GA, COC23-INS-2018-SG-GA, COC23-HMO-2018-LG-GA, COC23-HMO-2018-SG-GA, COC23-INS-RV-2018-LG-GA, COC23-INS-RV-2018-SG-GA) Plan document that explains covered services, terms, conditions, and limitations of the member's policy
- *Schedule of Benefits* (for example: *Schedule of Benefits SBN23-Medical-INS-2018-[Choice+Plus][Select+Plus][Doctors+Plus]-LG-GA*, *SBN23-Medical-INS-2018-[Choice+Plus][Select+Plus][Doctors+Plus]-SG-GA*, *SBN23-Medical-INS-RV-2018-HeritagePlus-LG-GA*, *SBN23-Medical-INS-RV-2018-HeritagePlus-SG-GA*, and *SBN23-Medical-HMO-2022-IEX-GA-ADV*) - Plan document that outlines member responsibilities

Process

Per the M/S *UHC Provider Administrative Guide* and the MH/SUD *Optum National Network Manual*, providers are required to timely submit complete claims with accurate coding. For example, coding must comply with nationally recognized CMS' Correct Coding Initiative (CCI) standards. UHC Plan documents reflect M/S and MH/SUD coverage determinations are made in accordance with the Plan's reimbursement policies.

Both M/S *UnitedHealthcare Commercial Reimbursement Policies* and MH/SUD *Optum Reimbursement Policies* are publicly available to providers through the respective provider portals (M/S: <https://www.uhcprovider.com/en/policies-protocols/commercial-policies/commercial-reimbursement-policies.html> and MH/SUD: <https://www.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/reimbursement-policies.html>). Providers are made aware of changes to these policies on [UHCprovider.com/networknews](https://www.uhcprovider.com/networknews) > Network Bulletin.

Reimbursement Policy Development

The Plan develops reimbursement policies to ensure accurate coding, billing and administration of claims for M/S and MH/SUD conditions. The Plan considers various elements including industry-standard reimbursement logic, regulatory requirements, and benefits design when developing the reimbursement policies.

The M/S and MH/SUD reimbursement policies apply to all INN and OON professionals who deliver health care services.

The Plan uses industry standards and third-party sources (e.g., AMA's CPT, CMS' Healthcare Common Procedure Coding System (HCPCS), CMS' CCI publications, etc.) in drafting reimbursement policy content. The Plan's M/S and MH/SUD reimbursement policies are supported by third-party external sources for policy creation and implementation using five phases of development in order to be approved for use:

1. Triage/Prioritization: Triaging consists of confirming the criteria and elements available to support a reimbursement policy
2. Research/Analysis: The Plan will request input from other M/S and MH/SUD business areas related to potential provider and/or member impact or concerns.
3. Governance: The reimbursement policies are reviewed and approved by the Plan
4. Communication: Providers are notified of new reimbursement policies through external provider portals,

Reimbursement Policy-Coding Edits Non-Quantitative Treatment Limitation (NQTL) Analysis

GA – UnitedHealthcare Insurance Company, UnitedHealthcare of Georgia, Inc., UnitedHealthcare Insurance Company of the River Valley
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according to regulatory requirements. Additional provider communications may be released based on provider impact

5. Deployment: The Plan develops the system programming to support the published reimbursement policy. Based upon applicable regulatory requirements, claims may be paid upon auto-adjudication; pended to request additional information from the provider; or administratively denied for various reasons such as unbundling code combinations, incorrect or missing modifiers, exceeding daily frequency limitations, etc.

The Plan reviews M/S and MH/SUD reimbursement policies on a quarterly basis for coding updates and on an annual basis to validate sourcing. Reimbursement policies may be reviewed and updated more frequently when there is new information relevant to reimbursement of the service or to provide clarification.

The M/S Reimbursement Policy Oversight Committee oversees the development of, provides approval for, and disseminates reimbursement policies. The Reimbursement Policy Oversight Committee is comprised of voting members representing areas such as Payment Integrity, United Clinical Services, UnitedHealth Networks Team and other shared services.

Similarly, the MH/SUD Payment Integrity Oversight and Governance Committee oversees the development of and provides approval for reimbursement policies. The Payment Integrity Oversight and Governance Committee is comprised of voting members representing areas such as Program and Network Integrity, Clinical Services, Benefits and Services, Network Pricing Team, Claims, Value and Healthcare Optimization.

Claims Processing

Providers may submit claims electronically or via hard copy. Both M/S and MH/SUD claims are routed to the Ingenix Claims Edit System (iCES).

iCES is a system application that automates application of the M/S and MH/SUD reimbursement policies to providers' claims. iCES utilizes rules which are based on the M/S and MH/SUD reimbursement policies and general health care claims industry standard coding requirements. iCES rules are maintained by the M/S clinicians at UnitedHealthcare Networks (UHN) Reimbursement Unit (RPU) and MH/SUD clinicians at OptumInsight.

Upon receiving a claim, iCES identifies the claim service lines containing CPT and HCPCS codes and identifies the member's associated claims history iCES then applies industry standard claims requirements to make a reimbursement disposition. iCES disposition codes reflect the action taken by iCES on each service line, such as closure, rejection, pending, adjustment, or no change.

Claims are returned to the claims processing system once iCES dispositions are complete. The claims processing system acts on the iCES disposition codes appropriately, by auto adjudicating the claim or placing it in a work queue for processing. Claims placed in work queues are manually reviewed against the M/S or MH/SUD reimbursement policies, along with industry standard coding requirements. Claims for M/S and MH/SUD services are paid, denied, or paid in part and denied in part generally within 30 days of receipt of the claim. The Plan communicates claims payments to providers and members via provider remittance notices and explanation of benefits respectively.

Providers are notified of the claims process via the *UHC Provider Administrative Guide*, which is available for M/S on UHCprovider.com, ([2023 UnitedHealthcare Care Provider Administrative Guide \(uhcprovider.com\)](https://uhcprovider.com/content/uhc-provider-administrative-guide)) and via the *Optum National Network Manual* for MH/SUD on Provider Express (<https://public.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/optum-network-manual.html>).

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Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, plan terms, and policies at issue. Identification of the specific MH/SUD and medical/surgical benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as medical/surgical.

Specific NQTL

- Development and application of reimbursement policies

Benefit Classification(s)

- Applies to all benefit classifications

Plan(s) at Issue

- Applies to all plans

Plan Terms/ Source Document(s)

The following language is reflected in the Plan's Certificate of Coverage documents:

Review and Determine Benefits in Accordance with our Reimbursement Policies

"We develop our reimbursement policy guidelines, as we determine, in accordance with one or more of the following methodologies:

- As shown in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS).
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that we accept.

Following evaluation and validation of certain provider billings (e.g., error, abuse, and fraud reviews), reimbursement policies are applied to provider billings. We share our reimbursement policies with Physicians and other providers in our Network through our provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by our reimbursement policies) and the billed charge. However, out-of-Network providers may bill you for any amounts we do not pay, including amounts that are denied because one of our reimbursement policies does not reimburse (in whole or in part) for the service billed. You may get copies of our reimbursement policies for yourself or to share with your out-of-Network Physician or provider by contacting us at [\[www.myuhc.com\]](http://www.myuhc.com) or the telephone number on your ID card.

We may apply a reimbursement methodology established by OptumInsight and/or a third-party vendor, which is based on CMS coding principles, to determine appropriate reimbursement levels for Emergency Health Care Services. The methodology is usually based on elements reflecting the patient complexity, direct costs, and indirect costs of an Emergency Health Care Service. If the methodology(ies) currently in use become no longer available, we will use a comparable methodology(ies). We and OptumInsight are related companies through common ownership by UnitedHealth Group. Refer to our website at [\[www.myuhc.com\]](http://www.myuhc.com) for information regarding the vendor that provides the applicable methodology."

INN providers adhere to the Plan's *UHC Provider Administrative Guide (M/S)* and the *Optum National Network Manual (MH/SUD)*, while OON providers are guided by the member's Plan documents. The *UHC Provider Administrative Guide (M/S)* states:

Reimbursement policies:

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“We apply reimbursement policies. Our reimbursement policies are available online at:

- uhcprovider.com/policies > For Commercial Plans > Reimbursement Policies for UnitedHealthcare Commercial Plans.
- uhcprovider.com/policies > For Medicare Advantage Plans > Reimbursement Policies for Medicare Advantage Plans.
- uhcprovider.com/policies > For Exchange Plans > Reimbursement Policies for UnitedHealthcare Individual Exchange Plans.

River Valley

- Claim payment is subject to reimbursement policies on uhcprovider.com/policies > Commercial Policies > Reimbursement Policies for Commercial. Claims Estimator tools are not available for River Valley members.
- We will inform you of changes to these policies on uhcprovider.com/news.
- Coding edits may also affect reimbursements. We apply coding edits based primarily on the NCCI edits developed by the Centers for Medicare and Medicaid Services (CMS), as well as the CMS’ Outpatient Code Editor (OCE). You may find NCCI and OCE edits on cms.gov > Medicare > Coding > National Correct Coding Initiative Edits
- uhcprovider.com/policies > For River Valley > Reimbursement Policies for UnitedHealthcare Commercial Plans

We use the terms “reimbursement policies” and “payment policies” interchangeably.”

The *Optum Reimbursement Policies*:

Our reimbursement policies are available online at: [Reimbursement Policies \(providerexpress.com\)](https://uhcprovider.com/policies)

List of M/S and MH/SUD Services Subject to NQTL

All covered M/S and MH/SUD services are subject to reimbursement policies as described in the Plan documents and reimbursement policies.

Step 2 – Factors Used in the Design and Application of the NQTL

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH or SUD benefits and medical or surgical benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

The Plan relies on several factors to develop reimbursement policies for both M/S and MH/SUD. The factors are:

- State and Federal Regulatory Requirements (Qualitative)
 - The State and Federal rules established as the standards for healthcare transactions
- Benefit Design (Qualitative)
 - Rules that structure how members access the Plan’s benefits

The Plan relies on several factors to apply reimbursement policies under iCES for both M/S and MH/SUD. The factors are:

- Industry-standard reimbursement logic (Qualitative)
- iCES logic to include:
 - Valid CPT/HCPCS Coding (Quantitative)
 - Identifies all the items and services included within certain designated health services (DHS) categories or that may qualify for certain exceptions
 - Correct Coding (Quantitative)
 - Promotes national correct coding methodologies and reduces improper coding, with the overall goal of reducing improper payments

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The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL. Meeting any one or more factors may be determinative. All covered M/S and MH/SUD services are subject to reimbursement policies.

Providers are required to timely submit complete claims with accurate coding. For example, coding must comply with nationally recognized CMS' Correct Coding Initiative (CCI) standards. UHC Plan documents reflect M/S and MH/SUD coverage determinations are made in accordance with the Plan's reimbursement policies.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and medical/surgical benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factors used in designing the Plan's M/S and MH/SUD reimbursement policies.

Factor – State and Federal Regulatory Requirements is defined as a set of rules to establish standards for healthcare transactions.

- The Plan's evidentiary standard and source that defines and/or triggers the State and Federal Regulatory requirements factor:
 - Relevant federal and state laws govern proper claims coding and reimbursement

Factor – Benefit Design is defined as rules that structure how members access the Plan's benefits.

- The Plan's evidentiary standard and source that defines and/or triggers the Benefit Design factor:
 - Governing plan document, e.g., COC, SPD

Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factors used in applying the Plan's M/S and MH/SUD reimbursement policies:

Factor – Industry Standard Reimbursement Logic is defined as standard reimbursement terminology that appears in managed care plan requirements (e.g., the administrative guide).

- The Plan's evidentiary standards and sources that define and/or trigger the Industry Standard Reimbursement factor:
 - CMS
 - Clinical Laboratory Fee Schedule (CLFS)
 - Medicare Administrative Contractors (MACs)

Factor – Valid CPT Coding is defined as the items and services included within certain DHS categories or that may qualify for certain exceptions.

- The Plan's evidentiary standards and sources that define and/or trigger the Valid CPT Coding factor:
 - AMA

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- CPT
- Associated publications and services

Factor – Valid HCPCS Coding is defined as the items and services included within certain DHS categories or that may qualify for certain exceptions.

- The Plan’s evidentiary standards and sources that define and/or trigger the Valid HCPCS Coding factor:
 - CMS
 - HCPCS
 - HCPCS Release and Code Sets

Factor – Correct Coding is defined as national correct coding methodologies to reduce improper coding, with the overall goal of reducing improper payments.

- The Plan’s evidentiary standards and sources that define and/or trigger the Correct Coding factor:
 - CMS
 - NCCI publications

These evidentiary standards and sources apply to both M/S and MH/SUD services.

The factors and evidentiary standards used as the basis for subjecting MH/SUD benefits to reimbursement policies are comparable to, and applied no more stringently than, the factors and evidentiary standards used as the basis for subjecting M/S benefits to reimbursement policies "as written" and "in operation." The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL.

Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan’s or issuer’s analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert’s qualifications and the extent to which the plan or issuer ultimately relied upon each expert’s evaluations in setting recommendations regarding both.

As Written

The Plan conducted a comparative analysis of the strategies, processes, factors, evidentiary standards, and source information used to develop M/S and MH/SUD reimbursement policies “as written.”

Review of Process for Developing of Reimbursement Policies

For both M/S and MH/SUD, the Plan uses industry standards and third-party sources (e.g., AMA’s CPT, CMS’ HCPCS, CMS’ NCCI publications) in drafting reimbursement policy content. The Plan’s M/S and MH/SUD reimbursement policies are both supported by third-party external sources for policy creation and implementation using five phases of development (described in the Process section) in order to be approved for use. These phases of development include confirming the criteria and elements available to support a reimbursement policy and requesting input from M/S and MH/SUD business areas related to potential provider and/or member impact or concerns.

The M/S Reimbursement Policy Oversight Committee oversees the development of, provides approval for, and disseminates reimbursement policies. The Reimbursement Policy Oversight Committee is comprised of voting members representing areas

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such as Payment Integrity, United Clinical Services, UnitedHealth Networks and other shared services.

Similarly, the MH/SUD Payment Integrity Oversight and Governance Committee oversees the development of and provides approval for reimbursement policies. The Payment Integrity Oversight and Governance Committee is comprised of voting members representing areas such as Program and Network Integrity, Clinical Services, Benefits and Services, Network Pricing Team, Claims, Value and Healthcare Optimization.

M/S and MH/SUD providers are notified of new reimbursement policies through external provider portals, according to regulatory requirements. (M/S: <https://www.uhcprovider.com/en/policies-protocols/commercial-policies/commercial-reimbursement-policies.html> MH/SUD: <https://www.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/reimbursement-policies.html>). Additional provider communications may be released based on provider impact.

The Plan develops the claims system programming to support the published reimbursement policies for both M/S and MH/SUD. Based upon applicable regulatory requirements, claims may be paid upon auto-adjudication, pending to request additional information from the provider, or administratively denied for various reasons such as unbundling code combinations, incorrect or missing modifiers, exceeding daily frequency limitations, etc.

Review of Process for Applying Reimbursement Policies

The strategy for applying the reimbursement policies is comparable for both M/S and MH/SUD. The Plan conducted a review of the M/S and MH/SUD reimbursement policy processes to confirm comparability. The review focused on the following aspects of the process for both M/S and MH/SUD:

- Claims process. Providers are notified of the claims process via the *UHC Provider Administrative Guide*, which is available for M/S on UHCprovider.com, (<https://www.uhcprovider.com/content/dam/provider/docs/public/admin-guides/2021-UnitedHealthcare-Administrative-Guide.pdf>) and via the *Optum National Network Manual* for MH/SUD on Provider Express (<https://www.providerexpress.com/content/dam/ope-provexpr/us/pdfs/clinResourcesMain/guidelines/netwManual/sept2022/9.26.22-NatNetManual.pdf>). For both M/S and MH/SUD, providers may submit claims electronically or via paper claim form
- Both M/S and MH/SUD claims are routed to the iCES. iCES applies claims edits based on the M/S and MH/SUD reimbursement policies
- Claims are returned to the claims processing system once iCES dispositions are complete
- Timeframe for Processing. Claims for M/S and MH/SUD are generally adjudicated within 30 days of receipt of the claim
- Determinations. For both M/S and MH/SUD, iCES disposition codes reflect the action taken by iCES on each claim service line, such as closure, rejection, pending, adjustment, or no change. The claims processing system acts on the iCES disposition codes appropriately, by auto adjudicating the claim or placing it in a work queue for processing. Claims placed in work queues are manually reviewed against the M/S or MH/SUD policies, along with industry standard coding requirements
- Determination Communications. The Plan notifies providers and members of benefit determinations via provider remittance notices and explanation of benefits respectively, consistent with state, federal, and accreditation requirements

In Operation

The Plan conducted a comparative analysis of the strategies, processes, factors, evidentiary standards, and source information used to apply the M/S and MH/SUD reimbursement policies “in operation.” The findings and conclusion from this analysis are discussed in greater detail in Step 5 below.

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The comparative analysis revealed the CPT, HCPC, and Correct Coding logic used to identify services that meet industry standards are comparable for M/S and MH/SUD. The analysis further indicated that the reimbursement policies supporting the claims logic for both M/S and MH/SUD are reviewed on a quarterly basis for coding updates and on an annual basis to validate sourcing. Reimbursement policies may be reviewed and updated more frequently when there is new information relevant to reimbursement of the service or to provide clarification.

In addition, the Plan reviewed data regarding the application of claims edits to claims received. The data indicates that M/S claims are more frequently subject to claims edits, indicating a stricter application to M/S services. For example, for laboratory claims, there are on average more than 25,000 M/S lab claims compared to 20 MH/SUD lab claims subject to coding edits monthly.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the plan's or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the plan or coverage is or is not in compliance with MHPAEA.

Findings

The findings of the Plan's analysis confirmed the strategies, processes, factors, evidentiary standards, and source information used to develop the MH/SUD reimbursement policies were comparable to, and applied no more stringently than, the strategies, processes, factors, evidentiary standards, and source information used to develop the M/S reimbursement policies.

The Plan adhered to a 5-phase process for the development of reimbursement policies for both M/S and MH/SUD, which included triage/prioritization, research/analysis, governance, provider communication, and claims platform deployment.

The Plan used comparable processes in applying the M/S and MH/SUD reimbursement policies. For both M/S and MH/SUD, providers may submit claims electronically or via hard copy. Both M/S and MH/SUD claims are then routed to iCES. The claims processing system acts on the iCES disposition codes by auto adjudicating the claim or placing it in a work queue for processing. Claims placed in work queues are manually reviewed against the M/S or MH/SUD reimbursement policies, along with industry standard coding requirements. Claims for M/S and MH/SUD services are generally adjudicated within 30 days of receipt of the claim. The Plan communicates claims payments to providers and members via provider remittance notices and explanation of benefits respectively, consistent with state, federal, and accreditation requirements.

The comparative analysis revealed the CPT, HCPC, and Correct Coding claims logic used to identify services that meet industry standards are comparable for M/S and MH/SUD. The analysis further indicated that reimbursement policies supporting the claims logic for both M/S and MH/SUD are reviewed on a quarterly basis for coding updates and on an annual basis to validate sourcing.

Conclusions

The Plan reviewed the M/S and MH/SUD reimbursement policies and procedures and concluded the methodology used to develop the MH/SUD reimbursement policies "as written" was comparable to, and applied no more stringently than, the methodology used to develop the M/S reimbursement policies "as written." Additionally, the Plan concluded that the MH/SUD reimbursement policies were applied no more stringently than, the M/S reimbursement policies were applied "as written."

The Plan reviewed the M/S and MH/SUD processes for applying the reimbursement policies and found they were comparable and no more stringently applied for MH/SUD. Additionally, from review of the M/S and MH/SUD processes for applying the

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reimbursement policies, including notification, timeframes for processing, determinations, and determination communications, the Plan concluded the methodology used to apply the MH/SUD reimbursement policies “in operation” was comparable to, and applied no more stringently than, the methodology used to apply the M/S reimbursement policies “in operation.”

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Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical/surgical (M/S) benefits. This generally means that the financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements, such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage.

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

Retrospective Review is a component of the Plan’s Utilization Management (UM) program. Medical directors and other clinical staff review services in order to detect and better manage over- and under-utilization and determine whether the services reviewed are consistent with the member’s coverage, medically appropriate, and consistent with evidence-based guidelines. Retrospective Review assesses the appropriateness of services on a case-by-case basis after the service has been provided but prior to payment for services. Retrospective Reviews are based on established review guidelines and may include:

- Review of medical necessity
- Appropriateness of level of care
- Identifying claims issues
- Eligibility determination
- Initiation of appropriate follow-up actions for utilization and quality issues

The Plan conducts medical necessity Retrospective Review of claims/requests for certain inpatient services that have not previously been reviewed as part of the Prior Authorization or Concurrent Review processes. The Plan may conduct Retrospective Review if the service or procedure codes do not match a diagnosis code, if services are experimental, investigational, or unproven (EIU), or if the services are subject to benefit limits/exclusions. The Plan conducts medical necessity Retrospective Review for inpatient services where Prior Authorization was required, but not obtained upon claim submission. INN M/S providers may also request Retrospective Review of inpatient claims that are denied.

This document includes the following information:

- The Retrospective Review process for M/S and MH/SUD inpatient services
- The description of the NQTL and application (Step 1)
- Factor used to determine which services are subject to the NQTL (Step 2)
- Evidentiary standards and sources used to define, trigger and/or implicate the factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

This comparative analysis refers to the following attachments:

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- *Utilization Management Program Description (UMPD) of United HealthCare Services, Inc. and UnitedHealthcare Insurance Company* - Summarizes the philosophy, structure and standards that govern UHC's medical management, UM and utilization review responsibilities and functions
- *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions* - M/S policy that defines Retrospective Review
- *Optum National Policy Definitions List* - MH/SUD policy that defines Retrospective Review
- *M/S Retrospective Review Codes* – Excel document that lists M/S codes that may be subject to Retrospective Review
- *Certificates of Coverage* (for example: *COC23-INS-2018-LG-GA*, *COC23-HMO-2018-LG-GA*, *COC23-INS-2018-SG-GA*, and *COC23-INS-RV-2018-LG-GA*) - Plan document that explains covered services, terms, conditions, and limitations of the member's policy
- *Core Principles and Practices* - MH/SUD policy that outlines the core principles and practices that should be used by personnel in their interactions with members, authorized member representatives, practitioners, and facilities, related to the management of behavioral health benefits, coverage determinations and appeals/grievances of non-coverage determinations
- *Performance Assessment and Incentives* - M/S policy confirming that clinical reviewers are not incented to make denials for financial reasons
- *2023 UnitedHealthcare Provider Administrative Guide* – Informs M/S providers of the Prior Authorization process. The *UnitedHealthcare Provider Administrative Guide* can be accessed on the website <https://www.uhcprovider.com/en/admin-guides.html>
- *September 2023 Optum National Network Manual* - Informs MH/SUD providers of the Prior Authorization process. <https://public.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/optum-network-manual.html>
- *Medical Necessity NQTL* – Comparative analysis that describes the processes, strategies, evidentiary standards and other factors used to apply medical necessity to M/S and MH/SUD services in accordance with MHPAEA and other regulatory guidance

The Plan concludes that the Retrospective Review requirements for M/S and MH/SUD are comparable and applied no more stringently to MH/SUD in-network (INN) inpatient benefits both “as written” and “in operation.”

Process

The Plan structures inpatient Retrospective Review processes to be compliant with all applicable federal and state laws. Retrospective Review is governed at both the state and federal level, which includes consumer protections such as external review for adverse benefit determinations after internal appeals options are exhausted.

The Plan delegates management of MH/SUD inpatient services, including Retrospective Review to United Behavioral Health d/b/a Optum Behavioral Health (OBH), its delegated MH/SUD Managed Behavioral Healthcare Organization (MBHO) vendor.

Retrospective Review of M/S Inpatient Admissions consists of the following:

Retrospective Review for certain inpatient services begins after the Plan receives claims or notification of inpatient admission post discharge from an INN facility. The Plan conducts medical necessity Retrospective Review of claims/requests for certain inpatient services that have not previously been reviewed as part of the Prior Authorization or Concurrent Review processes. The Plan may conduct Retrospective Review if the service or procedure codes do not match a diagnosis code, if services EIU, or if the services are subject to benefit limits/exclusions. The Plan conducts medical necessity Retrospective Review for inpatient services where Prior Authorization was required but not obtained upon claim submission.

Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. If needed, non-clinical staff request medical records for claims containing services that are subject to Retrospective Review. When medical records are received, the case is referred to clinical reviewers to assess medical necessity.

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First Level Clinical Review/Initial Review. The clinical reviewer (physicians or nurses) reviews the claim to determine if the inpatient service billed meets clinical criteria for coverage based on application of objective, evidence-based clinical criteria, nationally recognized guidelines, and the member's benefit plan documents. Clinical reviewers either approve claims for payment or refer claims to peer clinical reviewers (e.g., Medical Directors).

Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If a peer clinical reviewer determines that a service was not medically necessary, then an adverse benefit determination will be issued for the claim. The Plan communicates the adverse benefit determination, including applicable appeal rights, and offers a peer-to-peer conversation consistent with state, federal, and accreditation requirements. Appeal rights are set forth in the member's benefit plan document (*Certificate of Coverage*). The Plan communicates results of Retrospective Review within 30 days of receipt of a claim.

Adverse Benefit Determination. For M/S, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when benefits are exhausted. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials.

Clinical Criteria: Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based medical clinical policies or use clinical criteria from third party sources such as InterQual® or MCG® guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that Retrospective Review determinations are appropriate.

The Plan conducts end-to-end case audits that are designed and approved by clinical leadership each year. The end-to-end audits include all stages of a case review, from intake through appeal. These audits are conducted monthly and approximately 1500 cases are reviewed per month. Results are reported to an oversight team. All deficiencies are remediated. Remediation may include corrective actions and/or additional education, as indicated.

The Plan routinely monitors Retrospective Review performance through its clinical performance oversight functions. Outcomes are monitored against timeliness requirements, performance guarantees, and for potential trends, including overall utilization.

The Plan's National Medical Care Management Committee (NMCMC) annually reviews overall UM program outcomes, including inpatient Retrospective Review outcomes, to confirm overall utilization is appropriate. The NMCMC is comprised of the Chief Medical Officer, and representatives from clinical policy, clinical advocacy and grievances, business standardization and advancement, regional chief medical officers, inpatient care management, lines of business, medical policy, clinical operations, and Optum Behavioral Health. The Chair of the NMCMC must be an executive leader and licensed physician.

As of April 1, 2023, the Utilization Management Program Committee (UMPC) began overseeing the M/S UM program. The UMPC is responsible for the development and maintenance of the M/S Prior Authorization processes. The UMPC ensures that the UM program considers the factors and evidentiary standards for applying UM. The UMPC is comprised of:

- Chief Medical Officer, Medical Management (Co-Chair)
- Senior Vice President, Clinical Advancement (Co-Chair)
- Chief Medical Officer, UnitedHealthcare
- Senior Vice President, Clinical Appeals & Grievances
- Chief Medical Officer, Clinical Policy
- Chief Medical Officer, UnitedHealthcare Employer & Individual
- Chief Medical Officer, UnitedHealthcare Medicare & Retirement
- Chief Medical Officer, Community & State

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- Chief Medical Officer, UnitedHealthcare Individual & Family Plans
- Vice President, Clinical Transformation & Affordability
- Senior Director, Mental Health Parity
- Vice President, Utilization Management Strategy & Implementation

One of the chairs must be an executive leader and a licensed physician. UMPC meets at least six times per year but may meet more frequently if needed.

Per the M/S policy entitled, *Performance Assessment and Incentives*, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons.

M/S generally structures UM processes to comply with federal Employee Retirement Income Security Act of 1974 (ERISA) requirements, and state law where applicable.

Retrospective Review of MH/SUD Inpatient Admissions consist of the following:

The Plan delegates management of MH/SUD inpatient services, including Retrospective Review to United Behavioral Health d/b/a OBH, its delegated MH/SUD MBHO vendor.

MH/SUD claims/requests for inpatient services submitted by INN providers may be subject to Retrospective Review if the service or procedure code required Prior Authorization or Concurrent Review, but that review was not conducted and there is a mitigating circumstance. Additionally, claims may be subject to Retrospective Review if the billed services or procedure codes do not match the authorized codes or if services are EIU.

Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. If needed, non-clinical staff request medical records for requests or claims containing services that are subject to Retrospective Review. When medical records are received, the case is referred to clinical reviewers to assess medical necessity.

First Level Clinical Review/Initial Review. The clinical reviewer (e.g., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) review the claim to determine if the inpatient admission billed meets clinical criteria for coverage based on application of objective, evidence-based, clinical criteria, or nationally recognized guidelines. Clinical reviewers either approve requests for payment or refer requests to peer clinical reviewers (Medical Directors).

Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If the peer clinical reviewer determines that an admission was not medically necessary, then an adverse benefit determination will be issued for the claim. The Plan communicates the adverse benefit determination, including applicable appeal rights. Appeal rights are set forth in the member's benefit plan document (*Certificate of Coverage*). The Plan communicates results of Retrospective Review within 30 days of receipt of a request/claim.

Adverse Benefit Determination. For MH/SUD, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when benefits are exhausted. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials.

Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based behavioral clinical policies or use clinical criteria from third party sources such as American Society of Addiction Medicine (ASAM) Criteria®, Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System-Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) and Early Childhood Service Intensity Instrument (ECSII) guidelines.

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Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that inpatient Retrospective Review determinations are appropriate.

The Plan conducts monthly quality audits of individual non-clinical staff, clinical reviewers, and peer clinical reviewers, including staff performing appeal functions. These audits are designed and approved by clinical leadership each year. A minimum of two audits are completed per staff, per month. The results of these real-time audits are shared with supervisors for staff oversight, and all findings are remediated. Remediation may include corrective actions and/or additional education, as indicated.

The Plan routinely monitors Retrospective Review performance through its clinical performance oversight functions. Outcomes are monitored against timeliness requirements, performance guarantees, and for potential trends, including overall utilization.

The Plan's national Clinical Quality & Operations Committee (CQOC) annually reviews overall UM program outcomes, including inpatient Retrospective Review outcomes, to confirm overall utilization is appropriate. The national CQOC is comprised of representatives from sub-committees, and representatives from the clinical quality improvement, UM, care engagement, medical operations, medical policy and standards, clinical operations, appeals, product, legal, compliance, network strategy, provider experience, accreditation, and benefits teams. The Chair of the CQOC must be an executive leader, board certified in psychiatry or psychiatric subspecialty, and a licensed physician.

Per the MH/SUD policy entitled, *Core Principles and Practices*, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse clinical coverage benefit determinations (clinical denials) for financial reasons.

MH/SUD generally structures UM processes to comply with federal ERISA requirements, and state law where applicable.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- Retrospective Review

Benefit Classification(s)

- INN, inpatient

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHIC)
- UnitedHealthcare of Georgia, Inc. (UHCGA)
- UnitedHealthcare Insurance Company of the River Valley (UHICRV)

Plan Terms

The Plan's *Schedule of Benefits* notify members of Retrospective Review requirements.

"The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, Concurrent Review, case management, discharge planning, retrospective review or similar programs."

The *Utilization Management Program Description (UMPD)* discusses Post-Service Reviews and indicates:

"Post-service review assesses the appropriateness of medical services on a case-by-case basis after the service has been provided but prior to payment for services. Post- service reviews are based on established review guidelines and includes:

- Review of medical necessity;

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- Appropriateness of level of care;
- Identifying claims issues;
- Eligibility determination;
- Initiation of appropriate follow-up actions for utilization and quality issues; and
- Identifying appropriateness and administrative issues such as physician notification, emergency status of admission.”

The Plan’s delegate, United Behavioral Health d/b/a OBH, is discussed in the *UMPD*:

“United Behavioral Health (UBH) performs the review of requests for coverage of behavioral health services (i.e., substance abuse, and mental health requests for services). UBH provides comprehensive behavioral health care delivery for members through a network of behavioral health practitioners, ancillary care providers, hospitals and other facilities.

For mental health, substance-related disorder services, and wraparound services, UBH uses its Clinical Criteria (see below), behavioral clinical policies and best practice guidelines to make coverage determinations. UBH adopts externally-developed clinical criteria, and creates internally-developed Clinical Criteria, where appropriate, based on its assessment of relevant guidance. UBH develops clinical criteria that supersedes its standard set or adopts externally-developed clinical criteria when required to do so by contract or regulation.

- Clinical Criteria (Level of Care Utilization System-LOCUS) – Standardized level of care assessment tool developed by the American Association of Community Psychiatrists used to make clinical determinations and placement decisions for mental health disorder benefits for adults ages 19 and older when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (Child and Adolescent Level of Care/Service Intensity Utilization System-CALOCUS-CASII)- Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry (AACAP) and the American Association for Community Psychiatry (AACP) used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children and adolescents ages 6-18 when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (Early Childhood Service Intensity Instrument-ECSII) – Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children ages 0-5 when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (State or Contract Specific Level of Care Guidelines) - Criteria used to make medical necessity determinations for mental health disorder benefits when there are explicit mandates or contractual requirements.
- Clinical Criteria (American Society of Addiction Medicine [ASAM]) - Criteria developed by the American Society of Addiction Medicine used to make clinical determinations for substance-related disorder benefits.
- Clinical Criteria (Optum Developed)
 - Optum Behavioral Clinical Policies: Criteria that stem from evaluation of new services or treatments or new applications of existing services or treatments and are used to make clinical determinations regarding proven or unproven services and treatments.

Licensed practitioners conduct all reviews with a focus on measurable outcome goals and objectives for treatment. A senior UBH Medical Director is responsible for directing and implementing behavioral health utilization management programs. A referral is sent to UBH when a member is identified as potentially benefiting from behavioral health services during a “medical event.”

The UBH UM Program is staffed by clinical, non-clinical and administrative personnel. All clinical denials or adverse decisions are made by board certified psychiatrists, or, if the health plans choose, by a panel of other appropriate health care service reviewers. If the health plan chooses to use a panel to make adverse decisions, the panel contains at least one physician who is board certified in psychiatry. When the health care service under review is a mental health or substance abuse service, the adverse decision is made by a licensed physician who is board certified in psychiatry. All potential clinical denials are referred to a physician who is board certified in psychiatry for final determination. An evaluation of the overall effectiveness of the

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Behavioral Health UM Program is conducted annually to determine how well resources have been deployed to improve UM activities and the clinical care and service provided to members.”

The Plan’s terms require services to be medically necessary for coverage. INN providers are required to comply with the Plan’s UM protocols including complying with Retrospective Review requirements.

List of M/S and MH/SUD Services Subject to NQTL

- Services that have not previously been reviewed in Prior Authorization or Concurrent Review
- M/S Claims that are denied, if requested by an INN facility
- Services where the service or procedure codes do not match a diagnosis code
- EIU services
- Services that are subject to benefit limits/exclusions
- Codes identified by the Plan as subject to Retrospective Review
- Please see the file *M/S Retrospective Review Codes* for the list of M/S codes that may be subject to Retrospective Review
- MH/SUD claims/requests that include the following services are subject to Retrospective Review:
 - MH Non-Emergent Acute inpatient
 - MH Subacute Residential Treatment
 - SUD Acute Inpatient Detoxification
 - SUD Acute Inpatient Rehabilitation
 - SUD Subacute Residential Treatment

Step 2 – Factors Used to Determine Retrospective Review Applies

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

The Plan relies on the following factor to determine which INN inpatient admissions are subject to Retrospective Review. This factor applies to M/S and MH/SUD for the following:

- I. M/S INN inpatient admissions
 - II. MH/SUD INN inpatient admissions
- Consistency with Clinical Criteria (Qualitative):
 - Whether the application of Retrospective Review promotes optimal clinical outcomes

This factor applies to M/S and MH/SUD services. Meeting Consistency with Clinical Criteria is determinative in imposing the limitation.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factor used in designing or applying the Plan’s Retrospective Review requirement to INN inpatient services. These evidentiary standards and sources

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apply to the following:

- I. M/S INN inpatient admissions
- II. MH/SUD INN inpatient admissions

Factor: Consistency with Clinical Criteria is defined as whether the application of Retrospective Review promotes optimal clinical outcomes.

- The Plan's evidentiary standards and sources that define and/or trigger the Consistency with Clinical Criteria factor:
 - Clinical criteria from nationally recognized, third-party sources (e.g., InterQual or MCG for M/S services, and ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines for MH/SUD services)
 - Clinical Technology Assessment Committee (CTAC) and Medical Technology and Assessment Committee (MTAC) review
 - Objective, evidence-based medical/behavioral clinical policies and nationally recognized guidelines approved by professional healthcare associations (e.g., clinical guidance from the American Medical Association, American Psychiatric Association, etc.)

The *Medical Necessity NQTL* describes the process for determining how internally developed medical/behavioral clinical policies are developed and how externally developed third-party guidelines are reviewed and approved.

The Plan's evidentiary standards and sources apply to M/S and MH/SUD services. The Consistency with Clinical Criteria factor, evidentiary standards, and sources are defined in a qualitative manner.

The factor and evidentiary standards used as the basis for subjecting MH/SUD INN inpatient benefits to Retrospective Review are comparable to, and applied no more stringently than, the factor and evidentiary standards used as the basis for subjecting M/S INN inpatient benefits to Retrospective Review "as written" and "in operation."

Step 4 – NQTL "As Written" and "In Operation" Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

As Written

The Plan conducted a comparative analysis of the strategies, processes, factor, evidentiary standards, and source information used to determine which M/S and MH/SUD INN inpatient services are subject to Retrospective Review "as written." The Plan identified the factor and evidentiary standards used as the basis for subjecting M/S and MH/SUD benefits to Retrospective Review for each benefit classification.

Review of Factors and Evidentiary Standards

The Plan reviewed the factor that triggers an INN inpatient service to be subject to Retrospective Review. The factor and evidentiary standards were applied to M/S and MH/SUD services comparably and not more stringently to MH/SUD services than M/S services.

Review of Operational Policies and Procedures

The Plan reviewed M/S and MH/SUD operational policies and procedures and UM annual oversight to confirm comparability and found MH/SUD policies, procedures, and processes to be comparable and no more stringent than M/S policies, procedures and processes.

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- Medical management operational policies and procedures establish the standards for how the Plan conducts inpatient Retrospective Review. The policies and procedures are consistent with state and federal law governing Retrospective Review. Timeframes for decisions, content of adverse benefit determinations, appeal rights and external review are all governed by state and federal requirements
- UM oversight monitors and evaluates UM processes by reviewing denial rates, clinical appeals, and under- and over-utilization.

Review of Inpatient Retrospective Review Processes

The strategy for applying Retrospective Review to INN inpatient claims/requests is comparable for M/S and MH/SUD services and applied no more stringently to MH/SUD INN inpatient services. The Plan conducted a review of the M/S and MH/SUD Retrospective Review processes to confirm comparability. The review focused on the following aspects of the processes for both M/S and MH/SUD:

- **Responsibility.** INN M/S and MH/SUD facilities are contractually responsible for requesting Retrospective Review for inpatient services.
- **Timeframe to submit.** The *UnitedHealthcare Administrative Guide* (for M/S) and *Optum National Network Manual* (for MH/SUD) were reviewed for requirements related to timeliness of notification to the Plan and it was determined that MH/SUD was no more stringent.
 - For M/S, facilities must request the Retrospective Review within the requirements outlined in their provider contract
 - For MH/SUD, facilities have 180 days after the service is rendered to request a Retrospective Review
- **Clinical Reviews.** For M/S and MH/SUD claims/requests, the Plan may request clinical information and refer the claim/request to a clinical reviewer for a Retrospective Review. The clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. The clinical reviewer either approves cases that meet applicable clinical criteria or refers the case to a peer clinical reviewer.
- **Review Timeframes.** M/S and MH/SUD Retrospective Review determination timeframes are defined by state, and federal requirements. The same determination timeframes apply to M/S and MH/SUD determinations.
- **Determinations, First Level Clinical Review, and Second Level/Peer Clinical Reviews.** Clinical reviewers determine whether an inpatient admission is medically necessary. The clinical reviewer may approve the admission based on their review. The clinical reviewer refers cases they cannot approve to a peer clinical reviewer. If the peer clinical reviewer determines that an admission was not medically necessary and will not be covered, an adverse benefit determination will be issued. Only qualified peer clinical reviewers may issue adverse benefit determinations.
- **Adverse Benefit Determinations.** An adverse benefit determination is recorded as a clinical denial when it is based on clinical criteria and member clinical information and is recorded as an administrative denial when member benefits are exhausted.
- **Notification of Decisions to Providers and Members.** The Plan notifies M/S and MH/SUD INN facilities and members of approvals and adverse benefit determinations, including applicable appeal rights consistent with state and federal requirements.
- **Review of Staff Qualifications.** For M/S and MH/SUD, clinical staff qualifications align with the type of clinical review and state and federal requirements.
 - M/S is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are conducted by clinical staff (nurses, physicians) and all adverse benefit determinations are made by a physician or other appropriate health care professionals.
 - MH/SUD is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse benefit determinations are made by Medical Directors.
- **Clinical Criteria.** For M/S and MH/SUD, clinical reviewers and peer clinical reviewers base determinations on objective, evidence-based medical/behavioral clinical policies or use clinical criteria from third party sources such as InterQual, MCG, ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines.

In Operation

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The Plan compared the strategies, processes, factor, evidentiary standards, and source information used to determine which M/S and MH/SUD INN inpatient services are subject to Retrospective Review and how Retrospective Review is applied “in operation.”

The Plan subjected claims/requests for M/S and MH/SUD inpatient admissions to Retrospective Review that were not reviewed in the Prior Authorization or Concurrent Review process. Additionally, M/S claims/requests for inpatient services submitted by INN providers were subject to Retrospective Review if the services or procedure codes did not match a diagnosis code, if services were EIU, or if the services had benefit limits/exclusions. Claims/requests for inpatient services submitted by INN providers may be subject to Retrospective Review if the service or procedure code required Prior Authorization or Concurrent Review, but that review was not conducted and there is a mitigating circumstance. Additionally, claims may be subject to Retrospective Review if the billed services or procedure codes do not match the authorized codes or if services are EIU.

The Plan may have request member clinical information for M/S and MH/SUD inpatient claims/requests and referred them to a clinical reviewer. The clinical reviewer reviewed applicable member clinical information, benefit plan documents, and clinical criteria in the case review. The clinical reviewer approved cases that met applicable clinical criteria or referred cases to peer clinical reviewers. If an appropriately qualified peer clinical reviewer determined that a service was not medically necessary and would not be covered, an adverse benefit determination was issued for the claim.

The Plan communicated all adverse benefit determinations for M/S and MH/SUD inpatient claims/requests that did not meet applicable clinical criteria, including appeal rights, consistent with state and federal requirements.

The Plan conducted monthly quality audits of individual non-clinical staff, clinical reviewers, including staff performing appeal functions. The Plan routinely monitored Retrospective Review performance through its clinical performance oversight functions. In addition to comparing these “in operation” processes, the Plan reviewed medical necessity approval and denial rates, internal appeals outcomes, and external appeals outcomes related to Retrospective Review determinations for M/S and MH/SUD INN inpatient services.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The findings of the Plan's comparative analyses confirmed the strategies, processes, factor, evidentiary standards, and source information used to subject certain MH/SUD INN inpatient services to Retrospective Review were comparable to, and applied no more stringently than, the strategies, processes, factor, evidentiary standards, and source information used to subject certain M/S INN inpatient services to Retrospective Review “as written.”

The Plan found the factor used to subject INN MH/SUD inpatient services to Retrospective Review was comparable to and applied no more stringently than the factor used to subject INN M/S inpatient services to Retrospective Review “in operation.” All M/S and MH/SUD inpatient admissions were subject to Retrospective Review if they were not reviewed via Prior Authorization or Concurrent Review. Additionally, M/S and MH/SUD claims for inpatient services submitted by INN providers were subject to Retrospective Review if the services or procedure codes did not match a diagnosis code, if services were EIU, or if the services had benefit limits/exclusions. Claims/requests for inpatient services submitted by INN providers may be subject to Retrospective Review if the service or procedure code required Prior Authorization or Concurrent Review, but that review was not conducted and there is a mitigating circumstance.

The Plan used comparable processes to conduct Retrospective Review of claims/requests for M/S and MH/SUD inpatient

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services. The Plan may have requested clinical information if necessary. The Plan approved M/S and MH/SUD claims/requests for inpatient services that met applicable clinical criteria or guidelines. The Plan issued an adverse benefit determination for M/S and MH/SUD INN provider claims/requests for inpatient services that did not meet applicable clinical criteria or guidelines.

The Plan notes the UM outcomes data do not reflect material differences in Retrospective Review processes for M/S or MH/SUD benefit coverage determinations. Similarly, the appeals data do not reflect that members face a materially different or more stringent review process.

There is an insufficient number of MH/SUD INN inpatient cases from 01/01/2022-12/31/2022 to support an analysis of clinical outcomes data for UnitedHealthcare Insurance Company (UHIC)

There is an insufficient number of MH/SUD INN inpatient cases from 01/01/2022-12/31/2022 to support an analysis of clinical outcomes data for UnitedHealthcare of Georgia (UHCGA)

There is an insufficient number of MH/SUD INN inpatient cases from 01/01/2022-12/31/2022 to support an analysis of clinical outcomes data for UnitedHealthcare Insurance Company of the River Valley (UHICRV).

The following definitions are applicable to the charts below:

- Total # of Requests Received: the aggregate number of INN inpatient Retrospective Review requests received
- Total # of Requests Approved: the aggregate number of INN inpatient Retrospective Review requests approved
- Total # of Requests Clinically Denied: the aggregate number of INN inpatient Retrospective Review requests that were denied for clinical reasons (request did not meet medical necessity)
- Approval Rate %: (Requests Approved / Requests Received)
- Clinical Denial Rate %: (Total number of Requests Clinically Denied / Total number of Requests Received)
- Total # of Clinical Denials reviewed upon appeal: Total (internal & external): the aggregate number of INN inpatient Retrospective Review clinical internal and external appeals received
- Total # of Clinical Denials Overturned upon appeal: Total (internal & external): the aggregate number of INN inpatient Retrospective Review clinical internal and external appeals overturned
- Clinical Denial Overturn Rate %: Total (Internal & External): percent of INN inpatient Retrospective Review clinical internal and external appeals overturned (Total # of Clinical Denials Overturned upon internal and external appeal/Total # of Clinical Denials reviewed upon internal and external appeal)
- Total # of Clinical Denials Upheld: Total (Internal & External): the aggregate number of INN inpatient Retrospective Review clinical internal and external appeals upheld
- Clinical Denial Uphold Rate %: Total (Internal & External): percent of INN inpatient Retrospective Review clinical internal and external appeals upheld (Total # of Clinical Denials Upheld upon internal and external appeal/Total # of Clinical Denials reviewed upon internal and external appeal)
- Total # of Clinical Denials reviewed upon internal appeal only: the aggregate number of INN inpatient Retrospective Review clinical internal appeals received
- Total # of Clinical Denials Overturned upon internal appeal only: the aggregate number of INN inpatient Retrospective Review clinical internal appeals overturned
- Clinical Denial Overturn Rate %, internal appeal only: percent of INN inpatient Retrospective Review clinical internal appeals overturned (Total # of Clinical Denials Overturned upon internal appeal/Total # of Clinical Denials reviewed upon internal appeal)
- Total # of Clinical Denials Upheld upon internal appeal: the aggregate number of INN inpatient Retrospective Review clinical internal appeals upheld
- Clinical Denial Uphold Rate %, internal appeal only: percent of INN inpatient Retrospective Review clinical internal appeals upheld (Total # of Clinical Denials Upheld upon internal appeal/Total # of Clinical Denials reviewed upon internal appeal)
- Total # of Clinical Denials reviewed upon external appeal only: the aggregate number of INN inpatient Retrospective

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Review clinical external appeals received

- Total # of Clinical Denials Overturned upon external appeal only: the aggregate number of INN inpatient Retrospective Review clinical external appeals overturned
- Clinical Overturn Rate %, external appeal only: percent of INN inpatient Retrospective Review clinical external appeals overturned (Total # of Clinical Denials Overturned upon external appeal/Total # of Clinical Denials reviewed upon external appeal)
- Total # of Clinical Denials Upheld upon external appeal: the aggregate number of INN inpatient Retrospective Review clinical external appeals upheld
- Clinical Uphold Denial Rate %, external appeal only: percent of INN inpatient Retrospective Review clinical external appeals upheld (Total # of Clinical Denials Upheld upon external appeal/Total # of Clinical Denials reviewed upon external appeal)

UHC

Outcomes Data Retrospective Review Analysis:	In-Network Inpatient	
	M/S	MH/SUD
Total # of Requests Received	0	52
Total # of Requests Approved	0	52
Total # of Requests Clinically Denied	0	0
Approval Rate %	-	100.00%
Clinical Denial Rate %	-	0.00%
Total # of Clinical Denials reviewed upon appeal-Total (Internal & External)	6	0
Total # of Clinical Denials Overturned upon appeal--Total (Internal & External)	4	0
Clinical Denial Overturn Rate %- Total (Internal & External)	66.67%	-
Total # of Clinical Denials Upheld-Total (Internal & External)	2	0
Clinical Denial Uphold Rate %--Total (Internal & External)	33.33%	-
Total # of Clinical Denials reviewed upon internal appeal only	6	0
Total # of Clinical Denials Overturned upon internal appeal only	4	0
Clinical Denial Overturn Rate %, internal appeal only	66.67%	-
Total # of Clinical Denials Upheld upon internal appeal only	2	0
Clinical Denial Uphold Rate %, internal appeal only	33.33%	-
Total # of Clinical Denials reviewed upon external appeal only	0	0
Total # of Clinical Denials Overturned upon external appeal only	0	0
Clinical Overturn Rate %, external appeal only	-	-
Total # of Clinical Denials Upheld upon external appeal only	0	0
Clinical Uphold Denial Rate %, external appeal only	-	-

* Due to changes in internal systems, medical/surgical retrospective review data is only available for January through June 2022. The data reported has been annualized to estimate the complete year.

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UHCGA

Outcomes Data Retrospective Review Analysis:		In-Network Inpatient	
		M/S	MH/SUD
Total # of Requests Received		0	5
Total # of Requests Approved		0	5
Total # of Requests Clinically Denied		0	0
Approval Rate %		-	100.00%
Clinical Denial Rate %		-	0.00%
Total # of Clinical Denials reviewed upon appeal--Total (Internal & External)		0	1
Total # of Clinical Denials Overturned upon appeal--Total (Internal & External)		0	0
Clinical Denial Overturn Rate %- Total (Internal & External)		-	0.00%
Total # of Clinical Denials Upheld--Total (Internal & External)		0	1
Clinical Denial Uphold Rate %--Total (Internal & External)		-	100.00%
Total # of Clinical Denials reviewed upon internal appeal only		0	1
Total # of Clinical Denials Overturned upon internal appeal only		0	0
Clinical Denial Overturn Rate %, internal appeal only		-	0.00%
Total # of Clinical Denials Upheld upon internal appeal only		0	1
Clinical Denial Uphold Rate %, internal appeal only		-	100.00%
Total # of Clinical Denials reviewed upon external appeal only		0	0
Total # of Clinical Denials Overturned upon external appeal only		0	0
Clinical Overturn Rate %, external appeal only		-	-
Total # of Clinical Denials Upheld upon external appeal only		0	0
Clinical Uphold Denial Rate %, external appeal only		-	-

* Due to changes in internal systems, medical/surgical retrospective review data is only available for January through June 2022. The data reported has been annualized to estimate the complete year.

UHICRV

Outcomes Data Retrospective Review Analysis:		In-Network Inpatient	
		M/S	MH/SUD
Total # of Requests Received		0	4
Total # of Requests Approved		0	4
Total # of Requests Clinically Denied		0	0
Approval Rate %		-	100.00%
Clinical Denial Rate %		-	0.00%
Total # of Clinical Denials reviewed upon appeal--Total (Internal & External)		1	0
Total # of Clinical Denials Overturned upon appeal--Total (Internal & External)		1	0
Clinical Denial Overturn Rate %- Total (Internal & External)		100.00%	-
Total # of Clinical Denials Upheld--Total (Internal & External)		0	0
Clinical Denial Uphold Rate %--Total (Internal & External)		0.00%	-
Total # of Clinical Denials reviewed upon internal appeal only		1	0
Total # of Clinical Denials Overturned upon internal appeal only		1	0
Clinical Denial Overturn Rate %, internal appeal only		100.00%	-
Total # of Clinical Denials Upheld upon internal appeal only		0	0
Clinical Denial Uphold Rate %, internal appeal only		0.00%	-
Total # of Clinical Denials reviewed upon external appeal only		0	0
Total # of Clinical Denials Overturned upon external appeal only		0	0
Clinical Overturn Rate %, external appeal only		-	-
Total # of Clinical Denials Upheld upon external appeal only		0	0
Clinical Uphold Denial Rate %, external appeal only		-	-

* Due to changes in internal systems, medical/surgical retrospective review data is only available for January through June 2022. The data reported has been annualized to estimate the complete year.

Retrospective Review In-Network Inpatient Non-Quantitative Treatment Limitations (NQTL) Analysis

GA – UnitedHealthcare Insurance Company, UnitedHealthcare of Georgia,
Inc. and UnitedHealthcare Insurance Company of the River Valley
12/29/2023

Conclusions

The Plan concluded that how Retrospective Review is applied to MH/SUD INN inpatient services was comparable to, and applied no more stringently than, how Retrospective Review is applied to M/S INN inpatient services “as written.”

The Plan reviewed the M/S and MH/SUD processes including responsibility for submission, timeframes for submission and review, notification to members and providers, clinical standards for review, staff qualifications, and outcome data and concluded how the Plan conducts Retrospective Review for MH/SUD INN inpatient services “in operation” was comparable to, and applied no more stringently than, how the Plan conducts Retrospective Review for M/S INN inpatient services “in operation.”

Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical/surgical (M/S) benefits. This generally means that financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements, such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage.

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

Retrospective Review is a component of the Plan’s Utilization Management (UM) program. Medical directors and other clinical staff review services in order to detect and better manage over- and under-utilization and determine whether the services reviewed are consistent with the member’s coverage, medically appropriate, and consistent with evidence-based guidelines. Retrospective Review assesses the appropriateness of services on a case-by-case basis after the service has been provided, but prior to payment for services. Retrospective Reviews are based on established review guidelines and may include:

- Review of medical necessity
- Appropriateness of level of care
- Identifying claims issues
- Eligibility determination
- Initiation of appropriate follow-up actions for utilization and quality issues

The Plan conducts medical necessity Retrospective Review of claims/requests for certain outpatient services that have not previously been reviewed as part of the Prior Authorization or Concurrent Review processes. The Plan may conduct Retrospective Review if the service or procedure codes do not match a diagnosis code, if services are experimental, investigational, or unproven (EIU), or if the services are subject to benefit limits/exclusion. The Plan conducts medical necessity Retrospective Review for outpatient services where Prior Authorization was required, but not obtained upon claim submission. INN M/S providers may also request Retrospective Review of outpatient claims that are denied.

This document includes the following information:

- The Retrospective Review process for M/S and MH/SUD outpatient services
- The description of the NQTL and application (Step 1)
- Factor used to determine which services are subject to the NQTL (Step 2)
- Evidentiary standards and sources used to define, trigger and/or implicate a factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

This comparative analysis refers to the following attachments:

- *Utilization Management Program Description (UMPD) of United HealthCare Services, Inc. and UnitedHealthcare Insurance Company* - Summarizes the philosophy, structure and standards that govern UHC's medical management, UM and utilization review responsibilities and functions
- *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions* - M/S policy that defines Retrospective Review
- *Optum National Policy Definitions List* - MH/SUD policy that defines Retrospective Review
- *M/S Retrospective Review Codes* - Excel document that lists M/S codes that may be subject to Retrospective Review
- *Certificates of Coverage* (for example: *COC23-INS-2018-LG-GA*, *COC23-HMO-2018-LG-GA*, and *COC23-INS-2018-SG-GA*) - Plan document that explains covered services, terms, conditions, and limitations of the member's policy
- *Core Principles and Practices* - MH/SUD policy that outlines the core principles and practices that should be used by personnel in their interactions with members, authorized member representatives, practitioners, and facilities, related to the management of behavioral health benefits, coverage determinations and appeals/grievances of non-coverage determinations
- *Performance Assessment and Incentives* - M/S policy confirming that clinical reviewers are not incented to make denials for financial reasons
- *2023 UnitedHealthcare Provider Administrative Guide* - Informs M/S providers of the Prior Authorization process. The *UnitedHealthcare Provider Administrative Guide* can be accessed on the website <https://www.uhcprovider.com/en/admin-guides.html>
- *September 2023 Optum National Network Manual* - Informs MH/SUD providers of the Prior Authorization process. <https://public.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/optum-network-manual.html>
- *Medical Necessity NQTL* - Comparative analysis that describes the processes, strategies, evidentiary standards and other factors used to apply medical necessity to M/S and MH/SUD services in accordance with MHPAEA and other regulatory guidance

The Plan concludes that the Retrospective Review requirements for M/S and MH/SUD are comparable and applied no more stringently to MH/SUD in-network (INN) outpatient benefits both “as written” and “in operation.”

Process

The Plan structures outpatient Retrospective Review processes to be compliant with all applicable federal and state laws. Retrospective Review is governed at both the state and federal level, which includes consumer protections such as external review for adverse benefit determinations after internal appeals options are exhausted.

The Plan delegates management of MH/SUD outpatient services, including Retrospective Review to United Behavioral Health d/b/a Optum Behavioral Health (OBH), its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor.

Retrospective Review of M/S Outpatient Services consists of the following:

Retrospective Review for certain outpatient services begins after the Plan receives claims from INN providers. The Plan conducts medical necessity Retrospective Review of claims/requests for certain outpatient services that have not previously been reviewed as part of the Prior Authorization or Concurrent Review processes. The Plan may conduct Retrospective Review if the service or procedure codes do not match a diagnosis code, if services are EIU, or if the services are subject to benefit limits/exclusion. The Plan also conducts medical necessity Retrospective Review for outpatient services where Prior Authorization was required, but not obtained upon claim submission. INN providers may also request Retrospective Review of outpatient claims that are denied.

Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. If needed, non-clinical staff request medical records for claims containing services that are subject to Retrospective Review. When medical records are received, the case is referred to clinical reviewers to assess medical necessity.

First Level Clinical Review/Initial Review. The clinical reviewer (physician or nurse) reviews the claim to determine if the outpatient service billed meets clinical criteria for coverage based on application of objective, evidence-based clinical criteria, nationally recognized guidelines, and the member's benefit plan documents. Clinical reviewers either approve claims for payment or refer claims to peer clinical reviewers (Medical Directors).

Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If a peer clinical reviewer determines that a service was not medically necessary, then an adverse benefit determination will be issued for the claim. The Plan communicates the adverse benefit determination, including applicable appeal rights, and offers a peer-to-peer conversation consistent with state and federal requirements. Appeal rights are set forth in the member's benefit plan document (*Certificate of Coverage*). The Plan communicates results of Retrospective Review within 30 days of receipt of a claim.

Adverse Benefit Determination. For M/S, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when benefits are exhausted. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials.

Clinical Criteria: Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based medical clinical policies or use clinical criteria from third party sources such as InterQual® or MCG® guidelines.

Monitoring/Quality Oversight: The Plan conducts a variety of activities that ensure that Retrospective Review determinations are appropriate.

The Plan conducts end-to-end case audits that are designed and approved by clinical leadership each year. The end-to-end audits include all stages of a case review, from intake through appeal. These audits are conducted monthly and approximately 1500 cases are reviewed per month. Results are reported to an oversight team. All deficiencies are remediated. Remediation may include corrective actions and/or additional education, as indicated.

The Plan routinely monitors Retrospective Review performance through its clinical performance oversight functions. Outcomes are monitored against timeliness requirements, performance guarantees, and for potential trends, including overall utilization.

The Plan's National Medical Care Management Committee (NMCMC) annually reviews overall UM program outcomes, including inpatient Retrospective Review outcomes, to confirm overall utilization is appropriate. The NMCMC is comprised of the Chief Medical Officer, and representatives from clinical policy, clinical advocacy and grievances, business standardization and advancement, regional chief medical officers, inpatient care management, lines of business, medical policy, clinical operations, and Optum Behavioral Health. The Chair of the NMCMC must be an executive leader and licensed physician.

As of April 1, 2023, the Utilization Management Program Committee (UMPC) began overseeing the M/S UM program. The UMPC is responsible for the development and maintenance of the M/S Prior Authorization processes. The UMPC ensures that the UM program considers the factors and evidentiary standards for applying UM. The UMPC is comprised of:

- Chief Medical Officer, Medical Management (Co-Chair)
- Senior Vice President, Clinical Advancement (Co-Chair)
- Chief Medical Officer, UnitedHealthcare
- Senior Vice President, Clinical Appeals & Grievances
- Chief Medical Officer, Clinical Policy
- Chief Medical Officer, UnitedHealthcare Employer & Individual
- Chief Medical Officer, UnitedHealthcare Medicare & Retirement
- Chief Medical Officer, Community & State
- Chief Medical Officer, UnitedHealthcare Individual & Family Plans
- Vice President, Clinical Transformation & Affordability

- Senior Director, Mental Health Parity
- Vice President, Utilization Management Strategy & Implementation

One of the chairs must be an executive leader and a licensed physician. UMPC meets at least six times per year but may meet more frequently if needed.

Per the M/S policy entitled, *Performance Assessment and Incentives*, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons.

M/S generally structures UM processes to comply with federal Employee Retirement Income Security Act of 1974 (ERISA) requirements and state law where applicable.

Retrospective Review of MH/SUD Outpatient Services consists of the following:

The Plan delegates management of MH/SUD outpatient services, including Retrospective Review to United Behavioral Health d/b/a OBH, its delegated MH/SUD MBHO vendor.

MH/SUD claims/requests for outpatient services submitted by INN providers may be subject to Retrospective Review if the service or procedure code required Prior Authorization or Concurrent Review, but that review was not conducted and there is a mitigating circumstance. Additionally, claims may be subject to Retrospective Review if the billed services or procedure codes do not match the authorized codes or if services are EIU.

Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. If needed, non-clinical staff request medical records for claims containing services that are subject to Retrospective Review. When medical records are received, the case is referred to clinical reviewers to assess medical necessity.

First Level Clinical Review/Initial Review. The clinical reviewer (e.g., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) reviews the request or claim to determine if the outpatient service meets clinical criteria for coverage based on application of objective, evidence-based clinical criteria, or nationally recognized guidelines. Clinical reviewers either approve claims for payment or refer claims to peer clinical reviewers (Medical Directors or psychologists).

Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If the peer clinical reviewer determines that a service was not medically necessary, then an adverse benefit determination is issued. The Plan communicates the adverse benefit determination, including appeal rights, and offers a peer-to-peer conversation consistent with state and federal requirements. Appeal rights are set forth in the member's benefit plan document (*Certificate of Coverage*). The Plan communicates results of Retrospective Review within 30 days of receipt of a request/claim.

Adverse Benefit Determination. For MH/SUD, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when benefits are excluded. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials.

Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based behavioral clinical policies, or use clinical criteria from third party sources such as American Society of Addiction Medicine (ASAM) Criteria®, Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System-Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) and Early Childhood Service Intensity Instrument (ECSII) guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that outpatient Retrospective Review determinations are appropriate.

The Plan conducts monthly quality audits of individual non-clinical staff, clinical reviewers, and peer clinical reviewers, including staff performing appeal functions. These audits are designed and approved by clinical leadership each year. A minimum of two audits are completed per staff, per month. The results of these real-time audits are shared with supervisors for staff oversight, and all findings are remediated. Remediation may include corrective actions and/or additional education, as indicated.

The Plan routinely monitors Retrospective Review performance through its clinical performance oversight functions. Outcomes are monitored against timeliness requirements, performance guarantees, and for potential trends, including overall utilization.

The Plan's national Clinical Quality & Operations Committee (CQOC) annually reviews overall UM program outcomes, including outpatient Retrospective Review outcomes, to confirm overall utilization is appropriate. The national CQOC is comprised of representatives from sub-committees, and representatives from the clinical quality improvement, UM, care engagement, medical operations, medical policy and standards, clinical operations, appeals, product, legal, compliance, network strategy, provider experience, accreditation, and benefits teams. The Chair of the CQOC must be an executive leader, board certified in psychiatry or psychiatric subspecialty and a licensed physician.

Per the MH/SUD policy entitled, *Core Principles and Practices*, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse clinical coverage benefit determinations (clinical denials) for financial reasons.

MH/SUD generally structures UM processes to comply with federal ERISA requirements, and state law where applicable.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- Retrospective Review

Benefit Classification(s)

- INN, outpatient

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHIC)
- UnitedHealthcare of Georgia, Inc. (UHCGA)

Plan Terms

The Plan's *Certificates of Coverage* notify members of Retrospective Review requirements:

"The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, Concurrent Review, case management, discharge planning, Retrospective Review or similar programs."

The *Utilization Management Program Description (UMPD)* discusses Post-Service Reviews and indicates:

"Post-service review assesses the appropriateness of medical services on a case by-case basis after the service has been provided but prior to payment for services. Post- service reviews are based on established review guidelines and includes:

- Review of medical necessity
- Appropriateness of level of care
- Identifying claims issues
- Eligibility determination

- Initiation of appropriate follow-up actions for utilization and quality issues
- Identifying appropriateness and administrative issues such as physician notification, emergency status of admission”

The role of the Plan’s delegate, United Behavioral Health d/b/a OBH, is discussed in the *UMPD*:

“United Behavioral Health (UBH) performs the review of requests for coverage of behavioral health services (i.e., substance abuse, and mental health requests for services). UBH provides comprehensive behavioral health care delivery for members through a network of behavioral health practitioners, ancillary care providers, hospitals and other facilities.

For mental health, substance-related disorder services, and wraparound services, UBH uses its Clinical Criteria (see below), behavioral clinical policies and best practice guidelines to make coverage determinations. UBH adopts externally-developed clinical criteria, and creates internally-developed Clinical Criteria, where appropriate, based on its assessment of relevant guidance. UBH develops clinical criteria that supersedes its standard set or adopts externally-developed clinical criteria when required to do so by contract or regulation.

- Clinical Criteria (Level of Care Utilization System-LOCUS) – Standardized level of care assessment tool developed by the American Association of Community Psychiatrists used to make clinical determinations and placement decisions for mental health disorder benefits for adults ages 19 and older when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (Child and Adolescent Level of Care/Service Intensity Utilization System-CALOCUS-CASII) - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry (AACAP) and the American Association for Community Psychiatry (AAPC) used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children and adolescents ages 6-18 when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (Early Childhood Service Intensity Instrument-ECSII) – Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children ages 0-5 when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (State or Contract Specific Level of Care Guidelines) - Criteria used to make medical necessity determinations for mental health disorder benefits when there are explicit mandates or contractual requirements.
- Clinical Criteria (American Society of Addiction Medicine [ASAM]) - Criteria developed by the American Society of Addiction Medicine used to make clinical determinations for substance-related disorder benefits.
- Clinical Criteria (Optum Developed)
 - Optum Behavioral Clinical Policies: Criteria that stem from evaluation of new services or treatments or new applications of existing services or treatments and are used to make clinical determinations regarding proven or unproven services and treatments.
 - Optum Supplemental Clinical Criteria: Criteria used to make clinical determinations for Applied Behavior Analysis and Electroconvulsive Therapy.
 - Optum’s Supplement to the APA Psychological and Neuropsychological Testing Billing and Coding Guide: Additional criteria used regarding provider qualifications, coverage rationale, limitations, and developmental testing.

Licensed practitioners conduct all reviews with a focus on measurable outcome goals and objectives for treatment. A senior UBH Medical Director is responsible for directing and implementing behavioral health utilization management programs. A referral is sent to UBH when a member is identified as potentially benefiting from behavioral health services during a “medical event”.

The UBH UM Program is staffed by clinical, non-clinical and administrative personnel. All clinical denials or adverse decisions are made by board certified psychiatrists, or, if the health plans choose, by a panel of other appropriate health care service reviewers. If the health plan chooses to use a panel to make adverse decisions, the panel contains at least one physician who is board certified in psychiatry. When the health care service under review is a mental health or substance

abuse service, the adverse decision is made by a licensed physician who is board certified in psychiatry. All potential clinical denials are referred to a physician who is board certified in psychiatry for final determination. An evaluation of the overall effectiveness of the Behavioral Health UM Program is conducted annually to determine how well resources have been deployed to improve UM activities and the clinical care and service provided to members.”

The Plan’s terms require services to be medically necessary for coverage. INN providers are required to comply with UM protocols established by the Plan including complying with Retrospective Review requirements.

List of M/S and MH/SUD Services Subject to NQTL

- Services that have not previously been reviewed in Prior Authorization or Concurrent Review
- Claims that are denied, if requested by INN provider
- Services where the service or procedure codes do not match a diagnosis code
- EIU services
- Services that are subject to benefit limits/exclusions
- Codes identified by the Plan as subject to Retrospective Review
 - Please see the file *M/S Retrospective Review Codes* for the list of M/S codes that may be subject to Retrospective Review
- MH/SUD claims/requests that include the following services are subject to Retrospective Review:
 - Partial Hospitalization Program (PHP)/Day Treatment
 - Intensive Outpatient Program (IOP)
 - Transcranial Magnetic Stimulation (TMS)
 - Electroconvulsive Therapy (ECT)
 - Psychological Testing
 - Applied Behavioral Analysis (ABA)

Step 2 – Factors Used to Determine Retrospective Review Applies

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

The Plan relies on the following factor to determine which INN outpatient services are subject to Retrospective Review. This factor applies to M/S and MH/SUD for the following:

- I. M/S INN outpatient services
 - II. MH/SUD INN outpatient services
- Consistency with Clinical Criteria (Qualitative):
 - Whether the application of Retrospective Review promotes optimal clinical outcomes

This factor applies to M/S and MH/SUD services. Meeting Consistency with Clinical Criteria is determinative in imposing the limitation.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factor used in designing or applying

the Plan's Retrospective Review requirement to INN outpatient services. These evidentiary standards and sources apply to the following:

- I. M/S INN outpatient services
- II. MH/SUD INN outpatient services

Factor - Consistency with Clinical Criteria is defined as whether the application of Retrospective Review promotes optimal clinical outcomes

- The Plan's evidentiary standards and sources that define and/or trigger the Consistency with Clinical Criteria factor:
 - Clinical criteria from nationally recognized, third-party sources (e.g., InterQual or MCG for M/S services, and ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines for MH/SUD services)
 - Clinical Technology Assessment Committee (CTAC) and Medical Technology and Assessment Committee (MTAC) review
 - Objective, evidence-based medical/behavioral clinical policies and nationally recognized guidelines approved by professional healthcare associations (e.g., clinical guidance from the American Medical Association, American Psychiatric Association, etc.)

The *Medical Necessity NQTL* describes the process for determining how internally developed medical/behavioral clinical policies are developed and how externally developed third party guidelines are reviewed and approved.

The Plan's evidentiary standards and sources apply to M/S and MH/SUD services. The Consistency with Clinical Criteria factor, evidentiary standards, and sources are defined in a qualitative manner.

The factor and evidentiary standards used as the basis for subjecting MH/SUD INN outpatient benefits to Retrospective Review are comparable to, and applied no more stringently than, the factor and evidentiary standards used as the basis for subjecting M/S INN outpatient benefits to Retrospective Review "as written" and "in operation."

Step 4 – NQTL "As Written" and "In Operation" Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

As Written

The Plan conducted a comparative analysis of the strategies, processes, factor, evidentiary standards, and source information used to determine which M/S and MH/SUD INN outpatient services are subject to Retrospective Review "as written." The Plan identified the factor and evidentiary standards used as the basis for subjecting M/S and MH/SUD benefits to Retrospective Review for each benefit classification.

Review of Factors and Evidentiary Standards

The Plan reviewed the factor that triggers an INN outpatient services to be subject to Retrospective Review. The factor and evidentiary standards were applied to M/S and MH/SUD services comparably and not more stringently to MH/SUD services than M/S services.

Review of Operational Policies and Procedures

The Plan reviewed M/S and MH/SUD operational policies and procedures, and UM annual oversight to confirm comparability and found MH/SUD policies, procedures, and processes to be comparable and no more stringent than M/S policies,

procedures, and processes.

- Medical management operational policies and procedures establish the standards for how the Plan conducts outpatient Retrospective Review. The policies and procedures are consistent with state and federal law governing Retrospective Review. Timeframes for decisions, content of adverse benefit determinations, appeal rights, and external review are all governed by state and federal requirements.
- UM oversight monitors and evaluates UM processes by reviewing denial rates, clinical appeals, and under- and over-utilization.

Review of Outpatient Retrospective Review Processes

The strategy for applying Retrospective Review to INN outpatient claims/requests is comparable for M/S and MH/SUD services and applied no more stringently to MH/SUD INN outpatient services. The Plan conducted a review of the M/S and MH/SUD Retrospective Review processes to confirm comparability. The review focused on the following aspects of the process for M/S and MH/SUD:

- Responsibility. INN M/S and MH/SUD providers are contractually responsible for requesting Retrospective Review for outpatient services.
- Timeframe to submit. The *UnitedHealthcare Administrative Guide* (for M/S) and *Optum National Network Manual* (for MH/SUD) were reviewed for requirements relating to timeliness of notification to the Plan and it was determined MH/SUD was no more stringent.
 - For M/S, providers must request the Retrospective Review within the requirements outlined in their provider contract
 - For MH/SUD, providers have 180 days after the service is rendered to request a Retrospective Review
- Clinical Reviews. For M/S and MH/SUD requests and claims, the Plan may request clinical information and refer the claim to a clinical reviewer for a Retrospective Review. The clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. The clinical reviewer may approve cases that meet applicable clinical criteria or refer claims to peer clinical reviewers.
- Review Timeframes. M/S and MH/SUD Retrospective Review determination timeframes are defined by state and federal requirements. The same determination timeframes apply to M/S and MH/SUD determinations
- Determinations, First Level Clinical Review, and Second Level/Peer Clinical Reviews. Clinical reviewers determine whether an outpatient service is medically necessary. The clinical reviewer may approve the services based on their review. The clinical reviewer refers cases they cannot approve to a peer clinical reviewer. If the peer clinical reviewer determines that a service was not medically necessary and will not be covered, an adverse benefit determination will be issued. Only qualified peer clinical reviewers may issue adverse benefit determinations.
- Adverse Benefit Determinations. An adverse benefit determination is recorded as a clinical denial when it is based on clinical criteria and member clinical information and is recorded as an administrative denial when member benefits are exhausted.
- Notification of Decisions to Providers and Members. The Plan notifies M/S and MH/SUD INN providers and members of approvals and adverse benefit determinations, including applicable appeal rights, consistent with state and federal requirements.
- Review of Staff Qualifications. For M/S and MH/SUD, clinical staff qualifications align with the type of clinical review and state and federal requirements.
 - M/S is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are conducted by clinical staff (nurses) and all adverse benefit determinations are made by a physician or other appropriate health care professionals.
 - MH/SUD is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are conducted by clinical staff (physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse benefit determinations are made by Medical Directors or psychologists.
- Clinical Criteria. For M/S and MH/SUD, clinical reviewers and peer clinical reviewers base determinations on objective, evidence-based, medical/behavioral clinical policies or use clinical criteria from third party sources such as InterQual, MCG, ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines.

In Operation

The Plan compared the strategies, processes, factor, evidentiary standards, and source information used to determine which M/S and MH/SUD INN outpatient services are subject to Retrospective Review and how Retrospective Review is applied “in operation.”

The Plan subjected claims/requests for M/S and MH/SUD outpatient services to Retrospective Review that were not reviewed in the Prior Authorization or Concurrent Review process. Additionally, M/S claims for outpatient services submitted by INN providers were subject to Retrospective Review if the services or procedure codes did not match a diagnosis code, if services were EIU, or if the services had benefits limits. MH/SUD claims/requests for outpatient services submitted by INN providers may be subject to Retrospective Review if the service or procedure code required Prior Authorization or Concurrent Review, but that review was not conducted and there is a mitigating circumstance. Additionally, claims may be subject to Retrospective Review if the billed services or procedure codes do not match the authorized codes or if services are EIU.

The Plan may request member clinical information for M/S and MH/SUD outpatient claims and refer claims to a clinical reviewer. The clinical reviewer reviewed applicable member clinical information, benefit plan documents, and clinical criteria in the case review. The clinical reviewer approved cases that met applicable clinical criteria or referred cases to peer clinical reviewers. If an appropriately qualified peer clinical reviewer determined that a service was not medically necessary and would not be covered, an adverse benefit determination was issued for the claim.

The Plan communicated all adverse benefit determinations for M/S and MH/SUD outpatient claims/requests that did not meet applicable clinical criteria, including appeal rights, consistent with state and federal requirements.

The Plan conducted monthly quality audits of individual non-clinical staff, clinical reviewers, including staff performing appeal functions. The Plan routinely monitors Retrospective Review performance through its clinical performance oversight functions. In addition to comparing these “in operation” processes, the Plan reviewed medical necessity approval and denial rates, internal appeals outcomes, and external appeals outcomes related to Retrospective Review determinations for M/S and MH/SUD INN outpatient services.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The findings of the Plan's comparative analyses confirmed the strategies, processes, factor, evidentiary standards, and source information used to subject certain MH/SUD INN outpatient services to Retrospective Review were comparable to, and applied no more stringently than, the strategies, processes, factor, evidentiary standards, and source information used to subject certain M/S INN outpatient services to Retrospective Review “as written.”

The Plan found the factor used to subject INN MH/SUD outpatient services to Retrospective Review was comparable to and applied no more stringently than the factor used to subject INN M/S outpatient services to Retrospective Review “in operation.”

All M/S outpatient services were subject to Retrospective Review if they were not reviewed via Prior Authorization or Concurrent Review processes. Additionally, M/S claims for outpatient services submitted by INN providers were subject to Retrospective Review if the services or procedure codes did not match a diagnosis code, if services were EIU, or if the services had benefit limits. MH/SUD claims/requests for outpatient services submitted by INN providers may be subject to Retrospective Review if the service or procedure code required Prior Authorization or Concurrent Review, but that review was not conducted and there is a mitigating circumstance. Additionally, claims may be subject to Retrospective Review if the billed services or procedure codes do not match the authorized codes or if services are EIU.

The Plan used comparable processes to conduct Retrospective Review of claims/requests for M/S and MH/SUD outpatient services. The Plan may request clinical information if necessary. The Plan approved M/S and MH/SUD claims/requests for outpatient services that met applicable clinical criteria or guidelines. The Plan issued an adverse benefit determination for M/S and MH/SUD INN provider claims/requests for outpatient services that did not meet applicable clinical criteria or guidelines.

The Plan notes the UM outcomes data do not reflect material differences in Retrospective Review processes for M/S or MH/SUD benefit coverage determinations. Similarly, the appeals data do not reflect that members face a materially different or more stringent review process.

There is an insufficient number of MH/SUD INN outpatient cases from 01/01/2022-12/31/2022 to support an analysis of clinical outcomes data for UnitedHealthcare Insurance Company (UHC).

There is an insufficient number of MH/SUD INN outpatient cases from 01/01/2022-12/31/2022 to support an analysis of clinical outcomes data for UnitedHealthcare of Georgia (UHC GA).

The following definitions are applicable to the charts below:

- Total # of Requests Received: the aggregate number of INN outpatient Retrospective Review requests received
- Total # of Requests Approved: the aggregate number of INN outpatient Retrospective Review requests approved
- Total # of Requests Clinically Denied: the aggregate number of INN outpatient Retrospective Review requests that were denied for clinical reasons (request did not meet medical necessity)
- Approval Rate %: (Requests Approved / Requests Received)
- Clinical Denial Rate %: (Total number of Requests Clinically Denied / Total number of Requests Received)
- Total # of Clinical Denials reviewed upon appeal: Total (internal & external): the aggregate number of INN outpatient Retrospective Review clinical internal and external appeals received
- Total # of Clinical Denials Overturned upon appeal: Total (internal & external): the aggregate number of INN outpatient Retrospective Review clinical internal and external appeals overturned
- Clinical Denial Overturn Rate %: Total (Internal & External): percent of INN outpatient Retrospective Review clinical internal and external appeals overturned (Total # of Clinical Denials Overturned upon internal and external appeal/Total # of Clinical Denials reviewed upon internal and external appeal)
- Total # of Clinical Denials Upheld: Total (Internal & External): the aggregate number of INN outpatient Retrospective Review clinical internal and external appeals upheld
- Clinical Denial Uphold Rate %: Total (Internal & External): percent of INN outpatient Retrospective Review clinical internal and external appeals upheld (Total # of Clinical Denials Upheld upon internal and external appeal/Total # of Clinical Denials reviewed upon internal and external appeal)
- Total # of Clinical Denials reviewed upon internal appeal only: the aggregate number of INN outpatient Retrospective Review clinical internal appeals received
- Total # of Clinical Denials Overturned upon internal appeal only: the aggregate number of INN outpatient Retrospective Review clinical internal appeals overturned
- Clinical Denial Overturn Rate %, internal appeal only: percent of INN outpatient Retrospective Review clinical internal appeals overturned (Total # of Clinical Denials Overturned upon internal appeal/Total # of Clinical Denials reviewed upon internal appeal)
- Total # of Clinical Denials Upheld upon internal appeal: the aggregate number of INN outpatient Retrospective Review clinical internal appeals upheld
- Clinical Denial Uphold Rate %, internal appeal only: percent of INN outpatient Retrospective Review clinical internal appeals upheld (Total # of Clinical Denials Upheld upon internal appeal/Total # of Clinical Denials reviewed upon internal appeal)
- Total # of Clinical Denials reviewed upon external appeal only: the aggregate number of INN outpatient Retrospective Review clinical external appeals received
- Total # of Clinical Denials Overturned upon external appeal only: the aggregate number of INN outpatient Retrospective Review clinical external appeals overturned

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- Clinical Overturn Rate %, external appeal only: percent of INN outpatient Retrospective Review clinical external appeals overturned (Total # of Clinical Denials Overturned upon external appeal/Total # of Clinical Denials reviewed upon external appeal)
- Total # of Clinical Denials Upheld upon external appeal: the aggregate number of INN outpatient Retrospective Review clinical external appeals upheld
- Clinical Uphold Denial Rate %, external appeal only: percent of INN outpatient Retrospective Review clinical external appeals upheld (Total # of Clinical Denials Upheld upon external appeal/Total # of Clinical Denials reviewed upon external appeal)

UHIC

Outcomes Data Retrospective Review Analysis:	In-Network Outpatient	
	M/S*	MH/SUD
Total # of Requests Received	1,658	24
Total # of Requests Approved	1,486	24
Total # of Requests Clinically Denied	172	0
Approval Rate %	89.63%	100.00%
Clinical Denial Rate %	10.37%	0.00%
Total # of Clinical Denials reviewed upon appeal-Total (Internal & External)	227	0
Total # of Clinical Denials Overturned upon appeal--Total (Internal & External)	68	0
Clinical Denial Overturn Rate %- Total (Internal & External)	29.96%	-
Total # of Clinical Denials Upheld-Total (Internal & External)	159	0
Clinical Denial Uphold Rate %--Total (Internal & External)	70.04%	-
Total # of Clinical Denials reviewed upon internal appeal only	226	0
Total # of Clinical Denials Overturned upon internal appeal only	67	0
Clinical Denial Overturn Rate %, internal appeal only	29.65%	-
Total # of Clinical Denials Upheld upon internal appeal only	159	0
Clinical Denial Uphold Rate %, internal appeal only	70.35%	-
Total # of Clinical Denials reviewed upon external appeal only	1	0
Total # of Clinical Denials Overturned upon external appeal only	1	0
Clinical Overturn Rate %, external appeal only	100.00%	-
Total # of Clinical Denials Upheld upon external appeal only	0	0
Clinical Uphold Denial Rate %, external appeal only	0.00%	-

* Due to changes in internal systems, medical/surgical retrospective review data is only available for January through June 2022. The data reported has been annualized to estimate the complete year.

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UHC GA

Outcomes Data Retrospective Review Analysis:		In-Network Outpatient	
		M/S*	MH/SUD
Total # of Requests Received		149	2
Total # of Requests Approved		117	2
Total # of Requests Clinically Denied		32	0
Approval Rate %		78.52%	100.00%
Clinical Denial Rate %		21.48%	0.00%
Total # of Clinical Denials reviewed upon appeal--Total (Internal & External)		37	0
Total # of Clinical Denials Overturned upon appeal--Total (Internal & External)		15	0
Clinical Denial Overturn Rate %- Total (Internal & External)		40.54%	-
Total # of Clinical Denials Upheld--Total (Internal & External)		22	0
Clinical Denial Uphold Rate %--Total (Internal & External)		59.46%	-
Total # of Clinical Denials reviewed upon internal appeal only		36	0
Total # of Clinical Denials Overturned upon internal appeal only		15	0
Clinical Denial Overturn Rate %, internal appeal only		41.67%	-
Total # of Clinical Denials Upheld upon internal appeal only		21	0
Clinical Denial Uphold Rate %, internal appeal only		58.33%	-
Total # of Clinical Denials reviewed upon external appeal only		1	0
Total # of Clinical Denials Overturned upon external appeal only		0	0
Clinical Overturn Rate %, external appeal only		0.00%	-
Total # of Clinical Denials Upheld upon external appeal only		1	0
Clinical Uphold Denial Rate %, external appeal only		100.00%	-

* Due to changes in internal systems, medical/surgical retrospective review data is only available for January through June 2022. The data reported has been annualized to estimate the complete year.

Conclusions

The Plan concluded that how Retrospective Review is applied to MH/SUD INN outpatient services was comparable to, and applied no more stringently than, how Retrospective Review is applied to M/S INN outpatient services “as written.”

The Plan reviewed the M/S and MH/SUD processes including responsibility for submission, timeframes for submission and review, notification to members and providers, clinical standards for review, staff qualifications, and outcome data and concluded how the Plan conducts Retrospective Review for MH/SUD INN outpatient services “in operation” was comparable to, and applied no more stringently than, how the Plan conducts Retrospective Review for M/S INN outpatient services “in operation.”

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Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical/surgical (M/S) benefits. This generally means that the financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements, such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage.

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

Retrospective Review is a component of the Plan’s Utilization Management (UM) program. Medical directors and other clinical staff review services in order to detect and better manage over- and under-utilization and determine whether the services reviewed are consistent with the member’s coverage, medically appropriate, and consistent with evidence-based guidelines. Retrospective Review assesses the appropriateness of services on a case-by-case basis after the service has been provided but prior to payment for services. Retrospective Reviews are based on established review guidelines and may include:

- Review of medical necessity
- Appropriateness of level of care
- Identifying claims issues
- Eligibility determination
- Initiation of appropriate follow-up actions for utilization and quality issues

The Plan conducts medical necessity Retrospective Review of claims/requests for certain inpatient services that have not previously been reviewed as part of the Prior Authorization or Concurrent Review processes. The Plan may conduct Retrospective Review if the service or procedure codes do not match a diagnosis code, if services are experimental, investigational, or unproven (EIU), or if the services are subject to benefit limits/exclusions. The Plan conducts medical necessity Retrospective Review for inpatient services where Prior Authorization was required but not obtained upon claim submission.

This document includes the following information:

- The Retrospective Review process for M/S and MH/SUD inpatient services
- The description of the NQTL and application (Step 1)
- Factor used to determine which services are subject to the NQTL (Step 2)
- Evidentiary standards and sources used to define, trigger and/or implicate the factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

This comparative analysis refers to the following attachments:

- *Utilization Management Program Description (UMPD) of United HealthCare Services, Inc. and UnitedHealthcare Insurance Company* - summarizes the philosophy, structure and standards that govern UHC’s medical management, UM and utilization review responsibilities and functions

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- *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions* - M/S policy that defines Retrospective Review
- *Optum National Policy Definitions List* - MH/SUD policy that defines Retrospective Review
- *M/S Retrospective Review Codes* – Excel document that lists M/S codes that may be subject to Retrospective Review
- *Certificates of Coverage* (for example: *COC23-INS-2018-LG-GA*, *COC23-INS-2018-SG-GA*, *SBN23-Medical-INS-RV-2018-HeritagePlus-SG-GA* and *COC23-INS-RV-2018-LG-GA*) - Plan document that explains covered services, terms, conditions, and limitations of the member's policy
- *Core Principles and Practices* - MH/SUD policy that outlines the core principles and practices that should be used by personnel in their interactions with members, authorized member representatives, practitioners, and facilities, related to the management of behavioral health benefits, coverage determinations and appeals/grievances of non-coverage determinations
- *Performance Assessment and Incentives* - M/S policy confirming that clinical reviewers are not incented to make denials for financial reasons
- *Medical Necessity NQTL* – Comparative analysis that describes the processes, strategies, evidentiary standards and other factors used to apply medical necessity to M/S and MH/SUD services in accordance with MHPAEA and other regulatory guidance

The Plan concludes that the Retrospective Review requirements for M/S and MH/SUD are comparable and applied no more stringently to MH/SUD out-of-network (OON) inpatient benefits both “as written” and “in operation.”

Process

The Plan structures inpatient Retrospective Review processes to be compliant with all applicable federal and state laws. Retrospective Review is governed at both the state and federal level, which includes consumer protections such as external review for adverse benefit determinations after internal appeals options are exhausted.

The Plan delegates management of MH/SUD Inpatient services, including Retrospective Review to United Behavioral Health d/b/a Optum Behavioral Health (OBH), its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor.

Retrospective Review of M/S Inpatient Admissions consist of the following:

Retrospective Review for certain inpatient services begins after the Plan receives claims or notification of an inpatient admission post discharge from an OON facility. The Plan conducts medical necessity Retrospective Review of claims/requests for certain inpatient services that have not previously been reviewed as part of the Prior Authorization or Concurrent Review processes. The Plan may conduct Retrospective Review if the service or procedure codes do not match a diagnosis code, if services EIU, or if the services are subject to benefit limits/exclusions. The Plan conducts medical necessity Retrospective Review for inpatient services where Prior Authorization was required but not obtained upon claim submission.

Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. If needed, non-clinical staff request medical records for claims containing services that are subject to Retrospective Review. When medical records are received, cases are referred to clinical reviewers to assess medical necessity.

First Level Clinical Review/ Initial Review. The clinical reviewer (physicians or nurses) reviews the claim to determine if the inpatient service billed meets clinical criteria for coverage based on application of objective, evidence-based clinical criteria, nationally recognized guidelines, and the member's benefit plan documents. Clinical reviewers either approve claims for payment or refer claims to peer clinical reviewers (Medical Directors).

Second Level Clinical Review/ Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If a peer clinical reviewer determines that a service was not medically necessary, then an adverse benefit

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determination will be issued for the claim. The Plan communicates the adverse benefit determination, including applicable appeal rights, and offers a peer-to-peer conversation consistent with state, federal, and accreditation requirements. Appeal rights are set forth in the member's benefit plan document (*Certificate of Coverage*). The Plan communicates results of Retrospective Review within 30 days of receipt of a claim.

Adverse Benefit Determination. For M/S, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when benefits are exhausted. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials.

Clinical Criteria: Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based medical clinical policies or use clinical criteria from third party sources such as InterQual® or MCG® Guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that Retrospective Review determinations are appropriate.

The Plan conducts end-to-end case audits that are designed and approved by clinical leadership each year. The end-to-end audits include all stages of a case review, from intake through appeal. These audits are conducted monthly and approximately 1500 cases are reviewed per month. Results are reported to an oversight team. All deficiencies are remediated. Remediation may include corrective actions and/or additional education, as indicated.

The Plan routinely monitors Retrospective Review performance through its clinical performance oversight functions. Outcomes are monitored against timeliness requirements, performance guarantees, and for potential trends, including overall utilization.

The Plan's National Medical Care Management Committee (NMCMC) annually reviews overall UM program outcomes, including inpatient Retrospective Review outcomes, to confirm overall utilization is appropriate. The NMCMC is comprised of the Chief Medical Officer, and representatives from clinical policy, clinical advocacy and grievances, business standardization and advancement, regional chief medical officers, inpatient care management, lines of business, medical policy, clinical operations, and Optum Behavioral Health. The Chair of the NMCMC must be an executive leader and licensed physician.

As of April 1, 2023, the Utilization Management Program Committee (UMPC) began overseeing the M/S UM program. The UMPC is responsible for the development and maintenance of the M/S Prior Authorization processes. The UMPC ensures that the UM program considers the factors and evidentiary standards for applying UM. The UMPC is comprised of:

- Chief Medical Officer, Medical Management (Co-Chair)
- Senior Vice President, Clinical Advancement (Co-Chair)
- Chief Medical Officer, UnitedHealthcare
- Senior Vice President, Clinical Appeals & Grievances
- Chief Medical Officer, Clinical Policy
- Chief Medical Officer, UnitedHealthcare Employer & Individual
- Chief Medical Officer, UnitedHealthcare Medicare & Retirement
- Chief Medical Officer, Community & State
- Chief Medical Officer, UnitedHealthcare Individual & Family Plans
- Vice President, Clinical Transformation & Affordability
- Senior Director, Mental Health Parity
- Vice President, Utilization Management Strategy & Implementation

One of the chairs must be an executive leader and a licensed physician. UMPC meets at least six times per year but may meet more frequently if needed.

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Per the M/S policy entitled, *Performance Assessment and Incentives*, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons.

M/S generally structures UM processes to comply with federal Employee Retirement Income Security Act of 1974 (ERISA) requirements, and state law where applicable.

Retrospective Review of MH/SUD Inpatient Admissions consist of the following:

The Plan delegates management of MH/SUD inpatient services, including Retrospective Review to United Behavioral Health d/b/a OBH, its delegated MH/SUD MBHO vendor.

MH/SUD claims/requests for inpatient services submitted by OON providers may be subject to Retrospective Review if the service or procedure code required Prior Authorization or Concurrent Review, but that review was not conducted and there is a mitigating circumstance. Additionally, claims may be subject to Retrospective Review if the billed services or procedure codes do not match the authorized codes, or if services are EIU.

Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. If needed, non-clinical staff request medical records for requests or claims containing services that are subject to Retrospective Review. When medical records are received, the case is referred to clinical reviewers to assess medical necessity.

First Level Clinical Review/Initial Review. The clinical reviewer (e.g., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) review the claim to determine if the inpatient admission billed meets clinical criteria for coverage based on application of objective, evidence-based, clinical criteria, or nationally recognized guidelines. Clinical reviewers either approve claims for payment or refer claims to peer clinical reviewers (Medical Directors).

Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If the peer clinical reviewer determines that an admission was not medically necessary, then an adverse benefit determination will be issued for the claim. The Plan communicates the adverse benefit determination, including applicable appeal rights. Appeal rights are set forth in the member's benefit plan document (*Certificate of Coverage*). The Plan communicates results of Retrospective Review within 30 days of receipt of a request/claim.

The OON provider may bill non-reimbursable charges to the member.

Adverse Benefit Determination. For MH/SUD, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when benefits are exhausted. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials.

Clinical Criteria: Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based behavioral clinical policies or use clinical criteria from third party sources such as American Society of Addiction Medicine (ASAM) Criteria®, Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System-Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) and Early Childhood Service Intensity Instrument (ECSII) guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that inpatient Retrospective Review determinations are appropriate.

The Plan conducts monthly quality audits of individual non-clinical staff, clinical reviewers, and peer clinical reviewers, including staff performing appeal functions. These audits are designed and approved by clinical leadership each year. A

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minimum of two audits are completed per staff, per month. The results of these real-time audits are shared with supervisors for staff oversight, and all findings are remediated. Remediation may include corrective actions and/or additional education, as indicated.

The Plan routinely monitors Retrospective Review performance through its clinical performance oversight functions. Outcomes are monitored against timeliness requirements, performance guarantees, and for potential trends, including overall utilization.

The Plan's national Clinical Quality & Operations Committee (CQOC) annually reviews overall UM program outcomes, including inpatient Retrospective Review outcomes, to confirm overall utilization is appropriate. The national CQOC is comprised of representatives from sub-committees, and representatives from the clinical quality improvement, UM, care engagement, medical operations, medical policy and standards, clinical operations, appeals, product, legal, compliance, network strategy, provider experience, accreditation, and benefits teams. The Chair of the CQOC must be an executive leader, board certified in psychiatry or psychiatric subspecialty and a licensed physician.

Per the MH/SUD policy entitled, *Core Principles and Practices*, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse clinical coverage benefit determinations (clinical denials) for financial reasons.

MH/SUD generally structures UM processes to comply with federal ERISA requirements, and state law where applicable.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- Retrospective Review

Benefit Classification(s)

- OON, inpatient

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHIC)
- UnitedHealthcare Insurance Company of the River Valley (UHICRV)

Plan Terms

The Plan's *Certificates of Coverage* notify members of Retrospective Review requirements.

"The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, Concurrent Review, case management, discharge planning, retrospective review or similar programs"

The *Utilization Management Program Description (UMPD)* discusses Post-Service Reviews and indicates:

"Post-service review assesses the appropriateness of medical services on a case-by-case basis after the service has been provided but prior to payment for services. Post- service reviews are based on established review guidelines and includes:

- Review of medical necessity;
- Appropriateness of level of care;
- Identifying claims issues;
- Eligibility determination;
- Initiation of appropriate follow-up actions for utilization and quality issues; and
- Identifying appropriateness and administrative issues such as physician notification, emergency status of admission."

The Plan's delegate, United Behavioral Health d/b/a OBH, is discussed in the *UMPD*.

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“United Behavioral Health (UBH) performs the review of requests for coverage of behavioral health services (i.e., substance abuse, and mental health requests for services). UBH provides comprehensive behavioral health care delivery for members through a network of behavioral health practitioners, ancillary care providers, hospitals and other facilities.

For mental health, substance-related disorder services, and wraparound services, UBH uses its Clinical Criteria (see below), behavioral clinical policies and best practice guidelines to make coverage determinations. UBH adopts externally-developed clinical criteria, and creates internally-developed Clinical Criteria, where appropriate, based on its assessment of relevant guidance. UBH develops clinical criteria that supersedes its standard set or adopts externally-developed clinical criteria when required to do so by contract or regulation.

- Clinical Criteria (Level of Care Utilization System-LOCUS) – Standardized level of care assessment tool developed by the American Association of Community Psychiatrists used to make clinical determinations and placement decisions for mental health disorder benefits for adults ages 19 and older when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (Child and Adolescent Level of Care/Service Intensity Utilization System-CALOCUS-CASII)- Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry (AACAP) and the American Association for Community Psychiatry (AACP) used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children and adolescents ages 6-18 when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (Early Childhood Service Intensity Instrument-ECSII) - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children ages 0-5 when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (State or Contract Specific Level of Care Guidelines): Criteria used to make medical necessity determinations for mental health disorder benefits when there are explicit mandates or contractual requirements.
- Clinical Criteria (American Society of Addiction Medicine [ASAM]): Criteria developed by the American Society of Addiction Medicine used to make clinical determinations for substance-related disorder benefits.
- Clinical Criteria (Optum Developed)
 - Optum Behavioral Clinical Policies: Criteria that stem from evaluation of new services or treatments or new applications of existing services or treatments and are used to make clinical determinations regarding proven or unproven services and treatments.

Licensed practitioners conduct all reviews with a focus on measurable outcome goals and objectives for treatment. A senior UBH Medical Director is responsible for directing and implementing behavioral health utilization management programs. A referral is sent to UBH when a member is identified as potentially benefiting from behavioral health services during a “medical event.”

The UBH UM Program is staffed by clinical, non-clinical and administrative personnel. All clinical denials or adverse decisions are made by board certified psychiatrists, or, if the health plans choose, by a panel of other appropriate health care service reviewers. If the health plan chooses to use a panel to make adverse decisions, the panel contains at least one physician who is board certified in psychiatry. When the health care service under review is a mental health or substance abuse service, the adverse decision is made by a licensed physician who is board certified in psychiatry. All potential clinical denials are referred to a physician who is board certified in psychiatry for final determination. An evaluation of the overall effectiveness of the Behavioral Health UM Program is conducted annually to determine how well resources have been deployed to improve UM activities and the clinical care and service provided to members.”

The Plan’s terms require services to be medically necessary for coverage.

M/S and MH/SUD Services Subject to NQTL

- Services that have not previously been reviewed in Prior Authorization or Concurrent Review
- Services where the service or procedure codes do not match a diagnosis code

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- EIU services
- Services that are subject to benefit limits/exclusions
- Codes identified by the Plan as subject to Retrospective Review
- Please see the file *M/S Retrospective Review Codes* for the list of M/S codes that may be subject to Retrospective Review
- MH/SUD claims/requests that include the following services are subject to Retrospective Review:
 - MH Non-Emergent Acute Inpatient
 - MH Subacute Residential Treatment
 - SUD Acute Inpatient Detoxification
 - SUD Acute Inpatient Rehabilitation
 - SUD Subacute Residential Treatment

Step 2 – Factors Used to Determine Retrospective Review Applies

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

The Plan relies on the following factor to determine which OON inpatient admissions are subject to Retrospective Review. This factor applies to M/S and MH/SUD for the following:

- I. M/S OON inpatient admissions
 - II. MH/SUD OON inpatient admissions
- Consistency with Clinical Criteria (Qualitative):
 - Whether the application of Retrospective Review promotes optimal clinical outcomes.

This factor applies to M/S and MH/SUD services. Meeting Consistency with Clinical Criteria is determinative in imposing the limitation.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factor used in designing or applying the Plan's Retrospective Review requirements to OON inpatient services. These evidentiary standards and sources apply to the following:

- I. M/S OON inpatient admissions
- II. MH/SUD OON inpatient admissions

Factor: Consistency with Clinical Criteria is defined as whether the application of Retrospective Review promotes optimal clinical outcomes.

- The Plan's evidentiary standards and sources that define and/or trigger the Consistency with Clinical Criteria factor:
 - Clinical criteria from nationally recognized, third-party sources (e.g., InterQual or MCG for M/S services, and ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines for MH/SUD services)
 - Clinical Technology Assessment Committee (CTAC) and Medical Technology and Assessment Committee (MTAC) review
 - Objective, evidence-based medical/behavioral clinical policies and nationally recognized guidelines approved by professional healthcare associations (e.g., clinical guidance from the American Medical Association, American

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Psychiatric Association, etc.)

The *Medical Necessity NQTL* describes the process for determining how internally developed medical/behavioral clinical policies are developed and how externally developed third-party guidelines are reviewed and approved.

The Plan's evidentiary standards and sources apply to M/S and MH/SUD services. The Consistency with Clinical Criteria factor, evidentiary standards, and sources are defined in a qualitative manner.

The factor and evidentiary standards used as the basis for subjecting MH/SUD OON inpatient benefits to Retrospective Review are comparable to, and applied no more stringently than, the factor and evidentiary standards used as the basis for subjecting M/S OON inpatient benefits to Retrospective Review "as written" and "in operation."

Step 4 – NQTL "As Written" and "In Operation" Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

As Written

The Plan conducted a comparative analysis of the strategies, processes, factor, evidentiary standards, and source information used to determine which M/S and MH/SUD OON inpatient services are subject to Retrospective Review "as written." The Plan identified the factors and evidentiary standards used as the basis for subjecting M/S and MH/SUD benefits to Retrospective Review for each benefit classification.

Review of Factor and Evidentiary Standards

The Plan reviewed the factor that triggers an OON inpatient service to be subject to Retrospective Review. The factor and evidentiary standards were applied to M/S and MH/SUD services comparably and not more stringently to MH/SUD services than M/S services.

Review of Operational Policies and Procedures

The Plan reviewed M/S and MH/SUD operational policies and procedures and UM annual oversight to confirm comparability and found MH/SUD policies, procedures, and processes to be comparable and no more stringent than M/S policies, procedures, and processes.

- Medical management operational policies and procedures establish the standards for how the Plan conducts inpatient Retrospective Review. The policies and procedures are consistent with state and federal law governing Retrospective Review. Timeframes for decisions, content of adverse benefit determinations, appeal rights and external review are all governed by state and federal requirements
- UM oversight monitors and evaluates UM processes by reviewing denial rates, clinical appeals, and under- and over-utilization.

Review of Inpatient Retrospective Review Processes

The strategy for applying Retrospective Review to OON inpatient claims/requests is comparable for M/S and MH/SUD services and applied no more stringently to MH/SUD OON inpatient services. The Plan conducted a review of the M/S and MH/SUD Retrospective Review processes to confirm comparability. The review focused on the following aspects of the processes for both M/S and MH/SUD:

- Responsibility. The member is responsible for notifying the Plan of an inpatient admission to an OON provider or advising of a change to procedure for both M/S and MH/SUD. OON providers may submit notification on behalf of the member.

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- Timeframe to submit. The timeframe for the member to submit the Retrospective Review request was reviewed and it was determined that MH/SUD was no more stringent.
 - For M/S, members must notify the Plan within timely filing requirements
 - For MH/SUD, members have 180 days after the service is rendered to request a Retrospective Review
- Clinical Reviews. For M/S and MH/SUD claims/requests, the Plan may request clinical information and refers the claim/request to a clinical reviewer for Retrospective Review. The clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. The clinical reviewer either approves cases that meet applicable clinical criteria or refers the case to a peer clinical reviewer.
- Review Timeframes. M/S and MH/SUD Retrospective Review determination timeframes are defined by state and federal requirements. The same determination timeframes apply to M/S and MH/SUD determinations.
- Determinations, First Level Clinical Review, and Second Level/Peer Clinical Reviews. Clinical reviewers determine whether an inpatient admission is medically necessary. The clinical reviewer may approve the admission based on their review. The clinical reviewer refers cases they cannot approve to a peer clinical reviewer. If the peer clinical reviewer determines that an admission was not medically necessary and will not be covered, an adverse benefit determination will be issued. Only qualified peer clinical reviewers may issue adverse benefit determinations.
- Adverse Benefit Determinations. An adverse benefit determination is recorded as a clinical denial when it is based on clinical criteria and member clinical information and is recorded as an administrative denial when member benefits are exhausted.
- Notification of Decisions to Providers and Members. The Plan notifies M/S and MH/SUD OON facilities and members of approvals and adverse benefit determinations, including applicable appeal rights consistent with state and federal requirements.
- Review of Staff Qualifications. For M/S and MH/SUD, clinical staff qualifications align with the type of clinical review and state and federal requirements.
 - M/S is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are conducted by clinical staff (nurses, physicians) and all adverse benefit determinations are made by a physician or other appropriate health care professionals.
 - MH/SUD is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse benefit determinations are made by Medical Directors.
- Clinical Criteria. For M/S and MH/SUD, clinical reviewers and peer clinical reviewers base determinations on objective, evidence-based medical/behavioral clinical policies or use clinical criteria from third party sources such as InterQual, MCG, ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines.

In Operation

The Plan compared the strategies, processes, factor, evidentiary standards, and source information used to determine which M/S and MH/SUD OON inpatient services are subject to Retrospective Review and how Retrospective Review is applied “in operation.”

The Plan subjected claims/requests for M/S and MH/SUD inpatient admissions to Retrospective Review that were not reviewed via Prior Authorization or Concurrent Review. Additionally, M/S claims/requests for inpatient services submitted by OON providers were subject to Retrospective Review if the services or procedure codes did not match a diagnosis code, if services were EIU, or if the services had benefit limits/exclusions. Claims/requests for inpatient services submitted by OON providers may be subject to Retrospective Review if the service or procedure code required Prior Authorization or Concurrent Review, but that review was not conducted and there is a mitigating circumstance. Additionally, claims may be subject to Retrospective Review if the billed services or procedure codes do not match the authorized codes or if services are EIU.

The Plan may have requested member clinical information for M/S and MH/SUD inpatient claims/requests and referred them to a clinical reviewer. The clinical reviewer reviewed applicable member clinical information, benefit plan documents, and clinical criteria in the case review. The clinical reviewer approved cases that met applicable clinical criteria or referred cases to peer clinical reviewers. If an appropriately qualified peer clinical reviewer determined that a service was not medically

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necessary and would not be covered, an adverse benefit determination was issued for the claim.

The Plan communicated all adverse benefit determinations for M/S and MH/SUD inpatient claims/requests that did not meet applicable clinical criteria, including appeal rights, consistent with state and federal requirements.

The Plan conducted monthly quality audits of individual non-clinical staff, clinical reviewers, including staff performing appeal functions. The Plan routinely monitored Retrospective Review performance through its clinical performance oversight functions. In addition to comparing these “in operation” processes, the Plan reviewed medical necessity approval and denial rates, internal appeals outcomes, and external appeals outcomes related to Retrospective Review determinations for M/S and MH/SUD OON inpatient services.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The findings of the Plan's comparative analyses confirmed the strategies, processes, factor, evidentiary standards, and source information used to subject certain MH/SUD OON inpatient services to Retrospective Review were comparable to, and applied no more stringently than, the strategies, processes, factor, evidentiary standards, and source information used to subject certain M/S OON inpatient services to Retrospective Review “as written.”

The Plan found the factor used to subject OON MH/SUD inpatient services to Retrospective Review was comparable to and applied no more stringently than the factor used to subject ONN M/S inpatient services to Retrospective Review “in operation.” All M/S and MH/SUD inpatient admissions were subject to Retrospective Review if they were not reviewed via Prior Authorization or Concurrent Review. Additionally, M/S and MH/SUD claims for inpatient services submitted by OON providers were subject to Retrospective Review if the services or procedure codes did not match a diagnosis code, if services were EIU, or if the services had benefit limits/exclusions. Claims/requests for inpatient services submitted by OON providers may be subject to Retrospective Review if the service or procedure code required Prior Authorization or Concurrent Review, but that review was not conducted and there is a mitigating circumstance.

The Plan used comparable processes to conduct Retrospective Review of claims/requests for M/S and MH/SUD inpatient services. The Plan may have requested clinical information if necessary. The Plan approved M/S and MH/SUD claims/requests for inpatient services that met applicable clinical criteria or guidelines. The Plan issued an adverse benefit determination for M/S and MH/SUD OON provider claims/requests for inpatient services that did not meet applicable clinical criteria or guidelines.

The Plan notes the UM outcomes data do not reflect material differences in Retrospective Review processes for M/S or MH/SUD benefit coverage determinations. Similarly, the appeals data do not reflect that members face a materially different or more stringent review process.

There is an insufficient number of MH/SUD OON inpatient cases from 01/01/2022-12/31/2022 to support an analysis of clinical outcomes data for Unitedhealthcare Insurance Company (UHC)

There is an insufficient number of MH/SUD OON inpatient cases from 01/01/2022-12/31/2022 to support an analysis of clinical outcomes data for Unitedhealthcare of Georgia (UHCGA)

The following definitions are applicable to the charts below:

- Total # of Requests Received: the aggregate number of OON inpatient Retrospective Review requests received
- Total # of Requests Approved: the aggregate number of OON inpatient Retrospective Review requests approved

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- Total # of Requests Clinically Denied: the aggregate number of OON inpatient Retrospective Review requests that were denied for clinical reasons (request did not meet medical necessity)
- Approval Rate %: (Requests Approved / Requests Received)
- Clinical Denial Rate %: (Total number of Requests Clinically Denied / Total number of Requests Received)
- Total # of Clinical Denials reviewed upon appeal: Total (internal & external): the aggregate number of OON inpatient Retrospective Review clinical internal and external appeals received
- Total # of Clinical Denials Overturned upon appeal: Total (internal & external): the aggregate number of OON inpatient Retrospective Review clinical internal and external appeals overturned
- Clinical Denial Overturn Rate %: Total (Internal & External): percent of OON inpatient Retrospective Review clinical internal and external appeals overturned (Total # of Clinical Denials Overturned upon internal and external appeal/Total # of Clinical Denials reviewed upon internal and external appeal)
- Total # of Clinical Denials Upheld: Total (Internal & External): the aggregate number of OON inpatient Retrospective Review clinical internal and external appeals upheld
- Clinical Denial Uphold Rate %: Total (Internal & External): percent of OON inpatient Retrospective Review clinical internal and external appeals upheld (Total # of Clinical Denials Upheld upon internal and external appeal/Total # of Clinical Denials reviewed upon internal and external appeal)
- Total # of Clinical Denials reviewed upon internal appeal only: the aggregate number of OON inpatient Retrospective Review clinical internal appeals received
- Total # of Clinical Denials Overturned upon internal appeal only: the aggregate number of OON inpatient Retrospective Review clinical internal appeals overturned
- Clinical Denial Overturn Rate %, internal appeal only: percent of OON inpatient Retrospective Review clinical internal appeals overturned (Total # of Clinical Denials Overturned upon internal appeal/Total # of Clinical Denials reviewed upon internal appeal)
- Total # of Clinical Denials Upheld upon internal appeal: the aggregate number of OON inpatient Retrospective Review clinical internal appeals upheld
- Clinical Denial Uphold Rate %, internal appeal only: percent of OON inpatient Retrospective Review clinical internal appeals upheld (Total # of Clinical Denials Upheld upon internal appeal/Total # of Clinical Denials reviewed upon internal appeal)
- Total # of Clinical Denials reviewed upon external appeal only: the aggregate number of OON inpatient Retrospective Review clinical external appeals received
- Total # of Clinical Denials Overturned upon external appeal only: the aggregate number of OON inpatient Retrospective Review clinical external appeals overturned
- Clinical Overturn Rate %, external appeal only: percent of OON inpatient Retrospective Review clinical external appeals overturned (Total # of Clinical Denials Overturned upon external appeal/Total # of Clinical Denials reviewed upon external appeal)
- Total # of Clinical Denials Upheld upon external appeal: the aggregate number of OON inpatient Retrospective Review clinical external appeals upheld
- Clinical Uphold Denial Rate %, external appeal only: percent of OON inpatient Retrospective Review clinical external appeals upheld (Total # of Clinical Denials Upheld upon external appeal/Total # of Clinical Denials reviewed upon external appeal)

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UHIC

Outcomes Data Retrospective Review Analysis:	Out-of-Network Inpatient	
	M/S	MH/SUD
Total # of Requests Received	0	5
Total # of Requests Approved	0	5
Total # of Requests Clinically Denied	0	0
Approval Rate %	-	100.00%
Clinical Denial Rate %	-	0.00%
Total # of Clinical Denials reviewed upon appeal-Total (Internal & External)	1	3
Total # of Clinical Denials Overturned upon appeal--Total (Internal & External)	1	0
Clinical Denial Overturn Rate %- Total (Internal & External)	100.00%	0.00%
Total # of Clinical Denials Upheld-Total (Internal & External)	0	3
Clinical Denial Uphold Rate %--Total (Internal & External)	0.00%	100.00%
Total # of Clinical Denials reviewed upon internal appeal only	1	3
Total # of Clinical Denials Overturned upon internal appeal only	1	0
Clinical Denial Overturn Rate %, internal appeal only	100.00%	0.00%
Total # of Clinical Denials Upheld upon internal appeal only	0	3
Clinical Denial Uphold Rate %, internal appeal only	0.00%	100.00%
Total # of Clinical Denials reviewed upon external appeal only	0	0
Total # of Clinical Denials Overturned upon external appeal only	0	0
Clinical Overturn Rate %, external appeal only	-	-
Total # of Clinical Denials Upheld upon external appeal only	0	0
Clinical Uphold Denial Rate %, external appeal only	-	-

* Due to changes in internal systems, medical/surgical retrospective review data is only available for January through June 2022. The data reported has been annualized to estimate the complete year.

UHC GA

Outcomes Data Retrospective Review Analysis:	Out-of-Network Inpatient	
	M/S	MH/SUD
Total # of Requests Received	0	0
Total # of Requests Approved	0	0
Total # of Requests Clinically Denied	0	0
Approval Rate %	-	-
Clinical Denial Rate %	-	-
Total # of Clinical Denials reviewed upon appeal-Total (Internal & External)	0	0
Total # of Clinical Denials Overturned upon appeal--Total (Internal & External)	0	0
Clinical Denial Overturn Rate %- Total (Internal & External)	-	-
Total # of Clinical Denials Upheld-Total (Internal & External)	0	0
Clinical Denial Uphold Rate %--Total (Internal & External)	-	-
Total # of Clinical Denials reviewed upon internal appeal only	0	0
Total # of Clinical Denials Overturned upon internal appeal only	0	0
Clinical Denial Overturn Rate %, internal appeal only	-	-
Total # of Clinical Denials Upheld upon internal appeal only	0	0
Clinical Denial Uphold Rate %, internal appeal only	-	-
Total # of Clinical Denials reviewed upon external appeal only	0	0
Total # of Clinical Denials Overturned upon external appeal only	0	0
Clinical Overturn Rate %, external appeal only	-	-
Total # of Clinical Denials Upheld upon external appeal only	0	0
Clinical Uphold Denial Rate %, external appeal only	-	-

* Due to changes in internal systems, medical/surgical retrospective review data is only available for January through June 2022. The data

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reported has been annualized to estimate the complete year.

Conclusions

The Plan concluded that how Retrospective Review is applied to MH/SUD OON inpatient services was comparable to, and applied no more stringently than, how Retrospective Review is applied to M/S OON inpatient services “as written.”

The Plan reviewed the M/S and MH/SUD processes including responsibility for submission, timeframes for submission and review, notification to members and providers, clinical standards for review, staff qualifications, and outcome data and concluded how the Plan conducts Retrospective Review for MH/SUD OON inpatient services “in operation” was comparable to, and applied no more stringently than, how the Plan conducts Retrospective Review for M/S OON inpatient services “in operation.”

Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical/surgical (M/S) benefits. This generally means that financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements, such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage.

In the NQTL analysis below, the Plan identifies the services to which the NQTL applies (Step 1). The Plan also identifies the factors used to determine whether the NQTL applies (Step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (Step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (Step 4), and sets forth findings and conclusions, both “as written” and “in operation” (Step 5).

Specific NQTL

Retrospective Review is a component of the Plan’s Utilization Management (UM) program. Medical directors and other clinical staff review services in order to detect and better manage over- and under-utilization and determine whether the services reviewed are consistent with the member’s coverage, medically appropriate, and consistent with evidence-based guidelines. Retrospective Review assesses the appropriateness of services on a case-by-case basis after the service has been provided but prior to payment for services. Retrospective Reviews are based on established review guidelines and may include:

- Review of medical necessity
- Appropriateness of level of care
- Identifying claims issues
- Eligibility determination
- Initiation of appropriate follow-up actions for utilization and quality issues

The Plan conducts medical necessity Retrospective Review of claims/requests for certain outpatient services that have not previously been reviewed as part of the Prior Authorization or Concurrent Review processes. The Plan may conduct Retrospective Review if the service or procedure codes do not match a diagnosis code, if services are experimental, investigational, or unproven (EIU), or if the services are subject to benefit limits/exclusions. The Plan conducts medical necessity Retrospective Review for outpatient services where Prior Authorization was required, but not obtained upon claim submission.

This document includes the following information:

- The Retrospective Review process for M/S and MH/SUD outpatient services
- The description of the NQTL and application (Step 1)
- Factor used to determine which services are subject to the NQTL (Step 2)
- Evidentiary standards and sources used to define, trigger and/or implicate a factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

This comparative analysis refers to the following attachments:

- *Utilization Management Program Description (UMPD) of United HealthCare Services, Inc. and UnitedHealthcare Insurance Company* - Summarizes the philosophy, structure and standards that govern UHC’s medical management, UM and utilization review responsibilities and functions
- *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions* - M/S policy that defines Retrospective Review

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- *Optum National Policy Definitions List* – MH/SUD policy that defines Retrospective Review
- *M/S Retrospective Review Codes* - Excel document that lists the M/S codes that may be subject to Retrospective Review
- *Certificates of Coverage* (for example: *COC23-INS-2018-LG-GA* and *COC23-INS-2018-SG-GA*) - Plan document that explains covered services, terms, conditions, and limitations of the member's policy
- *Core Principles and Practices* - MH/SUD policy that outlines the core principles and practices that should be used by personnel in their interactions with members, authorized member representatives, practitioners and facilities, related to the management of behavioral health benefits, coverage determinations and appeals/grievances of non-coverage determinations
- *Performance Assessment and Incentives* - M/S policy confirming that clinical reviewers are not incented to make denials for financial reasons
- *Medical Necessity NQTL* – Comparative analysis that describes the processes, strategies, evidentiary standards and other factors used to apply medical necessity to M/S and MH/SUD services in accordance with MHPAEA and other regulatory guidance

The Plan concludes that the Retrospective Review requirements for M/S and MH/SUD are comparable and applied no more stringently to MH/SUD out-of-network (OON) outpatient benefits both "as written" and "in operation."

Process

The Plan structures outpatient Retrospective Review processes to be compliant with all applicable federal and state laws. Retrospective Review is governed at both the state and federal level, which includes consumer protections such as external review for adverse benefit determinations after internal appeals options are exhausted.

The Plan delegates management of MH/SUD outpatient services, including Retrospective Review to United Behavioral Health d/b/a Optum Behavioral Health (OBH), its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor.

Retrospective Review of M/S Outpatient Services consists of the following:

Retrospective Review for certain outpatient services begins after the Plan receives claims from OON providers. The Plan conducts medical necessity Retrospective Review of claims/requests for certain outpatient services that have not previously been reviewed as part of the Prior Authorization or Concurrent Review processes. The Plan may conduct Retrospective Review if the service or procedure codes do not match a diagnosis code, if services are EIU, or if the services are subject to benefit limits/exclusion. The Plan also conducts medical necessity Retrospective Review for outpatient services where Prior Authorization was required, but not obtained upon claim submission.

Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. If needed, non-clinical staff request medical records for claims containing services that are subject to Retrospective Review. When medical records are received, the case is referred to clinical reviewers to assess medical necessity.

First Level Clinical Review/Initial Review. The clinical reviewer (physicians or nurses) reviews the claim to determine if the outpatient service billed meets clinical criteria for coverage based on application of objective, evidence-based clinical criteria, nationally recognized guidelines, and the member's benefit plan documents. Clinical reviewers either approve claims for payment or refer claims to peer clinical reviewers (Medical Directors).

Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If a peer clinical reviewer determines that a service was not medically necessary, then an adverse benefit determination will be issued for the claim. The Plan communicates the adverse benefit determination, including applicable appeal rights, and offers a peer-to-peer conversation consistent with state and federal requirements. Appeal rights are set forth in the member's benefit plan document (*Certificate of Coverage*). The Plan communicates results of Retrospective Review within 30 days of receipt of a claim. The OON provider may bill non-reimbursable charges to the member.

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Adverse Benefit Determination. For M/S, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when benefits are exhausted. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials.

Clinical Criteria: Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based medical clinical policies or use clinical criteria from third party sources such as InterQual® or MCG® guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that Retrospective Review determinations are appropriate.

The Plan conducts end-to-end case audits that are designed and approved by clinical leadership each year. The end-to-end audits include all stages of a case review, from intake through appeal. These audits are conducted monthly and approximately 1500 cases are reviewed per month. Results are reported to an oversight team. All deficiencies are remediated. Remediation may include corrective actions and/or additional education, as indicated.

The Plan routinely monitors Retrospective Review performance through its clinical performance oversight functions. Outcomes are monitored against timeliness requirements, performance guarantees, and for potential trends, including overall utilization.

The Plan's National Medical Care Management Committee (NMCMC) annually reviews overall UM program outcomes, including inpatient Retrospective Review outcomes, to confirm overall utilization is appropriate. The NMCMC is comprised of the Chief Medical Officer, and representatives from clinical policy, clinical advocacy and grievances, business standardization and advancement, regional chief medical officers, inpatient care management, lines of business, medical policy, clinical operations, and Optum Behavioral Health. The Chair of the NMCMC must be an executive leader and licensed physician.

As of April 1, 2023, the Utilization Management Program Committee (UMPC) began overseeing the M/S UM program. The UMPC is responsible for the development and maintenance of the M/S Prior Authorization processes. The UMPC ensures that the UM program considers the factors and evidentiary standards for applying UM. The UMPC is comprised of:

- Chief Medical Officer, Medical Management (Co-Chair)
- Senior Vice President, Clinical Advancement (Co-Chair)
- Chief Medical Officer, UnitedHealthcare
- Senior Vice President, Clinical Appeals & Grievances
- Chief Medical Officer, Clinical Policy
- Chief Medical Officer, UnitedHealthcare Employer & Individual
- Chief Medical Officer, UnitedHealthcare Medicare & Retirement
- Chief Medical Officer, Community & State
- Chief Medical Officer, UnitedHealthcare Individual & Family Plans
- Vice President, Clinical Transformation & Affordability
- Senior Director, Mental Health Parity
- Vice President, Utilization Management Strategy & Implementation

One of the chairs must be an executive leader and a licensed physician. UMPC meets at least six times per year but may meet more frequently if needed.

Per the M/S policy entitled, *Performance Assessment and Incentives*, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons.

M/S generally structures UM processes to comply with federal Employee Retirement Income Security Act of 1974 (ERISA) requirements and state law where applicable.

Retrospective Review of MH/SUD Outpatient Services consists of the following:

The Plan delegates management of MH/SUD outpatient services, including Retrospective Review to United Behavioral Health d/b/a OBH, its delegated MH/SUD MBHO vendor.

MH/SUD claims/requests for outpatient services submitted by OON providers may be subject to Retrospective Review if the service or procedure code required Prior Authorization or Concurrent Review, but that review was not conducted and there is a mitigating circumstance. Additionally, claims may be subject to Retrospective Review if the billed services or procedure codes do not match the authorized codes or if services are EIU.

Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. If needed, non-clinical staff request medical records for claims containing services that are subject to Retrospective Review. When medical records are received, the case is referred to clinical reviewers to assess medical necessity.

First Level Clinical Review/Initial Review. The clinical reviewer (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) reviews the request or claim to determine if the outpatient service meets clinical criteria for coverage based on application of objective, evidence-based clinical criteria, or nationally recognized guidelines. Clinical reviewers either approve claims for payment or refer claims to peer clinical reviewers (Medical Directors or psychologists).

Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If the peer clinical reviewer determines that a service was not medically necessary, then an adverse benefit determination is issued. The Plan communicates the adverse benefit determination, including appeal rights, and offers a peer-to-peer conversation consistent with state and federal requirements. Appeal rights are set forth in the member's benefit plan document (*Certificate of Coverage*). The Plan communicates results of Retrospective Review within 30 days of receipt of a request/claim.

The OON provider may bill non-reimbursable charges to the member.

Adverse Benefit Determination. For MH/SUD, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when benefits are excluded. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials.

Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based behavioral clinical policies, or use clinical criteria from third party sources such as American Society of Addiction Medicine (ASAM) Criteria®, Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System-Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) and Early Childhood Service Intensity Instrument (ECSII) guidelines.

Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that outpatient Retrospective Review determinations are appropriate.

The Plan conducts monthly quality audits of individual non-clinical staff clinical reviewers, and peer clinical reviewers, including staff performing appeal functions. These audits are designed and approved by clinical leadership each year. A minimum of two audits are completed per staff, per month. The results of these real-time audits are shared with supervisors for staff oversight, and all findings are remediated. Remediation may include corrective actions and/or additional education, as indicated.

The Plan routinely monitors Retrospective Review performance through its clinical performance oversight functions. Outcomes are monitored against timeliness requirements, performance guarantees, and for potential trends, including overall utilization.

The Plan's national Clinical Quality & Operations Committee (CQOC) annually reviews overall UM program outcomes, including outpatient Retrospective Review outcomes, to confirm overall utilization is appropriate. The national CQOC is comprised of

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representatives from sub-committees, and representatives from the clinical quality improvement, UM, care engagement, medical operations, medical policy and standards, clinical operations, appeals, product, legal, compliance, network strategy, provider experience, accreditation, and benefits teams. The Chair of the CQOC must be an executive leader, board certified in psychiatry or psychiatric subspecialty and a licensed physician.

Per the MH/SUD policy entitled, *Core Principles and Practices*, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse clinical coverage benefit determinations (clinical denials) for financial reasons.

MH/SUD generally structures UM processes to comply with federal ERISA requirements, and state law where applicable.

Step 1 – NQTL and Application

FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.

Specific NQTL

- Retrospective Review

Benefit Classification(s)

- OON, outpatient

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHIC)

Plan Terms

The Plan's *Certificates of Coverage* notify members of Retrospective Review requirements.

"The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, Concurrent Review, case management, discharge planning, Retrospective Review or similar programs."

The *Utilization Management Program Description (UMPD)* discusses Post-Service Reviews and indicates:

"Post-service review assesses the appropriateness of medical services on a case-by-case basis after the service has been provided but prior to payment for services. Post-service reviews are based on established review guidelines and includes:

- Review of medical necessity
- Appropriateness of level of care
- Identifying claims issues
- Eligibility determination
- Initiation of appropriate follow-up actions for utilization and quality issues; and
- Identifying appropriateness and administrative issues such as physician notification, emergency status of admission.

The role of the Plan's delegate, United Behavioral Health d/b/a OBH, is discussed in the *UMPD*:

United Behavioral Health (UBH) performs the review of requests for coverage of behavioral health services (i.e., substance abuse, and mental health requests for services). UBH provides comprehensive behavioral health care delivery for members through a network of behavioral health practitioners, ancillary care providers, hospitals and other facilities.

For mental health, substance-related disorder services, and wraparound services, UBH uses its Clinical Criteria (see below), behavioral clinical policies and best practice guidelines to make coverage determinations. UBH adopts externally-developed clinical criteria, and creates internally-developed Clinical Criteria, where appropriate, based on its assessment of relevant guidance. UBH develops clinical criteria that supersedes its standard set or adopts externally-developed clinical criteria when required to do so by contract or regulation.

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- Clinical Criteria (Level of Care Utilization System-LOCUS) – Standardized level of care assessment tool developed by the American Association of Community Psychiatrists used to make clinical determinations and placement decisions for mental health disorder benefits for adults ages 19 and older when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (Child and Adolescent Level of Care/Service Intensity Utilization System-CALOCUS-CASII) - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry (AACAP) and the American Association for Community Psychiatry (AACP) used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children and adolescents ages 6-18 when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (Early Childhood Service Intensity Instrument-ECSII) – Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry used to make clinical determinations and to provide level of service intensity recommendations for mental health disorder benefits for children ages 0-5 when State or Contract Specific Level of Care Guidelines do not apply.
- Clinical Criteria (State or Contract Specific Level of Care Guidelines) -Criteria used to make medical necessity determinations for mental health disorder benefits when there are explicit mandates or contractual requirements.
- Clinical Criteria (American Society of Addiction Medicine [ASAM]) - Criteria developed by the American Society of Addiction Medicine used to make clinical determinations for substance-related disorder benefits.
- Clinical Criteria (Optum Developed)
 - Optum Behavioral Clinical Policies: Criteria that stem from evaluation of new services or treatments or new applications of existing services or treatments and are used to make clinical determinations regarding proven or unproven services and treatments.
 - Optum Supplemental Clinical Criteria: Criteria used to make clinical determinations for Applied Behavior Analysis and Electroconvulsive Therapy.
 - Optum's Supplement to the APA Psychological and Neuropsychological Testing Billing and Coding Guide: Additional criteria used regarding provider qualifications, coverage rationale, limitations, and developmental testing.

Licensed practitioners conduct all reviews with a focus on measurable outcome goals and objectives for treatment. A senior UBH Medical Director is responsible for directing and implementing behavioral health utilization management programs. A referral is sent to UBH when a member is identified as potentially benefiting from behavioral health services during a “medical event.”

The UBH UM Program is staffed by clinical, non-clinical and administrative personnel. All clinical denials or adverse decisions are made by board certified psychiatrists, or, if the health plans choose, by a panel of other appropriate health care service reviewers. If the health plan chooses to use a panel to make adverse decisions, the panel contains at least one physician who is board certified in psychiatry. When the health care service under review is a mental health or substance abuse service, the adverse decision is made by a licensed physician who is board certified in psychiatry. All potential clinical denials are referred to a physician who is board certified in psychiatry for final determination. An evaluation of the overall effectiveness of the Behavioral Health UM Program is conducted annually to determine how well resources have been deployed to improve UM activities and the clinical care and service provided to members.”

The Plan's terms require services to be medically necessary for coverage.

List of M/S and MH/SUD Services Subject to NQTL

- Services that have not previously been reviewed in Prior Authorization or Concurrent Review
- Services where the service or procedure codes do not match a diagnosis code
- EIU services
- Services that are subject to benefit limits
- Codes identified by the Plan as subject to Retrospective Review
 - Please see the file *M/S Retrospective Review Codes* for the list of M/S codes that may be subject to Retrospective Review
- MH/SUD claims that include the following services are subject to Retrospective Review:

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- Partial Hospitalization Program (PHP)/Day Treatment
- Intensive Outpatient Program (IOP)
- Transcranial Magnetic Stimulation (TMS)
- Electroconvulsive Therapy (ECT)
- Psychological Testing
- Applied Behavioral Analysis (ABA)

Step 2 – Factors Used to Determine Retrospective Review Applies

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

The Plan relies on the following factor to determine which OON outpatient services are subject to Retrospective Review. This factor applies to M/S and MH/SUD for the following:

- I. M/S OON outpatient services
 - II. MH/SUD OON outpatient services
- Consistency with Clinical Criteria (Qualitative):
 - Whether the application of Retrospective Review promotes optimal clinical outcomes.

This factor applies to M/S and MH/SUD services. Meeting Consistency with Clinical Criteria is determinative in imposing the limitation.

Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factor used in designing or applying the Plan's Retrospective Review requirement to OON outpatient services. These evidentiary standards and sources apply to the following:

- I. M/S OON outpatient services
- II. MH/SUD OON outpatient services

Factor - Consistency with Clinical Criteria is defined as whether the application of Retrospective Review promotes optimal clinical outcomes.

- The Plan's evidentiary standards and sources that define and/or trigger the Consistency with Clinical Criteria factor:
 - Clinical criteria from nationally recognized, third-party sources (e.g., InterQual or MCG for M/S services, and ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines for MH/SUD services)
 - Clinical Technology Assessment Committee (CTAC) and Medical Technology and Assessment Committee (MTAC) review
 - Objective, evidence-based medical/behavioral clinical policies and nationally recognized guidelines approved by professional healthcare associations (e.g., clinical guidance from the American Medical Association, American Psychiatric Association, etc.)

The *Medical Necessity NQTL* describes the process for determining how internally developed medical/behavioral clinical policies are created and how externally developed third party guidelines are reviewed and approved.

The Plan's evidentiary standards and sources apply to M/S and MH/SUD services. The Consistency with Clinical Criteria

factor, evidentiary standards, and sources are defined in a qualitative manner.

The factor and evidentiary standards used as the basis for subjecting MH/SUD OON outpatient benefits to Retrospective Review are comparable to, and applied no more stringently than, the factor and evidentiary standards used as the basis for subjecting M/S OON outpatient benefits to Retrospective Review “as written” and “in operation.”

Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.

As Written

The Plan conducted a comparative analysis of the strategies, processes, factor, evidentiary standards, and source information used to determine which M/S and MH/SUD OON outpatient services are subject to Retrospective Review “as written.” The Plan identified the factor and evidentiary standards used as the basis for subjecting M/S and MH/SUD benefits to Retrospective Review for each benefit classification.

Review of Factors and Evidentiary Standards

The Plan reviewed the factor that triggers an OON outpatient services to be subject to Retrospective Review. The factor and evidentiary standards were applied to M/S and MH/SUD services comparably and not more stringently to MH/SUD services than M/S services.

Review of Operational Policies and Procedures

The Plan reviewed M/S and MH/SUD operational policies and procedures, and UM annual oversight to confirm comparability and found MH/SUD policies, procedures, and processes to be comparable and no more stringent than M/S policies, procedures, and processes.

- Medical management operational policies and procedures establish the standards for how the Plan conducts outpatient Retrospective Review. The policies and procedures are consistent with state and federal requirements governing Retrospective Review. Timeframes for decisions, content of adverse benefit determinations, appeal rights, and external review are all governed by state and federal requirements.
- UM oversight monitors and evaluates UM processes by reviewing denial rates, clinical appeals, and under- and over-utilization.

Review of Outpatient Retrospective Review Processes

The strategy for applying Retrospective Review to OON outpatient claims is comparable for M/S and MH/SUD services and applied no more stringently to MH/SUD OON outpatient services. The Plan conducted a review of the M/S and MH/SUD Retrospective Review processes to confirm comparability. The review focused on the following aspects of the process for both M/S and MH/SUD:

- **Responsibility.** The member is responsible for requesting Retrospective Review for M/S and MH/SUD. OON providers may submit the request or claim on behalf of the member.
- **Timeframe to submit.** The timeframe for the member to submit a Retrospective Review request was reviewed and it was determined that MH/SUD was no more stringent.
 - For M/S, members must notify the Plan within timely filing requirements
 - For MH/SUD, members have 180 days after the service is rendered to request a Retrospective Review
- **Clinical Reviews.** For M/S and MH/SUD claims, the Plan may request clinical information and refer the claim to a clinical reviewer for a Retrospective Review. The clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. The clinical reviewer may approve cases that meet

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applicable clinical criteria. or refer claims to peer clinical reviewers.

- **Review Timeframes.** M/S and MH/SUD Retrospective Review determination timeframes are defined by state and federal requirements. The same determination timeframes apply to M/S and MH/SUD determinations.
- **Determinations, First Level Clinical Review, and Second Level/Peer Clinical Reviews.** Clinical reviewers determine whether an outpatient service is medically necessary. The clinical reviewer may approve the services based on their review. The clinical reviewer refers cases they cannot approve to a peer clinical reviewer. If the peer clinical reviewer determines that a service was not medically necessary and will not be covered, an adverse benefit determination will be issued. Only qualified peer clinical reviewers may issue adverse benefit determinations.
- **Adverse Benefit Determinations.** An adverse benefit determination is recorded as a clinical denial when it is based on clinical criteria and member clinical information and is recorded as an administrative denial when member benefits are exhausted.
- **Notification of Decisions to Providers and Members.** The Plan notifies M/S and MH/SUD OON providers and members of approvals and adverse benefit determinations, including applicable appeal rights, consistent with state and federal requirements.
- **Review of Staff Qualifications.** For M/S and MH/SUD, clinical staff qualifications align with the type of clinical review and state, and federal requirements.
 - M/S is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are conducted by clinical staff (nurses) and all adverse benefit determinations are made by a physician or other appropriate health care professionals.
 - MH/SUD is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians etc.) and all adverse benefit determinations are made by Medical Directors or psychologists.
- **Clinical Criteria.** For M/S and MH/SUD, clinical reviewers and peer clinical reviewers base determinations on objective, evidence-based medical/behavioral clinical policies or use clinical criteria from third party sources such as InterQual, MCG, ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines.

In Operation

The Plan compared the strategies, processes, factor, evidentiary standards, and source information used to determine which M/S and MH/SUD OON outpatient services are subject to Retrospective Review and how Retrospective Review is applied “in operation.”

The Plan subjected claims/requests for M/S and MH/SUD outpatient services to Retrospective Review that were not reviewed in the Prior Authorization or Concurrent Review process. Additionally, M/S claims for outpatient services submitted by OON providers were subject to Retrospective Review if the services or procedure codes did not match a diagnosis code, if services were EIU, or if the services had benefit limits. MH/SUD claims/requests for outpatient services submitted by OON providers may be subject to Retrospective Review if the service or procedure code required Prior Authorization or Concurrent Review, but that review was not conducted and there is a mitigating circumstance. Additionally, claims may be subject to Retrospective Review if the billed services or procedure codes do not match the authorized codes or if services are EIU.

The Plan may request member clinical information for M/S and MH/SUD outpatient claims and refer claims to a clinical reviewer. The clinical reviewer reviewed applicable member clinical information, benefit plan documents, and clinical criteria in the case review. The clinical reviewer approved cases that met applicable clinical criteria or referred cases to peer clinical reviewers. If an appropriately qualified peer clinical reviewer determined that a service was not medically necessary and would not be covered, an adverse benefit determination was issued for the claim.

The Plan communicated all adverse benefit determinations for M/S and MH/SUD outpatient claims/requests that did not meet applicable clinical criteria, including appeal rights, consistent with state and federal requirements.

The Plan conducts monthly quality audits of individual non-clinical staff, clinical reviewers, including staff performing appeal functions. The Plan routinely monitors Retrospective Review performance through its clinical performance oversight functions. In addition to comparing these “in operation” processes, the Plan reviewed medical necessity approval and denial rates,

internal appeals outcomes, and external appeals outcomes related to Retrospective Review determinations for M/S and MH/SUD OON outpatient services.

Step 5 – Findings and Conclusions

FAQ 45: A reasoned discussion of the Plan's or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.

Findings

The findings of the Plan's comparative analyses confirmed the strategies, processes, factor, evidentiary standards, and source information used to subject certain MH/SUD OON outpatient services to Retrospective Review were comparable to, and applied no more stringently than, the strategies, processes, factor, evidentiary standards, and source information used to subject certain M/S OON outpatient services to Retrospective Review "as written."

The Plan found the factor used to subject OON MH/SUD outpatient services to Retrospective Review was comparable to and applied no more stringently than the factor used to subject OON M/S outpatient services to Retrospective Review "in operation."

All M/S outpatient services were subject to Retrospective Review if they were not reviewed via Prior Authorization or Concurrent Review. Additionally, M/S claims for outpatient services submitted by OON providers were subject to Retrospective Review if the services or procedure codes did not match a diagnosis code, if services were EIU, or if the services had benefit limits. MH/SUD claims for outpatient services submitted by OON providers may be subject to Retrospective Review if the service or procedure code required Prior Authorization or Concurrent Review, but that review was not conducted and there is a mitigating circumstance. Additionally, claims may be subject to Retrospective Review if the billed services or procedure codes do not match the authorized codes or if services are EIU.

The Plan used comparable processes to conduct Retrospective Review of claims for M/S and MH/SUD outpatient services. The Plan may request clinical information if necessary. The Plan approved M/S and MH/SUD claims/requests for outpatient services that met applicable clinical criteria or guidelines. The Plan issued an adverse benefit determination for M/S and MH/SUD OON provider claims/requests for outpatient services that did not meet applicable clinical criteria or guidelines.

The Plan notes the UM outcomes data do not reflect material differences in Retrospective Review processes for M/S or MH/SUD benefit coverage determinations. Similarly, the appeals data do not reflect that members face a materially different or more stringent review process.

There is an insufficient number of MH/SUD OON outpatient cases from 01/01/2022-12/31/2022 to support an analysis of clinical outcomes data for UnitedHealthcare Insurance Company (UHC)

The following definitions are applicable to the charts below:

- Total # of Requests Received: the aggregate number of OON outpatient Retrospective Review requests received
- Total # of Requests Approved: the aggregate number of OON outpatient Retrospective Review requests approved
- Total # of Requests Clinically Denied: the aggregate number of OON outpatient Retrospective Review requests that were denied for clinical reasons (request did not meet medical necessity)
- Approval Rate %: (Requests Approved / Requests Received)
- Clinical Denial Rate %: (Total number of Requests Clinically Denied / Total number of Requests Received)
- Total # of Clinical Denials reviewed upon appeal: Total (internal & external): the aggregate number of OON outpatient Retrospective Review clinical internal and external appeals received
- Total # of Clinical Denials Overturned upon appeal: Total (internal & external): the aggregate number of OON outpatient Retrospective Review clinical internal and external appeals overturned
- Clinical Denial Overturn Rate %: Total (Internal & External): percent of OON outpatient Retrospective Review clinical internal and external appeals overturned (Total # of Clinical Denials Overturned upon internal and external

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- appeal/Total # of Clinical Denials reviewed upon internal and external appeal)
- Total # of Clinical Denials Upheld: Total (Internal & External): the aggregate number of OON outpatient Retrospective Review clinical internal and external appeals upheld
- Clinical Denial Uphold Rate %: Total (Internal & External): percent of OON outpatient Retrospective Review clinical internal and external appeals upheld (Total # of Clinical Denials Upheld upon internal and external appeal/Total # of Clinical Denials reviewed upon internal and external appeal)
- Total # of Clinical Denials reviewed upon internal appeal only: the aggregate number of OON outpatient Retrospective Review clinical internal appeals received
- Total # of Clinical Denials Overturned upon internal appeal only: the aggregate number of OON outpatient Retrospective Review clinical internal appeals overturned
- Clinical Denial Overturn Rate %, internal appeal only: percent of OON outpatient Retrospective Review clinical internal appeals overturned (Total # of Clinical Denials Overturned upon internal appeal/Total # of Clinical Denials reviewed upon internal appeal)
- Total # of Clinical Denials Upheld upon internal appeal: the aggregate number of OON outpatient Retrospective Review clinical internal appeals upheld
- Clinical Denial Uphold Rate %, internal appeal only: percent of OON outpatient Retrospective Review clinical internal appeals upheld (Total # of Clinical Denials Upheld upon internal appeal/Total # of Clinical Denials reviewed upon internal appeal)
- Total # of Clinical Denials reviewed upon external appeal only: the aggregate number of OON outpatient Retrospective Review clinical external appeals received
- Total # of Clinical Denials Overturned upon external appeal only: the aggregate number of OON outpatient Retrospective Review clinical external appeals overturned
- Clinical Overturn Rate %, external appeal only: percent of OON outpatient Retrospective Review clinical external appeals overturned (Total # of Clinical Denials Overturned upon external appeal/Total # of Clinical Denials reviewed upon external appeal)
- Total # of Clinical Denials Upheld upon external appeal: the aggregate number of OON outpatient Retrospective Review clinical external appeals upheld
- Clinical Uphold Denial Rate %, external appeal only: percent of OON outpatient Retrospective Review clinical external appeals upheld (Total # of Clinical Denials Upheld upon external appeal/Total # of Clinical Denials reviewed upon external appeal)

UHIC

Outcomes Data Retrospective Review Analysis:		Out-of-Network Outpatient	
		M/S*	MH/SUD
Total # of Requests Received		45	18
Total # of Requests Approved		26	18
Total # of Requests Clinically Denied		19	0
Approval Rate %		57.78%	100.00%
Clinical Denial Rate %		42.22%	0.00%
Total # of Clinical Denials reviewed upon appeal--Total (Internal & External)		92	1
Total # of Clinical Denials Overturned upon appeal--Total (Internal & External)		6	1
Clinical Denial Overturn Rate %-- Total (Internal & External)		6.52%	100.00%
Total # of Clinical Denials Upheld--Total (Internal & External)		86	0
Clinical Denial Uphold Rate %--Total (Internal & External)		93.48%	0.00%
Total # of Clinical Denials reviewed upon internal appeal only		79	1
Total # of Clinical Denials Overturned upon internal appeal only		4	1
Clinical Denial Overturn Rate %, internal appeal only		5.06%	100.00%
Total # of Clinical Denials Upheld upon internal appeal only		75	0
Clinical Denial Uphold Rate %, internal appeal only		94.94%	0.00%
Total # of Clinical Denials reviewed upon external appeal only		13	0
Total # of Clinical Denials Overturned upon external appeal only		2	0
Clinical Overturn Rate %, external appeal only		15.38%	-
Total # of Clinical Denials Upheld upon external appeal only		11	0
Clinical Uphold Denial Rate %, external appeal only		84.62%	-

*Due to changes in internal systems, medical/surgical retrospective review data is only available for January through June 2022. The data reported has been annualized to estimate the complete year.

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Conclusions

The Plan concluded that how Retrospective Review is applied to MH/SUD OON outpatient services was comparable to, and applied no more stringently than, how Retrospective Review is applied to M/S OON outpatient services “as written.”

The Plan reviewed the M/S and MH/SUD processes including responsibility for submission, timeframes for submission and review, notification to members and providers, clinical standards for review, staff qualifications, and outcome data for review and concluded how the Plan conducts Retrospective Review for MH/SUD OON outpatient services “in operation” was comparable to, and applied no more stringently than, how the Plan conducts Retrospective Review for M/S OON outpatient services “in operation.”

Outpatient Prescription Drug

UnitedHealthcare Insurance Company

Schedule of Benefits

[The correct plan name will be inserted.]

[Plan XXX]

When Are Benefits Available for Prescription Drug Products?

Benefits are available for Prescription Drug Products at a Network Pharmacy and are subject to Co-payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is placed.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Care Service [or is prescribed to prevent conception[, however this does not apply to emergency contraceptives]].

Benefits for Oral Chemotherapeutic Agents

Oral chemotherapeutic agent Prescription Drug Products will be provided at a level no less favorable than chemotherapeutic agents are provided under *Pharmaceutical Products – Outpatient* in your Certificate of Coverage, regardless of tier placement.

What Happens When a Brand-name Drug Becomes Available as a Generic?

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change. Therefore, your Co-payment may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

[Applies when plan design includes closed-panel benefits.]

[Benefits are provided only when the Prescription Order or Refill has been issued by a Network Physician or other Network provider.]

What Happens When a Biosimilar Product Becomes Available for a Reference Product?

[Applies when plan design includes ancillary charge.]

If a biosimilar becomes available for a reference product (a biological Prescription Drug Product), the tier placement of the reference product may change. Therefore, your Co-payment may change [and an Ancillary Charge may apply,] or you will no longer have Benefits for that particular reference product.

How Do Supply Limits Apply?

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Co-payment, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed. Supply limits are subject, from time to time, to our review and change. This may limit the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may find out whether a Prescription Drug Product has a supply limit for dispensing by [\[visiting benefits.surest.com\]\]](#) [\[or\]](#) [\[calling the telephone number on your ID card\]](#).

Does Prior Authorization Requirements Apply?

Before certain Prescription Drug Products are dispensed to you, your Physician, your pharmacist or you are required to obtain prior authorization from us or our designee. The reason for obtaining prior authorization from us is to determine whether the Prescription Drug Product, in accordance with our approved guidelines, is each of the following:

- It meets the definition of a Covered Health Care Service.
- It is not an Experimental or Investigational or Unproven Service.

We may also require you to obtain prior authorization from us or our designee so we can determine whether the Prescription Drug Product, in accordance with our approved guidelines, was prescribed by a Specialist.

Network Pharmacy Prior Authorization

When Prescription Drug Products are dispensed at a Network Pharmacy, the prescribing provider, the pharmacist, or you are responsible for obtaining prior authorization from us.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you may pay more for that Prescription Order or Refill. The Prescription Drug Products requiring prior authorization are subject, from time to time, to our review and change. There may be certain Prescription Drug Products that require you to notify us directly rather than your Physician or pharmacist. You may find out whether a particular Prescription Drug Product requires prior authorization by [\[visiting benefits.surest.com\]\]](#) [\[or\]](#) [\[calling the telephone number on your ID card\]](#).

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from us as described in the *Certificate of Coverage (Certificate)* in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Co-payment and Ancillary Charge. Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Care Service, or it is an Experimental or Investigational or Unproven Service.

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits related to such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements related to such programs by [\[visiting benefits.surest.com\]\]](#) [\[or\]](#) [\[calling the telephone number on your ID card\]](#).

Does Step Therapy Apply?

Certain Prescription Drug Products for which Benefits are described under this Prescription Drug Rider are subject to step therapy requirements. In order to receive Benefits for such Prescription Drug Products you must use a different Prescription Drug Product(s) first.

You may find out whether a Prescription Drug Product is subject to step therapy requirements by [\[visiting benefits.surest.com\]\]](#) [\[or\]](#) [\[calling the telephone number on your ID card\]](#).

What Do You Pay?

You are responsible for paying the applicable Co-payment described in the Benefit Information table in addition to any Ancillary Charge. You are not responsible for paying a Co-payment for PPACA Zero Cost Share Preventive Care Medications. [\[You are not responsible for paying a Co-payment for Prescription Drug Products on the List of Zero Cost Share Medications.\]](#)

[\[¹Applies when the plan design includes the mandatory generic program.\]](#)

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your [\[¹or the provider's\]](#) request and there is another drug that is Chemically Equivalent. The amount you pay for any of the following under this Rider will not be included in calculating any Out-of-Pocket Limit stated in your Certificate:

- Ancillary Charges.
- Certain coupons or offers from pharmaceutical manufacturers or an affiliate.
- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product. Our contracted rates (our Prescription Drug Charge) will not be available to you.
- [\[Any amount you pay for Prescription Drug Products for \[Iatrogenic Infertility\]\[,\] \[and\] \[Infertility\]\[,\] \[and\] \[Preimplantation Genetic Testing \(PGT\)\] that exceeds the Maximum Policy Amount.\]](#)

Payment Information

[\[The following provision is plan design variable.\]](#)

[\[The Infertility Annual Maximum Benefit is calculated on a \[calendar\] \[Policy\] year basis.\]](#)

Payment Term and Description	Amounts
[Infertility Annual Maximum Benefit]	
[Applicability of infertility annual maximum drug benefit is plan design variable.] [The maximum amount we will pay for covered Prescription Drug Products for Infertility during a year.]	[\$[250 - 10,000] per Covered Person.]
[Infertility Maximum Policy Benefit]	
[Applicability of infertility maximum policy benefit is plan design variable.] [The maximum amount we will pay for covered Prescription Drug Products for Infertility during the entire period of time you are enrolled for coverage under the Policy.]	[\$[250 - 10,000] per Covered Person.]
[[Iatrogenic Infertility][,] [and] [Infertility][,] [and] [Preimplantation Genetic Testing (PGT)] Maximum Policy Benefit]	
[Applicability of maximum policy benefit is plan design variable.]	[\$[250 - 10,000] per Covered Person.]

Payment Term and Description	Amounts
<p>[The maximum amount we will pay for any combination of covered Prescription Drug Products for [Iatrogenic Infertility][.] [and] [Infertility][.] [and] [Preimplantation Genetic Testing (PGT)] during the entire period of time you are enrolled for coverage under the Policy.]</p>	
<p>Co-payment</p>	
<p>Co-payment</p> <p>Co-payment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount.</p> <p>Co-payment</p> <p>Your Co-payment is determined by the Pharmacy and Therapeutics (P&T) Committee's tier placement of a Prescription Drug Product.</p> <p><i>[Include when regimen pricing applies to therapeutic treatments.]</i></p> <p>[We may cover multiple Prescription Drug Products for a single Co-payment if the combination of these multiple products provides a therapeutic treatment regimen that is supported by available clinical evidence. You may determine whether a therapeutic treatment regimen qualifies for a single Co-payment by [visiting [benefits.surest.com]] [or] [calling the telephone number on your ID card].]</p> <p>[Your Co-payment may be reduced when you participate in certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on these programs and any applicable prior authorization, participation or activation requirements associated with such programs by [visiting [benefits.surest.com]] [or] [calling the telephone number on your ID card].]</p> <p>Special Programs: We may have certain programs in which you may receive a reduced or increased Co-payment based on your actions such as adherence/compliance to medication or</p>	<p>For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lowest of the following:</p> <ul style="list-style-type: none"> • The applicable Co-payment. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. • The Prescription Drug Charge for that Prescription Drug Product. <p>For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of the following:</p> <ul style="list-style-type: none"> • The applicable Co-payment. • The Prescription Drug Charge for that Prescription Drug Product. <p>See the Co-payments stated in the <i>Benefit Information</i> table for amounts.</p> <p>You are not responsible for paying a Co-payment for PPACA Zero Cost Share Preventive Care Medications.</p> <p>[You are not responsible for paying a Co-payment for Prescription Drug Products on the List of Zero Cost Share Medications.]</p>

Payment Term and Description	Amounts
<p>treatment regimens, and/or participation in health management programs. You may access information on these programs by [visiting [benefits.surest.com]] [or] [calling the telephone number on your ID card].</p> <p><i>[Include when co-payment Waiver Program applies.]</i></p> <p>[Co-payment Waiver Program:] [If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Co-payment for one or more Prescription Orders or Refills.]</p> <p>[Variable Co-payment Program:]</p> <p>Certain coupons from pharmaceutical manufacturers or an affiliate may reduce the costs of your Specialty Prescription Drug Products. Your Co-payment may vary when you use a coupon. Contact [benefits.surest.com] or the telephone number on your ID card for an available list of Specialty Prescription Drug Products and the applicable Co-payment.]</p> <p>NOTE: The tier status of a Prescription Drug Product can change from time to time. These changes generally happen quarterly but no more than six times per calendar year, based on the P&T Committee's tiering decisions. When that happens, you may pay more or less for a Prescription Drug Product, depending on its tier placement. Please [visit [benefits.surest.com]] [or] [call the number on your ID card] for the most up-to-date tier status.</p> <p><i>[Include when use of coupons is limited.]</i></p> <p>[Coupons:] We may not permit you to use certain coupons or offers from pharmaceutical manufacturers or an affiliate to reduce your Co-payment.]</p>	

Benefit Information

The amounts you are required to pay as shown below in the <i>Outpatient Prescription Drug Schedule of Benefits</i> are based on the Prescription Drug Charge.	
Description and Supply Limits	What Is the Co-payment You Pay?
Specialty Prescription Drug Products	
<p>The following supply limits apply.</p> <ul style="list-style-type: none"> As written by the provider, up to a consecutive [30 - 31]-day supply of a Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits, or as allowed under the Smart Fill Program. <p>When a Specialty Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive [30 - 31]-day supply, the Co-payment that applies will reflect the number of days dispensed or days the drug will be delivered.</p> <p>Supply limits apply to Specialty Prescription Drug Products obtained at a Network Pharmacy [,] [or] [a mail order Network Pharmacy] [or] [a Designated Pharmacy].</p>	<p>Your Co-payment is determined by the P&T Committee's tier placement of the Specialty Prescription Drug Product. All Specialty Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2, or Tier 3. Please [visit benefits.surest.com] [or] [call the telephone number on your ID card] to find out tier placement.</p> <p>For a Tier 1 Specialty Prescription Drug Product: \$[100 - 550] per Prescription Order or Refill.</p> <p>For a Tier 2 Specialty Prescription Drug Product: \$[130 - 600] per Prescription Order or Refill.</p> <p>For a Tier 3 Specialty Prescription Drug Product: \$[150 - 650] per Prescription Order or Refill.</p> <p>[Applies when closed benefit plan applies.]</p> <p>[Specialty Prescription Drug Products that are not on Tier 1 [,] [or] [Tier 2] [,] [or] [Tier 3] of the Prescription Drug List are not covered.]</p>
Prescription Drugs from a Retail Network Pharmacy or Preferred Retail Network Pharmacy	
<p>The following supply limits apply:</p> <ul style="list-style-type: none"> As written by the provider, up to a consecutive 30 or 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. <p>[Applies when plan design includes contraceptive benefits.]</p> <ul style="list-style-type: none"> [A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Co-payment for each cycle supplied.] <p>When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a</p>	<p>Your Co-payment is determined by the P&T Committee's tier placement of the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2, or Tier 3. Please [visit benefits.surest.com] [or] [call the telephone number on your ID card] to find out tier status.</p> <p>For up to a 30-day supply at a retail Network Pharmacy, you pay:</p> <p>Preferred Retail Network Pharmacy</p> <p>For a Tier 1 Prescription Drug Product: \$[1 - 50] per Prescription Order or Refill.</p> <p>For a Tier 2 Prescription Drug Product: \$[20 - 150] per Prescription Order or Refill.</p> <p>For a Tier 3 Prescription Drug Product: \$[40 - 200] per Prescription Order or Refill.</p> <p>All Other Retail Network Pharmacy</p>

The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge.

Description and Supply Limits	What Is the Co-payment You Pay?
<p>consecutive 30 or 90-day supply, the Co-payment that applies will reflect the number of days dispensed or days the drug will be delivered.</p> <p>We may designate certain retail Network Pharmacies to be a Preferred Retail Network Pharmacy. We may, from time to time, change the Preferred designation of a retail Network Pharmacy. These changes generally will happen quarterly, but no more than six times per calendar year. These changes may happen without prior notice to you. You may find out whether a retail Network Pharmacy is a Preferred Retail Network Pharmacy by [visiting benefits.surest.com] [or] [calling the telephone number on your ID card].</p>	<p>For a Tier 1 Prescription Drug Product: \$[1 - 50] per Prescription Order or Refill.</p> <p>For a Tier 2 Prescription Drug Product: \$[20 - 150] per Prescription Order or Refill.</p> <p>For a Tier 3 Prescription Drug Product: \$[40 - 200] per Prescription Order or Refill.</p> <p>For up to a 90-day supply at a retail Network Pharmacy, you pay:</p> <p>Preferred Retail Network Pharmacy</p> <p>For a Tier 1 Prescription Drug Product: \$[1 - 50] per Prescription Order or Refill.</p> <p>For a Tier 2 Prescription Drug Product: \$[50 - 375] per Prescription Order or Refill.</p> <p>For a Tier 3 Prescription Drug Product: \$[100 - 500] per Prescription Order or Refill.</p> <p>All Other Retail Network Pharmacy</p> <p>For a Tier 1 Prescription Drug Product: \$[1 - 90] per Prescription Order or Refill.</p> <p>For a Tier 2 Prescription Drug Product: \$[50 - 375] per Prescription Order or Refill.</p> <p>For a Tier 3 Prescription Drug Product: \$[100 - 500] per Prescription Order or Refill.</p> <p>[Applies when closed benefit plan applies.]</p> <p>[Prescription Drug Products that are not on Tier 1 [,] [or] [Tier 2] [,] [or] [Tier 3] of the Prescription Drug List are not covered.]</p>
<p>Prescription Drug Products from a Mail Order Network Pharmacy</p>	
<p>The following supply limits apply:</p> <ul style="list-style-type: none"> As written by the provider, up to a consecutive 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. These supply limits do not apply to Specialty Prescription Drug Products. Specialty Prescription Drug Products from a mail order Network Pharmacy are subject to the supply limits stated above 	<p>Your Co-payment is determined by the P&T Committee's tier placement the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2 or Tier 3. Please [visit benefits.surest.com] [or] [call the telephone number on your ID card] to find out tier status.</p> <p>For up to a 90-day supply at a mail order Network Pharmacy, you pay:</p> <p>For a Tier 1 Prescription Drug Product: \$[1 - 90] per Prescription Order or Refill.</p> <p>For a Tier 2 Prescription Drug Product: \$[50 - 375] per Prescription Order or Refill.</p>

The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge.

Description and Supply Limits	What Is the Co-payment You Pay?
<p>under the heading <i>Specialty Prescription Drug Products</i>.</p> <p>To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate. You will be charged a Co-payment based on the day supply dispensed for any Prescription Orders or Refills sent to the mail order pharmacy. Be sure your Physician writes your Prescription Order or Refill for a 90-day supply, not a 30-day supply with three refills.</p>	<p>For a Tier 3 Prescription Drug Product: \$[100 - 500] per Prescription Order or Refill.</p> <p>[Applies when closed benefit plan applies.]</p> <p>[Prescription Drug Products that are not on Tier 1 [,] [or] [Tier 2] [,] [or] [Tier 3] of the Prescription Drug List are not covered.]</p>

Mental Health Parity Comparative Analysis Report

Confidentially Prepared for: Surest and all clients under Surest

Navitus has compiled an analysis and data illustrating the provision of benefits for mental health/substance abuse disorder (MH/SUD) drugs and medical/surgical (M/S) drugs. Navitus' processes ensure coverage, medical necessity, appropriate access to drugs for treatment, safety of the individual, compliance with federal and State requirements, and the prevention of overutilization.

It should be noted that Navitus administers pharmacy benefits based on the benefit design of a plan or plan sponsor. To demonstrate parity on behalf of a plan with reference to pharmacy benefits, Navitus has provided **Exhibit A** which is a side-by-side comparison of several Non-Quantitative Treatment Limitation (NQTL) categories which apply to MH/SUD and M/S drugs. This includes prior authorization, pharmacy concurrent drug utilization review, medical necessity, pharmacy step therapy, formulary and benefit levels and network standards. This includes the applied criteria, process including policy references, strategy, description of evidence, comparability, stringency, and any modifications for each category.

This is supported by the following policies which can be provided upon request:

- Coverage Determinations (Prior Authorization)
- Drug Formulary
- Drug Utilization Management Program Overview
- Drug Utilization Review Clinical Programs
- Formulary Advisory Committee
- Pharmacy and Therapeutics Committee
- Pharmacy Network Access and Availability
- Step Therapy Automated Review

Furthermore, activities involving prior authorization, formulary communication and network are included within the scope of Navitus' Pharmacy Benefits Management accreditation as evidenced on the [Navitus.com](https://www.navitus.com) homepage. Navitus has distinct standards that must be demonstrated and satisfied as part of Navitus operational processes by URAC on a sampling basis to achieve this three-year accreditation. This is done through evidence and observation by URAC to ensure compliance with these standards.

Data Analysis Results

Prior Authorization Prescription Counts

This data represents a period from January through December 2022 with comment on any high-level observations in the subsections below.

Drug category	# of PA requests	# of PA approvals	% of PA approvals	# of PA denials	% of PA denials	# of PA denials appealed	# of PA denials overturned	% of PA denials overturned
MH/SUD drugs	70,213	50,614	72%	19,599	28%	1195	560	46.9%
M/S drugs	326,617	158,369	48%	168,248	52%	11542	4759	41.2%
Total	396,830	208,983	53%	187,847	47%	12737	5319	41.7%

Observations: Navitus analysis of counts for prescription drug prior authorization requests did not reveal any direct concerns related to parity. The analysis was applied across the entire Navitus book-of-business and includes a general distinction between drug GPI groupings for MH/SUD using categories or classes of antianxiety, antidepressants, antipsychotics, hypnotics/sleep disorder drugs, ADHD/anti-narcolepsy, antidementia agents, hypoactive sexual desire disorder agents, premenstrual dysphoric disorder agents, anti-cataplectic agents, pseudobulbar affect agents, agents for chemical dependency, opioid use disorder drugs, and opioid antagonists (naloxone).

- The percentages of MH/SUD drugs compared to M/S drugs are all more favorable for MH/SUD drugs. The percent of overturned denials is in favor of M/S but not of statistical significance.
- No further observations.

Prior Authorization

This formulary data represents current formulary setups with comment on any high-level observations in the subsections below

Drug category	# of formulary drugs with a prior authorization (PA)	% of formulary drugs subject to prior authorization (PA)
MH/SUD drugs	11	2.4%
M/S drugs	391	3.3%

Step Therapy

Drug category	# of formulary drugs with a step therapy (ST) designation	% of formulary drugs subject to step therapy (ST)
MH/SUD drugs	1	<1%
M/S drugs	12	<1%

Quantity Limits

Drug category	# of formulary drugs with a Quantity Limit (QL) designation	% of formulary drugs subject to quantity limits (QL)
MH/SUD drugs	66	9.1%
M/S drugs	781	12.3%

Observations: Navitus analysis of counts for prescription drug prior authorization requests did not reveal any direct concerns related to parity. The analysis used the Navitus Select formulary and applied a general distinction between drug GPI groupings for MH/SUD using categories or classes of antianxiety, antidepressants, antipsychotics, hypnotics/sleep disorder drugs, ADHD/anti-narcolepsy, antimentia agents, hypoactive sexual desire disorder agents, premenstrual dysphoric disorder agents, anti-cataplectic agents, pseudobulbar affect agents, agents for chemical dependency, opioid use disorder drugs, and opioid antagonists (naloxone). Multi-source brand drugs with generic equivalents available on the market (Medi-Span multisource “O”) are excluded from the analysis as the generic equivalent is preferred and accounted for in the setup information.

- Numbers comparing coverage determination requirements for drugs for MH/SUD and M/S suggest equity in application of requirements around Prior Authorization, Step Therapy and Quantity Limits with minimal discrepancy.
- No further observations.

Formulary

This formulary data represents current formulary setups with comment on any high-level observations in the subsections below.

	MH/SUD drugs	M/S drugs
# of drugs on Tier 1/\$0	204	3578
% of drugs on Tier 1/\$0	44.6%	30.1%
# of drugs on Tier 2	55	1220
% of drugs on Tier 2	12.0%	10.3%
# of drugs on Tier 3	95	1453
% of drugs on Tier 3	20.8%	12.2%
# of drugs NC	103	5643
% of drugs NC	22.5%	47.4%
Total # drugs	457	11894

Observations: Navitus tabulates this analysis based on a data export that compares the percentage of drugs on each tier for MH/SUD classes compared to the remainder of the formulary. The analysis used the Navitus Select formulary and applied a general distinction between drug GPI groupings for MH/SUD using categories or classes of antianxiety, antidepressants, antipsychotics, hypnotics/sleep disorder drugs, ADHD/anti-narcolepsy, antimentia agents, hypoactive sexual desire disorder agents, premenstrual dysphoric disorder agents, anti-cataplectic agents, pseudobulbar affect agents, agents for chemical dependency, opioid use disorder drugs, and opioid antagonists (naloxone). Multi-source brand drugs with generic equivalents available on the market (Medi-Span multisource “O”) are excluded from the analysis as the generic equivalent is preferred and accounted for in the setup information.

- Numbers comparing availability of drugs on the formulary for MH/SUD and M/S drugs suggests a strong presence of both sets of drugs at the Tier 1/\$0 level enabling access to treatment.
- No further observations

Pharmacy Network

This data represents a period from January through December 2022 with comment on any high-level observations in the subsections below.

Pharmacy Network MH/SUD drugs	# of network pharmacy locations	# of pharmacies terminated from network
	64,111	134

Observations: Navitus analysis of pharmacy credentialing data revealed few direct parity concerns. Analysis was completed across Navitus' pharmacy network for the entire book-of-business. It should be noted that there is no specialty distinction for pharmacies in relation to MH/SUD or M/S drugs.

- No further observations.

Definitions:

- Concurrent Drug Utilization Review (CDUR) - Drug utilization review conducted at the point of claim adjudication. In pharmacy, this is not inpatient or outpatient service utilization review under medical benefits at the time of admission or during active treatment for mental health or substance abuse disorder.
- Drug Utilization Review- A process done by Navitus where a member's prescription drug use is looked at to find situations where we can improve the member's health and drug costs
- Formulary - Covered drugs that are covered by the pharmacy benefit plan
- Pharmacy Benefit Plan - Benefit plan or design determines what drugs the plan does and does not cover, in what quantities, from what pharmacies and other drug sources, and at what out-of-pocket cost to members.
- Prior Authorization - The process where specified drugs on the formulary require extra review by clinical staff before they are covered by the benefit plan

Other definitions used by Navitus may be found in its [Benefit Glossary](#).

Certificate of Coverage

UnitedHealthcare Insurance Company

What Is the Certificate of Coverage?

This *Certificate of Coverage (Certificate)* is part of the Policy that is a legal document between UnitedHealthcare Insurance Company and the Group. The *Certificate* describes Covered Health Care Services, subject to the terms, conditions, exclusions and limitations of the Policy. We issue the Policy based on the Group's *Application* and payment of the required Policy Charges.

In addition to this *Certificate*, the Policy includes:

- The *Schedule of Benefits*.
- The Group's *Application*.
- Riders.
- Amendments.

You can review the Policy at the Group's office during regular business hours.

Can This Certificate Change?

We may, from time to time, change this *Certificate* by attaching legal documents called Riders and/or Amendments that may change certain provisions of this *Certificate*. When this happens, we will send you a new *Certificate*, Rider, or Amendment.

Other Information You Should Have

We have the right to change, interpret, withdraw or add Benefits, or to end the Policy, as permitted by law, without your approval.

On its effective date, this *Certificate* replaces and overrules any *Certificate* that we may have previously issued to you. This *Certificate* will in turn be overruled by any *Certificate* we issue to you in the future.

The Policy will take effect on the date shown in the Policy. Coverage under the Policy starts at 12:01 a.m. and ends at 12:00 midnight in the time zone of the Group's location. The Policy will remain in effect as long as the Policy Charges are paid when they are due, subject to *Section 4: When Coverage Ends*.

We are delivering the Policy in Georgia. The Policy is subject to the laws of the state of Georgia and ERISA, unless the Group is not a private plan sponsor subject to ERISA. To the extent that state law applies, Georgia law governs the Policy.

Introduction to Your Certificate

This *Certificate* and the other Policy documents describe your Benefits, as well as your rights and responsibilities, under the Policy.

What Are Defined Terms?

Certain capitalized words have special meanings. We have defined these words in *Section 9: Defined Terms*.

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare Insurance Company.

When we use the words "you" and "your," we are referring to people who are Covered Persons, as that term is defined in *Section 9: Defined Terms*.

How Do You Use This Document?

Read your entire *Certificate* and any attached Riders and/or Amendments. You may not have all of the information you need by reading just one section. Keep your *Certificate* and *Schedule of Benefits* and any attachments in a safe place for your future reference. You can also get this *Certificate* at [\[benefits.surest.com\]](https://benefits.surest.com).

Review the Benefit limitations of this *Certificate* by reading the attached *Schedule of Benefits* along with *Section 1: Covered Health Care Services* and *Section 2: Exclusions and Limitations*. Read *Section 8: General Legal Provisions* to understand how this *Certificate* and your Benefits work. Call us if you have questions about the limits of the coverage available to you.

If there is a conflict between this *Certificate* and any summaries provided to you by the Group, this *Certificate* controls.

Please be aware that your Physician is not responsible for knowing or communicating your Benefits.

How Do You Contact Us?

You may [\[visit \[benefits.surest.com\] or\]](https://benefits.surest.com) call Surest Member Services at [\[833-576-6494\]](tel:833-576-6494). Throughout the document you will find statements that encourage you to contact us for more information.

Your Responsibilities

Enrollment and Required Contributions

Benefits are available to you if you are enrolled for coverage under the Policy. Your enrollment options, and the corresponding dates that coverage begins, are listed in *Section 3: When Coverage Begins*. To be enrolled and receive Benefits, both of the following apply:

- Your enrollment must be in accordance with the requirements of the Policy issued to your Group, including the eligibility requirements.
- You must qualify as a Subscriber or a Dependent as those terms are defined in *Section 9: Defined Terms*.

[*Insert when plan design requires election and activation of conditional coverage.*]

Your Group may require you to make certain payments to them, in order for you to remain enrolled under the Policy. [*When you elect and activate conditional coverage, as described in Section 3: When Coverage Begins, the Group may require you to make additional payments to them.*] If you have questions about this, contact your Group.

Be Aware the Policy Does Not Pay for All Health Care Services

The Policy does not pay for all health care services. Benefits are limited to Covered Health Care Services. The *Schedule of Benefits* will tell you the portion you must pay for Covered Health Care Services.

Decide What Services You Should Receive

Care decisions are between you and your Physician. We do not make decisions about the kind of care you should or should not receive.

Choose Your Physician

It is your responsibility to select the health care professionals who will deliver your care. We arrange for Physicians and other health care professionals and facilities to participate in a Network. Our credentialing process confirms public information about the professionals' and facilities' licenses and other credentials, but does not assure the quality of their services. These professionals and facilities are independent practitioners and entities that are solely responsible for the care they deliver.

Obtain Prior Authorization

Some Covered Health Care Services require prior authorization. Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization. However, if you choose to receive Covered Health Care Services from an out-of-Network provider, you are responsible for obtaining prior authorization before you receive the services. For detailed information on the Covered Health Care Services that require prior authorization, please refer to the *Schedule of Benefits*.

Pay Your Share

You must meet any applicable Co-payment for Covered Health Care Services. These payments are due at the time of service or when billed by the Physician, provider or facility. Any applicable Co-payment amounts are listed in the *Schedule of Benefits*.

Pay the Cost of Excluded Services

You must pay the cost of all excluded services and items. Review *Section 2: Exclusions and Limitations* to become familiar with the Policy's exclusions.

Show Your ID Card

You should show your ID card every time you request health care services. If you do not show your ID card, the provider may fail to bill the correct entity for the services delivered. *We must receive claims within one year of the date of service, as described in [If You Receive Covered Health Care Services from an Out-of-Network Provider](#) in [Section 5: How to File a Claim](#).*

File Claims with Complete and Accurate Information

When you receive Covered Health Care Services from an out-of-Network provider, you are responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described in *Section 5: How to File a Claim*.

Use Your Prior Health Care Coverage

If you have prior coverage that, as required by state law, extends benefits for a particular condition or a disability, we will not pay Benefits for health care services for that condition or disability until the prior coverage ends. We will pay Benefits as of the day your coverage begins under the Policy for all other Covered Health Care Services that are not related to the condition or disability for which you have other coverage.

Our Responsibilities

Determine Benefits

We make administrative decisions regarding whether the Policy will pay for any portion of the cost of a health care service you intend to receive or have received. Our decisions are for payment purposes only. We do not make decisions about the kind of care you should or should not receive. You and your providers must make those treatment decisions.

We have the final authority to do the following:

- Interpret Benefits and the other terms, limitations and exclusions set out in this *Certificate*, the *Schedule of Benefits* and any Riders and/or Amendments.
- Make factual determinations relating to Benefits.

We may assign this authority to other persons or entities that may provide administrative services for the Policy, such as claims processing. The identity of the service providers and the nature of their services may be changed from time to time as we determine. In order to receive Benefits, you must cooperate with those service providers.

Pay for Our Portion of the Cost of Covered Health Care Services

We pay Benefits for Covered Health Care Services as described in *Section 1: Covered Health Care Services* and in the *Schedule of Benefits*, unless the service is excluded in *Section 2: Exclusions and Limitations*. This means we only pay our portion of the cost of Covered Health Care Services. It also means that not all of the health care services you receive may be paid for (in full or in part) by the Policy.

Pay Network Providers

It is the responsibility of Network Physicians and facilities to file for payment from us. When you receive Covered Health Care Services from Network providers, you do not have to submit a claim to us.

Pay for Covered Health Care Services Provided by Out-of-Network Providers

In accordance with any state prompt pay requirements, we pay Benefits after we receive your request for payment that includes all required information. See *Section 5: How to File a Claim*.

Review and Determine Benefits in Accordance with our Reimbursement Policies

We develop our reimbursement policy guidelines, as we determine, in accordance with one or more of the following methodologies:

- As shown in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that we accept.

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), our reimbursement policies are applied to provider billings. We share our reimbursement policies with Physicians and other providers in our Network through our provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by our

reimbursement policies) and the billed charge. However, out-of-Network providers may bill you for any amounts we do not pay, including amounts that are denied because one of our reimbursement policies does not reimburse (in whole or in part) for the service billed. [\[You may get copies of our reimbursement policies for yourself or to share with your out-of-Network Physician or provider by \[visiting \[benefits.surest.com\] or\] calling the telephone number on your ID card.\]](#)

Offer Health Education Services to You

We may provide you with access to information about additional services that are available to you, such as disease management programs, health education and patient advocacy. It is solely your decision whether to take part in the programs, but we recommend that you discuss them with your Physician.

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Section 1: Covered Health Care Services

When Are Benefits Available for Covered Health Care Services?

Benefits are available only when all of the following are true:

- The health care service, including supplies or Pharmaceutical Products, is only a Covered Health Care Service if it is Medically Necessary. (See definitions of Medically Necessary and Covered Health Care Service in *Section 9: Defined Terms*.)
- You receive Covered Health Care Services while the Policy is in effect.
- You receive Covered Health Care Services prior to the date that any of the individual termination conditions listed in *Section 4: When Coverage Ends* occurs. **This restriction does not apply to those Covered Health Care Services described under *Extended Coverage for Total Disability* in *Section 4: When Coverage Ends*.**
- The person who receives Covered Health Care Services is a Covered Person and meets all eligibility requirements specified in the Policy.

The fact that a Physician or other provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms does not mean that the procedure or treatment is a Covered Health Care Service under the Policy.

Benefits are provided for services delivered via Telehealth/Telemedicine. Benefits are also provided for Remote Physiologic Monitoring. Benefits for these services are provided to the same extent as an in-person service under any applicable Benefit category in this section unless otherwise specified in the *Schedule of Benefits*.

This section describes Covered Health Care Services for which Benefits are available. Please refer to the attached *Schedule of Benefits* for details about:

- The amount you must pay for these Covered Health Care Services (including any Co-payment).
- Any limit that applies to these Covered Health Care Services (including visit, day and dollar limits on services).
- Any limit that applies to the portion of the Allowed Amount or the Recognized Amount when applicable you are required to pay in a year (Out-of-Pocket Limit).
- Any responsibility you have for obtaining prior authorization or notifying us.

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

How Does Your Policy Work?

[Insert when plan design requires election and activation of conditional coverages.]

This Policy is designed to help you make informed choices about your health care, costs, and coverage needs. With the [\[Surest\]](#) mobile application and the [\[benefits.surest.com\]](#) website you can search for available care, cost, and coverage options in advance from any geographic location to choose the best option for you. You can also call the telephone number on your ID card for assistance with navigating your coverage options.

Your Policy has no deductible or co-insurance, however, Co-payments are required for Covered Health Care Services. *[Your Policy also has a feature that allows you to activate conditional coverages in advance of seeking care.]*

By using the [Surest] mobile app or the [benefits.surest.com] website, you can search not only for a provider, but also by condition. Depending on the type of condition you enter into the search, the results will provide Covered Health Care Services information and other treatment options for you to consider and discuss with your Physician for the type of treatment you are searching for, such as office visits, rehabilitation services, complex imaging, as well as associated costs with each service. Please note that the [Surest] mobile app or the [benefits.surest.com] website does not currently display other treatment options for every condition.

[Insert when plan design requires election and activation of conditional coverages.]

[¹Once you are enrolled, your coverage also includes the right to activate conditional coverages for certain tests, treatments, or therapy. These coverages are conditional because you must first elect and activate the coverage for such test, treatment, or therapy under the Policy.

Conditional coverages include treatments and services, such as knee replacement and revision, hernia repairs, hysterectomies, lumbar spine fusion, knee arthroscopies, shoulder arthroscopies, and other services based on your condition. You can elect and activate these coverages at any time during the Policy year.]

[Include bracketed variable benefit categories below when the benefit is included in the plan design. Unbracketed benefit categories will always be included in plan design. Include any other specific conditions for coverage described within the category.]

[1.] [Acupuncture Services]

[Acupuncture services provided in an office setting for the following conditions:

- Pain therapy.
- Nausea that is related to surgery, Pregnancy or chemotherapy.

Benefits are provided regardless of whether the office is free-standing, located in a clinic or located in a Hospital.

Acupuncture services must be performed by a provider who is either:

- Practicing within the scope of his/her license (if state license is available); or
- Certified by a national accrediting body.]

[2.] Ambulance Services

Emergency ambulance transportation by a licensed ambulance service (either ground or Air Ambulance) to the nearest Hospital where the required Emergency Health Care Services can be performed.

Non-Emergency ambulance transportation by a licensed ambulance service (either ground or Air Ambulance, as we determine appropriate) between facilities only when the transport meets one of the following:

- From an out-of-Network Hospital to the closest Network Hospital when Covered Health Care Services are required.
- To the closest Network Hospital that provides the required Covered Health Care Services that were not available at the original Hospital.
- From a short-term acute care facility to the closest Network long-term acute care facility (LTAC), Network Inpatient Rehabilitation Facility, or other Network sub-acute facility where the required Covered Health Care Services can be delivered.

For the purpose of this Benefit the following terms have the following meanings:

- "Long-term acute care facility (LTAC)" means a facility or Hospital that provides care to people with complex medical needs requiring long-term Hospital stay in an acute or critical setting.

- "Short-term acute care facility" means a facility or Hospital that provides care to people with medical needs requiring short-term Hospital stay in an acute or critical setting such as for recovery following a surgery, care following sudden Sickness, Injury, or flare-up of a chronic Sickness.
- "Sub-acute facility" means a facility that provides intermediate care on short-term or long-term basis.

[3.] Cellular and Gene Therapy

Cellular Therapy and Gene Therapy received on an inpatient or outpatient basis at a Hospital or on an outpatient basis at an Alternate Facility or in a Physician's office.

Benefits for CAR-T therapy for malignancies are provided as described under Transplantation Services.

[4.] Clinical Trials

Routine patient care costs incurred while taking part in a qualifying clinical trial for the treatment of:

- Cancer or other life-threatening disease or condition. For purposes of this Benefit, a life-threatening disease or condition is one which is likely to cause death unless the course of the disease or condition is interrupted.

Benefits include the reasonable and necessary items and services used to prevent, diagnose and treat complications arising from taking part in a qualifying clinical trial.

Benefits are available only when you are clinically eligible, as determined by the researcher, to take part in the qualifying clinical trial.

Routine patient care costs for qualifying clinical trials include:

- Covered Health Care Services for which Benefits are typically provided absent a clinical trial.
- Covered Health Care Services required solely for the following:
 - The provision of the Experimental or Investigational Service(s) or item.
 - The clinically appropriate monitoring of the effects of the service or item, or
 - The prevention of complications.
- Covered Health Care Services needed for reasonable and necessary care arising from the receipt of an Experimental or Investigational Service(s) or item.

Routine costs for clinical trials do not include:

- The Experimental or Investigational Service(s) or item. The only exceptions to this are:
 - Certain *Category B* devices.
 - Certain promising interventions for patients with terminal illnesses.
 - Other items and services that meet specified criteria in accordance with our medical and drug policies.
- Items and services provided solely to meet data collection and analysis needs and that are not used in the direct clinical management of the patient.
- A service that clearly does not meet widely accepted and established standards of care for a particular diagnosis.
- Items and services provided by the research sponsors free of charge for any person taking part in the trial.

With respect to cancer or other life-threatening diseases or conditions, a qualifying clinical trial is a Phase I, Phase II, Phase III, or Phase IV clinical trial. It takes place in relation to the prevention, detection or

treatment of cancer or other life-threatening disease or condition. It meets any of the following criteria in the bulleted list below.

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
 - *National Institutes of Health (NIH)*. (Includes *National Cancer Institute (NCI)*.)
 - *Centers for Disease Control and Prevention (CDC)*.
 - *Agency for Healthcare Research and Quality (AHRQ)*.
 - *Centers for Medicare and Medicaid Services (CMS)*.
 - A cooperative group or center of any of the entities described above or the *Department of Defense (DOD)* or the *Veterans Administration (VA)*.
 - A qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants.
 - The *Department of Veterans Affairs*, the *Department of Defense* or the *Department of Energy* if the study or investigation has been reviewed and approved through a system of peer review. The peer review system is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:
 - ♦ Comparable to the system of peer review of studies and investigations used by the *National Institutes of Health*.
 - ♦ Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- The study or investigation takes place under an investigational new drug application reviewed by the *U.S. Food and Drug Administration*.
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.
- The clinical trial must have a written protocol that describes a scientifically sound study. It must have been approved by all relevant institutional review boards (*IRBs*) before you are enrolled in the trial. We may, at any time, request documentation about the trial.
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Care Service and is not otherwise excluded under the Policy.

[5.] Dental Services - Accident and Medical

Accident Only

Dental services when all of the following are true:

- Treatment is needed because of accidental damage.
- You receive dental services from a Doctor of Dental Surgery or Doctor of Medical Dentistry.
- The dental damage is severe enough that first contact with a Physician or dentist happened within 72 hours of the accident. (You may request this time period be longer if you do so within 60 days of the Injury and if extenuating circumstances exist due to the severity of the Injury.)

Please note that dental damage that happens as a result of normal activities of daily living or extraordinary use of the teeth is not considered an accidental Injury. Benefits are not available for repairs to teeth that are damaged as a result of such activities.

Dental services to repair damage caused by accidental Injury must follow these time-frames:

- Treatment is started within three months of the accident, or if not a Covered Person at the time of the accident, within the first three months of coverage under the Policy, unless extenuating

circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care).

- Treatment must be completed within 12 months of the accident, or if not a Covered Person at the time of the accident, within the first 12 months of coverage under the Policy.

Benefits for treatment of accidental Injury are limited to the following:

- Emergency exam.
- Diagnostic X-rays.
- Endodontic (root canal) treatment.
- Temporary splinting of teeth.
- Prefabricated post and core.
- Simple minimal restorative procedures (fillings).
- Extractions.
- Post-traumatic crowns if such are the only clinically acceptable treatment.
- Replacement of lost teeth due to Injury with implant, dentures or bridges.

Medical Only

Dental care (oral exam, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Policy, limited to:

- Transplant preparation.
- Prior to the initiation of immunosuppressive drugs.
- The direct treatment of acute traumatic Injury, cancer or cleft palate.

Services for general anesthesia and associated Hospital or Alternate Facility charges, when the dentist and Physician determine that services are necessary for a Covered Person who: a) is a child under age [five - ten], b) is severely disabled, or, c) has a medical condition, unrelated to the dental procedure that requires hospitalization or anesthesia for dental treatment.

[Oral Surgery]

[Removal of erupted or impacted teeth.]

[6.] Diabetes Services

Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care

Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. Services must be ordered by a Physician and provided by appropriately licensed or registered health care professionals.

Benefits also include medical eye exams (dilated retinal exams) and preventive foot care for diabetes.

Diabetic Self-Management Items

[Include paragraph below when group purchases the drug benefit]

[Blood glucose monitors for the legally blind and insulin pumps and supplies and continuous glucose monitors for the management and treatment of diabetes, based upon your medical needs. An insulin pump is subject to all the conditions of coverage stated under *Durable Medical Equipment (DME), Orthotics, Prosthetic Devices, and Supplies*], except for the Omnipod Dash insulin pump]. Benefits for [the Omnipod Dash insulin pump,] blood glucose meters, blood glucose monitors for the legally blind including continuous glucose monitors, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices, insulin, glucagon kits, insulin pumps including

insulin infusion pumps, therapeutic shoes, custom fitted inserts, and related orthopedic footwear are described under *Outpatient Prescription Drug Benefits*.]

[Include paragraph and bulleted list below when group does not purchase the drug benefit.]

[Insulin pumps and supplies for the management and treatment of diabetes, based upon your medical needs include:

- Insulin pumps are subject to all the conditions of coverage stated under *Durable Medical Equipment (DME), Orthotics, Prosthetic Devices, and Supplies*.
- Blood glucose meters including continuous glucose monitors.
- Insulin syringes with needles.
- Blood glucose and urine test strips.
- Ketone test strips and tablets.
- Lancets and lancet devices.]

[7.] Durable Medical Equipment (DME), Orthotics, Prosthetic Devices, and Supplies

Benefits are provided for DME, external prosthetic devices, and certain orthotics and supplies. If more than one item can meet your functional needs, Benefits are available only for the item that meets the minimum specifications for your needs. If you purchase an item that exceeds these minimum specifications, we will pay only the amount that we would have paid for the item that meets the minimum specifications, and you will be responsible for paying any difference in cost.

DME and Supplies

Examples of DME and supplies include:

- Equipment to help mobility, such as a standard wheelchair.
- A standard Hospital-type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Negative pressure wound therapy pumps (wound vacuums).
- Mechanical equipment needed for the treatment of long term or sudden respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters and personal comfort items are excluded from coverage).
- Burn garments.
- Insulin pumps and all related needed supplies as described under *Diabetes Services*. [Note: The Omnipod Dash insulin pump is covered under the *Outpatient Prescription Drug Benefits*.]
- External cochlear devices and systems. Benefits for cochlear implantation are provided under the applicable medical/surgical Benefit categories in this *Certificate*.
- Hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). These are electronic amplifying devices designed to bring sound more effectively into the ear. These consist of a microphone, amplifier and receiver.

Benefits are available for a hearing aid that is purchased through a licensed audiologist, hearing aid dispenser, otolaryngologist or other authorized provider. Benefits are provided for the hearing aid and associated fitting charges and testing.

[Benefits are also provided for certain over-the-counter hearing aids for Covered Persons age 18 and older who have mild to moderate hearing loss.

Benefits for over-the-counter hearing aids do not require any of the following:

- ♦ A medical exam.
- ♦ A fitting by an audiologist.
- ♦ A written prescription.]

Benefits do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Care Service for which Benefits are available under the applicable medical/surgical Covered Health Care Services categories in this *Certificate*. They are only available if you have either of the following:

- ♦ Craniofacial anomalies whose abnormal or absent ear canals prevent the use of a wearable hearing aid.
- ♦ Hearing loss severe enough that it would not be remedied by a wearable hearing aid.

[Benefits also include dedicated speech generating devices and tracheo-esophageal voice devices required for treatment of severe speech impairment or lack of speech directly due to Sickness or Injury. Benefits for the purchase of these devices are available only after completing a required three-month rental period. Benefits are limited as stated in the *Schedule of Benefits*.]

Prosthetic Devices

External prosthetic devices that replace a limb or a body part, limited to:

- Artificial arms, legs, feet and hands.
- Artificial face, eyes, ears and nose.
- Scalp/cranial hair prostheses (wigs) for scalp/head wound, burns, Injury, and alopecia areata.

Benefits include breast prosthesis, mastectomy bras and lymphedema stockings for the arm as required by the *Women's Health and Cancer Rights Act of 1998*.

Orthotics

Orthotic braces, including needed changes to shoes to fit braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are a Covered Health Care Service.

We will decide if the equipment should be purchased or rented. If the equipment is rented, the Co-payment may be split over the rental period, at which point the item may be purchased.

Benefits are available for repairs and replacement, except as described in *Section 2: Exclusions and Limitations*, under *Medical Supplies and Equipment* and under *Devices, Appliances and Prosthetics*.

These Benefits apply to external DME and prosthetic devices. Unless otherwise excluded, items that are fully implanted into the body are a Covered Health Care Service for which Benefits are available under the applicable medical/surgical Covered Health Care Service categories in this *Certificate*.

[Insert below language when the plan design places DME, orthotics, prosthetic devices and supplies into tiers.]

[DME, orthotics, prosthetic devices and supplies are assigned to tiers.

To determine the tiers to which DME, orthotics, prosthetic devices, and supplies are assigned, [visit [benefits.surest.com] or] call the telephone number on your ID card. This list is subject to periodic review and modification (generally quarterly, but not more than six times per year).]

[8.] Emergency Health Care Services - Outpatient

Services that are required to stabilize or begin treatment in an Emergency. Emergency Health Care Services must be received on an outpatient basis at a Hospital or Alternate Facility.

Benefits include the facility charge, supplies and all professional services required to stabilize your condition and/or begin treatment. This includes placement in an observation bed to monitor your condition (rather than being admitted to a Hospital for an Inpatient Stay).

[9.] Enteral Nutrition

Benefits are provided for specialized enteral formulas administered either orally or by tube feeding as the primary source of nutrition, for certain conditions under the direction of a Physician.

[10.] [Fertility Preservation for Iatrogenic Infertility]

[Benefits are available for fertility preservation for medical reasons that cause irreversible infertility such as chemotherapy, radiation treatment, and bilateral oophorectomy due to cancer. Services include the following procedures, when provided by or under the care or supervision of a Physician:

- Collection of sperm.
- Cryo-preservation of sperm.
- Ovarian stimulation, retrieval of eggs and fertilization.
- Oocyte cryo-preservation.
- Embryo cryo-preservation.

Benefits for medications related to the treatment of fertility preservation are provided as described under [your *Outpatient Prescription Drug Rider* or under] *Pharmaceutical Products* in this section.

Benefits are not available for elective fertility preservation.

Benefits are not available for embryo transfer.

Benefits are not available for long-term storage costs (greater than one year).]

[11.] Gender Dysphoria

Benefits for the treatment of gender dysphoria provided by or under the direction of a Physician.

For the purpose of this Benefit, "gender dysphoria" is a disorder characterized by the specific diagnostic criteria classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

[12.] Habilitative Services

For purposes of this Benefit, "habilitative services" means Skilled Care services that are part of a prescribed plan of treatment to help a person with a disabling condition to learn or improve skills and functioning for daily living. We will decide if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. Therapies provided for the purpose of general well-being or conditioning in the absence of a disabling condition are not considered habilitative services.

Habilitative services are limited to:

- Physical therapy.
- Occupational therapy.
- Manipulative Treatment.
- Speech therapy.

- Post-cochlear implant aural therapy.
- Cognitive therapy.

Benefits are provided for habilitative services for both inpatient services and outpatient therapy when you have a disabling condition when both of the following conditions are met:

- Treatment is administered by any of the following:
 - Licensed speech-language pathologist.
 - Licensed audiologist.
 - Licensed occupational therapist.
 - Licensed physical therapist.
 - Physician.
- Treatment must be proven and not Experimental or Investigational.

The following are not habilitative services:

- Custodial Care.
- Respite care.
- Day care.
- Therapeutic recreation.
- Educational/Vocational training.
- Residential Treatment.
- A service or treatment plan that does not help you meet functional goals.
- Services solely educational in nature.
- Educational services otherwise paid under state or federal law.

We may require the following be provided:

- Medical records.
- Other necessary data to allow us to prove that medical treatment is needed.

When the treating provider expects that continued treatment is or will be required to allow you to achieve progress.

Habilitative services provided in your home are provided as described under *Home Health Care*.

Benefits for DME and prosthetic devices, when used as a part of habilitative services, are described under *Durable Medical Equipment (DME), Orthotics, Prosthetic Devices, and Supplies*.

Outpatient habilitative services for occupational therapy, physical therapy and speech therapy for the treatment of Mental Illness are provided under *Mental Health and Substance-Related and Addictive Disorders Services*.

[13.] Home Health Care

Services received from a Home Health Agency that are all of the following:

- Ordered by a Physician.
- Provided in your home by a registered nurse, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.
- Provided on a part-time, Intermittent Care schedule.

- Provided when Skilled Care is required.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management.

[14.] Hospice Care

Hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. It includes the following:

- Physical, psychological, social, spiritual and respite care for the terminally ill person.
- Short-term grief counseling for immediate family members while you are receiving hospice care.

Benefits are available when you receive hospice care from a licensed hospice agency.

You can [visit \[benefits.surest.com\]](https://benefits.surest.com) or call the telephone number on your ID card for information about our guidelines for hospice care.

[15.] Hospital - Inpatient Stay

Services and supplies provided during an Inpatient Stay in a Hospital.

Benefits are available for:

- Supplies and Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- **Services and supplies for a mastectomy or lymph node dissection. The attending Physician will determine the length of stay.**

[16.] [Infertility Services]

[Services for the treatment of infertility when provided by or under the care or supervision of a Physician, limited to the following procedures:

- Ovulation induction (or controlled ovarian stimulation).
- Insemination procedures (artificial insemination (AI) and intrauterine insemination (IUI)).
- Assisted Reproductive Technologies (ART).
- Pharmaceutical Products for the treatment of infertility that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in your home.

Benefits are also provided for:

- Preimplantation Genetic Testing (PGT).
- Cryopreservation and short term storage (up to 12 months) for a Covered Person who will undergo cancer treatment that is expected to render them infertile.

To be eligible for Benefits, you must meet all of the following:

- You are not able to become pregnant after the following periods of time of regular unprotected intercourse or therapeutic donor insemination:
 - One year, if you are a female under age 35.
 - Six months, if you are a female age 35 or older.
- You have infertility not related to voluntary sterilization or to failed reversal of voluntary sterilization.

For the purposes of this Benefit, "therapeutic donor insemination" means insemination with a donor sperm sample for the purpose of conceiving a child.]

[17.] Lab, X-Ray and Diagnostic - Outpatient

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office include:

- Lab and radiology/X-ray.
- Mammography.

Benefits include Physician services, the facility charge, and the charge for supplies and equipment.

- Genetic Testing ordered by a Physician which results in available medical treatment options [\[following Genetic Counseling\]](#). Limited to Genetic Testing for the following:
 - Cancer susceptibility.
 - Hereditary diseases.
 - Unspecified molecular pathology.
 - Fetal aneuploidy.
- Presumptive Drug Tests and Definitive Drug Tests.

Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services*.

CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *Major Diagnostic and Imaging - Outpatient*.

[18.] Major Diagnostic and Imaging - Outpatient

Services for CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits include Physician services, the facility charge, and the charge for supplies and equipment.

[19.] Mental Health Care and Substance-Related and Addictive Disorders Services

Mental Health Care and Substance-Related and Addictive Disorders Services include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility, or either in-person in a provider's office or through telehealth services. All services must be provided by or under the direction of a behavioral health provider who is properly licensed and qualified by law and acting within the scope of their licensure.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.
- Biofeedback.
- E-Visit.

Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds).

Services include the following:

- Diagnostic evaluations, assessment and treatment, and/or procedures.
- Medication management.

- Individual, family, and group therapy.
- Crisis intervention.
- Mental Health Care Services for Autism Spectrum Disorder (including Intensive Behavioral Therapies such as *Applied Behavior Analysis (ABA)*) that are the following:
 - Focused on the treatment of core deficits of Autism Spectrum Disorder.
 - Provided by a *Board Certified Behavior Analyst (BCBA)* or other qualified provider under the appropriate supervision.
 - Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning.

This section describes only the behavioral component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a Covered Health Care Service for which Benefits are available under the applicable medical Covered Health Care Services categories in this *Certificate*.

The Mental Health/Substance-Related and Addictive Disorders Designee provides administrative services for all levels of care.

We encourage you to contact the Mental Health/Substance-Related and Addictive Disorders Designee for assistance in locating a provider and coordination of care.

[20.] Palliative Care

Palliative care for Covered Persons with a new or established diagnosis of progressive debilitating Sickness.

Covered Health Care Services for hospice care provided by a licensed hospice agency are described under *Hospice Care*.

[21.] Pharmaceutical Products - Outpatient

Certain Pharmaceutical Products for Covered Health Care Services administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in your home.

*[¹Include when plan design includes the administration of the drug within the benefit category co-payment.
²Include when the plan does not include the administration of the drug within the benefit category co-payment.]*

Benefits are provided for Pharmaceutical Products [¹and the administration of the Pharmaceutical Products] which, due to their traits (as determined by us), are administered or directly supervised by a qualified provider or licensed/certified health professional. [²Depending on where the Pharmaceutical Product is administered, Benefits will be provided for administration of the Pharmaceutical Product under the corresponding Benefit category in this *Certificate*.] [Benefits for medication normally available by a prescription or order or refill are provided as described under *Outpatient Prescription Drug Benefits*.]

[If you require certain Pharmaceutical Products[, including specialty Pharmaceutical Products,] we may direct you to a Designated Dispensing Entity. Such Dispensing Entities may include an outpatient pharmacy, specialty pharmacy, Home Health Agency provider, Hospital-affiliated pharmacy or hemophilia treatment center contracted pharmacy.]

[If you/your provider are directed to a Designated Dispensing Entity and you/your provider choose not to get your Pharmaceutical Product from a Designated Dispensing Entity, Network Benefits are not available for that Pharmaceutical Product.]

[Certain Pharmaceutical Products are subject to step therapy requirements. This means that in order to receive Benefits for such Pharmaceutical Products, you must use a different Pharmaceutical Product and/or prescription drug product first. You may find out whether a particular Pharmaceutical Product is

subject to step therapy requirements by [visiting benefits.surest.com] or] calling the telephone number on your ID card.]

[Certain Specialty Pharmaceutical Products are eligible for coupons or offers from pharmaceutical manufacturers or affiliates that may reduce the cost for your Specialty Pharmaceutical Product. We may help you determine whether your Specialty Pharmaceutical Product is eligible for this reduction. If you redeem a coupon from a pharmaceutical manufacturer or affiliate, your Co-payment may vary. Please contact www.benefits.surest.com] or the telephone number on your ID card for an available list of Specialty Pharmaceutical Drug Products. If you choose not to participate, you will pay the Co-payment as described in the *Schedule of Benefits*.

The amount of the coupon will not count toward any applicable out-of-pocket limits.]

To find out which Pharmaceutical Products are covered [visit benefits.surest.com] or] call the telephone number on your ID card.

[22.] Physician's Office Services - Sickness and Injury

Services provided at home, in-person in a Physician's office, or through telehealth services for the diagnosis and treatment of a Sickness or Injury. Benefits are provided regardless of whether the Physician's office is freestanding, located in a clinic or located in a Hospital.

Covered Health Care Services include medical education services that are provided in a Physician's office by appropriately licensed or registered health care professionals when both of the following are true:

- Education is required for a disease in which patient self-management is a part of treatment.
- There is a lack of knowledge regarding the disease which requires the help of a trained health professional.

[Covered Health Care Services include Genetic Counseling.]

Benefits include:

- Primary Care Physician and Specialist Physician office visits.
- Convenience Care Clinic (retail) visits.
- Allergy injections.
- Biofeedback.
- E-Visit.

Covered Health Care Services for preventive care provided in a Physician's office are described under *Preventive Care Services*.

Benefits for CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *Major Diagnostic and Imaging - Outpatient*.

When a test is performed or a sample is drawn in the Physician's office, Benefits for the analysis or testing of a lab, radiology/X-ray or other diagnostic service, whether performed in or out of the Physician's office, are described under *Lab, X-ray and Diagnostic - Outpatient*.

[23.] Pregnancy - Maternity Services

Benefits for Pregnancy include all maternity-related medical services for prenatal care, postnatal care, delivery and any related complications.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Care Services include related tests and treatment.

[We also have special prenatal programs to help during Pregnancy. They are voluntary and there is no extra cost for taking part in the program. To sign up, you should notify us during the first trimester, but no later than one month prior to the expected date of delivery. It is important that you notify us regarding your Pregnancy.]

We will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a normal vaginal delivery.
- 96 hours for the mother and newborn child following a cesarean section delivery.

If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames.

[24.] Preimplantation Genetic Testing (PGT) and Related Services

Preimplantation Genetic Testing (PGT) performed to identify and to prevent genetic medical conditions from being passed onto offspring. To be eligible for Benefits the following must be met:

- PGT must be ordered by a Physician after Genetic Counseling.
- The genetic medical condition, if passed onto offspring, would result in significant health problems or severe disability and be caused by a single gene (detectable by PGT-M) or structural changes of a parents' chromosome (detectable by PGT-SR).
- Benefits are limited to PGT for the specific genetic disorder and the following related services when provided by or under the supervision of a Physician:
 - Ovulation induction (or controlled ovarian stimulation).
 - Egg retrieval, fertilization and embryo culture.
 - Embryo biopsy.
 - Embryo transfer.
 - Cryo-preservation and short-term embryo storage (less than one year).

Benefits are not available for long-term storage costs (greater than one year).

[25.] Preventive Care Services

Preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.
- Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention*.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*. This includes well baby and well child care, including periodic review of a child's physical and emotional status.
- Per state law, benefits also include an annual chlamydia screening test.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

[¹Include if information is available online.]

Benefits defined under the *Health Resources and Services Administration (HRSA)* requirement include one breast pump per Pregnancy in conjunction with childbirth. [\[\[Breast pumps must be ordered by or provided by a Physician.\] You can find more information on how to access Benefits for breast pumps \[1by visiting \[benefits.surest.com\]\(https://benefits.surest.com\)\] or\] by calling the telephone number on your ID card.\]](#)

If more than one breast pump can meet your needs, Benefits are available only for the most cost effective pump. We will determine the following:

- Which pump is the most cost effective.
- Whether the pump should be purchased or rented (and the duration of any rental).
- Timing of purchase or rental.

[26.] Reconstructive Procedures

Reconstructive procedures when the primary purpose of the procedure is either of the following:

- Treatment of a medical condition.
- Improvement or restoration of physiologic function.

Reconstructive procedures include surgery or other procedures which are related to an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that you may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry. Other services required by the *Women's Health and Cancer Rights Act of 1998*, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Care Service. You can call the telephone number on your ID card for more information about Benefits for mastectomy-related services.

[27.] Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

Short-term outpatient rehabilitation services limited to:

- Physical therapy.
- Occupational therapy.
- Manipulative Treatment.
- Speech therapy.
- Pulmonary rehabilitation therapy.
- Cardiac rehabilitation therapy.
- Post-cochlear implant aural therapy.
- Cognitive rehabilitation therapy.
- [\[Vision therapy.\]](#)

Rehabilitation services must be performed by a Physician or by a licensed therapy provider. Benefits include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or

Alternate Facility. Rehabilitative services provided in your home are provided as described under *Home Health Care*.

Benefits can be denied or shortened when either of the following applies:

- You are not progressing in goal-directed rehabilitation services.
- Rehabilitation goals have previously been met.

Benefits are not available for maintenance/preventive treatment.

For outpatient rehabilitative services for speech therapy we will pay Benefits for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, or Congenital Anomaly. We will pay Benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or stroke.

Outpatient rehabilitation services for occupational therapy, physical therapy and speech therapy for the treatment of Mental Illness are provided under *Mental Health and Substance-Related and Addictive Disorders Services*.

[28.] Scopic Procedures - Outpatient Diagnostic and Therapeutic

Diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include:

- Colonoscopy.
- Sigmoidoscopy.

Please note that Benefits do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient*.

Benefits include Physician services, the facility charge, and the charge for supplies and equipment.

Benefits that apply to certain preventive screenings are described under *Preventive Care Services*.

[29.] Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Services and supplies provided during an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for:

- Supplies and Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).

Please note that Benefits are available only if both of the following are true:

- If the first confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a cost effective option to an Inpatient Stay in a Hospital.
- You will receive Skilled Care services that are not primarily Custodial Care.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management.

Benefits can be denied or shortened when either of the following applies:

- You are not progressing in goal-directed rehabilitation services.
- Discharge rehabilitation goals have previously been met.

[30.] Surgery - Outpatient

Surgery and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office or Convenience Care Clinic.

Benefits include certain scopic procedures, minor office procedures and complex office procedures.

Benefits include Physician services, the facility charge and the charge for supplies and equipment.

[31.] Temporomandibular Joint (TMJ) Services [and Orthognathic Surgery]

Services for the evaluation and treatment of TMJ and associated muscles.

Diagnosis: Exam, radiographs and applicable imaging studies and consultation.

Non-surgical treatment including:

- Clinical exams.
- [\[Oral appliances \(orthotic splints\).\]](#)
- Arthrocentesis.
- Trigger-point injections.

Benefits are provided for surgical treatment if the following criteria are met:

- There is radiographic evidence of joint abnormality.
- Non-surgical treatment has not resolved the symptoms.
- Pain or dysfunction is moderate or severe.

Benefits for surgical services include:

- Arthrocentesis.
- Arthroscopy.
- Arthroplasty.
- Arthrotomy.
- Open or closed reduction of dislocations.

Benefits for surgical services also include *FDA*-approved TMJ prosthetic replacements when all other treatment has failed.

[\[Benefits are also provided for orthognathic surgery.\]](#)

[32.] Therapeutic Treatments - Outpatient

Therapeutic treatments received at home (dialysis) or on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office, including:

- Apherisis.
- Dialysis (both hemodialysis and peritoneal dialysis).
- Hyperbaric oxygen therapy.
- Intravenous chemotherapy.
- Radiation oncology.

Covered Health Care Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered health care professionals when both of the following are true:

- Education is required for a disease in which patient self-management is a part of treatment.
- There is a lack of knowledge regarding the disease which requires the help of a trained health professional.

Benefits include Physician fees, the facility charge and the charge for related supplies and equipment.

[33.] Transplantation Services

Organ and tissue transplants, including CAR-T cell therapy for malignancies, when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Care Service, and is not an Experimental or Investigational or Unproven Service.

Examples of transplants for which Benefits are available include:

- Bone marrow, including CAR-T cell therapy for malignancies.
- Heart.
- Heart/lung.
- Lung.
- Kidney.
- Kidney/pancreas.
- Liver.
- Liver/small intestine.
- Pancreas.
- Small intestine.
- Cornea.

Donor costs related to transplantation are Covered Health Care Services and are payable through the organ recipient's coverage under the Policy, limited to donor:

- Identification.
- Evaluation.
- Organ removal.
- Direct follow-up care.

You can call the telephone number on your ID card for information about our specific guidelines regarding Benefits for transplant services.

[34.] Urgent Care Center Services

Covered Health Care Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under *Physician's Office Services - Sickness and Injury*.

[35.] Virtual Care Services

Virtual care for Covered Health Care Services that includes the diagnosis and treatment of medical [and behavioral health] conditions. Virtual care provides communication of medical information in real-time [or asynchronous time] between the patient and a distant Physician or health specialist, outside of a medical facility (for example, from home or from work).

[¹Product and state mandate variable. Include when Out-of-Network Benefits are available. Standard is to provide these services as network only, however in states that require both network and out-of-network

benefits be available (in products that have an out-of-network level of benefits) include this "Network" reference.]

[¹Network] Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by [visiting benefits.surest.com] or] calling the telephone number on your ID card.

Benefits are available for the following:

- [Primary care, which is general and non-emergency care, delivered through live video, audio only technology, or through federally compliant secure messaging applications with, or supervised by, a Primary Care Physician.]
- [Mental Health Care Services and Substance-Related and Addictive Disorders Services, delivered through video, audio only technology, or through federally compliant secure messaging applications with, or supervised by, a properly qualified behavioral health provider.]
- [Specialty care, delivered through live video or audio only technology, or through federally compliant secure messaging applications with, or supervised by, a Specialist. [Please refer to the *Schedule of Benefits* for specialties that are available virtually.]]
- [Physical[, occupational][,] [and/or] [speech] therapy, delivered through live video audio only technology.]
- [Urgent on-demand health care delivered through live video, audio only technology, or through federally compliant secure messaging applications for treatment of acute but non-emergency medical needs.]

Please Note: Not all medical [and behavioral health] conditions can be treated through virtual visits. The Designated Virtual Network Provider will identify any condition for which treatment by in-person Physician [or behavioral health provider] contact is needed.

Benefits do not include email[,] [or] fax [and standard telephone calls], or for services that occur within medical facilities (CMS defined originating facilities).

[36.] [Vision Exams]

[Routine vision exams received from a health care provider in the provider's office or outpatient facility. Routine vision exams include refraction to find vision impairment.

Benefits for eye exams required for the diagnosis and treatment of a Sickness or Injury are provided under *Physician's Office Services - Sickness and Injury*.]

[Include the Conditional Coverage section when the plan design requires conditional coverages to be elected and activated.]

[Conditional Coverage]

[¹Insert when the plan design requires conditional coverages to be elected and activated.]

[¹Benefits for one or more services listed below when conditional coverage is elected and activated as described in *Section 3: When Coverage Begins*. Except in the case of an Emergency or cancer-related treatment, when coverage for services listed below are not elected and activated, Benefits are excluded as described below in *Section 2: Exclusions and Limitations*.]

[37.] [Ankle and Foot Bone Fusion]

[Ankle and foot bone fusion surgery received from a health care provider in the provider's office or on an inpatient or outpatient basis at a Hospital or Alternate Facility.]

[38.] [Ankle Arthroscopy and Ligament Repair]

[Ankle arthroscopy and ligament repair received from a health care provider in the provider's office or on an inpatient or outpatient basis at a Hospital or Alternate Facility.]

[39.] [Ankle Replacement and Revision]

[Ankle replacement and revision received on an inpatient or outpatient basis at a Hospital or Alternate Facility.]

[40.] [Back Surgery, Cervical Spine Disc Decompression]

[Cervical spine disc decompression received on an inpatient or outpatient basis at a Hospital or Alternate Facility.]

[41.] [Back Surgery, Cervical Spine Fusion]

[Cervical spine fusion received on an inpatient or outpatient basis at a Hospital or Alternate Facility.]

[42.] [Back Surgery, Lumbar Spine Disc Decompression]

[Lumbar spine disc decompression received on an inpatient or outpatient basis at a Hospital or Alternate Facility.]

[43.] [Back Surgery, Lumbar Spine Fusion]

[Lumbar spine fusion received on an inpatient or outpatient basis at a Hospital or Alternate Facility.]

[44.] [Breast Reduction Surgery]

[Breast reduction surgery received from a health care provider in the provider's office or on an inpatient or outpatient basis at a Hospital or Alternate Facility.]

This does not include Benefits for breast reduction surgery for which Benefits are provided as described under *Gender Dysphoria* above or as provided as required by the *Women's Health and Cancer Rights Acts of 1998* under *Reconstructive Procedures* above.]

[45.] [Bunionectomy and Hammertoe Surgery]

[Bunionectomy and hammertoe surgery received from a health care provider in the provider's office or on an outpatient basis at a Hospital or Alternate Facility.]

[46.] [Cardiac Ablation]

[Cardiac ablation received on an inpatient or outpatient basis at a Hospital or Alternate Facility.]

[47.] [Carotid Endarterectomy and Stents]

[Carotid endarterectomy and stents received on an inpatient or outpatient basis at a Hospital or Alternate Facility.]

[48.] [Carpel Tunnel Surgery]

[Carpel tunnel surgery received from a health care provider in the provider's office or on an outpatient basis at a Hospital or Alternate Facility.]

[49.] [Cataract Surgery]

[Cataract surgery received from a health care provider in the provider's office or on an outpatient basis at a Hospital or Alternate Facility.]

[50.] [Coronary Artery Bypass Graft Surgery]

[Coronary artery bypass graft surgery received on an inpatient or outpatient basis at a Hospital or Alternate Facility.]

[51.] [Coronary Catheterization and Percutaneous Coronary Interventions]

[Coronary catheterization and percutaneous coronary interventions received from a health care provider in the provider's office or on an inpatient or outpatient basis at a Hospital or Alternate Facility.]

[52.] [Elbow Arthroscopy and Tenotomy]

[Elbow arthroscopy and tenotomy provided by or under the direction of a Physician in a Physician's office or on an inpatient or outpatient basis at a Hospital or Alternate Facility.]

[53.] [Elbow Replacement and Revision]

[Elbow replacement and revision provided by or under the direction of a Physician on an inpatient or outpatient basis at a Hospital or Alternate Facility.]

[54.] [Fibroid Removal (Myomectomy)]

[Fibroid removal (myomectomy) provided by or under the direction of a Physician in a Physician's office or on an inpatient or outpatient basis at a Hospital or Alternate Facility.]

[55.] [Gallbladder Removal Surgery (Cholecystectomy)]

[Gallbladder removal surgery (cholecystectomy) provided by or under the direction of a Physician in a Physician's office or on an inpatient or outpatient basis at a Hospital or Alternate Facility.]

[56.] [Ganglion Cyst Surgery]

[Ganglion cyst surgery provided by or under the direction of a Physician in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility.]

[57.] [Hernia Repair]

[Hernia repair provided by or under the direction of a Physician in a Physician's office or on an inpatient or outpatient basis at a Hospital or Alternate Facility.]

[58.] [Hip Arthroscopy and Repair]

[Hip arthroscopy and repair provided by or under the direction of a Physician in a Physician's office or on an inpatient or outpatient basis at a Hospital or Alternate Facility.]

[59.] [Hip Replacement and Revision]

[Hip replacement and revision provided by or under the direction of a Physician on an inpatient or outpatient basis at a Hospital or Alternate Facility.]

[60.] [Hysterectomy]

[Hysterectomy provided by or under the direction of a Physician in a Physician's office or on an inpatient or outpatient basis at a Hospital or Alternate Facility.]

This does not include Benefits which are provided as described above under *Gender Dysphoria*.]

[61.] [Kidney Stone Ablation and Removal (Lithotripsy)]

[Kidney stone ablation and removal (lithotripsy) provided by or under the direction of a Physician in a Physician's office or on an inpatient or outpatient basis at a Hospital or Alternate Facility.]

[62.] [Knee Arthroscopy and Repair]

[Knee arthroscopy and repair provided by or under the direction of a Physician in a Physician's office or on an inpatient or outpatient basis at a Hospital or Alternate Facility.]

[63.] [Knee Replacement and Revision]

[Knee replacement and revision provided by or under the direction of a Physician on an inpatient or outpatient basis at a Hospital or Alternate Facility.]

[64.] [Morton's Neuroma Surgery]

[Morton's neuroma surgery provided by or under the direction of a Physician in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility.]

[65.] [Pacemakers and Defibrillators]

[Pacemakers and defibrillators provided by or under the direction of a Physician on an inpatient or outpatient basis at a Hospital or Alternate Facility.]

[66.] [Plantar Fasciitis Surgery]

[Plantar fasciitis surgery provided by or under the direction of a Physician in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility.]

[67.] [Prostate Removal Surgery]

[Prostate removal surgery provided by or under the direction of a Physician in a Physician's office or on an inpatient or outpatient basis at a Hospital or Alternate Facility.]

[68.] [Reflux and Hiatal Hernia Surgery]

[Reflux and hiatal hernia surgery provided by or under the direction of a Physician in a Physician's office or on an inpatient or outpatient basis at a Hospital or Alternate Facility.]

[69.] [Shoulder Arthroscopy and Repair]

[Shoulder arthroscopy and repair provided by or under the direction of a Physician in a Physician's office or on an inpatient or outpatient basis at a Hospital or Alternate Facility.]

[70.] [Shoulder Replacement and Revision]

[Shoulder replacement and revision provided by or under the direction of a Physician on an inpatient or outpatient basis at a Hospital or Alternate Facility.]

[71.] [Sinus and Nasal Septum Surgery]

[Sinus and nasal septum surgery provided by or under the direction of a Physician in a Physician's office or on an inpatient or outpatient basis at a Hospital or Alternate Facility.]

[72.] [Sling Surgery for Urinary Incontinence]

[Sling surgery for urinary incontinence provided by or under the direction of a Physician in a Physician's office or on an inpatient or outpatient basis at a Hospital or Alternate Facility.]

[73.] [Spinal Cord Stimulator]

[Spinal cord stimulator provided by or under the direction of a Physician on an inpatient or outpatient basis at a Hospital or Alternate Facility.]

[74.] [Tonsillectomy and Adenoidectomy]

[Tonsillectomy and adenoidectomy provided by or under the direction of a Physician in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility.]

[75.] [Valve Replacement]

[Valve replacement provided by or under the direction of a Physician on an inpatient or outpatient basis at a Hospital or Alternate Facility.]

[76.] [Wrist and Hand Joint Replacement]

[Wrist and hand joint replacement provided by or under the direction of a Physician in a Physician's office or on an inpatient or outpatient basis at a Hospital or Alternate Facility.]

[77.] [Wrist Arthroscopy and Repair]

[Wrist arthroscopy and repair provided by or under the direction of a Physician in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility.]

Additional Benefits Required By Georgia Law

[78.] Autism Spectrum Disorder Services

Applied behavior analysis for the treatment of autism spectrum disorders is covered when it is determined by the covering entity that the treatment is medically necessary health care according to established criteria. A licensed physician or licensed psychologist may be required to demonstrate ongoing medical necessity for coverage provided under this section at least annually.

For purposes of this benefit, the following definitions apply: "Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

"Autism spectrum disorder" means autism spectrum disorders as defined by the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders*.

"Treatment of autism spectrum disorder" includes the following types of care prescribed, provided, or ordered for an individual diagnosed with an autism spectrum disorder:

- Habilitative or rehabilitative services, including applied behavior analysis or other professional or counseling services necessary to develop, maintain, and restore the functioning of an individual to the extent possible. To be eligible for coverage, applied behavior analysis shall be provided by a person professionally certified by a national board of behavior analysts or performed under the supervision of a person professionally certified by a national board of behavior analysts;
- Counseling services provided by a licensed psychiatrist, licensed psychologist, professional counselor, or clinical social worker; and
- Therapy services provided by a licensed or certified speech therapist, speech-language pathologist, occupational therapist, physical therapist, or marriage and family therapist.

[79.] Dental Services - Anesthesia and Hospitalization

Benefits include Covered Health Care Services provided in a Hospital or Alternate Facility for dental conditions likely to result in a medical condition if left untreated. Treatment is limited to a Covered Person who:

- Is under 8 years of age, and

- Is determined by a Physician to require dental treatment in a Hospital or Alternate Facility, due to a complex dental condition or a developmental disability that prevents effective treatment in a dental office; or
- Has one or more medical conditions that would create undue medical risk if dental treatment were provided in a dental office; or
- Is severely or developmentally disabled; or
- Has sustained extensive orofacial or dental trauma, unless covered by workers' compensation insurance.

Benefits do not include expenses for the diagnosis and treatment of dental disease.

Benefits include removal of impacted teeth and associated hospitalization.

[80.] Telehealth

Coverage is provided for Telehealth and Telemedicine services the same as other Covered Health Care Services.

Telehealth means the use of information and communications technologies, including, but not limited to, telephones, remote patient monitoring devices or other electronic means which support clinical health care, provider consultation, patient and professional health related education, public health, and health administration.

Telemedicine means a form of telehealth which is the delivery of clinical health care services by means of real-time two-way audio, visual, or other telecommunications or electronic communications, including the application of secure video conferencing or store and forward transfer technology to provide or support health care delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care by a health care provider practicing within his or her scope of practice as would be practiced in-person with a patient as prescribed by applicable federal and state laws, rules, and regulations, and legally allowed to practice in this state, while such patient is at an originating site and the health care provider is at a distant site. Such term includes audio-only telephone only when no other means of real-time two-way audio, visual, or other telecommunications or electronic communications are available to the patient due to lack of availability of such real-time two-way audio, visual, or other telecommunications or electronic communications, due to lack of adequate broadband access, or because the use of other means of real-time two-way audio, visual, or other telecommunications or electronic communications is infeasible, impractical, or otherwise not medically advisable, as determined by the health care provider providing telemedicine services to the patient or as determined by another health care provider with an existing relationship with the patient.

The following definitions apply to this covered benefit:

Distant site - means a site at which a health care provider legally allowed to practice in this state is located while providing health care services by means of telemedicine or telehealth, which may include the home of the health care provider.

Originating site - means a site in this state at which a patient is located at the time health care services are provided to him or her by means of telemedicine or telehealth, which may include a patient's home, workplace, or school; provided, however, that notwithstanding any other provision of law, insurers and providers may agree to alternative siting arrangements deemed appropriate by the parties.

Store and forward transfer - means the transmission of a patient's medical information either to or from an originating site or to or from the provider at the distant site, but does not require the patient being present nor must it be in real time.

Section 2: Exclusions and Limitations

How Do We Use Headings in this Section?

To help you find exclusions, we use headings (for example [\[B.\] Alternative Treatments](#) below). The headings group services, treatments, items, or supplies that fall into a similar category. Exclusions appear under the headings. A heading does not create, define, change, limit or expand an exclusion. All exclusions in this section apply to you.

We Do Not Pay Benefits for Exclusions

We will not pay Benefits for any of the services, treatments, items or supplies described in this section, even if either of the following is true:

- It is recommended or prescribed by a Physician.
- It is the only available treatment for your condition.

The services, treatments, items or supplies listed in this section are not Covered Health Care Services, except as may be specifically provided for in *Section 1: Covered Health Care Services* or through a Rider to the Policy.

Where Are Benefit Limitations Shown?

When Benefits are limited within any of the Covered Health Care Service categories described in *Section 1: Covered Health Care Services*, those limits are stated in the corresponding Covered Health Care Service category in the *Schedule of Benefits*. Limits may also apply to some Covered Health Care Services that fall under more than one Covered Health Care Service category. When this occurs, those limits are also stated in the *Schedule of Benefits* table. Please review all limits carefully, as we will not pay Benefits for any of the services, treatments, items or supplies that exceed these Benefit limits.

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

[Include bracketed variable exclusions below to support plan design. Unbracketed exclusions will always appear.]

[Include the Conditional Coverage exclusions when the plan design requires conditional coverages to be elected and activated.]

[A. Conditional Coverage]

- [1. Health care services listed below are excluded unless coverage for the health care service is elected and activated as described in *Section 3: When Coverage Begins*. When elected and activated, Benefits are available for these health care services as described under *Conditional Coverage* in this *Certificate* and the *Schedule of Benefits*. This exclusion does not apply when health care services listed below are provided due to an Emergency, trauma event, or cancer-related treatment (i.e. post-diagnosis), including surgery.

- [Ankle and foot bone fusion.]
- [Ankle arthroscopy and ligament repair.]
- [Ankle replacement and revision.]
- [Back surgery, cervical spine disc decompression.]
- [Back surgery, cervical spine fusion.]
- [Back surgery, lumbar spine disc decompression.]

- [Back surgery, lumbar spine fusion.]
- [Breast reduction surgery.]
- [Bunionectomy and hammertoe surgery.]
- [Cardiac ablation.]
- [Carotid endarterectomy and stents.]
- [Carpel tunnel surgery.]
- [Cataract surgery.]
- [Coronary artery bypass graft surgery.]
- [Coronary catheterization and percutaneous coronary interventions.]
- [Elbow arthroscopy and tenotomy.]
- [Elbow replacement and revision.]
- [Fibroid removal (myomectomy).]
- [Gallbladder removal surgery (cholecystectomy).]
- [Ganglion cyst surgery.]
- [Hernia repair.]
- [Hip arthroscopy and repair.]
- [Hip replacement and revision.]
- [Hysterectomy.]
- [Kidney stone ablation and removal (lithotripsy).]
- [Knee arthroscopy and repair.]
- [Knee replacement and revision.]
- [Morton's neuroma surgery.]
- [Pacemakers and defibrillators.]
- [Plantar fasciitis surgery.]
- [Prostate removal surgery.]
- [Reflux and hiatal hernia surgery.]
- [Shoulder arthroscopy and repair.]
- [Shoulder replacement and revision.]
- [Sinus and nasal septum surgery.]
- [Sling surgery for urinary incontinence.]
- [Spinal cord stimulator.]
- [Tonsillectomy and adenoidectomy.]
- [Valve replacement.]
- [Wrist and hand joint replacement.]
- [Wrist arthroscopy and repair.]]

[B.] Alternative Treatments

1. Health care services ordered by or rendered by providers or para-professionals unlicensed by the appropriate regulatory agency.
- [2.] [Acupressure [and acupuncture].]
- [3.] Aromatherapy.
- [4.] Hypnotism.
- [5.] Massage therapy that is not physical therapy or prescribed by a licensed provider as a component of multi-modality rehabilitation treatment plan.
- [6.] Rolfing.
- [7.] Wilderness, adventure, camping, outdoor, or other similar programs.
- [8.] Vocational therapy.
- [9.] Homeopathic or naturopathic medicine, including dietary supplements.
- [10.] Holistic medicine and services, including dietary supplements.
- [11.] Art therapy, music therapy, dance therapy, animal-assisted therapy, and other forms of alternative treatment as defined by the *National Center for Complementary and Integrative Health (NCCIH)* of the *National Institutes of Health*. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in *Section 1: Covered Health Care Services*.

[C.] Dental

1. Dental care (which includes dental X-rays, supplies and appliances and all related expenses, including hospitalizations and anesthesia). **This exclusion does not apply to Benefits as described under *Dental Services - Anesthesia and Hospitalization* in *Section 1: Covered Health Care Services*.**

This exclusion does not apply to dental services for which Benefits are provided as described under *Dental Services - Accident and Medical* in *Section 1: Covered Health Care Services*.

Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of tooth decay or cavities resulting from dry mouth after radiation treatment or as a result of medication.

Endodontics, periodontal surgery and restorative treatment are excluded.

2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include:
 - Removal, restoration and replacement of teeth.
 - Medical or surgical treatments of dental conditions.
 - Services to improve dental clinical outcomes.

This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement or the *Health Resources and Services Administration (HRSA)* requirement. This exclusion also does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident and Medical* in *Section 1: Covered Health Care Services*.

3. Dental implants, bone grafts and other implant-related procedures. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident and Medical* in *Section 1: Covered Health Care Services*.
4. Dental braces (orthodontics).

5. Treatment of congenitally missing, malpositioned or supernumerary teeth, even if part of a Congenital Anomaly.

[6.] [\[Removal of erupted or impacted teeth.\]](#)

[D.] Devices, Appliances and Prosthetics

1. Devices used as safety items or to help performance in sports-related activities.
2. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics and some types of braces, including over-the-counter orthotic braces. This exclusion does not apply to cranial molding helmets and cranial banding that meet clinical criteria. This exclusion does not apply to braces for which Benefits are provided as described under *Durable Medical Equipment (DME), Orthotics, Prosthetic Devices, and Supplies in Section 1: Covered Health Care Services*.
3. The following items are excluded, even if prescribed by a Physician:
 - Blood pressure cuff/monitor.
 - Enuresis alarm.
 - [\[Non-wearable external defibrillator.\]](#)
 - [\[Trusses.\]](#)
 - [\[Ultrasonic nebulizers.\]](#)
4. Devices and computers to help in communication and speech [\[except for dedicated speech generating devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment \(DME\), Orthotics, Prosthetic Devices, and Supplies in Section 1: Covered Health Care Services*\]](#).
5. Communication aids or devices; equipment to create, replace or augment communication abilities including speech processors, receivers, and communication boards; or computer or electronic assisted communication.
6. Oral appliances for snoring.
7. Repair or replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.
8. Diagnostic or monitoring equipment purchased for home use, unless otherwise described as a Covered Health Care Service.
9. Powered and non-powered exoskeleton devices.

[E.] Drugs

1. Prescription drug products for outpatient use that are filled by a prescription order or refill [\[except as provided as described under *Outpatient Prescription Drug Benefits*\]](#).
2. Self-administered or self-infused medications [\[except as provided as described under *Outpatient Prescription Drug Benefits*\]](#). This exclusion does not apply to medications which, due to their traits (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to certain hemophilia treatment centers that are contracted with a specific hemophilia treatment center fee schedule that allows medications used to treat bleeding disorders to be dispensed directly to Covered Persons for self-administration.
3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and used while in the Physician's office.
4. Over-the-counter drugs and treatments.

5. Growth hormone therapy [except as provided as described under *Outpatient Prescription Drug Benefits*].
6. Certain New Pharmaceutical Products and/or new dosage forms until the date as determined by us or our designee, but no later than December 31st of the following calendar year. This exclusion does not apply if you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment). If you have a life-threatening Sickness or condition, under such circumstances, Benefits may be available for the New Pharmaceutical Product to the extent provided in *Section 1: Covered Health Care Services*.
7. A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.
8. A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.
- [9.] [Benefits for Pharmaceutical Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.]
- [10.] A Pharmaceutical Product with an approved biosimilar or a biosimilar and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. For the purpose of this exclusion a "biosimilar" is a biological Pharmaceutical Product approved based on showing that it is highly similar to a reference product (a biological Pharmaceutical Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times per calendar year.
- [11.] Certain Pharmaceutical Products for which there are therapeutically equivalent (having essentially the same efficacy and adverse effect profile) alternatives available, unless otherwise required by law or approved by us. Such determinations may be made up to six times during a calendar year.
- [12.] Certain Pharmaceutical Products that have not been prescribed by a Specialist.
- [13.] Compounded drugs that contain certain bulk chemicals. Compounded drugs that are available as a similar commercially available Pharmaceutical Product.

[F.] Experimental or Investigational or Unproven Services

Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

This exclusion does not apply to Covered Health Care Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Care Services*.

[G.] Foot Care

1. Routine foot care. Examples include:
 - Cutting or removal of corns and calluses.
 - Nail trimming, nail cutting, or nail debridement.
 - Hygienic and preventive maintenance foot care including cleaning and soaking the feet and applying skin creams in order to maintain skin tone.

This exclusion does not apply to preventive foot care due to conditions associated with metabolic, neurologic, or peripheral vascular disease.

2. Treatment of flat feet.
3. Treatment of subluxation of the foot.
4. Shoes. [This exclusion does not apply to therapeutic, custom-molded shoes when prescribed by a Physician.]
5. Shoe orthotics. [This exclusion does not apply to therapeutic shoe orthotics when prescribed by a Physician.] This exclusion does not apply to orthotics used to support, align, prevent, or correct deformities.
6. Shoe inserts.
7. Arch supports.

Note: This exclusion does not apply to hammer toe or to therapeutic shoes, custom fitted inserts and related orthopedic footwear for Covered Persons with diabetes for which Benefits are provided as described under *Diabetes Services in Section 1: Covered Health Care Services*.

[H.] Gender Dysphoria

1. Cosmetic Procedures, including the following:

- Abdominoplasty.
- Blepharoplasty.
- Body contouring, such as lipoplasty.
- Brow lift.
- Calf implants.
- Cheek, chin, and nose implants.
- Injection of fillers or neurotoxins.
- Face lift, forehead lift, or neck tightening.
- Facial bone remodeling for facial feminizations.
- Hair removal, except as part of a genital reconstruction procedure by a Physician for the treatment of gender dysphoria.
- Hair transplantation.
- Lip augmentation.
- Lip reduction.
- Liposuction.
- Mastopexy.
- Pectoral implants for chest masculinization.
- Rhinoplasty.
- Skin resurfacing.

[I.] Medical Supplies and Equipment

1. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
 - Ace bandages.
 - Gauze and dressings.

- Bandages and tape.
- Antiseptics.
- Diapers and incontinence supplies.

This exclusion does not apply to:

- Disposable supplies necessary for the effective use of DME or prosthetic devices for which Benefits are provided as described under *Durable Medical Equipment (DME), Orthotics, Prosthetic Devices, and Supplies* in *Section 1: Covered Health Care Services*. This exception does not apply to supplies for the administration of medical food products.
 - Diabetic supplies for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Care Services*.
2. Tubings and masks except when used with DME as described under *Durable Medical Equipment (DME), Orthotics, Prosthetic Devices, and Supplies* in *Section 1: Covered Health Care Services*.
 3. Prescribed or non-prescribed publicly available devices, software applications and/or monitors that can be used for non-medical purposes.
 4. Repair or replacement of DME or orthotics due to misuse, malicious damage or gross neglect or to replace lost or stolen items.
 5. Over-the-counter medical equipment or supplies such as saturation monitors, prophylactic knee braces and bath chairs that can be purchased without a prescription even if a prescription has been ordered.

[J.] Mental Health Care and Substance-Related and Addictive Disorders

In addition to all other exclusions listed in this *Section 2: Exclusions and Limitations*, the exclusions listed directly below apply to services described under *Mental Health Care and Substance-Related and Addictive Disorders Services* in *Section 1: Covered Health Care Services*.

1. Services performed in connection with conditions not classified in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association*.
2. *Intense Early Intervention Using Behavioral Therapy (IEIBT)* and Lovaas. This exclusion does not apply when required for the treatment of Autism Spectrum Disorder.
3. Outside of an assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
4. Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.
5. Tuition or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the *Individuals with Disabilities Education Act*.
6. Outside of an assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
7. Transitional Living services.
8. Non-Medical 24-Hour Withdrawal Management.
9. High intensity residential care, including *American Society of Addiction Medicine (ASAM)* criteria, for Covered Persons with substance-related and addictive disorders who are unable to participate in their care due to significant cognitive impairment.

[10.] [Outside of an assessment, services as treatments for the primary diagnoses of [learning disabilities] [,] [pyromania] [,] [kleptomania] [,] [gambling disorder] [,] [and] [paraphilic disorders].]

[K.] Nutrition

1. Individual and group nutritional counseling, including non-specific disease nutritional education such as general good eating habits, calorie control or dietary preferences. This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement. This exclusion also does not apply to medical or behavioral/mental health related nutritional education services that are provided as part of treatment for a disease by appropriately licensed or registered health care professionals when both of the following are true:
 - Nutritional education is required for a disease in which patient self-management is a part of treatment.
 - There is a lack of knowledge regarding the disease which requires the help of a trained health professional.
2. Food of any kind, infant formula, standard milk-based formula, and donor breast milk. This exclusion does not apply to specialized enteral formula for which Benefits are provided as described under *Enteral Nutrition* in *Section 1: Covered Health Care Services*.
3. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements and electrolytes.

[L.] Personal Care, Comfort or Convenience

1. Television.
2. Telephone.
3. Beauty/barber service.
4. Guest service.
5. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
 - Air conditioners, air purifiers and filters and dehumidifiers.
 - Batteries and battery chargers.
 - Breast pumps. This exclusion does not apply to breast pumps for which Benefits are provided under the *Health Resources and Services Administration (HRSA)* requirement.
 - Car seats.
 - Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts and recliners.
 - Exercise equipment.
 - Home modifications such as elevators, handrails and ramps.
 - Hot and cold compresses.
 - Hot tubs.
 - Humidifiers.
 - Jacuzzis.
 - Mattresses.
 - Medical alert systems.
 - Motorized beds.

- Music devices.
- Personal computers.
- Pillows.
- Power-operated vehicles.
- Radios.
- Saunas.
- Stair lifts and stair glides.
- Strollers.
- Safety equipment.
- Treadmills.
- Vehicle modifications such as van lifts.
- Video players.
- Whirlpools.

[M.] Physical Appearance

1. Cosmetic Procedures. See the definition in *Section 9: Defined Terms*. Examples include:
 - Pharmacological regimens, nutritional procedures or treatments.
 - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
 - Skin abrasion procedures performed as a treatment for acne.
 - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
 - Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
 - Treatment for spider veins.
 - Hair removal or replacement by any means, except for hair removal as part of genital reconstruction prescribed by a Physician for the treatment of gender dysphoria.
 - Treatments for hair loss.
 - Varicose vein treatment of the lower extremities.
 2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the first breast implant followed mastectomy. See *Reconstructive Procedures* in *Section 1: Covered Health Care Services*.
 3. Treatment of benign gynecomastia (abnormal breast enlargement in males).
 4. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, health club memberships and programs, and spa treatments.
- [5.] [\[Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.\]](#)
- [6.] Wigs (scalp/cranial hair prostheses) except for Covered Persons with scalp/head wound, burns, injuries, alopecia aerate, cancer, and undergoing chemotherapy or radiation therapy.

[N.] Procedures and Treatments

1. Removal of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty and brachioplasty.
 2. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
 3. Rehabilitation services and Manipulative Treatment to improve general physical conditions that are provided to reduce potential risk factors, where improvement is not expected, including routine, long-term or maintenance/preventive treatment.
 4. Rehabilitation services for speech therapy except as required for treatment of a speech impairment or speech dysfunction that results from Injury, stroke, cancer, or Congenital Anomaly.
 5. Habilitative services for maintenance/preventive treatment.
 6. Outpatient cognitive rehabilitation therapy except as Medically Necessary following a post-traumatic brain Injury or stroke.
 7. Physiological treatments and procedures that result in the same therapeutic effects when performed on the same body region during the same visit or office encounter.
 8. The following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; [\[oral appliances \(orthotic splints\);\]](#) and dental restorations.
 9. Upper and lower jawbone surgery and jaw alignment. This exclusion does not apply to reconstructive jaw surgery when there is a facial skeletal abnormality and associated functional medical impairment. This exclusion does not apply to surgery for which Benefits are provided as described under *Temporomandibular Joint (TMJ) Services* [\[and Orthognathic Surgery\]](#) in *Section 1: Covered Health Care Services*. [This exclusion does not apply to Benefits as described under Dental Services - Anesthesia and Hospitalization and Temporomandibular Joint \(TMJ\) Services in Section 1: Covered Health Care Services.](#)
- [\[10.\] \[Medical and surgical treatment of excessive sweating \(hyperhidrosis\).\]](#)
- [\[11.\] \[Surgical and non-surgical treatment of obesity.\] \[Non-surgical treatment of obesity.\] \[Surgical treatment of obesity for open vertical banded gastroplasty and laparoscopic vertical banded gastroplasty.\]](#)
- [\[12.\] \[Stand-alone multi-disciplinary tobacco cessation programs. These are programs that usually include health care providers specializing in tobacco cessation and may include a psychologist, social worker or other licensed or certified professionals. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings.\]](#)
- [\[13.\] Breast reduction surgery that is determined to be a Cosmetic Procedure. This exclusion does not apply to breast reduction surgery which we determine is requested to treat a physiologic functional impairment or to coverage required by the *Women's Health and Cancer Rights Act of 1998* for which Benefits are described under *Reconstructive Procedures* in *Section 1: Covered Health Care Services*.](#)
- [\[14.\] \[Helicobacter pylori \(H. pylori\) serologic testing.\]](#)
- [\[15.\] \[Intracellular micronutrient testing.\]](#)
- [\[16.\] \[Chelation therapy, except to treat heavy metal poisoning.\]](#)
- [\[Applies to Network-only plans and to plans with Network and Out-of-Network Benefits when Out-of-Network Cellular and Gene Therapy Benefits are not available and plan design requires Cellular and Gene Therapy services to be received from a Designated Provider.\]](#)
- [\[17.\] \[Cellular and Gene Therapy services not received from a Designated Provider.\]](#)

[O.] Providers

1. Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
2. Services performed by a provider with your same legal address.
3. Services ordered or delivered by a Christian Science practitioner.
4. Service performed by an unlicensed provider or a provider who is operating outside of the scope of his/her license.

[P.] Reproduction

[Applies when plan design does not include benefits for infertility treatment.]

1. *[Health care services and related expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment.] [This exclusion does not apply to Benefits as described under [Fertility Preservation for Iatrogenic Infertility and] Preimplantation Genetic Testing (PGT) and Related Services in Section 1: Covered Health Care Services.]*

[Applies when plan design includes benefits for infertility treatment.]

[The following infertility treatment-related services:

- Cryo-preservation, other forms of preservation of reproductive materials, and storage of reproductive materials. This exclusion does not apply to embryo freezing, for embryos produced from one cycle, and short-term storage (up to 12 months), for a Covered Person who will undergo cancer treatment that is expected to leave them infertile.
- Donor services.
- Ovulation predictor kits.
- Multi-embryo transfer.
- Artificial reproductive treatments done for genetic or eugenic (selective breeding) purposes.
- Cloning.
- Embryo or oocyte accumulation defined as fresh oocyte retrieval prior to the depletion of previously banked frozen embryos or oocytes.
- Natural cycle insemination in the absence of sexual dysfunction or documented cervical trauma.
- Embryo transport.]

2. The following services related to a Gestational Carrier or Surrogate:

[Applies when plan design does not include benefits for infertility services.]

- *[All costs related to reproductive techniques including:*
 - ♦ Assisted reproductive technology.
 - ♦ Artificial insemination.
 - ♦ Intrauterine insemination.
 - ♦ Obtaining and transferring embryo(s).
 - ♦ Preimplantation Genetic Testing (PGT) and related services.]

[Applies when plan design includes benefits for infertility services.]

- *[All costs related to reproductive techniques including:*

- ♦ Assisted Reproductive Technology (ART).
- ♦ Artificial insemination.
- ♦ Intrauterine insemination.
- ♦ Obtaining and transferring embryo(s).
- ♦ Preimplantation Genetic Testing (PGT) and related services.

The exclusion for costs related to reproductive techniques does not apply when the Gestational Carrier or Surrogate is a Covered Person for whom Benefits are provided as described under *Infertility Services* and *Preimplantation Genetic Testing (PGT) and Related Services* in *Section 1: Covered Health Care Services*.]

- Health care services including:
 - ♦ Inpatient or outpatient prenatal care and/or preventive care.
 - ♦ Screenings and/or diagnostic testing.
 - ♦ Delivery and post-natal care.

The exclusion for the health care services listed above does not apply when the Gestational Carrier or Surrogate is a Covered Person.

- All fees including:
 - ♦ Screening, hiring and compensation of a Gestational Carrier or Surrogate including surrogacy agency fees.
 - ♦ Surrogate insurance premiums.
 - ♦ Travel or transportation fees.

3. Costs of donor eggs and donor sperm.

[Applies when plan design does not include benefits for infertility treatment.]

4. [Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue. This exclusion does not apply to short-term storage (less than one year) and retrieval of reproductive materials for which Benefits are provided as described under *[Fertility Preservation for Iatrogenic Infertility]* and *Preimplantation Genetic Testing (PGT) and Related Services* in *Section 1: Covered Health Care Services*.]

[5.] The reversal of voluntary sterilization [and voluntary sterilization].

[6.] [Health care services and related expenses for surgical, non-surgical or drug-induced Pregnancy termination. This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, or missed abortion (commonly known as a miscarriage). [This exclusion does not apply in situations where the life of the Covered Person would be endangered if the fetus is carried to full term.]]

[Include for groups that object to contraceptive services based on a statutory or regulatory exemption.]

[7.] [Contraceptive supplies and services.]

[Include for groups that object to emergency contraceptive services based on a statutory or regulatory exemption.]

[7.] [Emergency contraceptives.]

[8.] [Fetal reduction surgery.]

[9.] [Elective fertility preservation.]

[10.] [Maternity related medical services for Enrolled Dependent children. This exclusion does not apply to prenatal services for which Benefits are provided under *the United States Preventive Services*

Task Force requirement or the *Health Resources and Services Administration (HRSA)* requirement.]

[Applies when plan design includes benefits for infertility services.]

- [11.] [In vitro fertilization that is not an Assisted Reproductive Technology for the treatment of infertility. This exclusion does not apply to in vitro fertilization for which Benefits are provided as described under *Preimplantation Genetic Testing (PGT) and Related Services in Section 1: Covered Health Care Services.*]

[Applies when plan design does not include benefits for infertility services.]

- [12.] [In vitro fertilization regardless of the reason for treatment. This exclusion does not apply to in vitro fertilization for which Benefits are provided as described under *Preimplantation Genetic Testing (PGT) and Related Services in Section 1: Covered Health Care Services.*]

[Q.] Services Provided under another Plan

[Applies when plan design does not include benefits for 24 hour coverage.]

1. [Health care services for when other coverage is required by federal, state or local law to be bought or provided through other arrangements. Examples include coverage required by workers' compensation, or similar legislation.

If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected.]

[Applies when plan design includes benefits for 24 hour coverage.]

[Health care services for which other coverage is required by federal, state or local law to be bought or provided through other arrangements. This includes coverage required by workers' compensation, or similar legislation. This exclusion does not apply to Groups that are not required by law to buy or provide, through other arrangements, workers' compensation insurance for employees, owners and/or partners.]

2. Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy.
3. Health care services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
4. Health care services during active military duty.

[R.] Transplants

1. Health care services for organ and tissue transplants, except those described under *Transplantation Services in Section 1: Covered Health Care Services.*
2. Health care services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Policy.)
3. Health care services for transplants involving animal organs.

[Applies to plan designs that require services to be provided at a Designated Provider.]

- [4.] [Transplant services not received from a Designated Provider. This exclusion does not apply to cornea transplants.]

[S.] Travel

1. [\[Health care services provided in a foreign country, unless required as Emergency Health Care Services.\]](#)
- [2.]** Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Care Services received from a Designated Provider or other Network provider may be paid back as determined by us. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in *Section 1: Covered Health Care Services*.

[T.] Types of Care

1. Multi-disciplinary pain management programs provided on an inpatient basis for sharp, sudden pain or for worsened long term pain.
2. Custodial Care or maintenance care.
3. Domiciliary care.
4. Private Duty Nursing.
5. Respite care. This exclusion does not apply to respite care for which Benefits are provided as described under *Hospice Care* in *Section 1: Covered Health Care Services*.
6. Rest cures.
7. Services of personal care aides.
8. Work hardening (treatment programs designed to return a person to work or to prepare a person for specific work).

[U.] Vision and Hearing

1. Cost and fitting charge for eyeglasses and contact lenses. This exclusion does not apply to eyeglasses and contacts required due to cataract surgery or aphakia for which Benefits are provided as described in *Section 1: Covered Health Care Services* under *Durable Medical Equipment, Orthotics, Prosthetic Devices, and Supplies*.
- [2.]** [\[Routine vision exams, including refractive exams to determine the need for vision correction.\]](#)
- [3.]** Implantable lenses used only to fix a refractive error (such as *Intacs* corneal implants), artificial retinal devices, or retinal implants.
- [4.]** [\[Eye exercise or vision therapy.\]](#)
- [5.]** Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser and other refractive eye surgery (e.g. Lasik).
- [6.]** Bone anchored hearing aids except when either of the following applies:
 - You have craniofacial anomalies whose abnormal or absent ear canals prevent the use of a wearable hearing aid.
 - You have hearing loss of sufficient severity that it would not be remedied enough by a wearable hearing aid.

More than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time you are enrolled under the Policy.

Repairs and/or replacement for a bone anchored hearing aid when you meet the above coverage criteria, other than for malfunctions.

[V.] All Other Exclusions

1. Health care services and supplies that do not meet the definition of a Covered Health Care Service. Covered Health Care Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:
 - Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms.
 - Medically Necessary.
 - Described as a Covered Health Care Service in this *Certificate* under *Section 1: Covered Health Care Services* and in the *Schedule of Benefits*.
 - Not otherwise excluded in this *Certificate* under *Section 2: Exclusions and Limitations*.
2. Physical, psychiatric or psychological exams, testing, all forms of vaccinations and immunizations or treatments that are otherwise covered under the Policy when:
 - Required only for school, sports or camp[, travel,] [career or employment,] insurance, marriage or adoption, or as the result of incarceration.
 - Related to judicial or administrative proceedings or orders. This exclusion does not apply to services that are determined to be Medically Necessary.
 - Conducted for purposes of medical research. This exclusion does not apply to Covered Health Care Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Care Services*.
 - Required to get or maintain a license of any type.
3. Health care services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply if you are a civilian injured or otherwise affected by war, any act of war, or terrorism in non-war zones.
4. Health care services received after the date your coverage under the Policy ends. This applies to all health care services, even if the health care service is required to treat a medical condition that started before the date your coverage under the Policy ended. **This exclusion does not apply to those Covered Health Care Services covered as described under *Extended Coverage for Total Disability* in *Section 4: When Coverage Ends*.**
5. Health care services when you have no legal responsibility to pay, or when a charge would not ordinarily be made in the absence of coverage under the Policy.
6. In the event an out-of-Network provider waives, does not pursue, or fails to collect Co-payments or other amount owed for a particular health care service, no Benefits are provided for the health care service when the Co-payments are waived.
7. Charges in excess of the Allowed Amount, when applicable, or in excess of any specified limitation.
8. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products.
9. Autopsy and other coroner services and transportation services for a corpse.
10. Foreign language and sign language interpretation services offered by or required to be provided by a Network or out-of-Network provider.
11. Health care services related to a non-Covered Health Care Service: When a service is not a Covered Health Care Service, all services related to that non-Covered Health Care Service are also excluded. This exclusion does not apply to services we would otherwise determine to be Covered Health Care Services if the service treats complications that arise from the non-Covered Health Care Service.

For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

12. Charges for:
 - Missed appointments.
 - Completion of claims forms.
 - Record processing.
13. Over-the-counter self-administered home diagnostic tests, including HIV and Pregnancy tests.
14. Retail genetic tests direct to consumer.

Section 3: When Coverage Begins

How Do You Enroll?

Eligible Persons must complete an enrollment form given to them by the Group. The Group will submit the completed forms to us, along with any required Premium. We will not provide Benefits for health care services that you receive before your effective date of coverage.

What If You Are Hospitalized When Your Coverage Begins?

We will pay Benefits for Covered Health Care Services when all of the following apply:

- You are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins.
- You receive Covered Health Care Services on or after your first day of coverage related to that Inpatient Stay.
- You receive Covered Health Care Services in accordance with the terms of the Policy.

These Benefits are subject to your previous carrier's obligations under state law or contract.

You should notify us of your hospitalization within 48 hours of the day your coverage begins, or as soon as reasonably possible. For plans that have a Network Benefit level, Network Benefits are available only if you receive Covered Health Care Services from Network providers.

[Applies when plan design includes Medicare estimating.]

[What If You Are Eligible for Medicare?]

[Your Benefits may be reduced if you are eligible for Medicare but do not enroll in and maintain coverage under both Medicare Part A and Part B.

Your Benefits may also be reduced if you are enrolled in a *Medicare Advantage* (Medicare Part C) plan but do not follow the rules of that plan. Please see *How Are Benefits Paid When You Are Medicare Eligible?* in *Section 8: General Legal Provisions* for more information about how Medicare may affect your Benefits.]

Who Is Eligible for Coverage?

The Group determines who is eligible to enroll and who qualifies as a Dependent.

Eligible Person

Eligible Person usually refers to an employee or member of the Group who meets the eligibility rules. When an Eligible Person enrolls, we refer to that person as a Subscriber. For a complete definition of Eligible Person, Group and Subscriber, see *Section 9: Defined Terms*.

[Eligible Persons must live within the United States.]

[If both spouses are Eligible Persons of the Group, each may enroll as a Subscriber or be covered as an Enrolled Dependent of the other, but not both.]

Dependent

Dependent generally refers to the Subscriber's spouse and children. When a Dependent enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see *Section 9: Defined Terms*.

Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under the Policy.

[If both parents of a Dependent child are enrolled as a Subscriber, only one parent may enroll the child as a Dependent.]

When Do You Enroll and When Does Coverage Begin?

Except as described below, Eligible Persons may not enroll themselves or their Dependents.

Initial Enrollment Period

When the Group purchases coverage under the Policy from us, the Initial Enrollment Period is the first period of time when Eligible Persons can enroll themselves and their Dependents.

Coverage begins on the date shown in the Policy. We must receive the completed enrollment form and any required Premium within [30][31] days of the date the Eligible Person becomes eligible.

[Open Enrollment Period]

[The Group sets the Open Enrollment Period. During the Open Enrollment Period, Eligible Persons can enroll themselves and their Dependents.]

Coverage begins on the date identified by the Group. We must receive the completed enrollment form and any required Premium within [30][31] days of the date the Eligible Person becomes eligible.]

New Eligible Persons

Coverage for a new Eligible Person and his or her Dependents begins on the date agreed to by the Group. We must receive the completed enrollment form and any required Premium within [30][31] days of the date the new Eligible Person first becomes eligible.

Adding New Dependents

Subscribers may enroll Dependents who join their family because of any of the following events:

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.
- Legal guardianship.
- Court or administrative order.
- [Registering a Domestic Partner.]

Coverage for the Dependent begins on the date of the event. We must receive the completed enrollment form and any required Premium within [30][31] days of the event.

Special Enrollment Period

An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period. A special enrollment period is not available to an Eligible Person and his or her Dependents if coverage under the prior plan ended for cause, or because premiums were not paid on a timely basis.

An Eligible Person and/or Dependent does not need to elect COBRA continuation coverage to preserve special enrollment rights. Special enrollment is available to an Eligible Person and/or Dependent even if COBRA is not elected.

A special enrollment period applies to an Eligible Person and any Dependents when one of the following events occurs:

- Birth.

- Legal adoption.
- Placement for adoption.
- Marriage.
- [\[Registering a Domestic Partner.\]](#)

A special enrollment period also applies for an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period [\[or Open Enrollment Period\]](#) if any of the following are true:

- The Eligible Person previously declined coverage under the Policy, but the Eligible Person and/or Dependent becomes eligible for a premium assistance subsidy under *Medicaid* or *Children's Health Insurance Program (CHIP)*. Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date of determination of subsidy eligibility.
- The Eligible Person and/or Dependent had existing health coverage under another plan at the time they had an opportunity to enroll during the Initial Enrollment Period [\[or Open Enrollment Period\]](#) and coverage under the prior plan ended because of any of the following:
 - Loss of eligibility (including legal separation, divorce or death).
 - The employer stopped paying the contributions. This is true even if the Eligible Person and/or Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer.
 - In the case of COBRA continuation coverage, the coverage ended.
 - The Eligible Person and/or Dependent no longer resides, lives or works in an HMO service area if no other benefit option is available.
 - The plan no longer offers benefits to a class of individuals that includes the Eligible Person and/or Dependent.
 - The Eligible Person and/or Dependent loses eligibility under *Medicaid* or *Children's Health Insurance Program (CHIP)*. Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date coverage ended.

When an event takes place (for example, a birth, marriage or determination of eligibility for state subsidy), coverage begins on the date of the event. We must receive the completed enrollment form and any required Premium within [30][31] days of the event unless otherwise noted above.

For an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period [\[or Open Enrollment Period\]](#) because they had existing health coverage under another plan, coverage begins on the day following the day coverage under the prior plan ends. Except as otherwise noted above, coverage will begin only if we receive the completed enrollment form and any required Premium within [30][31] days of the date coverage under the prior plan ended.

[\[Insert below section when plan design requires election and activation of conditional coverages.\]](#)

[\[Election and Activation of Conditional Coverage\]](#)

[\[Conditional Coverage Elected and Activated After the Initial Enrollment Period \[or Open Enrollment Period\]\]](#)

[\[Once enrolled for coverage as described above, Covered Persons are eligible to elect and activate one or more conditional coverages for which Benefits are available as described under Section 1: Covered Health Care Services under Conditional Coverage.\]](#)

To elect conditional coverage, you must take the following steps to activate coverage:

1. [Choose the Covered Health Care Service for which you are electing conditional coverage.](#)
2. [Choose the provider and location for the elected Covered Health Care Service.](#)
3. [Attest to the Adverse Health Factor.](#)

4. Review the total cost of the elected conditional coverage.
5. Complete the activation process.*

*If the Covered Person who is electing conditional coverage is an Enrolled Dependent, the Subscriber must approve the conditional coverage election in order for the Enrolled Dependent to complete the activation process.

You can elect and activate coverage yourself on [Surest app] [or] [benefits.surest.com], or by calling the telephone number on your ID card. You must elect and activate conditional coverage at least three-business days in advance of receiving the Covered Health Care Service. During the three-business day waiting period, you may cancel the conditional coverage on [Surest app] [or] [benefits.surest.com], or by calling the telephone number on your ID card for assistance. You may, at your discretion, opt-out of the three-business day waiting period. If you choose to opt-out, you no longer have the right to cancel the elected conditional coverage during the three-business day waiting period. Once the conditional coverage is activated and is effective, it cannot be cancelled for the duration of the coverage period.

Coverage will begin on the third business day

- after the date you complete the election and activation process, or
- on the date of election and activation if you choose to opt-out of the three-business day waiting period.

Coverage continues for a coverage period of 120 days. The coverage period, if not expired, will continue into your next [calendar][Policy] year as long as coverage under the Policy is maintained into the next [calendar][Policy] year.

Conditional Coverage Elected and Activated During the Initial Enrollment Period [or Open Enrollment Period]

You may elect and activate one or more conditional coverages for which Benefits are available as described under *Section 1: Covered Health Care Services* under *Conditional Coverage* during the Initial Enrollment Period [or Open Enrollment Period] on [Surest app] [or] [benefits.surest.com], or by calling the telephone number on your ID card for assistance. Conditional coverage elected and activated during the Initial Enrollment Period [or Open Enrollment Period] begins the first day of the [calendar][Policy] year and continues for a coverage period of 120 days.]

Section 4: When Coverage Ends

General Information about When Coverage Ends

As permitted by law, we may end the Policy and/or all similar benefit plans at any time for the reasons explained in the Policy.

Your right to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date. Please note that this does not affect coverage that is extended under *Extended Coverage for Total Disability* below.

When your coverage ends, we will still pay claims for Covered Health Care Services that you received before the date your coverage ended. However, once your coverage ends, we will not pay claims for any health care services received after that date (even if the medical condition that is being treated occurred before the date your coverage ended). Please note that this does not affect coverage that is extended under *Extended Coverage for Total Disability* below.

Unless otherwise stated, an Enrolled Dependent's coverage ends on the date the Subscriber's coverage ends.

Please note that if you are subject to the *Extended Coverage for Total Disability* provision later in this section, entitlement to Benefits ends as described in that section.

What Events End Your Coverage?

[*Insert when plan design requires election and activation of conditional coverage.*]

Coverage^[1], including elected and activated conditional coverage,] ends on the earliest of the dates specified below:

- **The Entire Policy Ends**

Your coverage ends on the date the Policy ends. In this event, the Group is responsible for notifying you that your coverage has ended. For non-payment of Premium, we will send a written notice to you within 14 days of the end of the grace period. This notice will include information regarding your continuation rights.

If we end the entire Policy because we will no longer issue this particular type of group health benefit plan within the applicable market, we will provide written notification to you at least 90 days prior to the Group's renewal date. If we end the entire Policy because we will no longer issue any type of health benefit plan, we will provide written notification to you and the applicable state authority at least 180 days prior to the Group's renewal date.

[*Throughout this section, select appropriate option for "date" or "last day of the calendar month in which".*]

- **You Are No Longer Eligible**

Your coverage ends on the [date][last day of the calendar month in which] you are no longer eligible to be a Subscriber or Enrolled Dependent. Please refer to *Section 9: Defined Terms* for definitions of the terms "Eligible Person," "Subscriber," "Dependent" and "Enrolled Dependent."

- **We Receive Notice to End Coverage**

The Group is responsible for providing the required notice to us to end your coverage. Your coverage ends on the [date][last day of the calendar month in which] we receive the required notice from the Group to end your coverage, or on the date requested in the notice, if later.

- **Subscriber Retires or Is Pensioned**

The Group is responsible for providing the required notice to us to end your coverage. Your coverage ends the [date][last day of the calendar month in which] the Subscriber is retired or receiving benefits under the Group's pension or retirement plan.

This provision applies unless there is specific coverage classification for retired or pensioned persons in the Group's *Application*, and only if the Subscriber continues to meet any applicable eligibility requirements. The Group can provide you with specific information about what coverage is available for retirees.

[Insert when plan design requires election and activation of conditional coverages.]

- **[Conditional Coverage]**

[With respect to conditional coverage, for which Benefits are available as described in *Section 1: Covered Health Care Services under Conditional Coverage*, your coverage ends 120 days after the conditional coverage effective date, even if the date of service for the Covered Health Care Service occurs in the next [calendar][Policy] year as long as coverage under the Policy is maintained into the next [calendar][Policy] year.]

Fraud or Intentional Misrepresentation of a Material Fact

We will provide at least [30][31] days advance required notice to the Subscriber that coverage will end on the date we identify in the notice because you committed an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact. Examples include knowingly providing incorrect information relating to another person's eligibility or status as a Dependent. You may appeal this decision during the notice period. The notice will contain information on how to appeal the decision.

If we find that you have performed an act, practice, or omission that constitutes fraud, or have made an intentional misrepresentation of material fact we have the right to demand that you pay back all Benefits we paid to you, or paid in your name, during the time you were incorrectly covered under the Policy.

Note: If you disagree with a decision about terminating your coverage (not the entire Policy), termination will be delayed until you have exhausted the procedures outlined in *Section 6: Questions, Complaints and Appeals*.

Coverage for a Disabled Dependent Child

Coverage for an unmarried Enrolled Dependent child who is disabled will not end just because the child has reached a certain age. We will extend the coverage for that child beyond this age if both of the following are true:

- The Enrolled Dependent child is not able to support him/herself because of mental, developmental, or physical disability.
- The Enrolled Dependent child depends mainly on the Subscriber for support.

Coverage will continue as long as the Enrolled Dependent child is medically certified as disabled and dependent unless coverage otherwise ends in accordance with the terms of the Policy.

We may require you to furnish us with reasonable proof of the disability and financial dependence within 31 days of the date coverage would have ended because the child reached a certain age. Examples of reasonable proof may include medical certification from a Physician, social security documentation identifying proof of disability, or the Subscriber's most recent federal income tax return that verifies the Enrolled Dependent is in fact a Dependent of the Subscriber. Before we agree to this extension of coverage for the child, we may require that a Physician we choose examine the child. We will pay for that exam.

We may continue to ask you for proof that the child continues to be disabled and dependent. Such proof might include medical exams at our expense. We will not ask for this information more than once a year.

If you do not provide proof of the child's disability and dependency within [30][31] days of our request as described above, coverage for that child will end.

Extended Coverage for Total Disability

[Coverage when you are Totally Disabled on the date the entire Policy ends will not end automatically. We will extend the coverage, only for treatment of the condition causing the Total Disability. Benefits will be paid until the earlier of either of the following:

- The Total Disability ends.
- [Three - Eighteen] months from the date coverage would have ended when the entire Policy ends.

Continuation of Coverage

If your coverage ends under the Policy, you may have the right to elect continuation coverage (coverage that continues on in some form) in accordance with federal or state law.

Continuation coverage under *COBRA* (the federal *Consolidated Omnibus Budget Reconciliation Act*) is available only to Groups that are subject to the terms of *COBRA*. Contact your plan administrator to find out if your Group is subject to the provisions of *COBRA*.

If you chose continuation coverage under a prior plan which was then replaced by coverage under the Policy, continuation coverage will end as scheduled under the prior plan or in accordance with federal or state law, whichever is earlier.

We are not the Group's designated "plan administrator" as that term is used in federal law, and we do not assume any responsibilities of a "plan administrator" according to federal law.

We are not obligated to provide continuation coverage to you if the Group or its plan administrator fails to perform its responsibilities under federal law. Examples of the responsibilities of the Group or its plan administrator are:

- Notifying you in a timely manner of the right to elect continuation coverage.
- Notifying us in a timely manner of your election of continuation coverage.

Qualifying Events for Continuation Coverage under State Law

You are eligible for continuation coverage unless your coverage ended for any of the following reasons:

- Termination of your employment with the Group for misconduct.
- Termination of coverage for failure to make any required contributions to the Premium.
- The Policy with the Group was terminated and immediately replaced by similar coverage.

Notification Requirements and Election Period for Continuation Coverage under State Law

The Group will provide you with written notification of the right to continuation coverage under the Policy. You must elect continuation coverage the later of:

- 30 days from the date your coverage would otherwise end; or
- 30 days from the date you receive written notification.
- You should get an election form from the Group and, once election is made, forward all monthly Premiums to the Group for payment to us. Premiums are limited to 100% of the Premium that an actively-at-work Subscriber must contribute.

Terminating Events for Continuation Coverage under State Law

Continuation coverage under the Policy will end on the earliest of the following dates:

- 3 months from the date your continuation began.

- The date coverage ends for failure to make timely payment of the Premium.
- The date coverage ends because you violate a material condition of the Policy.
- The date coverage is or could be obtained under any other group health plan.
- The date the entire Policy ends.

Qualifying Events for Continuation Coverage under State Law for Covered Persons Aged 60 and Older

To be eligible, you must:

- Elect COBRA and exhaust benefits under COBRA.
- Have been covered under the Policy for at least six months prior to the date COBRA began.
- Be a Subscriber or a surviving spouse or divorced spouse of a Subscriber, 60 years of age or older on the date COBRA begins due to loss of employment, death or divorce, and including any dependent children whose coverage would otherwise terminate under the same circumstances.

Coverage must have ended due to one of the following qualifying events:

- Termination of the Subscriber from employment with the Group was for any reason other than voluntary (does not apply to health reasons) or cause.
- The Subscriber did not pay any required contributions.

Note: Continuation is not available when the Policy was terminated in its entirety or the class to which the Subscriber belonged was terminated. In such cases, conversion rights apply.

Payment of Premium for Covered Persons Aged 60 and Older

- Premiums for coverage are limited to not more than 102% of the Premium that an actively-at-work Covered person must pay. The first Premium must be paid on the first regular due date, following the expiration of continuation coverage under COBRA.

Terminating Events for Continuation Coverage under State Law for Covered Persons Aged 60 and Older

Continuation coverage under the Policy will end on the earliest of the following dates:

- The date coverage ends for failure to make timely payment of the Premium, subject to any applicable grace period described in the Policy.
- The date coverage is or could be obtained under any other group health plan.
- The date the Policy ends and a different group plan is not made available to Subscribers and Covered Persons
- The date the Covered Person becomes eligible for Medicare.

Section 5: How to File a Claim

How Are Covered Health Care Services from Network Providers Paid?

We pay Network providers directly for your Covered Health Care Services. If a Network provider bills you for any Covered Health Care Service, call the telephone number on your ID card. However, you are required to pay any required Co-payments to a Network provider.

How Are Covered Health Care Services from an Out-of-Network Provider Paid?

When you receive Covered Health Care Services from an out-of-Network provider, you are responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described below.

You should submit a request for payment of Benefits within 90 days after the date of service. If you don't provide this information to us within one year of the date of service, Benefits for that health care service will be denied or reduced, as determined by us. This time limit does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Required Information

When you request payment of Benefits from us, you must provide us with all of the following information:

- The Subscriber's name and address.
- The patient's name and age.
- The number stated on your ID card.
- The name, address, tax identification number, NPI number and license number, if available, of the provider of the service(s).
- The name and address of any ordering Physician.
- A diagnosis from the Physician.
- An itemized bill from your provider that includes the *Current Procedural Terminology* (CPT) codes or a description of each charge.
- The date the Injury or Sickness began.
- A statement indicating either that you are, or you are not, enrolled for coverage under any other health plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).
- Proof of payment may be requested to substantiate your claim but is not required upon initial submission.

The above information should be filed with us at the address on your ID card.

[When filing a claim for *Outpatient Prescription Drug Benefits*, your claim should be submitted by mail [or fax] to:

[[Mail:]

Navitus Health Solutions, LLC.

P.O. Box 999

Appleton, WI 54912-0999]

[Fax:
920-735-5315)]

[When you request payment of Benefits from us for *Outpatient Prescription Drug Benefits*, you must provide us with all of the following information:

- Manual claim form. You can call the telephone number on your ID card or visit [www.navitus.com/members/filing-a-claim] for a claim form.
- The number stated on your ID card.
- Copies of receipts for payment.
- A statement indicating either that you are, or you are not, enrolled for coverage under any other health plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).]

If We Require Additional Information

If we require additional information, we will acknowledge its receipt with a letter or notice and will describe additional information that we believe is necessary in order to make a determination of the claim.

After we receive all the additional information that we require for final proof of the loss, we will notify you of the acceptance or rejection of your claim. If the claim is rejected, the notice will state the reason(s) the claim was rejected.

We will pay interest at the rate of 12% per annum if we fail to pay your claim within the time frames listed below following receipt of all the necessary information:

- Electronic claims within 15 working days
- Paper claims within 30 calendar days

Please note: the time frames listed above also apply to claims that do not require additional information.

Payment of Benefits

You may not assign your Benefits under the Policy to an out-of-Network provider without our consent. When an assignment is not obtained, we will send the reimbursement directly to you (the Subscriber) for you to reimburse them upon receipt of their bill. We may, however, as we determine, pay an out-of-Network provider directly for services rendered to you. In the case of any such assignment of Benefits or payment to an out-of-Network provider, we reserve the right to offset Benefits to be paid to the provider by any amounts that the provider owes us.

When you assign your Benefits under the Policy to an out-of-Network provider with our consent, and the out-of-Network provider submits a claim for payment, you and the out-of-Network provider represent and warrant the following:

- The Covered Health Care Services were actually provided.
- The Covered Health Care Services were medically appropriate.

Allowed Amounts due to an out-of-Network provider for Covered Health Care Services that are subject to the *No Surprises Act* of the *Consolidated Appropriations Act (P.L. 116-260)* are paid directly to the provider.

Payment of Benefits under the Policy shall be in cash or cash equivalents, or in a form of other consideration that we determine to be adequate. Where Benefits are payable directly to a provider, such adequate consideration includes the forgiveness in whole or in part of the amount the provider owes us, or to other plans for which we make payments where we have taken an assignment of the other plans' recovery rights for value.

Section 6: Questions, Complaints and Appeals

Definitions

The following terms apply to this Section:

- "Appeal" means a formal request, either oral or written, to reconsider our determination of a pre-service request or denial of a claim. This term applies to pre-service and post-service claims and urgent situations.
- "Complaint" means a communication from you, either oral or written, concerning your dissatisfaction with us or our providers.
- "Grievance procedure" means a hearing for you, regarding denial of payment in whole or in part for health care services, treatment or claims after all other steps outlined in this Section have been completed.

To resolve a question, complaint, or appeal, just follow these steps:

What if You Have a Question?

Call the telephone number on your ID card if you have a question. Representatives are available to take your call during regular business hours, Monday through Friday.

What if You Have a Complaint?

Call the telephone number on your ID card if you have a complaint. Representatives are available to take your call during regular business hours, Monday through Friday.

If you would rather send your complaint to us in writing, the representative can provide you with the address.

If the representative cannot resolve the issue over the phone, he/she can help you prepare and submit a written complaint. We will notify you of our decision regarding your complaint within 60 days of receiving it.

How Do You Appeal a Claim Decision?

Post-service Claims

Post-service claims are claims filed for payment of Benefits after medical care has been received.

Pre-service Requests for Benefits

Pre-service requests for Benefits are requests that require prior authorization or benefit confirmation prior to receiving medical care.

How to Request an Appeal

If you disagree with a pre-service request for Benefits determination, post-service claim determination or a rescission of coverage determination, you can call the telephone number on your ID card to request an appeal filing form.

The appeal filing form should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.

- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to us within 180 days after you receive the denial of a pre-service request for Benefits or the claim denial.

Appeal Process - Level One

A qualified individual who was not involved in the decision being appealed will be chosen to decide the appeal. That individual will resolve your appeal within 30 working dates. If your appeal cannot be resolved within 30 working days, the individual will notify you before the 30th day about the reason(s) for the delay and will issue a written decision within 15 additional working days.

If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with expertise in the field, who was not involved in the prior determination. We may consult with, or ask medical experts to take part in the appeal process. You consent to this referral and the sharing of needed medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records and other information related to your claim for Benefits. If any new or additional evidence is relied upon or generated by us during the determination of the appeal, we will provide it to you free of charge and in advance of the due date of the response to the adverse benefit determination.

Grievance - Level Two

If you continue to disagree with our decision, you may submit a written request for a committee to review your appeal and you have the right to appear before the committee. If you cannot appear in person, we will arrange for you to communicate with the committee by a conference call or by completing a grievance form, supplied by the health plan.

We will appoint a committee, composed of representatives who were not involved in the previous determination. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field, who was not involved in the prior determination. We may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records, and other information relevant to your claim for Benefits.

The committee will resolve your appeal within 30 working days of receiving your request. We will send you written notification of the decision within 5 working days of the review. If you are still not satisfied, you have the right to take your appeal to the *Georgia Department of Insurance*.

Please note that you may contact the *Georgia Department of Insurance* at any time. If you file a complaint, they will provide a copy to us. We will respond within 10 working days to the department that sent us your complaint.

Appeals Determinations

Pre-service Requests for Benefits and Post-service Claim Appeals

For procedures related to urgent requests for Benefits, see *Urgent Appeals that Require Immediate Action* below.

You will be provided written or electronic notification of the decision on your appeal as follows:

- For appeals of pre-service requests for Benefits as defined above, the first level appeal will take place and you will be notified of the decision within 15 days from receipt of a request for appeal of a denied request for Benefits. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. This request must be submitted to us within 60 days from receipt of the first level appeal decision. The second level appeal will take place and you will be notified of the decision within 15 days from receipt of a request for review of the first level appeal decision.

- For appeals of post-service claims as defined above, the first level appeal will take place and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. This request must be submitted to us within 60 days from receipt of the first level appeal decision. The second level appeal will take place and you will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision.

Please note that our decision is based only on whether or not Benefits are available under the Policy for the proposed treatment or procedure.

You may have the right to external review through an *Independent Review Organization (IRO)* upon the completion of the internal appeal process. Instructions regarding any such rights, and how to access those rights, will be provided in our decision letter to you.

Urgent Appeals that Require Immediate Action

Your appeal may require urgent action if a delay in treatment could increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Physician should call us as soon as possible.
- We will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.
- If we need more information from your Physician to make a decision, we will notify you of the decision by the end of the next business day following receipt of the required information.

The appeal process for urgent situations does not apply to prescheduled treatments, therapies or surgeries.

Federal External Review Program

You may be entitled to request an external review of our determination after exhausting your internal appeals if either of the following apply:

- You are not satisfied with the determination made by us.
- We fail to respond to your appeal within the timeframe required by the applicable regulations.

If one of the above conditions is met, you may request an external review of adverse benefit determinations based upon any of the following:

- Clinical reasons.
- The exclusions for Experimental or Investigational Service(s) or Unproven Service(s).
- Rescission of coverage (coverage that was cancelled or discontinued retroactively).
- As otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address listed in the determination letter. You or your representative may request an expedited external review, in urgent situations as defined below, by calling the telephone number on your ID card or by sending a written request to the address listed in the determination letter. A request must be made within four months after the date you received our final appeal decision.

An external review request should include all of the following:

- A specific request for an external review.
- Your name, address, and insurance ID number.
- Your designated representative's name and address, when applicable.

- The service that was denied.
- Any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an *Independent Review Organization (IRO)*. We have entered into agreements with three or more *IROs* that have agreed to perform such reviews. There are two types of external reviews available:

- A standard external review.
- An expedited external review.

Standard External Review

A standard external review includes all of the following:

- A preliminary review by us of the request.
- A referral of the request by us to the *IRO*.
- A decision by the *IRO*.

After receipt of the request, we will complete a preliminary review within the applicable timeframe, to determine whether the individual for whom the request was submitted meets all of the following:

- Is or was covered under the Policy at the time the health care service or procedure that is at issue in the request was provided.
- Has exhausted the applicable internal appeals process.
- Has provided all the information and forms required so that we may process the request.

After we complete this review, we will issue a notification in writing to you. If the request is eligible for external review, we will assign an *IRO* to conduct such review. We will assign requests by either rotating the assignment of claims among the *IROs* or by using a random selection process.

The *IRO* will notify you in writing of the request's eligibility and acceptance for external review and if necessary, for any additional information needed to conduct the external review. You will generally have to submit the additional information in writing to the *IRO* within ten business days after the date you receive the *IRO's* request for the additional information. The *IRO* is not required to, but may, accept and consider additional information submitted by you after ten business days.

We will provide to the assigned *IRO* the documents and information considered in making our determination. The documents include:

- All relevant medical records.
- All other documents relied upon by us.
- All other information or evidence that you or your Physician submitted. If there is any information or evidence you or your Physician wish to submit that was not previously provided, you may include this information with your external review request. We will include it with the documents forwarded to the *IRO*.

In reaching a decision, the *IRO* will review the claim as new and not be bound by any decisions or conclusions reached by us. The *IRO* will provide written notice of its determination (the "*Final External Review Decision*") within 45 days after it receives the request for the external review (unless they request additional time and you agree). The *IRO* will deliver the notice of *Final External Review Decision* to you and us, and it will include the clinical basis for the determination.

If we receive a *Final External Review Decision* reversing our determination, we will provide coverage or payment for the Benefit claim at issue according to the terms and conditions of the Policy, and any applicable law regarding plan remedies. If the *Final External Review Decision* agrees with our determination, we will not be obligated to provide Benefits for the health care service or procedure.

Expedited External Review

An expedited external review is similar to a standard external review. The main difference between the two is that the time periods for completing certain portions of the review process are much shorter for the expedited external review, and in some instances you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review, separately or at the same time you have filed a request for an expedited internal appeal, if you receive either of the following:

- An adverse benefit determination of a claim or appeal that involves a medical condition for which the time frame for completion of an expedited internal appeal would either jeopardize:
 - The life or health of the individual.
 - The individual's ability to regain maximum function.

In addition, you must have filed a request for an expedited internal appeal.

- A final appeal decision, that either:
 - Involves a medical condition where the timeframe for completion of a standard external review would either jeopardize the life or health of the individual or jeopardize the individual's ability to regain maximum function.
 - Concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received emergency care services, but has not been discharged from a facility.

Immediately upon receipt of the request, we will determine whether the individual meets both of the following:

- Is or was covered under the Policy at the time the health care service or procedure that is at issue in the request was provided.
- Has provided all the information and forms required so that we may process the request.

After we complete the review, we will send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, we will assign an *IRO* in the same manner we utilize to assign standard external reviews to *IROs*. We will provide all required documents and information we used in making the adverse benefit determination or final adverse benefit determination to the assigned *IRO* electronically or by telephone or facsimile or any other available method in a timely manner. The *IRO*, to the extent the information or documents are available and the *IRO* considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the *IRO* will review the claim as new and not be bound by any decisions or conclusions reached by us. The *IRO* will provide notice of the final external review decision for an expedited external review as quickly as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the *IRO* receives the request. If the *IRO's* final external review decision is first communicated verbally, the *IRO* will follow-up with a written confirmation of the decision within 48 hours of that verbal communication.

You may call the telephone number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

Section 7: Coordination of Benefits

Benefits When You Have Coverage under More than One Plan

This section describes how Benefits under the Policy will be coordinated with those of any other plan that provides benefits to you. The language in this section is from model laws drafted by the *National Association of Insurance Commissioners (NAIC)* and represents standard industry practice for coordinating benefits.

When Does Coordination of Benefits Apply?

This *Coordination of Benefits (COB)* provision applies when a person has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules below govern the order in which each Plan will pay a claim for benefits.

- **Primary Plan.** The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses.
- **Secondary Plan.** The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense. Allowable Expense is defined below.

Definitions

For purposes of this section, terms are defined as follows:

- A. **Plan.** A Plan is any of the following that provides benefits or services for medical, pharmacy or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.
1. Plan includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.
 2. Plan does not include: hospital indemnity coverage insurance or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.
- Each contract for coverage under 1. or 2. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.
- B. **This Plan.** This Plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.
- C. **Order of Benefit Determination Rules.** The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan. When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is

secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.

- D. **Allowable Expense.** Allowable Expense is a health care expense, including deductibles, co-insurance and co-payments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or according to contractual agreement is prohibited from charging a Covered Person is not an Allowable Expense.

The following are examples of expenses or services that are not Allowable Expenses:

1. The difference between the cost of a semi-private hospital room and a private room is not an Allowable Expense unless one of the Plans provides coverage for private hospital room expenses.
 2. If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.
 3. If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
 4. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.
 5. The amount of any benefit reduction by the Primary Plan because a Covered Person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions and preferred provider arrangements.
- E. **Closed Panel Plan.** Closed Panel Plan is a Plan that provides health care benefits to Covered Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.
- F. **Custodial Parent.** Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

What Are the Rules for Determining the Order of Benefit Payments?

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

- A. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.
- B. Except as provided in the next paragraph, a Plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary unless the provisions of both Plans state that the complying plan is primary.

Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be in excess of any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

- C. A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.
- D. Each Plan determines its order of benefits using the first of the following rules that apply:
 - 1. **Non-Dependent or Dependent.** The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.
 - 2. **Dependent Child Covered Under More Than One Coverage Plan.** Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:
 - a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
 - (1) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
 - (2) If both parents have the same birthday, the Plan that covered the parent longest is the Primary Plan.
 - b) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:
 - (1) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the Primary Plan. This shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.
 - (2) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph a) above shall determine the order of benefits.
 - (3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph a) above shall determine the order of benefits.
 - (4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:
 - (a) The Plan covering the Custodial Parent.
 - (b) The Plan covering the Custodial Parent's spouse.

- (c) The Plan covering the non-Custodial Parent.
 - (d) The Plan covering the non-Custodial Parent's spouse.
- c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under subparagraph a) or b) above as if those individuals were parents of the child.
- d) (i) For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in paragraph (5) applies.
 - (ii) In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in subparagraph (a) to the dependent child's parent(s) and the dependent's spouse.
- 3. **Active Employee or Retired or Laid-off Employee.** The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired is the Primary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and, as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.
- 4. **COBRA or State Continuation Coverage.** If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan, and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.
- 5. **Longer or Shorter Length of Coverage.** The Plan that covered the person the longer period of time is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.
- 6. If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

Effect on the Benefits of This Plan

- A. When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.
- B. If a Covered Person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

[Applies when plan design includes Medicare estimating.]

- [C. This Coverage Plan reduces its benefits as described below for Covered Persons who are eligible for Medicare when Medicare would be the Primary Plan.

Medicare benefits are determined as if the full amount that would have been payable under Medicare was actually paid under Medicare, even if:

- The person is entitled but not enrolled in Medicare. Medicare benefits are determined as if the person were covered under Medicare Parts A and B.
- The person is enrolled in a *Medicare Advantage* (Medicare Part C) plan and receives non-covered services because the person did not follow all rules of that plan. Medicare benefits are determined as if the services were covered under Medicare Parts A and B.
- The person receives services from a provider who has elected to opt-out of Medicare. Medicare benefits are determined as if the services were covered under Medicare Parts A and B and the provider had agreed to limit charges to the amount of charges allowed under Medicare rules.
- The services are provided in any facility that is not eligible for Medicare reimbursements, including a Veterans Administration facility, facility of the Uniformed Services, or other facility of the federal government. Medicare benefits are determined as if the services were provided by a facility that is eligible for reimbursement under Medicare.
- The person is enrolled under a plan with a *Medicare Medical Savings Account*. Medicare benefits are determined as if the person were covered under Medicare Parts A and B.

Important: If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under this Coverage Plan), you should enroll for and maintain coverage under both Medicare Part A and Part B. If you don't enroll and maintain that coverage, and if we are secondary to Medicare, we will pay Benefits under this Coverage Plan as if you were covered under both Medicare Part A and Part B. As a result, your out-of-pocket costs will be higher.

If you have not enrolled in Medicare, Benefits will be determined as if you timely enrolled in Medicare and obtained services from a Medicare participating provider if either of the following applies:

- You are eligible for, but not enrolled in, Medicare and this Coverage Plan is secondary to Medicare.
- You have enrolled in Medicare but choose to obtain services from a doctor that opts-out of the Medicare program.

When calculating this Coverage Plan's Benefits in these situations for administrative convenience, we may, as we determine, treat the provider's billed charges, rather than the Medicare approved amount or Medicare limiting charge, as the Allowable Expense for both this Coverage Plan and Medicare.]

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. We may get the facts we need from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits.

We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give us any facts we need to apply those rules and determine benefits payable. If you do not provide us the information we need to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

Payments Made

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, we may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount

again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Does This Plan Have the Right of Recovery?

If the amount of the payments we made is more than we should have paid under this COB provision, we may recover the excess from one or more of the persons we have paid or for whom we have paid; or any other person or organization that may be responsible for the benefits or services provided for you. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

How Are Benefits Paid When This Plan is Secondary to Medicare?

If This Plan is secondary to Medicare, then Benefits payable under This Plan will be based on Medicare's reduced benefits.

Section 8: General Legal Provisions

What Is Your Relationship with Us?

It is important for you to understand our role with respect to the Group's Policy and how it may affect you. We help finance or administer the Group's Policy in which you are enrolled. We do not provide medical services or make treatment decisions. This means:

- We communicate to you decisions about whether the Group's Policy will cover or pay for the health care that you may receive. The Policy pays for Covered Health Care Services, which are more fully described in this *Certificate*.
- The Policy may not pay for all treatments you or your Physician may believe are needed. If the Policy does not pay, you will be responsible for the cost.

We may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. We will use individually identifiable information about you as permitted or required by law, including in our operations and in our research. We will use de-identified data for commercial purposes including research.

Please refer to our *Notice of Privacy Practices* for details.

What Is Our Relationship with Providers and Groups?

We have agreements in place that govern the relationship between us, our Groups and Network providers, some of which are affiliated providers. Network providers enter into agreements with us to provide Covered Health Care Services to Covered Persons.

We do not provide health care services or supplies, or practice medicine. We arrange for health care providers to participate in a Network and we pay Benefits. Network providers are independent practitioners who run their own offices and facilities. Our credentialing process confirms public information about the providers' licenses and other credentials. It does not assure the quality of the services provided. We are not responsible for any act or omission of any provider.

We are not considered to be an employer for any purpose with respect to the administration or provision of benefits under the Group's Policy. We are not responsible for fulfilling any duties or obligations of an employer with respect to the Group's Policy.

The Group is solely responsible for all of the following:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of the Policy Charge to us.
- Notifying you of when the Policy ends.

When the Group purchases the Policy to provide coverage under a benefit plan governed by the *Employee Retirement Income Security Act* ("ERISA"), 29 U.S.C. §1001 et seq., we are not the plan administrator or named fiduciary of the benefit plan, as those terms are used in ERISA. If you have questions about your welfare benefit plan, you should contact the Group. If you have any questions about this statement or about your rights under ERISA, contact the nearest area office of the *Employee Benefits Security Administration, U. S. Department of Labor*.

What Is Your Relationship with Providers and Groups?

The relationship between you and any provider is that of provider and patient.

You are responsible for all of the following:

- Choosing your own provider.

- Paying, directly to your provider, any amount identified as a member responsibility, including Co-payments and any amount that exceeds the Allowed Amount, when applicable.
- Paying, directly to your provider, the cost of any non-Covered Health Care Service.
- Deciding if any provider treating you is right for you. This includes Network providers you choose and providers that they refer.
- Deciding with your provider what care you should receive.

Your provider is solely responsible for the quality of the services provided to you.

The relationship between you and the Group is that of employer and employee, Dependent or other classification as defined in the Policy.

Notice

When we provide written notice regarding administration of the Policy to an authorized representative of the Group, that notice is deemed notice to all affected Subscribers and their Enrolled Dependents. The Group is responsible for giving notice to you.

Statements by Group or Subscriber

All statements made by the Group or by a Subscriber shall, in the absence of fraud, be deemed representations and not warranties. We will not use any statement made by the Group to void the Policy after it has been in force for two years unless it is a fraudulent statement.

Do We Pay Incentives to Providers?

We pay Network providers through various types of contractual arrangements. Some of these arrangements may include financial incentives to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction and/or cost-effectiveness.
- Capitation - a group of Network providers receives a monthly payment from us for each Covered Person who selects a Network provider within the group to perform or coordinate certain health care services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.
- Bundled payments - certain Network providers receive a bundled payment for a group of Covered Health Care Services for a particular procedure or medical condition. Your Co-payment will be calculated based on the provider type that received the bundled payment. The Network providers receive these bundled payments regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment. If you receive follow-up services related to a procedure where a bundled payment is made, an additional Co-payment may not be required if such follow-up services are included in the bundled payment. You may receive some Covered Health Care Services that are not considered part of the inclusive bundled payment and those Covered Health Care Services would be subject to the applicable Co-payment as described in your *Schedule of Benefits*.

We use various payment methods to pay specific Network providers. From time to time, the payment method may change. If you have questions about whether your Network provider's contract with us includes any financial incentives, we encourage you to discuss those questions with your provider. You may also call us at the telephone number on your ID card. We can advise whether your Network provider is paid by any financial incentive, including those listed above.

Are Incentives Available to You?

Sometimes we may offer coupons, enhanced Benefits, or other incentives to encourage you to take part in various programs, including wellness programs, certain disease management programs, surveys, discount programs and/or programs to seek care in a more cost effective setting and/or from Designated Providers. In some instances, these programs may be offered in combination with a non-UnitedHealthcare entity. The decision about whether or not to take part in a program is yours alone. However, we recommend that you discuss taking part in such programs with your Physician. You can [\[visit \[benefits.surest.com\]\(https://benefits.surest.com\)\]](https://benefits.surest.com) or call the telephone number on your ID card if you have any questions.

Do We Receive Rebates and Other Payments?

We may receive rebates for certain drugs that are administered to you in your home or in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet any applicable deductible. As determined by us, we may pass a portion of these rebates on to you. When rebates are passed onto you, they may be taken into account in determining your Co-payment.

Who Interprets Benefits and Other Provisions under the Policy?

We have the final authority to do all of the following:

- Interpret Benefits under the Policy.
- Interpret the other terms, conditions, limitations and exclusions set out in the Policy, including this *Certificate*, the *Schedule of Benefits* and any Riders and/or Amendments.
- Make factual determinations related to the Policy and its Benefits.

We may assign this authority to other persons or entities that provide services in regard to the administration of the Policy.

In certain circumstances, for purposes of overall cost savings or efficiency, we may offer Benefits for services that would otherwise not be Covered Health Care Services. The fact that we do so in any particular case shall not in any way be deemed to require us to do so in other similar cases.

Who Provides Administrative Services?

We provide administrative services or, as we determine, we may arrange for various persons or entities to provide administrative services, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time as we determine. We are not required to give you prior notice of any such change, nor are we required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

Amendments to the Policy

To the extent permitted by law, we have the right, as we determine and without your approval, to change, interpret, withdraw or add Benefits or end the Policy.

Any provision of the Policy which, on its effective date, is in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which the Policy is delivered) is amended to conform to the minimum requirements of such statutes and regulations.

No other change may be made to the Policy unless it is made by an Amendment or Rider which has been signed by one of our officers and consistent with applicable notice requirements. All of the following conditions apply:

- Amendments and Riders to the Policy are effective upon the Group's next anniversary date, except as otherwise permitted by law.
- No agent has the authority to change the Policy or to waive any of its provisions.

- No one has authority to make any oral changes or amendments to the Policy.

How Do We Use Information and Records?

We may use your individually identifiable health information as follows:

- To administer the Policy and pay claims.
- To identify procedures, products, or services that you may find valuable.
- As otherwise permitted or required by law.

We may request additional information from you to decide your claim for Benefits. We will keep this information confidential. We may also use de-identified data for commercial purposes, including research, as permitted by law. More detail about how we may use or disclose your information is found in our *Notice of Privacy Practices*.

By accepting Benefits under the Policy, you authorize and direct any person or institution that has provided services to you to furnish us with all information or copies of records relating to the services provided to you. We have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Subscriber's enrollment form. We agree that such information and records will be considered confidential.

We have the right to release records concerning health care services when any of the following apply:

- Needed to put in place and administer the terms of the Policy.
- Needed for medical review or quality assessment.
- Required by law or regulation.

During and after the term of the Policy, we and our related entities may use and transfer the information gathered under the Policy in a de-identified format for commercial purposes, including research and analytic purposes. Please refer to our *Notice of Privacy Practices*.

For complete listings of your medical records or billing statements you may contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from us, we also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, as permitted by law, we will designate other persons or entities to request records or information from or related to you, and to release those records as needed. Our designees have the same rights to this information as we have.

Do We Require Examination of Covered Persons?

In the event of a question or dispute regarding your right to Benefits, we may require that a Network Physician of our choice examine you at our expense.

Is Workers' Compensation Affected?

Benefits provided under the Policy do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

[Applies when plan design includes Medicare estimating.]

[How Are Benefits Paid When You Are Medicare Eligible?]

[Benefits under the Policy are not intended to supplement any coverage provided by Medicare. Nevertheless, in some circumstances Covered Persons who are eligible for or enrolled in Medicare may also be enrolled under the Policy.]

If you are eligible for or enrolled in Medicare, please read the following information carefully.

If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under the Policy), you should enroll in and maintain coverage under both Medicare Part A and Part B. If you don't enroll and maintain that coverage, and if we are the secondary payer as described in *Section 7: Coordination of Benefits*, we will pay Benefits under the Policy as if you were covered under both Medicare Part A and Part B. As a result, you will be responsible for the costs that Medicare would have paid and you will incur a larger out-of-pocket cost.

If you are enrolled in a *Medicare Advantage* (Medicare Part C) plan on a primary basis (Medicare pays before Benefits under the Policy), you should follow all rules of that plan that require you to seek services from that plan's participating providers. When we are the secondary payer, we will pay any Benefits available to you under the Policy as if you had followed all rules of the *Medicare Advantage* plan. You will be responsible for any additional costs or reduced Benefits that result from your failure to follow these rules, and you will incur a larger out-of-pocket cost.]

Per state mandate, may not use the term "subrogation" in Georgia. Other provisions were deleted or revised to comply with state requirements.

Reimbursement

We have the right to reimbursement. References to "you" or "your" in this *Reimbursement* section shall include you, your Estate and your heirs and beneficiaries unless otherwise stated.

The right to reimbursement means that if it is alleged that any third party caused or is responsible for a Sickness or Injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to us 100% of any Benefits you receive for that Sickness or Injury. The right of reimbursement shall apply to any benefits received at any time until the rights are extinguished, resolved or waived in writing.

Reimbursement Example:

Suppose you are injured in a boating accident that is not your fault, and you receive Benefits under the Policy as a result of your injuries. In addition, you receive a settlement in a court proceeding from the individual who caused the accident. You must use the settlement funds to return to the Policy 100% of any Benefits you received to treat your injuries.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages.
- Your employer in a workers' compensation case or other matter alleging liability.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity against whom you may have any claim for professional and/or legal malpractice arising out of or connected to a Sickness or Injury you allege or could have alleged were the responsibility of any third party.
- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with us in protecting our legal and equitable rights to reimbursement in a timely manner, including, but not limited to:

- Notifying us, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable.
- Providing any relevant information requested by us.
- Signing and/or delivering such documents as we or our agents reasonably request to secure the reimbursement claim.
- Responding to requests for information about any accident or injuries.
- Making court appearances.
- Obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.
- Complying with the terms of this section.

Your failure to cooperate with us is considered a breach of contract. As such, we have the right to terminate or deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits we have paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by us due to you or your representative not cooperating with us. If we incur attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, we have the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to us.

- We have a first priority right to receive payment on any claim against any third party before you receive payment from that third party. Further, our first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- Our reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, your Estate, your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. We are not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from our recovery without our express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- Regardless of whether you have been fully compensated or made whole, we may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which we may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit our reimbursement rights.
- Benefits paid by us may also be considered to be Benefits advanced.
- If you receive any payment from any party as a result of Sickness or Injury, and we allege some or all of those funds are due and owed to us, you and/or your representative shall hold those funds in trust, either in a separate bank account in your name or in your representative's trust account.
- By participating in and accepting Benefits under the Policy, you agree that (i) any amounts recovered by you from any third party shall constitute Policy assets (to the extent of the amount of Benefits provided on behalf of the Covered Person), (ii) you and your representative shall be fiduciaries of the Policy (within the meaning of ERISA) with respect to such amounts, and (iii) you shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by us to enforce its reimbursement rights.

- Our right to recovery will not be reduced due to your own negligence.
- By participating in and accepting Benefits from us, you agree to assign to us any benefits, claims or rights of recovery you have under any automobile policy - including no-fault benefits, PIP benefits and/or medical payment benefits - other coverage or against any third party, to the full extent of the Benefits we have paid for the Sickness or Injury. By agreeing to provide this assignment in exchange for participating in and accepting benefits, you acknowledge and recognize our right to assert, pursue and recover on any such claim, whether or not you choose to pursue the claim, and you agree to this assignment voluntarily.
- We may, at our option, take necessary and appropriate action to preserve our rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical benefits you receive for the Sickness or Injury out of any settlement, judgment or other recovery from any third party considered responsible; and filing suit in your name or your Estate's name, which does not obligate us in any way to pay you part of any recovery we might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund Benefits as required under the terms of the Policy is governed by a six-year statute of limitations.
- You may not accept any settlement that does not fully reimburse us, without our written approval.
- We have the final authority to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries. In the case of your death our right of reimbursement shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages. The obligation to reimburse us is not extinguished by a release of claims or settlement agreement of any kind.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse us for 100% of our interest unless we provide written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by any third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this reimbursement clause shall apply to that claim.
- If any third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under the Policy, the provisions of this section continue to apply, even after you are no longer covered.
- In the event that you do not abide by the terms of the Policy pertaining to reimbursement, we may terminate Benefits to you, your dependents or the subscriber, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits we have paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by us due to your failure to abide by the terms of the Policy. If we incur attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, we have the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to us.
- We and all Administrators administering the terms and conditions of the Policy's reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of our final authority to (1) construe and enforce the terms of the Policy's reimbursement rights and (2) make determinations with respect to the reimbursements owed to us.

- We agree that our right of recovery shall be limited only to the recovery of Benefits paid for covered medical services under the Policy and shall not include non-medical items. Money received for future medical care or pain and suffering may not be recovered.

When Do We Receive Refunds of Overpayments?

If we pay Benefits for expenses incurred on your account, you, or any other person or organization that was paid, must make a refund to us if any of the following apply:

- All or some of the expenses were not paid or did not legally have to be paid by you.
- All or some of the payment we made exceeded the Benefits under the Policy.
- All or some of the payment was made in error.

The refund equals the amount we paid in excess of the amount we should have paid under the Policy. If the refund is due from another person or organization, you agree to help us get the refund when requested.

If the refund is due from you and you do not promptly refund the full amount, we may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, your future Benefits that are payable under the Policy. If the refund is due from a person or organization other than you, we may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part; (i) future Benefits that are payable in connection with services provided to other Covered Persons under the Policy; or (ii) future Benefits that are payable in connection with services provided to persons under other plans for which we make payments, pursuant to a transaction in which our overpayment recovery rights are assigned to such other plans in exchange for such plans' remittance of the amount of the reallocated payment.

The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future benefits.

Is There a Limitation of Action?

You cannot bring any legal action against us to recover reimbursement until you have completed all the steps in the appeal process described in *Section 6: Questions, Complaints and Appeals*. After completing that process, if you want to bring a legal action against us you must do so within three years of the date we notified you of our final decision on your appeal or you lose any rights to bring such an action against us.

What Is the Entire Policy?

The Policy, this *Certificate*, the *Schedule of Benefits*, the Group's *Application* and any Riders and/or Amendments, make up the entire Policy that is issued to the Group.

Section 9: Defined Terms

[Adverse Health Factor - a medical condition that coincides with the services described under *Conditional Coverage in Section 1: Covered Health Care Services*, and to which the Covered Person must self-attest that they have as part of the election and activation process.]

Air Ambulance - medical transport by rotary wing Air Ambulance or fixed wing Air Ambulance as defined in 42 CFR 414.605.

Allowed Amounts - for Covered Health Care Services, incurred while the Policy is in effect, Allowed Amounts are determined by us or determined as required by law as shown in the *Schedule of Benefits*.

Allowed Amounts are determined in accordance with our reimbursement policy guidelines or as required by law. We develop these guidelines, as we determine, after review of all provider billings in accordance with one or more of the following methodologies:

- As shown in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that we accept.

Alternate Facility - a health care facility that is not a Hospital. It provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Emergency Health Care Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

It may also provide Mental Health Care Services or Substance-Related and Addictive Disorders Services on an outpatient or inpatient basis.

Amendment - any attached written description of added or changed provisions to the Policy. It is effective only when signed by us. It is subject to all conditions, limitations and exclusions of the Policy, except for those that are specifically amended.

Ancillary Services - items and services provided by out-of-Network Physicians at a Network facility that are any of the following:

- Related to emergency medicine, anesthesiology, pathology, radiology, and neonatology;
- Provided by assistant surgeons, hospitalists, and intensivists;
- Diagnostic services, including radiology and laboratory services, unless such items and services are excluded from the definition of Ancillary Services as determined by the Secretary;
- Provided by such other specialty practitioners as determined by the Secretary; and
- Provided by an out-of-Network Physician when no other Network Physician is available.

Annual Deductible - the total of the Allowed Amount or the Recognized Amount, when applicable, you must pay for Covered Health Care Services per year before we will begin paying for Benefits. It does not include any amount that exceeds Allowed Amounts or the Recognized Amounts, when applicable. The *Schedule of Benefits* will tell you if your plan is subject to payment of an Annual Deductible and how it applies.

[Applies when plan design includes benefits for infertility services.]

[Assisted Reproductive Technology (ART)] - the term for procedures involving the manipulation of human reproductive materials (such as sperm, eggs and/or embryos) to achieve Pregnancy. Examples of such procedures are:

- In vitro fertilization (IVF).
- Gamete intrafallopian transfer (GIFT).
- Pronuclear stage tubal transfer (PROST).
- Tubal embryo transfer (TET).
- Zygote intrafallopian transfer (ZIFT).]

Autism Spectrum Disorder - means autism spectrum disorders as defined by the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders*.

Benefits - your right to payment for Covered Health Care Services that are available under the Policy.

Cellular Therapy - administration of living whole cells into a patient for the treatment of disease.

Congenital Anomaly - a physical developmental defect that is present at the time of birth, and that is identified within the first twelve months of birth.

Convenience Care Clinic - a category of walk-in clinic located in retail stores, supermarkets and pharmacies that treat uncomplicated minor Sickness and provide preventive care services.

Co-payment - the charge, stated as a set dollar amount, that you are required to pay for Covered Health Care Services.

Please note that for Covered Health Care Services, you are responsible for paying the lesser of the following:

- The Co-payment.
- The Allowed Amount or the Recognized Amount when applicable.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function.

Covered Health Care Service(s) - health care services, including supplies or Pharmaceutical Products, which we determine to be all of the following:

- Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms.
- Medically Necessary.
- Described as a Covered Health Care Service in this *Certificate* under *Section 1: Covered Health Care Services* and in the *Schedule of Benefits*.
- Not excluded in this *Certificate* under *Section 2: Exclusions and Limitations*.

Covered Person - the Subscriber or a Dependent, but this term applies only while the person is enrolled under the Policy. We use "you" and "your" in this *Certificate* to refer to a Covered Person.

Custodial Care - services that are any of the following non-Skilled Care services:

- Non health-related services such as help with daily living activities. Examples include eating, dressing, bathing, transferring and ambulating.
- Health-related services that can safely and effectively be performed by trained non-medical personnel and are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function, as opposed to improving that function to an extent that might allow for a more independent existence.

Definitive Drug Test - test to identify specific medications, illicit substances and metabolites and is qualitative or quantitative to identify possible use or non-use of a drug.

[Options related to dependent eligibility are variable based upon the group's benefit plan eligibility rules.]

Dependent - the Subscriber's legal spouse or a child of the Subscriber or the Subscriber's spouse. *[All references to the spouse of a Subscriber shall include a Domestic Partner, except for the purpose of coordinating Benefits with Medicare.]* As described in *Section 3: When Coverage Begins*, the Group determines who is eligible to enroll and who qualifies as a Dependent. The term "child" includes:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed in foster care.
- A child placed for adoption.
- A child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse.
- A child for whom health care coverage is required through a *Qualified Medical Child Support Order* or other court or administrative order. The Group is responsible for determining if an order meets the criteria of a *Qualified Medical Child Support Order*.

The following conditions apply:

- A Dependent includes a child listed above under age *[26 - 30]*.
- A child is no longer eligible as a Dependent on the last day of the *[month][year]* following the date the child reaches age *[26 - 30]* except as provided in *Section 4: When Coverage Ends* under *Coverage for a Disabled Dependent Child*.

[A child who meets the requirements set forth above ceases to be eligible as a Dependent on the last day of the [month] [year] following the date the child reaches age [26 - 30].]

The Subscriber must reimburse us for any Benefits paid during a time a child did not satisfy these conditions.

[A Dependent does not include anyone who is also enrolled as a Subscriber. No one can be a Dependent of more than one Subscriber.]

[Designated Dispensing Entity - a pharmacy or other provider that has entered into an agreement with us, or with an organization contracting on our behalf, to provide Pharmaceutical Products for the treatment of specified diseases or conditions. Not all Network pharmacies or Network providers are Designated Dispensing Entities.]

Designated Provider - a provider and/or facility that has entered into an agreement with us, or with an organization contracting on our behalf, to provide Covered Health Care Service for the treatment of specific diseases or conditions.

A Designated Provider may or may not be located within your geographic area. Not all Network Hospitals or Network Physicians are Designated Providers.

You can find out if your provider is a Designated Provider by *[visiting benefits.surest.com]* or *[calling the telephone number on your ID card]*.

Designated Virtual Network Provider - a provider or facility that has entered into an agreement with us, or with an organization contracting on our behalf, to deliver Covered Health Care Services through live audio with video technology *[or audio only]* *[, and/or through federally compliant secure messaging applications]*.

[Domestic Partner - a person of the [opposite sex] [same sex] [opposite or same sex] with whom the Subscriber has a Domestic Partnership.]

[Domestic Partnership - a relationship between a Subscriber and one other person of the [opposite sex] [same sex] [opposite or same sex]. All of the following requirements apply to both persons. They must:

- Not be related by blood or a degree of closeness that is prohibited by law in the state of residence.
- Not be currently married to, or a Domestic Partner of, another person under either statutory or common law.
- Share the same permanent residence and the common necessities of life.
- Be at least 18 years of age.
- Be mentally able to consent to contract.

^[1]Applies if group requires documentation of financial interdependence.]

- They must be financially interdependent [¹and they have furnished documents to support at least two of the following conditions of such financial interdependence:
 - [They have a single dedicated relationship of at least [6 - 18] months.]
 - [They have joint ownership of a residence.]
 - [They have at least two of the following:
 - ♦ A joint ownership of an automobile.
 - ♦ A joint checking, bank or investment account.
 - ♦ A joint credit account.
 - ♦ A lease for a residence identifying both partners as tenants.
 - ♦ A will and/or life insurance policies which designates the other as primary beneficiary].]

^[2]Include if group requires signed affidavit.]

[²The Subscriber and Domestic Partner must jointly sign the required affidavit of Domestic Partnership.]]

Durable Medical Equipment (DME) - medical equipment that is all of the following:

- Ordered or provided by a Physician for outpatient use primarily in a home setting.
- Used for medical purposes.
- Not consumable or disposable except as needed for the effective use of covered DME.
- Not of use to a person in the absence of a disease or disability.
- Serves a medical purpose for the treatment of a Sickness or Injury.
- Primarily used within the home.

Eligible Person - an employee of the Group or other person connected to the Group who meets the eligibility requirements shown in both the Group's *Application* and the Policy. [\[An Eligible Person must live within the United States.\]](#)

Emergency - a **physical or mental** condition manifesting itself by acute symptoms of sufficient severity (including severe pain), **regardless of the initial, interim, final, or other diagnoses that are given**, so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the Covered Person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency Health Care Services - with respect to an Emergency:

- An appropriate medical screening exam (as required under section 1867 of the *Social Security Act* or as would be required under such section if such section applied to an Independent Freestanding Emergency Department) that is within the capability of the emergency department of a Hospital, or an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency, and
- Such further medical exam and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital or an Independent Freestanding Emergency Department, as applicable, as are required under section 1867 of the *Social Security Act*, or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further exam or treatment is provided). For the purpose of this definition, "to stabilize" has the meaning as given such term in section 1867(e)(3) of the *Social Security Act* (42 U.S.C. 1395dd(e)(3)).
- Emergency Health Care Services include items and services otherwise covered under the Policy when provided by an out-of-Network provider or facility (regardless of the department of the Hospital in which the items and services are provided) after the patient is stabilized and as part of outpatient observation, or an Inpatient Stay or outpatient stay that is connected to the original Emergency, unless each of the following conditions are met:
 - a) The attending Emergency Physician or treating provider determines the patient is able to travel using nonmedical transportation or non-Emergency medical transportation to an available Network provider or facility located within a reasonable distance taking into consideration the patient's medical condition.
 - b) The provider furnishing the additional items and services satisfies notice and consent criteria in accordance with applicable law.
 - c) The patient is in such a condition to receive information as stated in b) above and to provide informed consent in accordance with applicable law.
 - d) The provider or facility satisfies any additional requirements or prohibitions as may be imposed by state law.
 - e) Any other conditions as specified by the Secretary.

The above conditions do not apply to unforeseen or urgent medical needs that arise at the time the service is provided regardless of whether notice and consent criteria has been satisfied.

Enrolled Dependent - a Dependent who is properly enrolled under the Policy.

E-Visit - services provided by a Physician without face to face interaction through electronic (including telephonic) communication through an online portal or telephone. Examples are emails, texts, or patient portal message.

Experimental or Investigational Service(s) - medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications, or devices that, at the time we make a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified as appropriate for proposed use in any of the following:
 - *AHFS Drug Information (AHFS DI)* under therapeutic uses section;
 - *Elsevier Gold Standard's Clinical Pharmacology* under the indications section;

- *DRUGDEX System by Micromedex* under the therapeutic uses section and has a strength recommendation rating of class I, class IIa, or class IIb; or
- *National Comprehensive Cancer Network (NCCN)* drugs and biologics compendium category of evidence 1, 2A, or 2B.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase I, II or III clinical trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.
- Only obtainable, with regard to outcomes for the given indication, within research settings.

Exceptions:

- Clinical trials for which Benefits are available as described under *Clinical Trials* in *Section 1: Covered Health Care Services*.
- Services subject to a *Surest Coverage with Evidence Development Policy (CED Policy reference)*.
- We may, as we determine, consider an otherwise Experimental or Investigational Service to be a Covered Health Care Service for that Sickness or condition if:
 - You are not a participant in a qualifying clinical trial, as described under *Clinical Trials* in *Section 1: Covered Health Care Services*; and
 - You have a Sickness or condition that is likely to cause death within one year of the request for treatment.

Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Gene Therapy - therapeutic delivery of nucleic acid (DNA or RNA) into a patient's cells as a drug to treat a disease.

[Genetic Counseling - counseling by a qualified clinician that includes:

- Identifying your potential risks for suspected genetic disorders;
- An individualized discussion about the benefits, risks and limitations of Genetic Testing to help you make informed decisions about Genetic Testing; and
- Interpretation of the Genetic Testing results in order to guide health decisions.

Certified genetic counselors, medical geneticists and physicians with a professional society's certification that they have completed advanced training in genetics are considered qualified clinicians when Covered Health Care Services for Genetic Testing require Genetic Counseling.]

Genetic Testing - exam of blood or other tissue for changes in genes (DNA or RNA) that may indicate an increased risk for developing a specific disease or disorder, or provide information to guide the selection of treatment of certain diseases, including cancer.

Gestational Carrier - a female who becomes pregnant by having a fertilized egg (embryo) implanted in her uterus for the purpose of carrying the fetus to term for another person. The Gestational Carrier does not provide the egg and is therefore not biologically related to the child.

Group - the employer, or other defined or otherwise legally established group, to whom the Policy is issued.

Home Health Agency - a program or organization authorized by law to provide health care services in the home.

Hospital - an institution that is operated as required by law and that meets both of the following:

- It is mainly engaged in providing inpatient health care services, for the short term care and treatment of injured or sick persons. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- It has 24-hour nursing services.

A Hospital is not mainly a place for rest, Custodial Care or care of the aged. It is not a nursing home, convalescent home or similar institution.

[Iatrogenic Infertility - an impairment of fertility by surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes.]

Independent Freestanding Emergency Department - a health care facility that:

- Is geographically separate and distinct and licensed separately from a Hospital under applicable state law; and
- Provides Emergency Health Care Services.

Initial Enrollment Period - the first period of time when Eligible Persons may enroll themselves and their Dependents under the Policy.

Injury - damage to the body, including all related conditions and symptoms.

Inpatient Rehabilitation Facility - any of the following that provides inpatient rehabilitation health care services (including physical therapy, occupational therapy and/or speech therapy), as authorized by law:

- A long term acute rehabilitation center,
- A Hospital, or
- A special unit of a Hospital designated as an Inpatient Rehabilitation Facility.

Inpatient Stay - a continuous stay that follows formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Behavioral Therapy (IBT) - outpatient Mental Health Care Services that aim to reinforce adaptive behaviors, reduce maladaptive behaviors and improve the mastery of functional age appropriate skills in people with Autism Spectrum Disorders. The most common IBT is *Applied Behavior Analysis (ABA)*.

Intensive Outpatient Treatment - a structured outpatient treatment program.

- For Mental Health Care Services the program may be freestanding or Hospital-based and provides services for at least three hours per day, two or more days per week.
- For Substance-Related and Addictive Disorders Services, the program provides nine to nineteen hours per week of structured programming for adults and six to nineteen hours for adolescents, consisting primarily of counseling and education about addiction related and mental health problems.

Intermittent Care - skilled nursing care that is provided either:

- Fewer than seven days each week.
- Fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in certain circumstances when the need for more care is finite and predictable.

Level 1 Procedure - category of minor procedures typically performed in an outpatient office setting.

Level 2 Procedure - category of minor surgeries and procedures or services typically performed in an outpatient Hospital setting.

Level 3 Procedure - category of major surgeries and procedures typically performed in an outpatient or inpatient Hospital setting.

Level 4 Procedure - category of major surgeries typically performed in an inpatient Hospital setting.

Level 5 Procedure - category of more complex major surgeries typically performed in an inpatient Hospital setting.

Manipulative Treatment (adjustment) - a form of care provided by chiropractors and osteopaths for diagnosed muscle, nerve and joint problems. Body parts are moved either by hands or by a small instrument to:

- Restore or improve motion.
- Reduce pain.
- Increase function.

Medically Necessary - health care services, that are all of the following as determined by us or our designee.

- In accordance with *Generally Accepted Standards of Care*.
- Clinically appropriate, in terms of type, frequency, extent, service site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s), service site or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.
- Or, are subject to *Bind Coverage with Evidence Development Policy (CED Policy)*.

Generally Accepted Standards of Care are evidence based independent standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties. Valid, evidence based sources reflecting generally accepted standards of care include credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or nationally recognized clinical practice guidelines may be considered. We have the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be determined by us.

We develop and maintain clinical policies that describe the *Generally Accepted Standards of Care* scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. [[These clinical policies (as developed by us and revised from time to time), are available to Covered Persons through [MyBind.com] or by calling the telephone number on your ID card.] [They are [also] available to Physicians and other health care professionals on [MyBind.com].]]

[[These clinical policies (as developed by us and revised from time to time), are available to Covered Persons through [benefits.surest.com] or by calling the telephone number on your ID card.] [They are [also] available to Physicians and other health care professionals on [benefits.surest.com].]]

Medicare - Parts A, B, C and D of the insurance program established by Title XVIII, *United States Social Security Act*, as amended by 42 U.S.C. Sections 1394, *et seq.* and as later amended.

Mental Health Care Services - services for the diagnosis and treatment of those mental health or psychiatric categories that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or the *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical*

Manual of the American Psychiatric Association does not mean that treatment for the condition is a Covered Health Care Service.

Mental Health/Substance-Related and Addictive Disorders Designee - the organization or individual, designated by us, that provides or arranges Mental Health Care Services and Substance-Related and Addictive Disorders Services.

Mental Illness - those mental health or psychiatric diagnostic categories that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Care Service.

[*Applies when the Shared Savings Program is included.*]

[*"Shared Savings Program" is bracketed for possible name change.*]

Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with us or with our affiliate to participate in our Network. This does not include those providers who have agreed to discount their charges for Covered Health Care Services [*by way of their participation in the [Shared Savings Program]*]. Our affiliates are those entities affiliated with us through common ownership or control with us or with our ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Care Services, but not all Covered Health Care Services, or to be a Network provider for only some of our products. In this case, the provider will be a Network provider for the Covered Health Care Services and products included in the participation agreement and an out-of-Network provider for other Covered Health Care Services and products. The participation status of providers will change from time to time.

Network Benefits - the description of how Benefits are paid for Covered Health Care Services provided by Network providers. The *Schedule of Benefits* will tell you if your plan offers Network Benefits and how Network Benefits apply.

New Pharmaceutical Product - a Pharmaceutical Product or new dosage form of a previously approved Pharmaceutical Product. It applies to the period of time starting on the date the Pharmaceutical Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ends on the earlier of the following dates:

- The date as determined by us or our designee, which is based on when the Pharmaceutical Product is reviewed and when utilization management strategies are implemented.
- December 31st of the following calendar year.

Non-Medical 24-Hour Withdrawal Management - an organized residential service, including those defined in the *American Society of Addiction Medicine (ASAM)* criteria providing 24-hour supervision, observation, and support for patients who are intoxicated or experiencing withdrawal, using peer and social support rather than medical and nursing care.

[*Open Enrollment Period* - a period of time, after the Initial Enrollment Period, when Eligible Persons may enroll themselves and Dependents under the Policy. The Group sets the period of time that is the Open Enrollment Period.]

Out-of-Network Benefits - the description of how Benefits are paid for Covered Health Care Services provided by out-of-Network providers. The *Schedule of Benefits* will tell you if your plan offers Out-of-Network Benefits and how Out-of-Network Benefits apply.

Out-of-Pocket Limit - the maximum amount you pay every year. The *Schedule of Benefits* will tell you how the Out-of-Pocket Limit applies.

Partial Hospitalization/Day Treatment - a structured ambulatory program. The program may be freestanding or Hospital-based and provides services for at least 20 hours per week.

Pharmaceutical Product(s) - U.S. Food and Drug Administration (FDA)-approved prescription medications or products administered in connection with a Covered Health Care Service by a Physician.

Physician - any *Doctor of Medicine* or *Doctor of Osteopathy* who is properly licensed and qualified by law.

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that we describe a provider as a Physician does not mean that Benefits for services from that provider are available to you under the Policy.

Policy - the entire agreement issued to the Group that includes all of the following:

- *Group Policy.*
- *Certificate.*
- *Schedule of Benefits.*
- *Group Application.*
- *Riders.*
- *Amendments.*

These documents make up the entire agreement that is issued to the Group.

Policy Charge - the sum of the Premiums for all Covered Persons enrolled under the Policy.

Pregnancy - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with Pregnancy.

Preimplantation Genetic Testing (PGT) - a test performed to analyze the DNA from oocytes or embryos for human leukocyte antigen (HLA) typing or for determining genetic abnormalities. These include:

- PGT-M: For monogenic disorder (formerly single-gene PGD).
- PGT-SR: For structural rearrangements (formerly chromosomal PGD).

Premium - the periodic fee required for each Subscriber and each Enrolled Dependent, in accordance with the terms of the Policy.

Presumptive Drug Test - test to determine the presence or absence of drugs or a drug class in which the results are indicated as negative or positive result.

Primary Care Physician - a Physician who has a majority of his or her practice in general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Private Duty Nursing - nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or home setting when any of the following are true:

- Services exceed the scope of Intermittent Care in the home.
- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or home-care basis, whether the service is skilled or non-skilled independent nursing.
- Skilled nursing resources are available in the facility.
- The Skilled Care can be provided by a Home Health Agency on a per visit basis for a specific purpose.

Recognized Amount - the amount which the Co-payment and any applicable deductible is based on for the below Covered Health Care Services when provided by out-of-Network providers:

- Out-of-Network Emergency Health Care Services.
- Non-Emergency Covered Health Care Services received at certain Network facilities by out-of-Network Physicians, when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section 2799B-2(d) of the *Public Health Service Act*. For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in 1861(e) of the *Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in 1861(mm)(1) of the *Social Security Act*), an ambulatory surgical center described in section 1833(i)(1)(A) of the *Social Security Act*, and any other facility specified by the Secretary.

The amount is based on one of the following in the order listed below as applicable:

- 1) An *All Payer Model Agreement* if adopted,
- 2) State law, or
- 3) The lesser of the qualifying payment amount as determined under applicable law, or the amount billed by the provider or facility.

The Recognized Amount for Air Ambulance services provided by an out-of-Network provider will be calculated based on the lesser of the qualifying payment amount as determined under applicable law or the amount billed by the Air Ambulance service provider.

Note: Covered Health Care Services that use the Recognized Amount to determine your cost sharing may be higher or lower than if cost sharing for these Covered Health Care Services were determined based upon an Allowed Amount.

Remote Physiologic Monitoring - the automatic collection and electronic transmission of patient physiologic data that are analyzed and used by a licensed Physician or other qualified health care professional to develop and manage a plan of treatment related to a chronic and/or acute health illness or condition. The plan of treatment will provide milestones for which progress will be tracked by one or more Remote Physiologic Monitoring devices. Remote Physiologic Monitoring must be ordered by a licensed Physician or other qualified health care professional who has examined the patient and with whom the patient has an established, documented, and ongoing relationship. Remote Physiologic Monitoring may not be used while the patient is inpatient at a Hospital or other facility. Use of multiple devices must be coordinated by one Physician.

Residential Treatment - treatment in a facility established and operated as required by law, which provides Mental Health Care Services or Substance-Related and Addictive Disorders Services. It must meet all of the following requirements:

- Provides a program of treatment, under the active participation and direction of a Physician.
- Offers organized treatment services that feature a planned and structured regimen of care in a 24-hour setting and provides at least the following basic services:
 - Room and board.
 - Evaluation and diagnosis.
 - Counseling.
 - Referral and orientation to specialized community resources.

A Residential Treatment facility that qualifies as a Hospital is considered a Hospital.

Rider - any attached written description of additional Covered Health Care Services not described in this *Certificate*. Covered Health Care Services provided by a Rider may be subject to payment of additional Premiums. Riders are effective only when signed by us and are subject to all conditions, limitations and exclusions of the Policy except for those that are specifically amended in the Rider.

Secretary - as that term is applied in the *No Surprises Act* of the *Consolidated Appropriations Act (P.L. 116-260)*.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Care Service, the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is Medically Necessary, or when a Semi-private Room is not available.

[Applies when the Shared Savings Program is included.]

["Shared Savings Program" is bracketed for possible name change.]

[[Shared Savings Program] - a program in which we may obtain a discount to an out-of-Network provider's billed charges. This discount is usually based on a schedule previously agreed to by the out-of-Network provider and a third party vendor. When this program applies, the out-of-Network provider's billed charges will be discounted. Our policy provisions or administrative practices may supersede the scheduled rate. This means, when contractually permitted, we may pay the lesser of the [Shared Savings Program] discount or an amount determined by us, such as:

- A percentage of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market.
- An amount determined based on available data resources of competitive fees in that geographic area.
- A fee schedule established by a third party vendor.
- A negotiated rate with the provider.
- The median amount negotiated with Network providers for the same or similar service.

In this case, the out-of-Network provider may bill you for the difference between the billed amount and the rate determined by us. If this happens, you should call the telephone number shown on your ID card for assistance with resolving that issue. [Shared Savings Program] providers are not Network providers and are not credentialed by us.]

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this *Certificate* includes Mental Illness or substance-related and addictive disorders, regardless of the cause or origin of the Mental Illness or substance-related and addictive disorder.

Skilled Care - skilled nursing, skilled teaching, skilled habilitation and skilled rehabilitation services when all of the following are true:

- Must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- Ordered by a Physician.
- Not delivered for the purpose of helping with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- Requires clinical training in order to be delivered safely and effectively.
- Not Custodial Care, which can safely and effectively be performed by trained non-medical personnel.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law.

Specialist - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Subscriber - an Eligible Person who is properly enrolled under the Policy. The Subscriber is the person (who is not a Dependent) on whose behalf the Policy is issued to the Group.

Substance-Related and Addictive Disorders Services - services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current edition of the

International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association. The fact that a disorder is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Care Service.

Surrogate - a female who becomes pregnant usually by artificial insemination or transfer of a fertilized egg (embryo) for the purpose of carrying the fetus for another person.

Telehealth/Telemedicine - live, interactive audio with visual transmissions [,and/or transmissions through federally compliant secure messaging applications] of a Physician-patient encounter from one site to another using telecommunications technology. The site may be a CMS defined originating facility or another location such as a Covered Person's home or place of work. Telehealth/Telemedicine does not include virtual care services provided by a Designated Virtual Network Provider.

Total Disability or Totally Disabled - a Subscriber's inability to perform all of the substantial and material duties of his or her regular employment or occupation; and a Dependent's inability to perform the normal activities of a person of like age and sex.

Transitional Living - Mental Health Care Services and Substance-Related and Addictive Disorders Services provided through facilities, group homes and supervised apartments which provide 24-hour supervision, including those defined in the *American Society of Addiction Medicine (ASAM)* criteria, and are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. They provide stable and safe housing, an alcohol/drug-free environment and support for recovery. They may be used as an addition to ambulatory treatment when it doesn't offer the intensity and structure needed to help you with recovery.
- Supervised living arrangements which are residences such as facilities, group homes and supervised apartments. They provide stable and safe housing and the opportunity to learn how to manage activities of daily living. They may be used as an addition to treatment when it doesn't offer the intensity and structure needed to help you with recovery.

Unproven Service(s) - services, including medications and devices, regardless of *U.S. Food and Drug Administration (FDA)* approval, that are not determined to be effective for treatment of the medical condition or not determined to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies from more than one institution. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

We have a process by which we compile and review clinical evidence with respect to certain health care services. From time to time, we issue medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. [\[You can view these policies at benefits.surest.com\].](https://benefits.surest.com/)

Please note:

- If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, as we determine, consider an otherwise Unproven Service to be a Covered Health Care Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Urgent Care Center - a facility that provides Covered Health Care Services that are required to prevent serious deterioration of your health. These services are required as a result of an unforeseen Sickness, Injury, or the onset of sudden or severe symptoms.

[Section 10: Outpatient Prescription Drug Benefits]

[NOTE: The Coordination of Benefits provision in *Section 7: Coordination of Benefits* applies to Prescription Drug Products. Benefits for Prescription Drug Products will be coordinated with those of any other health plan in the same manner as Benefits for Covered Health Care Services.]

[NOTE: The Coordination of Benefits provision in *Section 7: Coordination of Benefits* does not apply to Prescription Drug Products. Benefits for Prescription Drug Product will not be coordinated with those of any other health coverage plan.]

[NOTE: The Coordination of Benefits provision in *Section 7: Coordination of Benefits* does not apply to Prescription Drug Products, except that Benefits for Prescription Drug Products will be coordinated with prescription drug benefits provided under Medicare [Part B] [Part D] [Parts B and D].]

[Coverage Policies and Guidelines]

Our Pharmacy and Therapeutics (P&T) Committee makes tier placement changes on our behalf. The P&T Committee places *FDA*-approved Prescription Drug Product into tiers by considering a number of factors including clinical and economic factors. Clinical factors may include review of the place in therapy or use as compared to other similar product or services, site of care, relative safety or effectiveness of the Prescription Drug Product, as well as if certain supply limits or prior authorization requirements should apply. Economic factors may include the Prescription Drug Product's total cost including any rebates and evaluations of the cost effectiveness of the Prescription Drug Product.

Some Prescription Drug Products are more cost effective for treating specific conditions as compared to others; therefore, a Prescription Drug Product may be placed on multiple tiers according to the condition for which the Prescription Drug Product was prescribed to treat, or according to whether it was prescribed by a Specialist.

We may, from time to time, change the placement of a Prescription Drug Product among the tiers. These changes generally will happen quarterly, but no more than six times per calendar year. These changes may happen without prior notice to you.

When considering a Prescription Drug Product for tier placement, the P&T Committee reviews clinical and economic factors regarding Covered Persons as a general population. Whether a particular Prescription Drug Product is appropriate for you is a determination that is made by you and your prescribing Physician.

NOTE: The tier placement of a Prescription Drug Product may change, from time to time, based on the process described above. As a result of such changes, you may be required to pay more or less for that Prescription Drug Product. Please [visit benefits.surest.com] [or] [call the telephone number on your ID card] for the most up-to-date tier placement.

Identification Card (ID Card) - Network Pharmacy

You must either show your Surest ID card at the time you obtain your Prescription Drug Product at a Network Pharmacy or you must provide the Network Pharmacy with identifying information that can be verified by us during regular business hours.

If you don't show your Surest ID card or provide verifiable information at a Network Pharmacy, you must pay the Usual and Customary Charge for the Prescription Drug Product at the pharmacy.

You may seek reimbursement from us as described in *Section 5: How to File a Claim*. When you submit a claim on this basis, you may pay more because you did not verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Co-payment and Ancillary Charge.

Submit your claim to:

[Navitus Health Solutions, LLC
P.O. Box 999
Appleton, WI 54912-0999]

Designated Pharmacies

If you require certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products.

If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from a Designated Pharmacy, no Benefit will be paid for that Prescription Drug Product.

[Smart Fill Program - Split Fill]

Certain Specialty Prescription Drug Products may be dispensed by the Designated Pharmacy in 15-day supplies up to 90 days and at a pro-rated Co-payment. You will receive a 15-day supply of their Specialty Prescription Drug Product to find out if you will tolerate the Specialty Prescription Drug Product prior to purchasing a full supply. The Designated Pharmacy will contact you each time prior to dispensing the 15-day supply to confirm if you are tolerating the Specialty Prescription Drug Product. You may find a list of Specialty Prescription Drug Products included in the *Smart Fill Program*, by [visiting benefits.surest.com] [or] [calling the telephone number on your ID card].]

[When Do We Limit Selection of Pharmacies?

If we determine that you may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, your choice of Network Pharmacies may be limited. If this happens, we may require you to choose one Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the chosen Network Pharmacy. If you don't make a choice within 30 days of the date we notify you, we will choose a Network Pharmacy for you.]

Rebates and Other Payments

We may receive rebates for certain drugs included on the Prescription Drug List. As determined by us, we may pass a portion of these rebates on to you. When rebates are passed on to you, they may be taken into account in determining your Co-payment.

We, and a number of our affiliated entities, conduct business with pharmaceutical manufacturers. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this *Outpatient Prescription Drug Benefit*. We are not required to pass on to you, and do not pass on to you, such amounts.

Coupons, Incentives and Other Communications

At various times, we may send mailings or provide other communications to you, your Physician, or your pharmacy that communicate a variety of messages, including information about Prescription and non-prescription Drug Products. These communications may include offers that enable you, as you determine, to purchase the described product at a discount. In some instances, non-UnitedHealthcare entities may support and/or provide content for these communications and offers. Only you and your Physician can determine whether a change in your Prescription and/or non-prescription Drug regimen is appropriate for your medical condition.

[Variable Co-payment Program]

[Certain Specialty Prescription Drug Products are eligible for coupons or offers from pharmaceutical manufacturers or affiliates that may reduce the cost for your Prescription Drug Product. We may help you determine whether your Specialty Prescription Drug Product is eligible for this reduction. If you redeem a

coupon from a pharmaceutical manufacturer or affiliate, your Co-payment and/or Co-insurance may vary. Please contact [www.myuhc.com] or the telephone number on your ID card for an available list of Specialty Prescription Drug Products. If you choose not to participate, you will pay the Co-payment or Co-insurance as described in the *Outpatient Prescription Drug Schedule of Benefits*.

The amount of the coupon will not count toward any applicable deductible or out-of-pocket limits.]

Special Programs

We may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens, and/or taking part in health management programs. You may access information on these programs by [visiting [benefits.surest.com]] [or] [calling the telephone number on your ID card].

Maintenance Medication Program

If you require certain Maintenance Medications, we may direct you to the mail order Network Pharmacy to obtain those Maintenance Medications.

Prescription Drug Products Prescribed by a Specialist

You may receive an enhanced or reduced Benefit, or no Benefit, based on whether the Prescription Drug Product was prescribed by a Specialist. You may access information on which Prescription Drug Products are subject to Benefit enhancement, reduction or no Benefit by [visiting [benefits.surest.com]] [or] [calling the telephone number on your ID card].

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy and are subject to Co-payments and other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is placed. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for applicable Co-payments.

[Benefits for contraceptives are variable by plan design.]

[¹Applies to plan designs that include closed-panel benefits.]

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Care Service [or is prescribed to prevent conception[, however this does not apply to emergency contraceptives]]. [¹Benefits are provided only when the Prescription Order or Refill has been issued by a Network Physician or other Network provider.]

Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products.

If you require Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Specialty Prescription Drug Products.

If you are directed to a Designated Pharmacy and you choose not to obtain your Specialty Prescription Drug Product from a Designated Pharmacy, no Benefit will be paid for that Specialty Prescription Drug Product.

Please see *Defined Terms* for a full description of Specialty Prescription Drug Product and Designated Pharmacy.

The *Outpatient Prescription Drug Schedule of Benefits* will tell you how Specialty Prescription Drug Product supply limits apply.

Prescription Drugs from a Retail Network Pharmacy

Benefits are provided for Prescription Drug Products dispensed by a retail Network Pharmacy.

The *Outpatient Prescription Drug Schedule of Benefits* will tell you how retail Network Pharmacy supply limits apply.

[Include when plan design supports a value/narrow or limited pharmacy network.]

[This Benefit offers limited Network Pharmacy providers. You can confirm that your pharmacy is a Network Pharmacy by [visiting [benefits.surest.com]] [or] [calling the telephone number on your ID card].]

Prescription Drug Products from a Mail Order Network Pharmacy

Benefits are provided for certain Prescription Drug Products dispensed by a mail order Network Pharmacy.

The *Outpatient Prescription Drug Schedule of Benefits* will tell you how mail order Network Pharmacy supply limits apply.

Please [visit [benefits.surest.com]] [or] [call the telephone number on your ID card] to find out if Benefits are provided for your Prescription Drug Product and for information on how to obtain your Prescription Drug Product through a mail order Network Pharmacy.

Exclusions

Exclusions from coverage listed in *Section 2: Exclusions and Limitations* also apply to this section. In addition, the exclusions listed below apply.

When an exclusion applies to only certain Prescription Drug Products, you can [visit [benefits.surest.com]] [or] [call the telephone number on your ID card] for information on which Prescription Drug Products are excluded.

[Variable exclusions below are plan design-specific.]

1. Outpatient Prescription Drug Products obtained from an out-of-Network Pharmacy
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
3. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
4. Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
5. Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
6. Experimental or Investigational or Unproven Services and medications; medications used for experimental treatments for specific diseases and/or dosage regimens determined by us to be experimental, investigational or unproven. This exclusion does not apply to drugs prescribed for a use that is different from the use for which that drug has been approved for marketing by the federal *Food and Drug Administration* ("FDA"), provided all of the following conditions are met:
 - The drug has been approved by the *FDA*;
 - The drug is prescribed by a Physician for:
 - ♦ the treatment of a life-threatening disease or condition, or
 - ♦ the treatment of a chronic and seriously debilitating disease or condition and is medically appropriate to treat that disease or condition, or
 - ♦ the treatment of a disease or condition in a child where it has been approved by the *FDA* for similar conditions or diseases in adults and the drug is medically appropriate to treat that disease or condition; and
 - The drug has been recognized for treatment of that disease or condition or pediatric application by one of the following:

- ◆ *The American Medical Association Drug Evaluations;*
 - ◆ *The American Hospital Formulary Service Drug Information;*
 - ◆ *The United States Pharmacopoeia Dispensing Information;* or
 - ◆ *Two articles from major peer reviewed medical journals.*
7. Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
 8. Prescription Drug Products for any condition, Injury, Sickness or Mental Illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
- [9.] [Any product dispensed for the purpose of appetite suppression or weight loss.]
- [10.] A Pharmaceutical Product for which Benefits are provided under Pharmaceutical Products in *Section 1: Covered Health Care Services*. [This includes [certain] [all] forms of vaccines/immunizations.] [This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.] [This exclusion does not apply to [certain] immunizations administered in a [Network] [or] [a Designated] Pharmacy.]
- [11.] Durable Medical Equipment, including certain insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided under *Durable Medical Equipment, Orthotics, Prosthetic Devices, and Supplies* in *Section 1: Covered Health care Services*. Prescribed and non-prescribed outpatient supplies. This does not apply to [the Omnipod Dash insulin pump,]diabetic supplies and inhaler spacers specifically stated as covered.
- [12.] General vitamins, except the following, which require a Prescription Order or Refill:
- Prenatal vitamins.
 - Vitamins with fluoride.
 - Single entity vitamins.
- [13.] Certain unit dose packaging or repackagers of Prescription Drug Products.
- [14.] Medications used for cosmetic or convenience purposes.
- [15.] Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that we determine do not meet the definition of a Covered Health Care Service.
- [16.] Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
- [17.] [Prescription Drug Products when prescribed to treat infertility. This exclusion does not apply to Prescription Drug Products prescribed [to treat Iatrogenic Infertility and] for Preimplantation Genetic Testing (PGT) as described in this *Certificate*.]
- [Include for groups that object to contraceptive services based on a statutory or regulatory exemption.]
- [18.] [Prescription Drug Products when prescribed to prevent conception. This includes, but is not limited to, oral contraceptives, diaphragms, Depo Provera and other injectable drugs used for contraception.]
- [Include for groups that object to emergency contraceptives based on a statutory or regulatory exemption.]
- [18.] [Prescription Drug Products that are emergency contraceptives.]
- [19.] Certain Prescription Drug Products for tobacco cessation.

[Applies for plan designs with closed PDL.]

- [20.] [Prescription Drug Products not placed on Tier 1 [,] [or] [Tier 2] [,] [or] [Tier 3] of the Prescription Drug List at the time the Prescription Order or Refill is dispensed. We have developed a process for reviewing Benefits for a Prescription Drug Product that is not on an available tier of the Prescription Drug List, but that has been prescribed as a Medically Necessary alternative. For information about this process, [visit [benefits.surest.com]] [or] [call the telephone number on your ID card].]
- [21.] A Prescription Drug Product prescribed by an out-of-Network Physician or other out-of-Network provider.

[¹Applies when plan design includes compounds. ²Applies when plan design excludes compounds.]

- [22.] [¹Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration (FDA) and requires a Prescription Order or Refill. Compounded drugs that contain a non-FDA approved bulk chemical. Compounded drugs that are available as a similar commercially available Prescription Drug Product.(Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are placed on Tier [2] [3] .)] [²Any prescription medication that must be compounded into its final form by the dispensing pharmacist, Physician, or other health care provider.]

[¹Include when a prescription order/refill is required for coverage. ²Include if group purchases benefits for tobacco cessation that include over-the-counter drugs.]

- [23.] [Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless we have designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product [¹and it is obtained with a Prescription Order or Refill from a Physician]. Prescription Drug Products that are available in over-the-counter form or made up of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that we have determined are Therapeutically Equivalent to an over-the-counter drug or supplement. Such determinations may be made up to six times during a calendar year. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision. [²This exclusion does not apply to over-the-counter drugs used for tobacco cessation.]]
- [24.] [Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and placed on a tier by our P&T Committee.]

[¹Applies when plan design excludes growth hormone therapy for all conditions. ²Applies when plan design includes limited benefits for growth hormone therapy.]

- [25.] [¹Growth hormone therapy.] [²Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).]
- [26.] [Any oral non-sedating antihistamine or antihistamine-decongestant combination.]
- [27.] [Any medication that is used for the treatment of erectile dysfunction or sexual dysfunction.]
- [28.] Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products even when used for the treatment of Sickness or Injury.
- [29.] [Prescription Drug Products designed to adjust sleep schedules, such as for jet lag or shift work.]
- [30.] [Prescription Drug Products when prescribed as sleep aids.]
- [31.] [A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.]
- [32.] [A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such

determinations may be made up to six times during a calendar year. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.]

[33.] Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available, unless otherwise required by law or approved by us. Such determinations may be made up to six times during a calendar year. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

[34.] Certain Prescription Drug Products that have not been prescribed by a Specialist.

[35.] A Prescription Drug Product that contains marijuana, including medical marijuana.

[36.] Dental products, including but not limited to prescription fluoride topicals.

[37.] A Prescription Drug Product with either:

- An approved biosimilar.
- A biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product.

For the purpose of this exclusion a "biosimilar" is a biological Prescription Drug Product approved based on both of the following:

- It is highly similar to a reference product (a biological Prescription Drug Product).
- It has no clinically meaningful differences in terms of safety and effectiveness from the reference product.

Such determinations may be made up to six times during a calendar year. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

[38.] Diagnostic kits and products.

[39.] Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.

[40.] Certain Prescription Drug Products that are *FDA* approved as a package with a device or application, including smart package sensors and/or embedded drug sensors. This exclusion does not apply to a device or application that assists you with the administration of a Prescription Drug Product.

Defined Terms

[Variable definitions below are plan design-specific.]

[¹Applies to the mandatory generic program.]

Ancillary Charge - a charge, in addition to the Co-payment, that you must pay when a covered Prescription Drug Product is dispensed at your [¹or the provider's] request, when a Chemically Equivalent Prescription Drug Product is available.

For Prescription Drug Products from Network Pharmacies, the Ancillary Charge is the difference between:

- The Prescription Drug Charge for the Prescription Drug Product.
- The Prescription Drug Charge for the Chemically Equivalent Prescription Drug Product.

Brand-name - a Prescription Drug Product: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that we identify as a Brand-name product, based on available data resources. This includes data sources such as Medi-Span, that classify drugs as either brand or generic based on a number of factors. Not all products identified as a "brand name" by the manufacturer, pharmacy, or your Physician will be classified as Brand-name by us.

Chemically Equivalent - when Prescription Drug Products contain the same active ingredient.

Designated Pharmacy - a pharmacy that has entered into an agreement with us or with an organization contracting on our behalf, to provide specific Prescription Drug Products. This includes Specialty Prescription Drug Products. Not all Network Pharmacies are Designated Pharmacies.

Generic - a Prescription Drug Product: (1) that is Chemically Equivalent to a Brand-name drug; or (2) that we identify as a Generic product based on available data resources. This includes, data sources such as Medi-Span, that classify drugs as either brand or generic based on a number of factors. Not all products identified as a "generic" by the manufacturer, pharmacy or your Physician will be classified as a Generic by us.

[Infertility - not able to become pregnant after the following periods of time of regular unprotected intercourse or therapeutic donor insemination:

- One year, if you are a female under age 35.
- Six months, if you are a female age 35 or older.

In addition, in order to be eligible for Benefits, you must also have infertility not related to voluntary sterilization or to failed reversal of voluntary sterilization.]

[Infertility Annual Maximum Benefit - the maximum amount we will pay for covered Prescription Drug Products for Infertility during a year. The *Outpatient Prescription Drug Schedule of Benefits* will tell you how the Infertility Annual Maximum Benefit applies.]

[Infertility Maximum Policy Benefit - the maximum amount we will pay for covered Prescription Drug Products for Infertility during the entire period of time you are enrolled for coverage under the Policy. The *Outpatient Prescription Drug Schedule of Benefits* will tell you how the Infertility Maximum Policy Benefit applies.]

[List of Zero Cost Share Medications - a list that identifies certain Prescription Drug Products on the Prescription Drug List that are available at zero cost share (no cost to you) when obtained from a retail Network Pharmacy. Certain Prescription Drug Products on the List of Zero Cost Share Medication may be available at a mail order Network Pharmacy. You may find the List of Zero Cost Share Medications by contacting us at [benefits.surest.com] or the telephone number on your ID card.]

Maintenance Medication - a Prescription Drug Product expected to be used for six months or more to treat or prevent a chronic condition. You may find out if a Prescription Drug Product is a Maintenance Medication by [visiting [benefits.surest.com]] [or] [calling the telephone number on your ID card].

Network Pharmacy - a pharmacy that has:

- Entered into an agreement with us or an organization contracting on our behalf to provide Prescription Drug Products to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by us as a Network Pharmacy.

New Prescription Drug Product - a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ending on the earlier of the following dates:

- The date it is placed on a tier by our P&T Committee.
- December 31st of the following calendar year.

Pharmacy and Therapeutics (P&T) Committee - the committee that we designate for placing Prescription Drug Products into specific tiers.

PPACA - Patient Protection and Affordable Care Act of 2010.

PPACA Zero Cost Share Preventive Care Medications - the medications that are obtained at a Network Pharmacy [with a Prescription Order or Refill from a Physician] and that are payable at 100% of

the Prescription Drug Charge (without application of any Co-payment,) as required by applicable law under any of the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.

[Applies if immunizations are covered under the pharmacy benefit:]

- [Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention*.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

You may find out if a drug is a PPACA Zero Cost Share Preventive Care Medication as well as information on access to coverage of Medically Necessary alternatives by [visiting [benefits.surest.com]] [or] [calling the telephone number on your ID card].

Preferred Retail Network Pharmacy - a retail pharmacy that we identify as a preferred pharmacy within the Network.

Prescription Drug Charge - the rate we have agreed to pay our Network Pharmacies for a Prescription Drug Product dispensed at a Network Pharmacy. The rate includes any applicable dispensing fee and sales tax.

Prescription Drug List - a list that places into tiers medications or products that have been approved by the *U.S. Food and Drug Administration (FDA)*. This list is subject to our review and change from time to time. You may find out to which tier a particular Prescription Drug Product has been placed by [visiting [benefits.surest.com]] [or] [calling the telephone number on your ID card] for the most up-to-date tier placement.

Prescription Drug Product - a medication or product that has been approved by the *U.S. Food and Drug Administration (FDA)* and that can, under federal or state law, be dispensed only according to a Prescription Order or Refill. A Prescription Drug Product includes a medication that is generally appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of Benefits under the Policy, this definition includes:

- [Omnipod Dash insulin pump;]
- Inhalers (with spacers).
- Insulin.
- Glucagon kits.
- [[Certain vaccines/immunizations] [Vaccines/immunizations] administered in a Network Pharmacy.]
- The following diabetic supplies:
 - standard insulin syringes with needles;
 - blood-testing strips - glucose;
 - urine-testing strips - glucose;
 - ketone-testing strips and tablets;
 - lancets and lancet devices; and
 - glucose meters, including continuous glucose monitors.

Prescription Order or Refill- the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice allows issuing such a directive.

Specialty Prescription Drug Product - Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses. [Specialty Prescription Drug Products include certain drugs for Infertility.] [Specialty Prescription Drug Products include certain drugs for [fertility preservation and] Preimplantation Genetic Testing (PGT) for which Benefits are described in this *Certificate* under [Fertility Preservation for Iatrogenic Infertility and] *Preimplantation Genetic Testing (PGT) and Related Services* in *Section 1: Covered Health Care Services*.] You may access a complete list of Specialty Prescription Drug Products by [visiting [benefits.surest.com]] [or] [calling the telephone number on your ID card].

Therapeutically Equivalent - when Prescription Drug Products have essentially the same efficacy and adverse effect profile.

Usual and Customary Charge - the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties. This fee includes any applicable dispensing fee and sales tax.

[Applies when based on plan design]

[Your Right to Request an Exclusion Exception]

[When a Prescription Drug Product is excluded from coverage, you or your representative may request an exception to gain access to the excluded Prescription Drug Product. To make a request, contact us in writing or call the toll-free number on your ID card. We will notify you of our determination within 72 hours.

Please note, if your request for an exception is approved by us, you may be responsible for paying the applicable Co-payment based on the Prescription Drug Product tier placement, or at the highest tier as described in the *Benefit Information* table in the *Outpatient Prescription Drug Schedule of Benefits*, in addition to any applicable Ancillary Charge.

Urgent Requests

If your request requires immediate action and a delay could significantly increase the risk to your health, or the ability to regain maximum function, call us as soon as possible. We will provide a written or electronic determination within 24 hours.

External Review

If you are not satisfied with our determination of your exclusion exception request, you may be entitled to request an external review. You or your representative may request an external review by sending a written request to us to the address set out in the determination letter or by calling the toll-free number on your ID card. The *Independent Review Organization (IRO)* will notify you of our determination within 72 hours.

Expedited External Review

If you are not satisfied with our determination of your exclusion exception request and it involves an urgent situation, you or your representative may request an expedited external review by calling the toll-free number on your ID card or by sending a written request to the address set out in the determination letter. The *IRO* will notify you of our determination within 24 hours.]]

[This form is filed to support non-grandfathered plans. Please note that non-grandfathered plans require all network cost sharing to apply to the Out-of-Pocket Limit, including all cost sharing for Essential Health Benefits. Out-of-Pocket Limit variables will never exceed the annual limitation on cost-sharing for the current plan year for non-grandfathered plans.]

[¹Product names are variable for possible future name change. ²The correct plan name will be inserted.]

[¹Surest Choice Plus]

[²Plan XXX]

UnitedHealthcare Insurance Company

Schedule of Benefits

How Do You Access Benefits?

Network Benefits apply to Covered Health Care Services that are provided by a Network Physician or other Network provider.

Out-of-Network Benefits apply to Covered Health Care Services that are provided by an out-of-Network Physician or other out-of-Network provider, or Covered Health Care Services that are provided at an out-of-Network facility.

Emergency Health Care Services provided by an out-of-Network provider will be reimbursed as set forth under *Allowed Amounts* as described at the end of this *Schedule of Benefits*.

Covered Health Care Services provided at certain Network facilities by an out-of-Network Physician, when not Emergency Health Care Services, will be reimbursed as set forth under *Allowed Amounts* as described at the end of this *Schedule of Benefits*. For these Covered Health Care Services, "certain Network facility" is limited to a hospital (as defined in 1861(e) of the Social Security Act), a hospital outpatient department, a critical access hospital (as defined in 1861(mm)(1) of the Social Security Act), an ambulatory surgical center as described in section 1833(i)(1)(A) of the Social Security Act, and any other facility specified by the Secretary.

Ground and Air Ambulance transport provided by an out-of-Network provider will be reimbursed as set forth under *Allowed Amounts* as described at the end of this *Schedule of Benefits*.

[Include when Shared Savings Program applies][¹Shared Savings name bracketed for possible future name change]

[Depending on the geographic area and the service you receive, you may have access through our [¹Shared Savings Program] to out-of-Network providers who have agreed to discount their billed charges for Covered Health Care Services. Refer to the definition of [¹Shared Savings Program] in *Section 9: Defined Terms* of the *Certificate* for details about how the [¹Shared Savings Program] applies.]

You must show your identification card (ID card) every time you request health care services from a Network provider. If you do not show your ID card, Network providers have no way of knowing that you are enrolled under an UnitedHealthcare Policy. As a result, they may bill you for the entire cost of the services you receive.

Additional information about the network of providers and how your Benefits may be affected appears at the end of this *Schedule of Benefits*.

If there is a conflict between this *Schedule of Benefits* and any summaries provided to you by the Group, this *Schedule of Benefits* will control.

Does Prior Authorization Apply?

[Insert language when plan design requires election and activation of a conditional coverage.]

We require prior authorization for certain Covered Health Care Services. Network providers are responsible for obtaining prior authorization before they provide these services to you. [\[Benefits for conditional coverage do not require Network provider prior authorization, with the exception of a pre-admission notification for Covered Health Care Services for Inpatient Stays.\]](#)

We recommend that you confirm with us that all Covered Health Care Services have been prior authorized as required. Before receiving these services from a Network provider, you may want to call us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they do not prior authorize as required. You can call us at the telephone number on your ID card.

When you choose to receive certain Covered Health Care Services from out-of-Network providers, you are responsible for obtaining required prior authorization or pre-admission notification before you receive these services. Note that your obligation to obtain prior authorization is also applicable when an out-of-Network provider intends to admit you to a Network facility or to an out-of-Network facility or refers you to other Network or out-of-Network providers. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization. Services for which you are required to obtain prior authorization are shown in the *Schedule of Benefits* table within each Covered Health Care Service category.

To obtain prior authorization, call the telephone number on your ID card. This call starts the utilization review process.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the *Schedule of Benefits* table to find out how far in advance you must obtain prior authorization.

For Covered Health Care Services that do not require you to obtain prior authorization, when you choose to receive services from out-of-Network providers, we urge you to confirm with us that the services you plan to receive are Covered Health Care Services. That's because in some instances, certain procedures may not be Medically Necessary or may not otherwise meet the definition of a Covered Health Care Service, and therefore are excluded. In other instances, the same procedure may meet the definition of Covered Health Care Services. By calling before you receive treatment, you can check to see if the service is subject to limitations or exclusions.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those received, our final coverage determination will be changed to account for those differences, and we will only pay Benefits based on the services delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Care Service, you will be responsible for paying all charges and no Benefits will be paid.

Care Management

When you seek prior authorization as required, we will work with you to put in place the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis (Medicare pays before we pay Benefits under the Policy), the prior authorization requirements do not apply to you. Since Medicare is the primary payer, we will pay as secondary payer as described in *Section 7: Coordination of Benefits*. You are not required to obtain authorization before receiving Covered Health Care Services.

What Will You Pay for Covered Health Care Services?

Benefits for Covered Health Care Services are described in the tables below.

Out-of-Pocket Limits are calculated on a [\[calendar\]](#) [\[Policy\]](#) year basis.

When Benefit limits apply, the limit stated refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.

Benefit limits are calculated on a [\[calendar\]](#) [\[Policy\]](#) year basis unless otherwise specifically stated.

Payment Term And Description	Amounts
Annual Deductible	
The amount you pay for Covered Health Care Services per year before you are eligible to receive Benefits.	Network and Out-of-Network No Annual Deductible
Out-of-Pocket Limit	
<p>The maximum you pay per year for Co-payments. Once you reach the Out-of-Pocket Limit, Benefits are payable at 100% of Allowed Amounts during the rest of that year. The Out-of-Pocket Limit applies to Covered Health Care Services under the Policy as indicated in this <i>Schedule of Benefits</i>, including Covered Health Care Services provided under <i>Outpatient Prescription Drug Benefits</i>.</p> <p>Details about the way in which Allowed Amounts are determined appear at the end of the <i>Schedule of Benefits</i> table.</p> <p>The Out-of-Pocket Limit does not include any of the following and, once the Out-of-Pocket Limit has been reached, you still will be required to pay the following:</p> <ul style="list-style-type: none">Any charges for non-Covered Health Care Services.The amount you are required to pay if you do not obtain prior authorization as required.Charges that exceed Allowed Amounts. <p>Coupons: We may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Out-of-Pocket Limit.</p> <p>Any amount that you pay for Covered Health Care Services that is applied to the Network Out-of-Pocket Limit will also be applied to the out-of-Network Out-of-Pocket Limit. Any amount you pay for Covered Health Care Services that is applied to the out-of-Network Out-of-Pocket Limit will not be applied to the Network Out-of-Pocket Limit.</p>	<p>Network</p> <p>[^ANon-embedded.]</p> <p>[^BEmbedded.]</p> <p>[^AFor single coverage, the Out-of-Pocket Limit is \$[0 - 9,100].</p> <p>If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Limit stated above does not apply. For family coverage, the family Out-of-Pocket Limit is \$[0 - 9,100].]</p> <p>[^B\$[0 - 9,100] per Covered Person.]</p> <p>[^B\$[0 - 9,100] per Covered Person, not to exceed \$[0 - 18,200] for all Covered Persons in a family.]</p> <p>Out-of-Network</p> <p>[^ANon-embedded.]</p> <p>[^BEmbedded.]</p> <p>[^AFor single coverage, the Out-of-Pocket Limit is \$[0 - 30,000].</p> <p>If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Limit stated above does not apply. For family</p>

Payment Term And Description	Amounts
	<p>coverage, the family Out-of-Pocket Limit is \$[0 - 60,000].]</p> <p>[^B\$[0 - 30,000] per Covered Person.]</p> <p>[^B\$[0 - 30,000] per Covered Person, not to exceed \$[0 - 60,000] for all Covered Persons in a family.]</p> <p>[No Out-of-Pocket Limit.]</p> <p><i>[⁴Include combined network and out-of-network heading and statements below when OOPL provision applies to combined network and out-of-network benefits and delete the separate "Network" and "Out-of-Network" provisions above.]</i></p> <p><i>[⁴Network and Out-of-Network]</i></p> <p><i>[^A Non-embedded.]</i></p> <p><i>[^B Embedded.]</i></p> <p>[^AFor single coverage, the Out-of-Pocket Limit is \$[0 - 9,100].</p> <p>If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Limit stated above does not apply. For family coverage, the family Out-of-Pocket Limit is \$[0 - 9,100].]</p> <p>[^B \$[0 - 9,100] per Covered Person.]</p> <p>[^B\$[0 - 9,100] per Covered Person, not to exceed \$[0 - 18,200] for all Covered Persons in a family.]</p>
Co-payment	
<p>Co-payment is the amount you pay (calculated as a set dollar amount) each time you receive Covered Health Care Services. Co-payments are shown as the amount is listed on the following pages next to the description for each Covered Health Care Service.</p> <p>Please note that for Covered Health Care Services, you are responsible for paying the lesser of:</p> <ul style="list-style-type: none"> • The applicable Co-payment. • The Allowed Amount or the Recognized Amount, when applicable. <p>Details about the way in which Allowed Amounts are determined appear at the end of the <i>Schedule of Benefits</i> table.</p> <p>In the Benefits table below, some Co-payments are listed as a range. Providers are assigned Co-payments within the range based on treatment outcomes and cost information that identifies Network providers that provide cost-efficient care.</p> <p><i>[Insert language when plan design requires election and activation of a conditional coverage.]</i></p>	

Payment Term And Description	Amounts		
<p>[In the <i>Benefits for Conditional Coverage</i> table below, Co-payments for Network Benefits are listed as a Co-payment maximum. For these Covered Health Care Services, you may be eligible for reduced Co-payments if you use Network providers who are high value providers, as determined by us, based on their rates of effectiveness, low risk of complications, and total cost. These Co-payments may be updated on a semi-annual basis.]</p> <p>For Benefits listed with a Co-payment range or with a Co-payment maximum, you should [visit benefits.surest.com]. [check the Surest app]. [or] call the telephone number on your ID card for current provider specific Co-payment information.</p>			
<p><i>[Include bracketed variable benefit categories below when the benefit is included in the plan design. Unbracketed benefit categories will always be included in plan design.]</i></p> <p><i>[Include the following variables according to plan design:</i></p> <p><i>-Benefit limits and levels.</i></p> <p><i>-Prior authorization requirements and any penalty for failure to prior authorize.</i></p> <p><i>-Any other specific conditions for coverage described within the category.]</i></p>			
<p>When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.</p>			
<p>Amounts which you are required to pay as shown below in the <i>Schedule of Benefits</i> are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the <i>Certificate</i>, Recognized Amounts. The <i>Allowed Amounts</i> provision near the end of this <i>Schedule of Benefits</i> will tell you when you are responsible for amounts that exceed the Allowed Amount.</p>			
<p>*Co-payments in the table below marked with an asterisk indicate a Co-payment range. For these Covered Health Care Services, providers are assigned Co-payments within the range based on analysis of treatment outcomes and cost information that identify Network providers that provide cost-efficient care.</p> <p>**Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.</p>			
Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
[1]. [Acupuncture Services]			
[Limited to [10 - 100] treatments per year.]	<i>[Network]</i> [\$[5 - 150] per visit]	[Yes]	[No]
[Limits above do not apply for the treatment of Mental Illness or substance-related and addictive disorders.]	<i>[Out-of-Network]</i> [\$[5 - 500] per visit]	[Yes]	[No]
[2.] Ambulance Services			

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.

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***Co-payments in the table below marked with an asterisk indicate a Co-payment range. For these Covered Health Care Services, providers are assigned Co-payments within the range based on analysis of treatment outcomes and cost information that identify Network providers that provide cost-efficient care.**

****Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.**

Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
<p align="center">Prior Authorization Requirement</p> <p>In most cases, we will initiate and direct non-Emergency ambulance transportation.</p> <p>For Out-of-Network Benefits, if you are requesting non-Emergency Air Ambulance services (including any affiliated non-Emergency ground ambulance transport in conjunction with non-Emergency Air Ambulance transport), you must obtain authorization as soon as possible before transport. If you do not obtain prior authorization as required, [the amount you are required to pay will be increased to [5 - 50]% of the Allowed Amount] [you will be responsible for paying all charges and no Benefits will be paid].</p>			
<p>Emergency Ambulance</p> <p>Allowed Amounts for ground and Air Ambulance transport provided by an out-of-Network provider will be determined as described below under <i>Allowed Amounts</i> in this <i>Schedule of Benefits</i>.</p>	<p>Network</p> <p><i>Ground Ambulance</i></p> <p>\$[50 - 1,200] per transport</p>	Yes	No
	<p><i>Air Ambulance</i></p> <p>\$[50 - 1,200] per transport</p>	Yes	No
	<p>Out-of-Network</p> <p><i>Ground Ambulance</i></p> <p>\$[50 - 1,200] per transport</p> <p><i>Air Ambulance</i></p>	Yes	No

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Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
Non-Emergency Ambulance Ground or Air Ambulance, as we determine appropriate. Allowed Amounts for Air Ambulance transport provided by an out-of-Network provider will be determined as described below under <i>Allowed Amounts</i> in this <i>Schedule of Benefits</i> .	Same as Network Network <i>Ground Ambulance</i> \$[50 - 1,200] per transport	Same as Network Yes	Same as Network No
	<i>Air Ambulance</i> \$[50 - 1,200] per transport	Yes	No
	Out-of-Network <i>Ground Ambulance</i> \$[50 - 1,200] per transport	Yes	No
	<i>Air Ambulance</i> Same as Network	Same as Network	Same as Network
[3.] Cellular and Gene Therapy			

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Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
<p align="center">[Prior Authorization Requirement]</p> <p>[For Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of a Cellular or Gene Therapy arises. If you do not obtain prior authorization as required, [the amount you are required to pay will be increased to [5 - 50]% of the Allowed Amount] [you will be responsible for paying all charges and no Benefits will be paid].]</p> <p>[In addition, for Out-of-Network Benefits, you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.]</p>			
For Network Benefits, Cellular or Gene Therapy services must be received from a Designated Provider.	<p>Network</p> <p>Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i>.</p> <p>Out-of-Network</p> <p>[Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i>.]</p> <p>[Out-of-Network Benefits are not available.]</p>		
[4.] Clinical Trials	<p align="center">Prior Authorization Requirement</p> <p>For Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you do not obtain prior authorization as required, [the amount you are required to pay will be increased to [5 - 50]% of the Allowed Amount] [you will be responsible for paying all charges and no Benefits will be paid].</p>		

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Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
Depending upon the Covered Health Care Service, Benefit limits are the same as those stated under the specific Benefit category in this <i>Schedule of Benefits</i> .	<p>Network</p> <p>Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i>.</p> <p>Out-of-Network</p> <p>Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i>.</p>		
[5.] Dental Services - Accident and Medical			
	<p>Network</p> <p><i>Oral Surgery</i></p> <p>\$[5 - 700] per visit</p> <p><i>All Other Services</i></p> <p><i>Inpatient</i></p> <p>\$[100 - 5,000] per Inpatient Stay</p> <p><i>Outpatient Hospital</i></p> <p>*\$[20 - 500] to [200 - 2,000] per visit</p> <p><i>Outpatient Office Visit</i></p>	<p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p>	<p>No</p> <p>No</p> <p>No</p> <p>No</p>

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Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
	*\$[5 - 60] to [25 - 300] per visit		
	Out-of-Network		
	<i>Oral Surgery</i>		
	\$[5 - 2,000] per visit	Yes	No
	<i>All Other Services</i>		
	<i>Inpatient</i>		
	\$[2,000 - 15,000] per Inpatient Stay	Yes	No
	<i>Outpatient Hospital</i>		
	\$[200 - 4,000] per visit	Yes	No
	<i>Outpatient Office Visit</i>		
	\$[5 - 600] per visit	Yes	No

[6.] Diabetes Services

[Prior Authorization Requirement]

[For Out-of-Network Benefits, you must obtain prior authorization before obtaining any DME for the management and treatment of diabetes [that costs more than \$[1,000 - 5,000] (either retail purchase cost or cumulative retail rental cost of a single item)]. If you do not obtain prior authorization as required, [the amount you are required to pay will be increased to [5 - 50]% of the Allowed Amount] [you will be responsible for paying all charges and no Benefits will be paid].]

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Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care [Limited to one pair of therapeutic, custom-molded shoes, when prescribed by a Physician for the treatment of diabetes, per year.]	Network Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management and training/diabetic eye exams/foot care will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i> . Out-of-Network Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management and training/diabetic eye exams/foot care will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i> .		
Diabetes Self-Management Items [Benefits for diabetes equipment that meets the definition of DME are subject to the limit stated under <i>Durable Medical Equipment (DME), Orthotics, Prosthetic Devices, and Supplies</i> .]	Network Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management items will be the same as those stated under <i>Durable Medical Equipment (DME), Orthotics, Prosthetic Devices, and Supplies</i> and in <i>Outpatient Prescription Drug Schedule of Benefits</i> . Out-of-Network Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management items will be the same as those stated under <i>Durable Medical Equipment (DME),</i>		

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Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
	Orthotics, Prosthetic Devices, and Supplies and in the Outpatient Prescription Drug Schedule of Benefits.		
[7.] Durable Medical Equipment (DME), Orthotics, Prosthetic Devices, and Supplies			
<p>[Prior Authorization Requirement]</p> <p>[For Out-of-Network Benefits, you must obtain prior authorization before obtaining any DME, prosthetic devices, or orthotic [that costs more than \$[1,000 - 5,000] (either retail purchase cost or cumulative retail rental cost of a single item)]. If you do not obtain prior authorization as required, [the amount you are required to pay will be increased to [5 - 50]% of the Allowed Amount] [you will be responsible for paying all charges and no Benefits will be paid].]</p>			
<p>[To determine the tiers to which DME, orthotics, prosthetic devices, and supplies are assigned, [visit benefits.surest.com] or] call the telephone number on your ID card.]</p> <p>Limited to one hearing aid per hearing impaired ear not to exceed \$3,000 per hearing aid including its Medically Necessary services and</p>	Network		
	[[None]][*][\$[1 - 100]] to [\$100 - 1,500] per item	[Yes]	[No]
	<i>[Tier 1]</i> [[None]][\$[5 - 20]] per item	[Yes]	[No]
	<i>[Tier 2]</i> [\$[20 - 40] per item]	[Yes]	[No]
	<i>[Tier 3]</i> [\$[40 - 60] per item]	[Yes]	[No]
	<i>[Tier 4]</i>		

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Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
supplies. Repair and/or replacement of a hearing aid is limited to a single purchase per hearing impaired ear every three years.	[\$60 - 80] per item [Tier 5]	[Yes]	[No]
	[\$80 - 100] per item [Tier 6]	[Yes]	[No]
[The above limit does not apply to over-the-counter hearing aids. For over-the-counter hearing aids, Benefits are limited to \$[500 - 1,200] every [year] [12 months].]	[\$100 - 150] per item [Tier 7]	[Yes]	[No]
[Benefits are [further] limited to a single purchase every year.]	[\$150 - 200] per item [Tier 8]	[Yes]	[No]
	[\$200 - 250] per item [Tier 9]	[Yes]	[No]
[Scalp/cranial hair prosthesis (wigs) are limited to \$[25 - 3,000]] [one - three] per year.]	[\$250 - 350] per item [Tier 10]	[Yes]	[No]
	[\$300 - 500] per item [Tier 11]	[Yes]	[No]
[Cataract surgery or aphakia is limited to one eyeglasses frame and one pair of lenses, or one pair of contact lenses, or one year supply of disposable contact lenses.]	[\$400 - 1,000] per item [Tier 12]	[Yes]	[No]
	[\$500 - 1,500] per item	[Yes]	[No]
[Benefits for dedicated speech generating devices and tracheo-esophageal voice devices are limited to the purchase of one device during the entire period of time a Covered Person is enrolled			

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Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
<p>under the Policy. Benefits for repair/replacement are limited to once every [three years] [36 months].]</p> <p>[To receive Network Benefits, you must purchase, rent, or obtain the DME or orthotic from the vendor we identify or purchase it directly from the prescribing Network Physician.]</p> <p>Note: returning home with Durable Medical Equipment, such as crutches, after an appointment with a health care provider or from an outpatient procedure or Inpatient Stay, may result in an additional Co-payment. [Co-payments will be dependent on the tier the item is assigned to.]</p>	<p>Out-of-Network</p> <p>[**][[None]]\$5 - 3,000] per item]</p> <p>[Tier 1]</p> <p>[[None]]\$[5 - 40]] per item]</p>	<p>[Yes]</p> <p>[Yes]</p>	<p>[No]</p> <p>[No]</p>

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Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
	[Tier 2] [\$40 - 80] per item	[Yes]	[No]
	[Tier 3] [\$80 - 120] per item	[Yes]	[No]
	[Tier 4] [\$120 - 160] per item	[Yes]	[No]
	[Tier 5] [\$160 - 200] per item	[Yes]	[No]
	[Tier 6] [\$200 - 300] per item	[Yes]	[No]
	[Tier 7] [\$300 - 400] per item	[Yes]	[No]
	[Tier 8] [\$400 - 500] per item	[Yes]	[No]
	[Tier 9] [\$500 - 700] per item	[Yes]	[No]
	[Tier 10] [\$600 - 1,000] per item	[Yes]	[No]
	[Tier 11] [\$800 - 2,000] per item	[Yes]	[No]

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Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
	[Tier 12] [\$[1,000 - 3,000] per item]	[Yes]	[No]
[8.] Emergency Health Care Services - Outpatient			
Note: If you are confined in an out-of-Network Hospital after you receive outpatient Emergency Health Care Services, you must notify us within one business day or on the same day of admission if reasonably possible. We may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the out-of-Network Hospital after the date we decide a transfer is medically appropriate, Network Benefits will not be provided. Out-of-Network Benefits may be available if the continued stay is determined to be a Covered Health Care Service. If you are admitted as an inpatient to a Hospital directly from the Emergency room, the Benefits provided as	Network \$[100 - 1,500] per visit.	Yes	No
	Out-of-Network Same as Network	Same as Network	Same as Network

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Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
<p>described under <i>Hospital - Inpatient Stay</i> will apply. You will not have to pay the Emergency Health Care Services Co-payment.</p> <p>Allowed Amounts for Emergency Health Care Services provided by an out-of-Network provider will be determined as described below under <i>Allowed Amounts</i> in this <i>Schedule of Benefits</i>.</p> <p>Note: returning home with Durable Medical Equipment, such as crutches, after an Emergency room visit may result in an additional Co-payment. [Co-payments will be dependent on the tier the item is assigned to.] Refer to the <i>Durable Medical Equipment (DME), Orthotics, Prosthetic Devices, and Supplies</i> category in this <i>Schedule of Benefits</i>.</p>			
[9.] Enteral Nutrition			
[In addition to the Co-payment stated in this section, you will also be responsible for the Co-	Network	Yes	No

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Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
payment stated under the <i>Home Health Care Benefit</i> if you also receive services from a Home Health Agency.]	<p>[\$5 - 150] per 30-day supply</p> <p>Out-of-Network</p> <p>[\$5 - 200] per 30-day supply</p>	Yes	No
[10.] [Fertility Preservation for Iatrogenic Infertility]			
<p>[Prior Authorization Requirement]</p> <p>[For Out-of-Network Benefits, you must obtain prior authorization as soon as possible. If you do not obtain prior authorization as required, [the amount you are required to pay will be increased to [5 - 50]% of the Allowed Amount] [you will be responsible for paying all charges and no Benefits will be paid].]</p>			
<p><i>[Applies for plan designs that include Infertility Services.]</i></p> <p>[Benefit limits will be the same as, and combined with, those stated under <i>Infertility Services</i>. Benefits are further limited to one cycle of fertility preservation for Iatrogenic Infertility per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy.]</p>	<p>[Network]</p> <p>[\$[100 - 3,000] per visit.]</p>	[Yes]	[No]

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**Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.

Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
<p>[Applies for plan designs that do not include Infertility Services.]</p> <p>[Limited to \$[2,000 - 30,000] per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy. This Benefit limit will be the same as, and combined with, those stated under <i>Preimplantation Genetic Testing (PGT) and Related Services</i>. Benefits are further limited to one cycle of fertility preservation for Iatrogenic Infertility per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy.]</p>	<p>[Out-of-Network]</p> <p>[\$[200 - 6,000] per visit.]</p> <p>[Out-of-Network Benefits are not available.]</p>	<p>[Yes]</p> <p>[Out-of-Network Benefits are not available.]</p>	<p>[No]</p> <p>[Out-of-Network Benefits are not available.]</p>
[11.] Gender Dysphoria			

Prior Authorization Requirement for Surgical Treatment

For Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of surgery arises. If you do not obtain prior authorization as required, [the amount you are required to pay will be increased to [5 - 50]% of the Allowed Amount] [you will be responsible for paying all charges and no Benefits will be paid].

In addition, for Out-of-Network Benefits, you must contact us 24 hours before admission for an Inpatient Stay.

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

*Co-payments in the table below marked with an asterisk indicate a Co-payment range. For these Covered Health Care Services, providers are assigned Co-payments within the range based on analysis of treatment outcomes and cost information that identify Network providers that provide cost-efficient care.

**Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.

Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
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It is important that you notify us as soon as the possibility of surgery arises. Your notification allows the opportunity for us to provide you with additional information and services that may be available to you and are designed to achieve the best outcomes for you.

Prior Authorization Requirement for Non-Surgical Treatment

Depending upon where the Covered Health Care Service is provided, any applicable prior authorization requirements will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.

	<p>Network</p> <p>Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i> and in the <i>Outpatient Prescription Drug Schedule of Benefits</i>.</p> <p>Out-of-Network</p> <p>Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i> and in the <i>Outpatient Prescription Drug Schedule of Benefits</i>.</p>
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[12.] Habilitative Services

[Prior Authorization Requirement]

[For Out-of-Network Benefits for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. If you do not obtain prior authorization as required, [the amount you are required to pay will be increased to [5 - 50]% of the Allowed Amount] [you will be responsible for paying all charges and no Benefits will be paid].]

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

*Co-payments in the table below marked with an asterisk indicate a Co-payment range. For these Covered Health Care Services, providers are assigned Co-payments within the range based on analysis of treatment outcomes and cost information that identify Network providers that provide cost-efficient care.

**Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.

Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
<p>[In addition, for Out-of-Network Benefits, you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.]</p> <p>[For Out-of-Network Benefits for outpatient therapies, you must obtain prior authorization five business days before receiving [physical therapy] [,] [and] [occupational therapy] [,] [and] [Manipulative Treatment] [,] [and] [speech therapy] [,] [and] [post-cochlear implant aural therapy] [,] [and] [cognitive therapy] or as soon as is reasonably possible. If you do not obtain prior authorization as required, [the amount you are required to pay will be increased to [5 - 50]% of the Allowed Amount] [you will be responsible for paying all charges and no Benefits will be paid].]</p>			
<p>[Inpatient services limited per year as follows:]</p> <p>[Limit will be the same as, and combined with, those stated under <i>Skilled Nursing Facility/Inpatient Rehabilitation Services</i>.]</p> <p>[Outpatient therapies:]</p> <ul style="list-style-type: none"> [Manipulative Treatment.] [Physical therapy.] [Occupational therapy.] [Speech therapy.] [Post-cochlear implant aural therapy.] [Cognitive therapy.] 	<p>Network</p> <p><i>Inpatient</i></p> <p>Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i>.</p> <p><i>Outpatient</i></p> <p><i>Manipulative Treatment</i></p> <p>\$[5 - 200] per visit</p>		
		Yes	No

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**Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.

Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
<p>[For the above outpatient therapies:]</p> <ul style="list-style-type: none"> [Limits will be the same as, and combined with, those stated under <i>Rehabilitation Services - Outpatient Therapy [and Manipulative Treatment].</i>] <p>Note: returning home with Durable Medical Equipment, such as a walker, following habilitative services may result in an additional Co-payment. [Co-payments will be dependent on the tier the item is assigned to.] Refer to the <i>Durable Medical Equipment (DME), Orthotics, Prosthetic Devices, and Supplies</i> category in this <i>Schedule of Benefits</i>.</p>	<p><i>Occupational Therapy for the Treatment of Mental Illness and Substance-Related and Addictive Disorders</i></p> <p>[[None]]\$[1 - 100]] per visit</p> <p><i>Occupational Therapy for All Other Conditions</i></p> <p>[*]\$[[5 - 50] to [25 - 200]]\$[5 - 200]] per visit</p>	<p>Yes</p> <p>Yes</p>	<p>No</p> <p>No</p>

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

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**Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.

Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
	Physical Therapy for the Treatment of Mental Illness and Substance-Related and Addictive Disorders [[None]]\$[1 - 100]] per visit	Yes	No
	Physical Therapy for All Other Conditions [*]\$[[5 - 50] to [25 - 200]]\$[5 - 200] per visit	Yes	No
	Speech Therapy for the Treatment of Mental Illness and Substance-Related and Addictive Disorders [[None]]\$[1 - 100]] per visit	Yes	No
	Speech Therapy for All Other Conditions [*]\$[[5 - 50] to [25 - 200]]\$[5 - 200] per visit	Yes	No
	Post-cochlear Implant Aural Therapy	Yes	No

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**Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.

Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
	<p>[*]\$[[1 - 60] to [25 - 300]][5 - 600] per visit</p> <p><i>Cognitive Therapy</i></p> <p>[*]\$[[5 - 50] to [25 - 200]][5 - 200] per visit</p> <p>Out-of-Network</p> <p><i>Inpatient</i></p> <p>Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i>.</p> <p><i>Outpatient</i></p> <p><i>Manipulative Treatment</i></p> <p>\$[5 - 400] per treatment</p> <p><i>Occupational Therapy for the Treatment of Mental Illness and Substance-Related and Addictive Disorders</i></p> <p>[[None]][\$[1 - 250]] per visit</p> <p><i>Occupational Therapy for All Other Conditions</i></p> <p>\$[5 - 500] per visit</p>	<p>Yes</p> <p>Yes</p> <p>Yes</p>	<p>No</p> <p>No</p> <p>No</p>

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

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**Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.

Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
	<i>Physical Therapy for the Treatment of Mental Illness and Substance-Related and Addictive Disorders</i> [[None]]\$[1 - 250]] per visit	Yes	Yes
	<i>Physical Therapy for All Other Conditions</i> \$[5 - 500] per visit	Yes	No
	<i>Speech Therapy for the Treatment of Mental Illness and Substance-Related and Addictive Disorders</i> [[None]]\$[1 - 250]] per visit	Yes	No
	<i>Speech Therapy for All Other Conditions</i> \$[5 - 500] per visit	Yes	No
	<i>Post-cochlear Implant Aural Therapy</i> \$[5 - 600] per visit	Yes	No
	<i>Cognitive Therapy</i>		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.

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**Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.

Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
	\$[5 - 500] per visit	Yes	No
<p>[13.] Home Health Care</p> <p style="text-align: center;">[Prior Authorization Requirement]</p> <p>[For Out-of-Network Benefits, you must obtain prior authorization five business days before receiving services or as soon as is reasonably possible. If you do not obtain prior authorization as required, [the amount you are required to pay will be increased to [5 - 50]% of the Allowed Amount] [you will be responsible for paying all charges and no Benefits will be paid].]</p>			
<p><i>[Rehabilitative/Habilitative Services provided in the home by other than a Home Health Agency]</i></p> <p>[Limit will be the same as, and combined with, those stated under <i>Habilitative Services</i> and <i>Rehabilitation Services - Outpatient Therapy and Manipulative Treatment</i>.]</p>	<p>Network</p> <p><i>Rehabilitative/Habilitative Services provided in the Home</i></p> <p>\$[5 - 200] per visit</p>	Yes	No
	<p><i>Home Health Care Visit for Enteral Feeding</i></p> <p>\$[5 - 50] per visit</p>	Yes	No
<p><i>[All Other Services]</i></p> <p>[Limited to [40 - 200] visits per year. One visit equals up to four hours of skilled care services.]</p>	<p><i>Home Health Care Visit for All Other Services</i></p> <p>\$[5 - 200] per visit</p>	Yes	No

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.

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*Co-payments in the table below marked with an asterisk indicate a Co-payment range. For these Covered Health Care Services, providers are assigned Co-payments within the range based on analysis of treatment outcomes and cost information that identify Network providers that provide cost-efficient care.

**Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.

Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
<p>[Visit limits above do not include any service which is billed only for the administration of intravenous infusion.]</p> <p>[Visit limits above do not apply for the treatment of Mental Illness and substance-related and addictive disorders.]</p> <p>[In addition to the Co-payment stated in this section, you will also be responsible for the Co-payment stated under the <i>Enteral Nutrition</i> Benefit for enteral formulas and low protein modified food products.]</p> <p>[To receive Network Benefits for the administration of intravenous infusion, you must receive services from a provider we identify.]</p>	<p>Out-of-Network</p> <p><i>Rehabilitative/Habilitative Services provided in the Home</i></p> <p>\$[5 - 400] per visit</p>	Yes	No

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.

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**Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.

Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
	<i>Home Health Care Visit for Enteral Feeding</i> \$[5 - 100] per visit	Yes	No
	<i>Home Health Care Visit for All Other Services</i> \$[5 - 400] per visit	Yes	No
[14.] Hospice Care			
<p align="center">[Prior Authorization Requirement]</p> <p>[For Out-of-Network Benefits, you must obtain prior authorization five business days before admission for an Inpatient Stay in a hospice facility or as soon as is reasonably possible. If you do not obtain prior authorization as required, [the amount you are required to pay will be increased to [5 - 50]% of the Allowed Amount] [you will be responsible for paying all charges and no Benefits will be paid].]</p> <p>[In addition, for Out-of-Network Benefits, you must contact us within 24 hours of admission for an Inpatient Stay in a hospice facility.]</p>			
	Network <i>Home Visit</i> \$[5 - 200] per visit <i>Inpatient</i> \$[100 - 5,000] per Inpatient Stay	Yes Yes	No No
	Out-of-Network		

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**Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.

Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
	<i>Home Visit</i> \$[5 - 400] per visit	Yes	No
	<i>Inpatient</i> \$[100 - 15,000] per Inpatient Stay	Yes	No
[15.] Hospital - Inpatient Stay			
<p align="center">Prior Authorization Requirement</p> <p>For Out-of-Network Benefits for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. If you do not obtain prior authorization as required, [the amount you are required to pay will be increased to [5 - 50]% of the Allowed Amount] [you will be responsible for paying all charges and no Benefits will be paid].</p> <p>[In addition, for Out-of-Network Benefits, you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.]</p>			
Note: returning home with Durable Medical Equipment, such as crutches, following an inpatient Hospital admission may result in an additional Co-payment. [Co-payments will be dependent on the tier the item is assigned to.] Refer to the <i>Durable Medical Equipment (DME), Orthotics, Prosthetic Devices, and</i>	<p>Network</p> <p><i>Level 3 Procedure</i></p> <p>*\$[25 - 6,000] to [35 - 7,000] per Inpatient Stay</p>	Yes	No

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Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
<i>Supplies category in this Schedule of Benefits.</i>	<p><i>Level 4 Procedure</i> *\$[25 - 6,000] to [35 - 7,000] per Inpatient Stay</p> <p><i>Level 5 Procedure</i> *\$[400 - 6,000] to [800 - 7,000] per Inpatient Stay</p> <p><i>All Other Inpatient Stays</i> \$[100 - 5,000] per Inpatient Stay</p> <p>Out-of-Network</p> <p><i>Level 3 Procedure</i> **\$[100 - 15,000] per visit</p> <p><i>Level 4 Procedure</i> **\$[100 - 15,000] per Inpatient Stay</p> <p><i>Level 5 Procedure</i> **\$[2,000 - 15,000] per visit</p> <p><i>All Other Inpatient Stays</i></p>	<p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p>	<p>No</p> <p>No</p> <p>No</p> <p>No</p> <p>No</p> <p>No</p>

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Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
	\$[2,000 - 15,000] per Inpatient Stay	Yes	No

[16.] [Infertility Services]

[Prior Authorization Requirement]

[For Out-of-Network Benefits, you must obtain prior authorization as soon as possible. If you do not obtain prior authorization as required, [the amount you are required to pay will be increased to [5 - 50]% of the Allowed Amount] [you will be responsible for paying all charges and no Benefits will be paid].]

<p>[Limited to \$[2,000 - 30,000] per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy. [This limit does [not] include Benefits for infertility medications provided under <i>Outpatient Prescription Drug Benefits</i>.] This limit does not include Physician office visits for the treatment of infertility for which Benefits are described under <i>Physician's Office Services - Sickness and Injury</i> below.]</p> <p>[Benefits for Assisted Reproductive Technology (ART) are limited to [one - three] procedure[s] during the entire period of time a</p>	[Network]		
	<i>[Artificial Insemination]</i>		
	[\$[5 - 200] per visit]	[Yes]	[No]
	<i>[Egg Retrieval]</i>		
	[\$[5 - 1,500] per visit]	[Yes]	[No]
	<i>[Embryo Implantation]</i>		
	[\$[5 - 1,500] per visit]	[Yes]	[No]
	<i>[Cryopreservation]</i>		
	[\$[5 - 1,000] per visit]	[Yes]	[No]
	<i>[Short-Term Storage]</i>		
	[\$[5 - 500] per visit]	[Yes]	[No]
	<i>[Thawing]</i>		
	[\$[5 - 1,000] per visit]	[Yes]	[No]

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Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
Covered Person is enrolled under the Policy.]	<i>[Preimplantation Genetic Testing (PGT)]</i> [\$[5 - 1,000] per visit]	[Yes]	[No]
	<i>[Out-of-Network]</i> <i>[Artificial Insemination]</i> [\$[5 - 400] per visit]	[Yes]	[No]
	<i>[Egg Retrieval]</i> [\$[5 - 4,000] per visit]	[Yes]	[No]
	<i>[Embryo Implantation]</i> [\$[5 - 4,000] per visit]	[Yes]	[No]
	<i>[Cryopreservation]</i> [\$[5 - 3,000] per visit]	[Yes]	[No]
	<i>[Short-Term Storage]</i> [\$[5 - 1,500] per visit]	[Yes]	[No]
	<i>[Thawing]</i> [\$[5 - 3,000] per visit]	[Yes]	[No]
	<i>[Preimplantation Genetic Testing (PGT)]</i> [\$[5 - 3,000] per visit]	[Yes]	[No]
	[Out-of-Network Benefits are not available.]	[Out-of-Network Benefits are not available.]	[Out-of-Network Benefits are not available.]

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Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
[17.] Lab, X-Ray and Diagnostic - Outpatient			
<p align="center">[Prior Authorization Requirement]</p> <p>[For Out-of-Network Benefits for [Genetic Testing[, including BRCA testing]] [,] [and] [sleep studies] [,] [and] [stress echocardiography] [,] [and] [transesophageal echocardiogram] [,] [and] [transthoracic echocardiogram], you must obtain prior authorization five business days before scheduled services are received. If you do not obtain prior authorization as required, [the amount you are required to pay will be increased to [5 - 50]% of the Allowed Amount] [you will be responsible for paying all charges and no Benefits will be paid].]</p>			
Lab Testing - Outpatient [Limited to [15 - 25] Presumptive Drug Tests per year.] [Limited to [15- 25] Definitive Drug Tests per year.]	Network <i>Genetic Testing, other than BRCA</i> [None][[\$[25 - 1,000]] per visit <i>Allergy Testing</i> [None][[\$[5 - 300]] per visit <i>All Other Lab Testing, including BRCA</i> [None][[\$[5 - 200]] per visit Out-of-Network <i>Genetic Testing, other than BRCA</i>	 Yes Yes Yes Yes	 No No No No

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Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
X-Ray and Diagnostic Ultrasound - Outpatient If imaging is performed on multiple areas of the body, such as the lumbar spine and the cervical spine, on the same date of service, more than one Co-payment may apply. If more than one type of imaging is performed, such as an x-ray and ultrasound, on the same date of service, more than one Co-payment may apply.	[None][[\$100 - 3,000]] per visit		
	<i>Allergy Testing</i> [None][[\$5 - 800]] per visit	Yes	No
	<i>All Other Lab Testing, including BRCA</i> [None][[\$5 - 400]] per visit	Yes	No
	Network [None][[\$5 - 200]] per visit	Yes	No
	Out-of-Network [None][[\$5 - 400]] per visit	Yes	No

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Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
All Other Diagnostic Testing - Outpatient If more than one type of diagnostic testing is performed, such as an EKG exercise stress test and an electroencephalogram (EEG), on the same date of service, more than one Co-payment may apply.	Network <i>Transesophageal Echocardiogram</i> [None][*]\$[5 - 2,000] to [200 - 6,000] per visit	Yes	No
	<i>Sleep Study - Home</i> \$[40 - 300] per visit	Yes	No
	<i>Sleep Study - Facility</i> [*]\$[50 - 300] to [300 - 2,000] per visit	Yes	Yes
	<i>All Other Diagnostic Testing - Outpatient</i> [None][*]\$[5 - 500] to [50 - 2,000] per visit	Yes	No
	Out-of-Network <i>Transesophageal Echocardiogram</i> \$[100 - 15,000] per visit <i>Sleep Study - Home</i>	Yes	No

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Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
	\$[100 - 600] per visit	Yes	No
	<i>Sleep Study - Facility</i>		
	\$[1,000 - 5,000] per visit	Yes	No
	<i>All Other Diagnostic Testing - Outpatient</i>		
	[None][[*]\$[5 - 5,000] per visit	Yes	No
[18.] Major Diagnostic and Imaging - Outpatient			
<p align="center">[Prior Authorization Requirement]</p> <p>[For Out-of-Network Benefits for [CT] [,] [and] [PET scans] [,][and] [MRI] [,] [and] [MRA] [,][and] [angiography] [,] [and] [nuclear medicine], including nuclear cardiology, you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you do not obtain prior authorization as required, [the amount you are required to pay will be increased to [5 - 50]% of the Allowed Amount] [you will be responsible for paying all charges and no Benefits will be paid].]</p>			
<p>If imaging is performed on multiple areas of the body, such as the lumbar spine and the cervical spine, on the same date of service, more than one Co-payment may apply.</p> <p>If more than one type of imaging is performed, such as</p>	<p>Network</p> <p>*\$[20 - 1,500] to [250 - 1,500] per visit</p>	Yes	No

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Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
an MRI and CT scan, on the same date of service, more than one Co-payment may apply.	Out-of-Network [**][None][\${5 - 3,500}] per visit]	Yes	No
[19.] Mental Health Care and Substance-Related and Addictive Disorders Services	<p align="center">Prior Authorization Requirement</p> <p>For Out-of-Network Benefits for a scheduled admission for Mental Health Care and Substance-Related and Addictive Disorders Services (including an admission for services at a Residential Treatment facility), you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions.</p> <p>[In addition, for Out-of-Network Benefits, you must obtain prior authorization before the following services are received: [Partial Hospitalization/Day Treatment][;] [Intensive Outpatient Treatment programs][;] [outpatient electro-convulsive treatment][;] [psychological testing; transcranial magnetic stimulation][;] [Intensive Behavioral Therapy, including <i>Applied Behavior Analysis (ABA)</i>].]</p> <p>If you do not obtain prior authorization as required, [the amount you are required to pay will be increased to [5 - 50]% of the Allowed Amount] [you will be responsible for paying all charges and no Benefits will be paid].</p>		
	Network <i>Inpatient Hospital</i>		

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Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
	\$[100 - 5,000] per Inpatient Stay	Yes	No
	<i>Residential Treatment</i>		
	\$[100 - 5,000] per Inpatient Stay	Yes	No
	<i>Outpatient</i>		
	<i>Office Visit - In-Person</i>		
	[None][*\$5 - 300] per visit	Yes	No
	<i>Office Visit - Telehealth</i>		
	[None][*\$5 - 300] per visit	Yes	No
	<i>Applied Behavioral Analysis (ABA)</i>		
	[\$5 - 100] per visit	Yes	No
	<i>Biofeedback</i>		
	[\$5 - 300] per visit	Yes	No
	<i>E-Visit/Telephone Visit</i>		
	[None][*\$5 - 300] per visit	Yes	No
	<i>Substance-Related and Addictive Disorders Medication Management</i>		
	[None][*\$5 - 150] per visit	Yes	No

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Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
	<i>Partial Hospitalization</i> \$[5 - 500] per visit	Yes	No
	<i>Electroconvulsive Therapy</i> \$[5 - 500] per visit	Yes	No
	<i>Intensive Outpatient Treatment</i> \$[5 - 200] per visit	Yes	No
	<i>Subacute Detoxification Care</i> \$[5 - 200] per visit	Yes	No
	<i>Transcranial Magnetic Stimulation (TMS) Therapy</i> \$[5 - 400] per visit	Yes	No
	<i>All Other Outpatient Services</i> \$[5 - 500] per visit	Yes	No
	Out-of-Network <i>Inpatient Hospital</i> \$[100 - 15,000] per Inpatient Stay	Yes	No

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Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
	<i>Residential Treatment</i> \$[100 - 15,000] per Inpatient Stay	Yes	No
	<i>Outpatient</i> <i>Office Visit - In-Person</i> \$[5 - 600] per visit	Yes	No
	<i>Office Visit - Telehealth</i> \$[5 - 600] per visit	Yes	No
	<i>Applied Behavioral Analysis (ABA)</i> \$[50 - 300] per visit	Yes	No
	<i>Biofeedback</i> \$[5 - 600] per visit	Yes	No
	<i>E-Visit/Telephone Visit</i> [None][5 - 600] per visit	Yes	No
	<i>Substance-Related and Addictive Disorders Medication Therapy</i> \$[5 - 150] per visit	Yes	No
	<i>Partial Hospitalization</i> \$[5 - 1,000] per visit	Yes	No

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Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
	<i>Electroconvulsive Therapy</i> \$[5 - 1,000] per visit	Yes	No
	<i>Intensive Outpatient Treatment</i> \$[5 - 750] per visit	Yes	No
	<i>Subacute Detoxification Care</i> \$[5 - 750] per visit	Yes	No
	<i>Transcranial Magnetic Stimulation (TMS) Therapy</i> \$[100 - 600] per visit	Yes	No
	<i>All Other Outpatient Services</i> \$[5 - 1,000] per visit	Yes	No
[20.] Palliative Care			
<p align="center">[Prior Authorization Requirement]</p> <p align="center">[Depending upon where the Covered Health Care Service is provided, any applicable prior authorization requirements will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i>.]</p>			
Note: returning home with Durable Medical Equipment,	Network		

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Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
such as a walker, following palliative care may result in an additional Co-payment. [Co-payments will be dependent on the tier the item is assigned to.] Refer to the <i>Durable Medical Equipment (DME), Orthotics, Prosthetic Devices, and Supplies</i> category in this <i>Schedule of Benefits</i> .	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i> . Out-of-Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i> .		
[21.] Pharmaceutical Products - Outpatient			
<p align="center">[Prior Authorization Requirement]</p> <p>[For Out-of-Network Benefits, you must obtain prior authorization five business days before scheduled intravenous infusions are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you do not obtain prior authorization as required, [the amount you are required to pay will be increased to [5 - 50]% of the Allowed Amount] [you will be responsible for paying all charges and no Benefits will be paid].]</p> <p>[For Out-of-Network Benefits, you must obtain prior authorization five business days before certain Pharmaceutical Products are received, or for non-scheduled services, within one business day or as soon as is reasonably possible. If you do not obtain prior authorization as required, [the amount you are required to pay will be increased to [5 - 50]% of the Allowed Amount] [you will be responsible for paying all charges and no Benefits will be paid]. You may find out whether a particular</p>			

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Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
Pharmaceutical Product requires prior authorization by [visiting benefits.surest.com] or] calling the telephone number on your ID card.]			
[Certain coupons from pharmaceutical manufacturers or an affiliate may reduce the costs of your Specialty Pharmaceutical Products. Your Co-payment may vary when you use a coupon. Contact www.benefits.surest.com] or the telephone number on your ID card for an available list of Specialty Pharmaceutical Products and the applicable Co-payment.]	Network [*][$\$5 - 3,000$][[None][$1 - 3,000$] to [[None][$1 - 6,000$]] per visit	Yes	No
	Out-of-Network [**][None][$\$5 - 15,000$] per visit	Yes	No
[22.] Physician's Office Services - Sickness and Injury			
Note: returning home with Durable Medical Equipment, such as crutches, following an office visit may result in an additional Co-payment. [Co-payments will be dependent on the tier the item is assigned	Network <i>Primary Care Physician/Specialist</i> <i>Office Visit - In-Person</i>	Yes	No

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Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
<p>to.] Refer to the <i>Durable Medical Equipment (DME), Orthotics, Prosthetic Devices, and Supplies</i> category in this <i>Schedule of Benefits</i>.</p> <p>[In addition to the Co-payment stated in this section, the Co-payment for following services also apply when the Covered Health Care Service is performed in a Physician's office:]</p> <ul style="list-style-type: none"> [Lab, radiology/X-rays and other diagnostic services described under <i>Lab, X-Ray and Diagnostic - Outpatient</i>.] [Major diagnostic and nuclear medicine described under <i>Major Diagnostic and Imaging - Outpatient</i>.] [Outpatient Pharmaceutical Products described under <i>Pharmaceutical Products - Outpatient</i>.] 	<p>*[[None]][\$[1 - 60]] to [25 - 300]] per visit</p> <p><i>Telehealth Visit</i></p> <p>*[[None]][\$[1 - 60]] to [25 - 300]] per visit</p> <p><i>Visit in the Home</i></p> <p>[None]][\$[10 -200]] per visit</p> <p><i>Convenience Care/Retail</i></p> <p>[None]][\$[5 – 150]] per visit</p> <p><i>Allergy Injections</i></p> <p>[None]][\$[5 - 150]] per visit</p> <p><i>Biofeedback</i></p> <p>\$[5 - 200] per visit</p> <p><i>E-Visit/Telephone Visit</i></p> <p>[None]][\$[5 - 300]] per visit</p> <p><i>Anticoagulant Management</i></p> <p>\$[5 - 50] per visit</p>	<p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p>	<p>No</p> <p>No</p> <p>No</p> <p>No</p> <p>No</p> <p>No</p> <p>No</p>

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Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
<ul style="list-style-type: none"> • [[Certain] diagnostic and therapeutic scopic procedures described under <i>Scopic Procedures - Outpatient Diagnostic and Therapeutic.</i>] • [[Certain] Outpatient surgery procedures described under <i>Surgery - Outpatient.</i>] • [[Certain] Outpatient therapeutic procedures described under <i>Therapeutic Treatments - Outpatient.</i>] 	<p>Out-of-Network</p> <p><i>Primary Care Physician/Specialist</i></p> <p><i>Office Visit In-Person</i></p> <p>\$[5 - 600] per visit</p> <p><i>Telehealth Visit</i></p> <p>\$[5 - 600] per visit</p> <p><i>Visit in the Home</i></p> <p>[None][\$[5 -500]] per visit</p>	<p>Yes</p> <p>Yes</p> <p>Yes</p>	<p>No</p> <p>No</p> <p>No</p>

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Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
	<i>Convenience Care/Retail</i> [\$5 - 300] per visit [Out-of-Network Benefits are not available]	[Yes] [Out-of-Network Benefits are not available]	[No] [Out-of-Network Benefits are not available]
	<i>Allergy Injections</i> [None][*\$5 - 300] per visit	Yes	No
	<i>Biofeedback</i> \$[5 - 400] per visit	Yes	No
	<i>E-Visit/Telephone Visit</i> \$[5 - 600] per visit	Yes	No
	<i>Anticoagulant Management</i> \$[5 - 150] per visit	Yes	No

[23.] Pregnancy - Maternity Services

Prior Authorization Requirement

For Out-of-Network Benefits, you must obtain prior authorization as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery. If you do not obtain prior authorization as required, [the amount you are required to pay will be increased to [5 - 50]% of the Allowed Amount] [you will be responsible for paying all charges and no Benefits will be paid].

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**Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.

Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.			
Note: returning home with Durable Medical Equipment, such as a fetal monitor, following an office visit or inpatient admission may result in an additional Co-payment. [Co-payments will be dependent on the tier the item is assigned to.] Refer to the <i>Durable Medical Equipment (DME), Orthotics, Prosthetic Devices, and Supplies</i> category in this <i>Schedule of Benefits</i> .	Network		
	<i>Routine Prenatal and Postnatal Care</i>	Yes	No
	None per visit		
	<i>Amniocentesis</i>		
	[\$100 - 1,000] per test	Yes	No
	<i>Chorionic Villus Sampling (CVS)</i>		
	[\$100 - 1,500] per test	Yes	No
	<i>Home Birth</i>		
	[\$100 - 2,000] per delivery	Yes	No
	<i>Inpatient Delivery</i>		

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Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
	<p>*\$[100 - 2,500] to \$[750 - 5,000] per Inpatient Stay, except that if a newborn stays in the Hospital longer than the mother, an additional Co-payment will apply for the newborn Inpatient Stay.</p> <p><i>All Other Services</i></p> <p>Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i>.</p>	Yes	No
	<p>Out-of-Network</p> <p><i>Routine Prenatal and Postnatal Care</i></p> <p>\$[5 - 500] per visit</p> <p><i>Amniocentesis</i></p> <p>\$[200 - 3,000] per test</p> <p><i>Chorionic Villus Sampling (CVS)</i></p> <p>\$[200 - 3,500] per test</p> <p><i>Home Birth</i></p> <p>\$[100 - 6,000] per delivery</p>	<p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p>	<p>No</p> <p>No</p> <p>No</p> <p>No</p>

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Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
	<i>Inpatient Delivery</i> \$[100 - 15,000] per Inpatient Stay, except that if a newborn stays in the Hospital longer than the mother, an additional Co-payment will apply for the newborn Inpatient Stay. <i>All Other Services</i> Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i> .	Yes	No
[24.] Preimplantation Genetic Testing (PGT) and Related Services			
<p style="text-align: center;">[Prior Authorization Requirement]</p> <p>[For Out-of-Network Benefits, you must obtain prior authorization as soon as possible. If you do not obtain prior authorization as required, [the amount you are required to pay will be increased to [5 - 50]% of the Allowed Amount] [you will be responsible for paying all charges and no Benefits will be paid].]</p>			
<i>[Applies for plan designs that include Infertility Services.]</i> <i>[Benefit limits for related services will be the same as, and combined with, those stated under Infertility Services. This limit does not</i>	Network \$[5 - 1,000] per visit	Yes	No

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**Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.

Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
<p>include Preimplantation Genetic Testing (PGT) for the specific genetic disorder.]</p> <p>[This limit includes Benefits for ovarian stimulation medications provided under the <i>Outpatient Prescription Drug Rider</i>.]</p> <p>[Applies for plan designs that do not include Infertility Services but do include Fertility Preservation for Iatrogenic Infertility.]</p> <p>[Benefit limits for related services will be the same as, and combined with, those stated under <i>Fertility Preservation for Iatrogenic Infertility</i>. This limit does not include Preimplantation Genetic Testing (PGT) for the specific genetic disorder.]</p> <p>[This limit includes Benefits for ovarian stimulation medications provided under the <i>Outpatient Prescription Drug Rider</i>.]</p> <p>[Benefits for related services are limited to [one - three]</p>			

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**Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.

Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
<p>Assisted Reproductive Technology (ART) procedure[s] during the entire period of time a Covered Person is enrolled under the Policy. This limit does not include the Preimplantation Genetic Testing (PGT) for the specific genetic disorder.]</p> <p>[This limit includes Benefits for ovarian stimulation medications provided under the <i>Outpatient Prescription Drug Rider</i>.]</p>	<p>Out-of-Network</p> <p>[\$[5 - 3,000] per visit]</p> <p>[Out-of-Network Benefits are not available.]</p>	<p>[Yes]</p> <p>[Out-of-Network Benefits are not available.]</p>	<p>[No]</p> <p>[Out-of-Network Benefits are not available.]</p>
[25.] Preventive Care Services	<p align="center">[Prior Authorization Requirement]</p> <p>[For Out-of-Network Benefits, you must obtain prior authorization before obtaining a breast pump. [If you do not obtain prior authorization as required, [the amount you are required to pay will be increased to [5 - 50]% of the Allowed Amount] [you will be responsible for paying all charges and no Benefits will be paid].]]</p>		

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**Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.

Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
Physician office services	Network None Out-of-Network [[None]]\$[5 - 500] per visit] [Out-of-Network Benefits are not available.]	No [Yes] [Out-of-Network Benefits are not available.]	No [No] [Out-of-Network Benefits are not available.]
Lab, X-ray or other preventive tests	Network None Out-of-Network [Major Diagnostic Imaging] [[None]]\$[50 - 3,500] per visit] [All Other Services] [[None]]\$[5 - 400] per service] [Out-of-Network Benefits are not available.]	No [Yes] [Yes] [Out-of-Network Benefits are not available.]	No [No] [No] [Out-of-Network Benefits are not available.]
Breast pumps	Network		

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**Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.

Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
	None Out-of-Network [Benefits will be the same as stated under <i>Durable Medical Equipment (DME)</i> , <i>Orthotics</i> , <i>Prosthetic Devices</i> , and <i>Supplies</i> in this <i>Schedule of Benefits</i> .] [Out-of-Network Benefits are not available.]	No	No
[26.] Reconstructive Procedures			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization five business days before a scheduled reconstructive procedure is performed or, for non-scheduled procedures, within one business day or as soon as is reasonably possible. If you do not obtain prior authorization as required, [the amount you are required to pay will be increased to [5 - 50]% of the Allowed Amount] [you will be responsible for paying all charges and no Benefits will be paid]. [In addition, for Out-of-Network Benefits, you must contact us 24 hours before admission for scheduled inpatient admissions or as soon as is reasonably possible for non-scheduled inpatient admissions.]			
Note: returning home with Durable Medical Equipment, such as a walker, following a reconstructive procedure may result in an additional Co-payment. [Co-payments will be dependent on the tier the item is assigned to.] Refer to the <i>Durable Medical</i>	Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i> .		

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Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
<i>Equipment (DME), Orthotics, Prosthetic Devices, and Supplies</i> category in this <i>Schedule of Benefits</i> .	Out-of-Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i> .		
[27.] Rehabilitation Services - Outpatient Therapy and Manipulative Treatment			
[Prior Authorization Requirement] [For Out-of-Network Benefits, you must obtain prior authorization five business days before receiving [physical therapy] [,] [and] [occupational therapy] [,] [and] [Manipulative Treatment] [,] [and] [speech therapy] [,] [and] [pulmonary rehabilitation therapy] [,] [and] [cardiac rehabilitation therapy] [,] [and] [post-cochlear implant aural therapy] [,] [and] [cognitive rehabilitation therapy] [and] [vision therapy] or as soon as is reasonably possible. If you do not obtain prior authorization as required, [the amount you are required to pay will be increased to [5 - 50]% of the Allowed Amount] [you will be responsible for paying all charges and no Benefits will be paid].]			
[Limited per year as follows:] <ul style="list-style-type: none">• [[10 - 100] visits of physical therapy.]• [[10 - 100] visits of occupational therapy.]• [[10 - 100] visits of occupational therapy and	Network <i>Manipulative Treatment</i> \$[5 - 200] per treatment	Yes	No

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Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
<p>cognitive rehabilitation therapy combined.]</p> <ul style="list-style-type: none"> • [[10 - 100] Manipulative Treatments.] • [[10 - 100] visits of speech therapy.] • [[10 - 100] visits of speech therapy and post-cochlear implant aural therapy combined.] • [[10 - 100] visit of pulmonary rehabilitation therapy.] • [[10 - 100] visits of cardiac rehabilitation therapy.] • [[10 - 100] visits of cognitive rehabilitation therapy.] • [[10 - 100] visits of vision therapy.] <p>[Visits limits above for Manipulative Treatment, physical therapy, occupational therapy, and speech therapy do not apply for the treatment of Mental Illness or substance-</p>			

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Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
<p>related and addictive disorders.]</p> <p>Note: returning home with Durable Medical Equipment, such as a walker, following rehabilitation therapy may result in an additional Co-payment. [Co-payments will be dependent on the tier the item is assigned to.] Refer to the <i>Durable Medical Equipment (DME), Orthotics, Prosthetic Devices, and Supplies</i> category in this <i>Schedule of Benefits</i>.</p>	<p><i>Occupational Therapy for the Treatment of Mental Illness and Substance-Related and Addictive Disorders</i></p> <p>[[None]][\$1 - 100] per visit</p> <p><i>Occupational Therapy for All Other Conditions</i></p> <p>[*]\$\$[5 - 50] to [25 - 200]]\$[5 - 200] per visit</p> <p><i>Physical Therapy for the Treatment of Mental</i></p>	<p>Yes</p> <p>Yes</p>	<p>No</p> <p>No</p>

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Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
	<i>Illness and Substance-Related and Addictive Disorders</i> [[None]]\$[1 - 100]] per visit	Yes	No
	<i>Physical Therapy for All Other Conditions</i> [*]\$[[5 - 50] to [25 - 200]]\$[5 - 200] per visit	Yes	No
	<i>Speech Therapy for the Treatment of Mental Illness and Substance-Related and Addictive Disorders</i> [[None]]\$[1 - 100]] per visit	Yes	No
	<i>Speech Therapy for All Other Conditions</i> [*]\$[[5 - 50] to [25 - 200]]\$[5 - 200] per visit	Yes	No
	<i>Pulmonary Rehabilitation Therapy</i> [*]\$[[5 - 50] to [25 - 200]]\$[5 - 200] per visit	Yes	No

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Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
	<i>Cardiac Rehabilitation Therapy</i> [*]\$[[5 - 50] to [25 - 200]][5 - 200] per visit	Yes	No
	<i>Post-cochlear Implant Aural Therapy</i> [*]\$[[1 - 60] to [25 - 300]][5 - 600] per visit	Yes	No
	<i>Cognitive Rehabilitation Therapy</i> [*]\$[[5 - 50] to [25 - 200]][5 - 200] per visit	Yes	No
	Out-of-Network <i>Manipulative Treatment</i> \$[5 - 400] per treatment	Yes	No
	<i>Occupational Therapy for the Treatment of Mental Illness and Substance-Related and Addictive Disorders</i> [[None]][1 - 250] per visit	Yes	No
	<i>Occupational Therapy for All Other Conditions</i>	Yes	No

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Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
	<p>\$[5 - 500] per visit</p> <p><i>Physical Therapy for the Treatment of Mental Illness and Substance-Related and Addictive Disorders</i></p> <p>[[None]][\$1 - 250] per visit</p> <p><i>Physical Therapy for All Other Conditions</i></p> <p>\$[5 - 500] per visit</p> <p><i>Speech Therapy for the Treatment of Mental Illness and Substance-Related and Addictive Disorders</i></p> <p>[[None]][\$1 - 250] per visit</p> <p><i>Speech Therapy for All Other Conditions</i></p> <p>\$[5 - 500] per visit</p> <p><i>Pulmonary Rehabilitation Therapy</i></p> <p>\$[5 - 400] per visit</p>	<p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p>	<p>No</p> <p>No</p> <p>No</p> <p>No</p> <p>No</p>

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Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
	<i>Cardiac Rehabilitation Therapy</i> \$[5 - 400] per visit	Yes	No
	<i>Post-cochlear Implant Aural Therapy</i> \$[5 - 600] per visit	Yes	No
	<i>Cognitive Rehabilitation Therapy</i> \$[5 - 500] per visit	Yes	No
[28.] Scopic Procedures - Outpatient Diagnostic and Therapeutic			
[Prior Authorization Requirement] [For Out-of-Network Benefits, you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you do not obtain prior authorization as required, [the amount you are required to pay will be increased to [5 - 50]% of the Allowed Amount] [you will be responsible for paying all charges and no Benefits will be paid].]			
	Network <i>Level 1 Procedure</i> *\$[5 - 1,300] to [10 - 3,000] per visit	Yes	No
	<i>Level 2 Procedure</i>	Yes	No

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Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

*Co-payments in the table below marked with an asterisk indicate a Co-payment range. For these Covered Health Care Services, providers are assigned Co-payments within the range based on analysis of treatment outcomes and cost information that identify Network providers that provide cost-efficient care.

**Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.

Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
	<p>*\$[5 - 5,000] to [100 - 6,000] per visit</p> <p><i>Level 3 Procedure</i></p> <p>*\$[25 - 6,000] to [35 - 7,000] per visit</p> <p><i>All Other Procedures</i></p> <p>\$[50 - 2,000] *[[20 - 500] to [200 - 2,000]] per visit</p> <p>Out-of-Network</p> <p><i>Level 1 Procedure</i></p> <p>**\$[25 - 10,000] per visit</p> <p><i>Level 2 Procedure</i></p> <p>**\$[100 - 15,000] per visit</p> <p><i>Level 3 Procedure</i></p> <p>**\$[100 - 15,000] per visit</p> <p><i>All Other Procedures</i></p> <p>\$[200 - 4,000] per visit</p>	<p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p>	<p>No</p> <p>No</p> <p>No</p> <p>No</p> <p>No</p>
[29.] Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			

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Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

***Co-payments in the table below marked with an asterisk indicate a Co-payment range. For these Covered Health Care Services, providers are assigned Co-payments within the range based on analysis of treatment outcomes and cost information that identify Network providers that provide cost-efficient care.**

****Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.**

Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
<p align="center">Prior Authorization Requirement</p> <p>For Out-of-Network Benefits for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. If you do not obtain prior authorization as required, [the amount you are required to pay will be increased to [5 - 50]% of the Allowed Amount] [you will be responsible for paying all charges and no Benefits will be paid].</p> <p>[In addition, for Out-of-Network Benefits, you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.]</p>			
<p>[Limited to [40 - 180] days per year.]</p> <p>[Limited to:</p> <ul style="list-style-type: none"> • [[30 - 180] days per year in a Skilled Nursing Facility.] • [Covered Health Care Services in a Skilled Nursing Facility are not subject to an annual limit.] • [[30 - 180] days per year in an Inpatient Rehabilitation Facility.] • [Covered Health Care Services in an Inpatient Rehabilitation Facility are 	<p>Network</p> <p><i>Skilled Nursing Facility</i></p> <p>\$[100 - 5,000] per Inpatient Stay</p> <p><i>Inpatient Rehabilitation Facility</i></p> <p>\$[100 - 5,000] per Inpatient Stay</p>	<p>Yes</p> <p>Yes</p>	<p>No</p> <p>No</p>

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

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**Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.

Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
<p>not subject to an annual limit.]]</p> <p>[Network Benefits are limited to [40 - 180] days per year. Out-of-Network Benefits are limited to [40 - 180] days per year.]</p> <p>Note: returning home with Durable Medical Equipment, such as a walker, following an admission may result in an additional Co-payment. [Co-payments will be dependent on the tier the item is assigned to.] Refer to the <i>Durable Medical Equipment (DME), Orthotics, Prosthetic Devices, and Supplies</i> category in this <i>Schedule of Benefits</i>.</p>	<p>Out-of-Network</p> <p><i>Skilled Nursing Facility</i></p> <p>\$[100 - 12,000] per Inpatient Stay</p> <p><i>Inpatient Rehabilitation Facility</i></p> <p>\$[100 - 12,000] per Inpatient Stay</p>	<p>Yes</p> <p>Yes</p>	<p>No</p> <p>No</p>

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**Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.

Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
[30.] Surgery - Outpatient			
<p><i>[¹ Does not apply if prior authorization is required for all pain management.]</i></p> <p>[Prior Authorization Requirement]</p> <p>[For Out-of-Network Benefits [for all outpatient surgeries] [for [blepharoplasty] [,] [and] [cardiac catheterization] [,] [and] [cochlear implants] [,] [and] [uvulopalatopharyngoplasty] [,] [and] [pacemaker insertion] [,] [and] [¹pain management procedures] [,] [and] [vein procedures] [,] [and] [spine surgery] [,] [and] [total joint replacements] [,] [and] [implantable cardioverter defibrillators] [,] [and] [diagnostic catheterization and electrophysiology implant] [and] [sleep apnea surgery]], you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you do not obtain prior authorization as required, [the amount you are required to pay will be increased to [5 - 50]% of the Allowed Amount] [you will be responsible for paying all charges and no Benefits will be paid].]</p>			
Note: returning home with Durable Medical Equipment, such as crutches, following an outpatient surgery may result in an additional Co-payment. [Co-payments will be dependent on the tier the item is assigned to.] Refer to the <i>Durable Medical Equipment (DME), Orthotics, Prosthetic Devices, and Supplies</i> category in this <i>Schedule of Benefits</i> .	<p>Network</p> <p><i>Level 1 Procedure</i></p> <p>*[[None]][\$[5 - 1,300]] to [10 - 3,000] per visit</p> <p><i>Level 2 Procedure</i></p>	<p>Yes</p> <p>Yes</p>	<p>No</p> <p>No</p>

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**Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.

Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
	<p>*[[None]]\$[5 - 5,000] to [100 - 6,000] per visit</p> <p><i>Level 3 Procedure</i></p> <p>*[[None]]\$[25 - 6,000] to [35 - 7,000] per visit</p> <p><i>All Other Procedures</i></p> <p>*\$[50 - 2,000] [[20 - 500] to [200 - 2,000] per visit</p> <p>Out-of-Network</p> <p><i>Level 1 Procedure</i></p> <p>**\$[25 - 10,000] per visit</p> <p><i>Level 2 Procedure</i></p> <p>**\$[100 - 15,000] per visit</p> <p><i>Level 3 Procedure</i></p> <p>**\$[100 - 15,000] per visit</p> <p><i>All Other Procedures</i></p> <p>\$[200 - 4,000] per visit</p>	<p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p>	<p>No</p> <p>No</p> <p>No</p> <p>No</p> <p>No</p> <p>No</p> <p>No</p>
[31.] Temporomandibular Joint (TMJ) Services [and Orthognathic Surgery]			
[Prior Authorization Requirement]			

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**Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.

Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
<p>[For Out-of-Network Benefits, you must obtain prior authorization five business days before TMJ [or orthognathic surgery] services are performed during an Inpatient Stay in a Hospital. If you do not obtain prior authorization as required, [the amount you are required to pay will be increased to [5 - 50]% of the Allowed Amount] [you will be responsible for paying all charges and no Benefits will be paid].]</p> <p>[In addition, for Out-of-Network Benefits, you must contact us 24 hours before admission for scheduled inpatient admissions.]</p>			
<p>[Note: returning home with Durable Medical Equipment, such as an oral appliance, following orthognathic surgery may result in an additional Co-payment. [Co-payments will be dependent on the tier the item is assigned to.] Refer to the <i>Durable Medical Equipment (DME), Orthotics, Prosthetic Devices, and Supplies</i> category in this <i>Schedule of Benefits</i>.]</p>	<p>Network</p> <p><i>[Orthognathic Surgery]</i></p> <p>[\$[100 - 6,000] per Inpatient Stay]</p>	[Yes]	[No]
	<p><i>[All Other Services]</i></p> <p><i>Inpatient</i></p> <p>\$[100 - 5,000] per Inpatient Stay</p>	Yes	No
	<p><i>Outpatient Office Visit</i></p>	Yes	No

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**Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.

Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
	<p>[*]\$[[5 - 60] to [25 - 300]] [5 - 300] per visit <i>Outpatient Hospital</i></p> <p>[*]\$[20 - 500] to [200 - 2,000] per visit Out-of-Network <i>[Orthognathic Surgery]</i> [\$[200 - 15,000] per Inpatient Stay] <i>[All Other Services]</i> <i>Inpatient</i> \$[100 - 15,000] per Inpatient Stay <i>Outpatient Office Visit</i> \$[5 - 600] per visit <i>Outpatient Hospital</i> \$[100 - 4,000] per visit</p>	<p>Yes</p> <p>[Yes]</p> <p>Yes</p> <p>Yes</p> <p>Yes</p>	<p>No</p> <p>[No]</p> <p>No</p> <p>No</p> <p>No</p>
[32.] Therapeutic Treatments - Outpatient	<p>[Prior Authorization Requirement]</p> <p>[For Out-of-Network Benefits, you must obtain prior authorization [for all outpatient therapeutic services] [for the following outpatient therapeutic services] five business days before scheduled</p>		

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**Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.

Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
<p>services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. [Services that require prior authorization: [apherisis] [,] [and] [dialysis] [,] [and] [chemotherapy] [,] [and] [IV infusion] [,] [and] [radiation oncology] [,] [and] [intensity modulated radiation therapy] [,] [and] [hyperbaric oxygen therapy] [and] [MR-guided focused ultrasound].] If you do not obtain prior authorization as required, [the amount you are required to pay will be increased to [5 - 50]% of the Allowed Amount] [you will be responsible for paying all charges and no Benefits will be paid].]</p>			
	<p>Network</p> <p><i>Dialysis - Home</i></p> <p>[*]\$[[5 - 500] to [10 - 3,000]][5 - 3,000] per visit</p> <p><i>Dialysis - All Other Settings</i></p> <p>[*]\$[[5 - 500] to [100 - 5,000]][5 - 5,000] per visit</p> <p><i>Apherisis</i></p> <p>[*]\$[[5 - 500] to [100 - 6,000]][5 - 6,000] per visit</p> <p><i>Hyperbaric Oxygen Therapy</i></p> <p>[*]\$[[5 - 700] to [100 - 3,000]] [5 - 3,000] per visit</p> <p><i>Chemotherapy</i></p>	<p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p>	<p>No</p> <p>No</p> <p>No</p> <p>No</p> <p>No</p>

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**Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.

Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
	[*]\$[[5 - 500] to [100 - 9,000]][5 - 9,000] per visit <i>Radiation Oncology</i>	Yes	No
	[*]\$[[5 - 3,000] to [100 - 5,000]] per visit Out-of-Network <i>Dialysis - Home</i>	Yes	No
	\$[5 - 10,000] per visit <i>Dialysis - All Other Settings</i>	Yes	No
	\$[5 - 10,000] per visit <i>Apherisis</i>	Yes	No
	\$[5 - 15,000] per visit <i>Hyperbaric Oxygen Therapy</i>	Yes	No
	\$[5 - 15,000] per visit <i>Chemotherapy</i>	Yes	No
	\$[5 - 15,000] per visit <i>Radiation Oncology</i>	Yes	No
	[**]\$[5 - 15,000] per visit	Yes	No

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**Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.

Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
[33.] Transplantation Services	<p style="text-align: center;">[Prior Authorization Requirement]</p> <p>[For Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you do not obtain prior authorization as required, [the amount you are required to pay will be increased to [5 - 50]% of the Allowed Amount] [you will be responsible for paying all charges and no Benefits will be paid].]</p> <p>[In addition, for Out-of-Network Benefits, you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.]</p>		
For Network Benefits, transplantation services must be received from a Designated Provider. We do not require that cornea transplants be received from a Designated Provider in order for you to receive Network Benefits.	<p>Network</p> <p>Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i>.</p> <p>Out-of-Network</p> <p>[Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i>.]</p> <p>[Out-of-Network Benefits are not available.]</p>		
[34.] Urgent Care Center Services			

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****Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.**

Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
Note: returning home with Durable Medical Equipment, such as a crutches, following an urgent care visit may result in an additional Co-payment. [Co-payments will be dependent on the tier the item is assigned to.] Refer to the <i>Durable Medical Equipment (DME), Orthotics, Prosthetic Devices, and Supplies</i> category in this <i>Schedule of Benefits</i> .	Network \$[5 - 200] per visit Out-of-Network \$[5 - 400] per visit	Yes Yes	No No
[35.] Virtual Care Services			
[¹Network] Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by [visiting benefits.surest.com or] calling the telephone number on your ID card.	Network [Primary Care] [None][[\$[5 - 50]]][*][[\$[1 - 50] to [\$[25 - 100]] per visit]] [Behavioral Health Care]	[Yes]	[No]

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**Co-payments in the table below marked with two asterisks indicate the maximum Co-payment you will pay for that benefit category. For these Covered Health Care Services, the Co-payment will depend on the type of service you receive but will never be greater than the Co-payment listed.

Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
	[None][[\$5 - 50]][*][[\$1 - 50] to [\$25 - 100]] per visit]] <i>[Urgent Care]</i>	[Yes]	[No]
	[None][[\$5 - 50]][*][[\$1 - 50] to [\$25 - 100]] per visit]] <i>[Physical[, Occupational] [,] [and/or] [Speech] Therapy]</i>	[Yes]	[No]
	[None][[\$5 - 50]][*][[\$1 - 50] to [\$25 - 100]] per visit]] <i>[Specialty Care]</i>	[Yes]	[No]
	[None][[\$5 - 50]][*][[\$1 - 50] to [\$25 - 100]] per visit]] <i>[Specialty Care]</i> <i>[Allergy]</i>	[Yes]	[No]
	[None][[\$5 - 50]][*][[\$1 - 50] to [\$25 - 100]] per visit]] <i>[Cardiac/Cardio-thoracic Surgery]</i>	[Yes]	[No]

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Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
	[None][[\$[5 - 50]][*][[\$[1 - 50] to [\$[25 - 100]] per visit]] [Cardiology]	[Yes]	[No]
	[None][[\$[5 - 50]][*][[\$[1 - 50] to [\$[25 - 100]] per visit]] [Dermatology]	[Yes]	[No]
	[None][[\$[5 - 50]][*][[\$[1 - 50] to [\$[25 - 100]] per visit]] [Endocrinology]	[Yes]	[No]
	[None][[\$[5 - 50]][*][[\$[1 - 50] to [\$[25 - 100]] per visit]] [Gastroenterology]	[Yes]	[No]
	[None][[\$[5 - 50]][*][[\$[1 - 50] to [\$[25 - 100]] per visit]] [Infectious Disease]	[Yes]	[No]
	[None][[\$[5 - 50]][*][[\$[1 - 50] to [\$[25 - 100]] per visit]] [Nephrology]	[Yes]	[No]

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Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
	[None][[\$5 - 50]][*][[\$1 - 50] to [\$25 - 100]] per visit]] <i>[Neurology]</i>	[Yes]	[No]
	[None][[\$5 - 50]][*][[\$1 - 50] to [\$25 - 100]] per visit]] <i>[Neurosurgery]</i>	[Yes]	[No]
	[None][[\$5 - 50]][*][[\$1 - 50] to [\$25 - 100]] per visit]] <i>[Obstetrics/Gynecology]</i>	[Yes]	[No]
	[None][[\$5 - 50]][*][[\$1 - 50] to [\$25 - 100]] per visit]] <i>[Oncology]</i>	[Yes]	[No]
	[None][[\$5 - 50]][*][[\$1 - 50] to [\$25 - 100]] per visit]] <i>[Orthopedic Surgery]</i>	[Yes]	[No]
	[None][[\$5 - 50]][*][[\$1 - 50] to [\$25 - 100]] per visit]] <i>[Pulmonology]</i>	[Yes]	[No]

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Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
	[None][[\$[5 - 50]][*](\$[1 - 50] to [\$[25 - 100]] per visit)] <i>[Reproductive Endocrinology]</i>	[Yes]	[No]
	[None][[\$[5 - 50]][*](\$[1 - 50] to [\$[25 - 100]] per visit)] <i>[Rheumatology]</i>	[Yes]	[No]
	[None][[\$[5 - 50]][*](\$[1 - 50] to [\$[25 - 100]] per visit)] <i>[Sleep Disorder Services]</i>	[Yes]	[No]
	Out-of-Network [Out-of-Network Benefits are not available.]	[Out-of-Network Benefits are not available.]	[Out-of-Network Benefits are not available.]
	<i>[Primary Care]</i> [[None][[**]\$[1 - 500]] per visit]	[Yes]	[No]

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Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
	<i>[Behavioral Health Care]</i> [[None]][**] \$[1 - 500] per visit	[Yes]	[No]
	<i>[Physical], [Occupational] [,] [and/or] [Speech Therapy]</i> [[None]][**] \$[1 - 500] per visit	[Yes]	[No]
	<i>[Specialty Care]</i> [[None]][**] \$[1 - 500] per visit	[Yes]	[No]
	<i>[Specialty Care]</i> <i>[Allergy]</i> [[None]][**] \$[1 - 500] per visit	[Yes]	[No]
	<i>[Cardiac/Cardio-thoracic Surgery]</i> [[None]][**] \$[1 - 500] per visit	[Yes]	[No]
	<i>[Cardiology]</i> [[None]][**] \$[1 - 500] per visit	[Yes]	[No]

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Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
	<i>[Dermatology]</i> [[None]][**]\$[1 - 500] per visit	[Yes]	[No]
	<i>[Endocrinology]</i> [[None]][**]\$[1 - 500] per visit	[Yes]	[No]
	<i>[Gastroenterology]</i> [[None]][**]\$[1 - 500] per visit	[Yes]	[No]
	<i>[Infectious Disease]</i> [[None]][**]\$[1 - 500] per visit	[Yes]	[No]
	<i>[Nephrology]</i> [[None]][**]\$[1 - 500] per visit	[Yes]	[No]
	<i>[Neurology]</i> [[None]][**]\$[1 - 500] per visit	[Yes]	[No]
	<i>[Neurosurgery]</i> [[None]][**]\$[1 - 500] per visit	[Yes]	[No]
	<i>[Obstetrics/Gynecology]</i>		

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Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
	[[None]][**]\$[1 - 500]] per visit <i>[Oncology]</i> [[None]][**]\$[1 - 500]] per visit <i>[Orthopedic Surgery]</i> [[None]][**]\$[1 - 500]] per visit <i>[Pulmonology]</i> [[None]][**]\$[1 - 500]] per visit <i>[Reproductive Endocrinology]</i> [[None]][**]\$[1 - 500]] per visit <i>[Rheumatology]</i> [[None]][**]\$[1 - 500]] per visit <i>[Sleep Disorder Services]</i> [[None]][**]\$[1 - 500]] per visit	[Yes] [Yes] [Yes] [Yes] [Yes] [Yes] [Yes]	[No] [No] [No] [No] [No] [No] [No]
[36.] [Vision Exams]			

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[Limited to [1 exam] [[2 - 3] exams] every [[12 - 36] months] [year] [2 - 3 years].]	<p>[Network]</p> <p>[[None]][\$[5 – 300]] per visit]</p>	[Yes]	[No]
	<p>[Out-of-Network]</p> <p>[[None]][\$[5 – 600]] per visit]</p> <p>[Out-of-Network Benefits are not available.]</p>	<p>[Yes]</p> <p>[Out-of-Network Benefits are not available.]</p>	<p>[No]</p> <p>[Out-of-Network Benefits are not available.]</p>

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Covered Health Care Service	What Is the Maximum Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
[37.] [Ankle and Foot Bone Fusion]			
	[Network] [[*][None]][\$[5 - 4,000]] [Out-of-Network] [\$[1,000 - 8,000]]	[Yes] [Yes]	[No] [No]
[38.] [Ankle Arthroscopy and Ligament Repair]			
	[Network] [[*][None]][\$[5 - 4,000]] [Out-of-Network] [\$[1,000 - 8,000]]	[Yes] [Yes]	[No] [No]
[39.] [Ankle Replacement and Revision]			
	[Network] [[*][None]][\$[5 - 4,000]] [Out-of-Network] [\$[1,000 - 8,000]]	[Yes] [Yes]	[No] [No]

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Covered Health Care Service	What Is the Maximum Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
[40.] [Back Surgery, Cervical Spine Disc Decompression]			
	<i>[Network]</i> [[*][None]][\$[5 - 4,000]]	[Yes]	[No]
	<i>[Out-of-Network]</i> [\$[1,000 - 8,000]]	[Yes]	[No]
[41.] [Back Surgery, Cervical Spine Fusion]			
	<i>[Network]</i> [[*][None]][\$[5 - 4,000]]	[Yes]	[No]
	<i>[Out-of-Network]</i> [\$[1,000 - 8,000]]	[Yes]	[No]
[42.] [Back Surgery, Lumbar Spine Disc Decompression]			
	<i>[Network]</i> [[*][None]][\$[5 - 4,000]]	[Yes]	[No]
	<i>[Out-of-Network]</i> [\$[1,000 - 8,000]]	[Yes]	[No]

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Covered Health Care Service	What Is the Maximum Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
[43.] [Back Surgery, Lumbar Spine Fusion]			
	<i>[Network]</i> [[*][None]][\$[5 - 4,000]]	[Yes]	[No]
	<i>[Out-of-Network]</i> [\$[1,000 - 8,000]]	[Yes]	[No]
[44.] [Breast Reduction Surgery]			
	<i>[Network]</i> [[*][None]][\$[5 - 4,000]]	[Yes]	[No]
	<i>[Out-of-Network]</i> [\$[500 - 8,000]]	[Yes]	[No]
[45.] [Bunionectomy and Hammertoe Surgery]			
	<i>[Network]</i> [[*][None]][\$[5 - 2,500]]	[Yes]	[No]
	<i>[Out-of-Network]</i> [\$[500 - 5,000]]	[Yes]	[No]

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Covered Health Care Service	What Is the Maximum Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
[46.] [Cardiac Ablation]			
	[Network] [[*][None]][\$[5 - 4,000]]	[Yes]	[No]
	[Out-of-Network] [\$[1,000 - 8,000]]	[Yes]	[No]
[47.] [Carotid Endarterectomy and Stents]			
	[Network] [[*][None]][\$[5 - 4,000]]	[Yes]	[No]
	[Out-of-Network] [\$[1,000 - 8,000]]	[Yes]	[No]
[48.] [Carpal Tunnel Surgery]			
	[Network] [[*][None]][\$[5 - 2,000]]	[Yes]	[No]
	[Out-of-Network] [\$[500 - 4,000]]	[Yes]	[No]
[49.] [Cataract Surgery]			

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Covered Health Care Service	What Is the Maximum Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
	[Network] [[*][None]][\$5 - 2,000]] [Out-of-Network] [\$50 - 4,000]]	[Yes] [Yes]	[No] [No]
[50.] [Coronary Artery Bypass Graft Surgery]			
	[Network] [[*][None]][\$5 - 5,000]] [Out-of-Network] [\$1,000 - 8,000]]	[Yes] [Yes]	[No] [No]
[51.] [Coronary Catheterization and Percutaneous Coronary Intervention]			
	[Network] [[*][None]][\$5 - 4,000]] [Out-of-Network] [\$1,000 - 8,000]]	[Yes] [Yes]	[No] [No]

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Covered Health Care Service	What Is the Maximum Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
[52.] [Elbow Arthroscopy and Tenotomy]			
	<i>[Network]</i> [[*][None]][\$[5 - 2,000]]	[Yes]	[No]
	<i>[Out-of-Network]</i> [\$[500 - 4,000]]	[Yes]	[No]
[53.] [Elbow Replacement and Revision]			
	<i>[Network]</i> [[*][None]][\$[5 - 4,000]]	[Yes]	[No]
	<i>[Out-of-Network]</i> [\$[1,000 - 8,000]]	[Yes]	[No]
[54.] [Fibroid Removal (Myomectomy)]			
	<i>[Network]</i> [[*][None]][\$[5 - 4,000]]	[Yes]	[No]
	<i>[Out-of-Network]</i> [\$[1,000 - 8,000]]	[Yes]	[No]

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Covered Health Care Service	What Is the Maximum Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
[55.] [Gallbladder Removal Surgery (Cholecystectomy)]			
	[Network] [[*][None]][\$[5 - 3,000]]	[Yes]	[No]
	[Out-of-Network] [\$[1,000 - 6,000]]	[Yes]	[No]
[56.] [Ganglion Cyst Surgery]			
	[Network] [[*][None]][\$[5 - 2,000]]	[Yes]	[No]
	[Out-of-Network] [\$[400 - 4,000]]	[Yes]	[No]
[57.] [Hernia Repair]			
	[Network] [[*][None]][\$[5 - 3,000]]	[Yes]	[No]
	[Out-of-Network] [\$[1,000 - 6,000]]	[Yes]	[No]

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Covered Health Care Service	What Is the Maximum Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
[58.] [Hip Arthroscopy and Repair]			
	[Network] [[*][None]][\$[5 - 4,000]]	[Yes]	[No]
	[Out-of-Network] [\$[1,000 - 8,000]]	[Yes]	[No]
[59.] [Hip Replacement and Revision]			
	[Network] [[*][None]][\$[5 - 4,000]]	[Yes]	[No]
	[Out-of-Network] [\$[1,000 - 8,000]]	[Yes]	[No]
[60.] [Hysterectomy]			
	[Network] [[*][None]][\$[5 - 4,000]]	[Yes]	[No]
	[Out-of-Network] [\$[1,000 - 8,000]]	[Yes]	[No]

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Covered Health Care Service	What Is the Maximum Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
[61.] [Kidney Stone Ablation and Removal (Lithotripsy)]			
	<i>[Network]</i> [[*][None]][\$[5 - 2,500]]	[Yes]	[No]
	<i>[Out-of-Network]</i> [\$[500 - 5,000]]	[Yes]	[No]
[62.] [Knee Arthroscopy and Repair]			
	<i>[Network]</i> [[*][None]][\$[5 - 2,500]]	[Yes]	[No]
	<i>[Out-of-Network]</i> [\$[1,000 - 5,000]]	[Yes]	[No]
[63.] [Knee Replacement and Revision]			
	<i>[Network]</i> [[*][None]][\$[5 - 4,000]]	[Yes]	[No]
	<i>[Out-of-Network]</i> [\$[1,000 - 8,000]]	[Yes]	[No]

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[Insert when plan requires conditional coverages to be elected and activated.]

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[*Co-payments in the table below marked with an asterisk indicate a Co-payment maximum amount. You may be eligible for reduced Co-payments if you use Network providers who are high value providers, as determined by us, based on their rates of effectiveness, low risk of complications and total cost.]

Covered Health Care Service	What Is the Maximum Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
[64.] [Morton's Neuroma Surgery]			
	<i>[Network]</i> [[*][None]][\$[5 - 2,000]]	[Yes]	[No]
	<i>[Out-of-Network]</i> [\$[200 - 4,000]]	[Yes]	[No]
[65.] [Pacemakers and Defibrillators]			
	<i>[Network]</i> [[*][None]][\$[5 - 4,000]]	[Yes]	[No]
	<i>[Out-of-Network]</i> [\$[1,000 - 8,000]]	[Yes]	[No]
[66.] [Plantar Fasciitis Surgery]			
	<i>[Network]</i> [[*][None]][\$[5 - 2,000]]	[Yes]	[No]
	<i>[Out-of-Network]</i> [\$[600 - 4,000]]	[Yes]	[No]

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

[Include the Conditional Coverage section when the plan design requires conditional coverages to be elected and activated.]

[Benefits for Conditional Coverage]

[Insert when plan requires conditional coverages to be elected and activated.]

[Benefits for conditional coverage have a coverage period of 120 days from their effective date. Refer to Section 3: When Coverage Begins of the Certificate for details on electing and activating conditional coverage.]

[*Co-payments in the table below marked with an asterisk indicate a Co-payment maximum amount. You may be eligible for reduced Co-payments if you use Network providers who are high value providers, as determined by us, based on their rates of effectiveness, low risk of complications and total cost.]

Covered Health Care Service	What Is the Maximum Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
[67.] [Prostate Removal Surgery]			
	[Network] [[*][None]][\$[5 - 3,000]] [Out-of-Network] [\$[1,000 - 6,000]]	[Yes] [Yes]	[No] [No]
[68.] [Reflux and Hiatal Hernia Surgery]			
	[Network] [[*][None]][\$[5 - 4,000]] [Out-of-Network] [\$[1,000 - 8,000]]	[Yes] [Yes]	[No] [No]
[69.] [Shoulder Arthroscopy and Repair]			
	[Network] [[*][None]][\$[5 - 4,000]] [Out-of-Network] [\$[1,000 - 8,000]]	[Yes] [Yes]	[No] [No]

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

[Include the Conditional Coverage section when the plan design requires conditional coverages to be elected and activated.]

[Benefits for Conditional Coverage]

[Insert when plan requires conditional coverages to be elected and activated.]

[Benefits for conditional coverage have a coverage period of 120 days from their effective date. Refer to Section 3: When Coverage Begins of the Certificate for details on electing and activating conditional coverage.]

[*Co-payments in the table below marked with an asterisk indicate a Co-payment maximum amount. You may be eligible for reduced Co-payments if you use Network providers who are high value providers, as determined by us, based on their rates of effectiveness, low risk of complications and total cost.]

Covered Health Care Service	What Is the Maximum Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
[70.] [Shoulder Replacement and Revision]			
	<i>[Network]</i> [[*][None]][\$5 - 4,000]]	[Yes]	[No]
	<i>[Out-of-Network]</i> [\$1,000 - 8,000]]	[Yes]	[No]
[71.] [Sinus and Nasal Septum Surgery]			
	<i>[Network]</i> [[*][None]][\$5 - 3,000]]	[Yes]	[No]
	<i>[Out-of-Network]</i> [\$1,000 - 6,000]]	[Yes]	[No]
[72.] [Sling Surgery for Urinary Incontinence]			
	<i>[Network]</i> [[*][None]][\$5 - 4,000]]	[Yes]	[No]
	<i>[Out-of-Network]</i> [\$1,000 - 8,000]]	[Yes]	[No]

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

[Include the Conditional Coverage section when the plan design requires conditional coverages to be elected and activated.]

[Benefits for Conditional Coverage]

[Insert when plan requires conditional coverages to be elected and activated.]

[Benefits for conditional coverage have a coverage period of 120 days from their effective date. Refer to Section 3: When Coverage Begins of the Certificate for details on electing and activating conditional coverage.]

[*Co-payments in the table below marked with an asterisk indicate a Co-payment maximum amount. You may be eligible for reduced Co-payments if you use Network providers who are high value providers, as determined by us, based on their rates of effectiveness, low risk of complications and total cost.]

Covered Health Care Service	What Is the Maximum Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
[73.] [Spinal Cord Stimulator]			
	[Network] [[*][None]][\$[5 - 4,000]]	[Yes]	[No]
	[Out-of-Network] [\$[1,000 - 6,000]]	[Yes]	[No]
[74.] [Tonsillectomy and Adenoidectomy]			
	[Network] [[*][None]][\$[5 - 2,000]]	[Yes]	[No]
	[Out-of-Network] [\$[700 - 4,000]]	[Yes]	[No]
[75.] [Valve Replacement]			
	[Network] [[*][None]][\$[5 - 4,000]]	[Yes]	[No]
	[Out-of-Network] [\$[1,000 - 8,000]]	[Yes]	[No]

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

[Include the Conditional Coverage section when the plan design requires conditional coverages to be elected and activated.]

[Benefits for Conditional Coverage]

[Insert when plan requires conditional coverages to be elected and activated.]

[Benefits for conditional coverage have a coverage period of 120 days from their effective date. Refer to Section 3: When Coverage Begins of the Certificate for details on electing and activating conditional coverage.]

[*Co-payments in the table below marked with an asterisk indicate a Co-payment maximum amount. You may be eligible for reduced Co-payments if you use Network providers who are high value providers, as determined by us, based on their rates of effectiveness, low risk of complications and total cost.]

Covered Health Care Service	What Is the Maximum Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
[76.] [Wrist and Hand Joint Replacement]			
	[Network] [[*][None]][\$[5 - 3,000]]	[Yes]	[No]
	[Out-of-Network] [\$[800 - 6,000]]	[Yes]	[No]
[77.] [Wrist Arthroscopy and Repair]			
	[Network] [[*][None]][\$[5 - 3,000]]	[Yes]	[No]
	[Out-of-Network] [\$[800 - 4,000]]	[Yes]	[No]

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment You Pay?	Does the Amount You Pay Apply to	Does an Annual Deductible Apply?
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When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

[Include the Conditional Coverage section when the plan design requires conditional coverages to be elected and activated.]

[Benefits for Conditional Coverage]

[Insert when plan requires conditional coverages to be elected and activated.]

[Benefits for conditional coverage have a coverage period of 120 days from their effective date. Refer to Section 3: When Coverage Begins of the Certificate for details on electing and activating conditional coverage.]

[*Co-payments in the table below marked with an asterisk indicate a Co-payment maximum amount. You may be eligible for reduced Co-payments if you use Network providers who are high value providers, as determined by us, based on their rates of effectiveness, low risk of complications and total cost.]

Covered Health Care Service	What Is the Maximum Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
		the Out-of-Pocket Limit?	

Additional Benefits Required By Georgia Law

[78.] Autism Spectrum Disorder Services

Prior Authorization Requirement

For Out-of-Network Benefits for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95] % of Allowed Amounts.

Unlimited physical, speech, and occupational therapy services for Autism Spectrum Disorder for members age 20 and under.

Network

Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.

Out-of-Network

Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

[Include the Conditional Coverage section when the plan design requires conditional coverages to be elected and activated.]

[Benefits for Conditional Coverage]

[Insert when plan requires conditional coverages to be elected and activated.]

[Benefits for conditional coverage have a coverage period of 120 days from their effective date. Refer to Section 3: When Coverage Begins of the Certificate for details on electing and activating conditional coverage.]

[*Co-payments in the table below marked with an asterisk indicate a Co-payment maximum amount. You may be eligible for reduced Co-payments if you use Network providers who are high value providers, as determined by us, based on their rates of effectiveness, low risk of complications and total cost.]

Covered Health Care Service	What Is the Maximum Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
[79.] Dental Services - Anesthesia and Hospitalization			
<p>Prior Authorization Requirement</p> <p>For Out-of-Network Benefits for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Allowed Amounts.</p>			
	<p>Network</p> <p>Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i>.</p> <p>Out-of-Network</p> <p>Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i>.</p>		
[80.] Telehealth			
Telehealth does not include virtual care services provided by a Designated Virtual Network Provider for which	<p>Network</p> <p>Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i>.</p>		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

[Include the Conditional Coverage section when the plan design requires conditional coverages to be elected and activated.]

[Benefits for Conditional Coverage]

[Insert when plan requires conditional coverages to be elected and activated.]

[Benefits for conditional coverage have a coverage period of 120 days from their effective date. Refer to Section 3: When Coverage Begins of the Certificate for details on electing and activating conditional coverage.]

[*Co-payments in the table below marked with an asterisk indicate a Co-payment maximum amount. You may be eligible for reduced Co-payments if you use Network providers who are high value providers, as determined by us, based on their rates of effectiveness, low risk of complications and total cost.]

Covered Health Care Service	What Is the Maximum Co-payment You Pay?	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does an Annual Deductible Apply?
Benefits are provided under <i>Virtual Care Services</i> .	<i>Out-of-Network</i> Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i> .		

Allowed Amounts

Allowed Amounts are the amount we determine that we will pay for Benefits.

- For Network Benefits for Covered Health Care Services provided by a Network provider, except for your cost sharing obligations, you are not responsible for any difference between Allowed Amounts and the amount the provider bills.
- For Out-of-Network Benefits, except as described below, you are responsible for paying, directly to the out-of-Network provider, any difference between the amount the provider bills you and the amount we will pay for Allowed Amounts.
 - For Covered Health Care Services that are **Ancillary Services received at certain Network facilities on a non-Emergency basis from out-of-Network Physicians**, you are not responsible, and the out-of-Network provider may not bill you, for amounts in excess of your Co-payment which is based on the Recognized Amount as defined in the *Certificate*.
 - For Covered Health Care Services that are **non-Ancillary Services received at certain Network facilities on a non-Emergency basis from out-of-Network Physicians who have not satisfied the notice and consent criteria or for unforeseen or urgent medical needs that arise at the time a non-Ancillary Service is provided for which notice and consent**

has been satisfied as described below, you are not responsible, and the out-of-Network provider may not bill you, for amounts in excess of your Co-payment which is based on the Recognized Amount as defined in the *Certificate*.

- For Covered Health Care Services that are ***Emergency Health Care Services provided by an out-of-Network provider***, you are not responsible, and the out-of-Network provider may not bill you, for amounts in excess of your applicable Co-payment which is based on the Recognized Amount as defined in the *Certificate*.
- For Covered Health Care Services that are ***Air Ambulance services provided by an out-of-Network provider***, you are not responsible, and the out-of-Network provider may not bill you, for amounts in excess of your applicable Co-payment which is based on the rates that would apply if the service was provided by a Network provider which is based on the Recognized Amount as defined in the *Certificate*.

Allowed Amounts are determined in accordance with our reimbursement policy guidelines or as required by law, as described in the *Certificate*.

Network Benefits

Allowed Amounts are based on the following:

- When Covered Health Care Services are received from a Network provider, Allowed Amounts are our contracted fee(s) with that provider.
- When Covered Health Care Services are received from an out-of-Network provider as arranged by us, including when there is no Network provider who is reasonably accessible or available to provide Covered Health Care Services, Allowed Amounts are an amount negotiated by us or an amount permitted by law. Please contact us if you are billed for amounts in excess of your applicable Co-payment. We will not pay excessive charges or amounts you are not legally obligated to pay.

Out-of-Network Benefits

When Covered Health Care Services are received from an out-of-Network provider, as described below, Allowed Amounts are determined as follows:

- **For non-Emergency Covered Health Care Services received at certain Network facilities from out-of-Network Physicians** when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section 2799B-2(d) of the *Public Health Service Act* with respect to a visit as defined by the Secretary, the Allowed Amount is based on one of the following in the order listed below as applicable:
 - The reimbursement rate as determined by a state *All Payer Model Agreement*.
 - The reimbursement rate as determined by state law.
 - The initial payment made by us or the amount subsequently agreed to by the out-of-Network provider and us.
 - The amount determined by *Independent Dispute Resolution (IDR)*.

For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in 1861(e) of the *Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in 1861(mm)(1) of the *Social Security Act*), an ambulatory surgical center as described in section 1833(i)(1)(A) of the *Social Security Act*, and any other facility specified by the Secretary.

IMPORTANT NOTICE: For Ancillary Services, non-Ancillary Services provided without notice and consent, and non-Ancillary Services for unforeseen or urgent medical needs that arise at the time a service is provided for which notice and consent has been satisfied, you are not responsible, and an out-of-Network Physician may not bill you, for amounts in excess of your applicable Co-payment which is based on the Recognized Amount as defined in the *Certificate*.

- **For Emergency Health Care Services provided by an out-of-Network provider**, the Allowed Amount is based on one of the following in the order listed below as applicable:
 - The reimbursement rate as determined by a state *All Payer Model Agreement*.
 - The reimbursement rate as determined by state law.
 - The initial payment made by us or the amount subsequently agreed to by the out-of-Network provider and us.
 - The amount determined by *Independent Dispute Resolution (IDR)*.

IMPORTANT NOTICE: You are not responsible, and an out-of-Network provider may not bill you, for amounts in excess of your applicable Co-payment which is based on the Recognized Amount as defined in the *Certificate*.

- **For Air Ambulance transportation provided by an out-of-Network provider**, the Allowed Amount is based on one of the following in the order listed below as applicable:
 - The reimbursement rate as determined by a state *All Payer Model Agreement*.
 - The reimbursement rate as determined by state law.
 - The initial payment made by us or the amount subsequently agreed to by the out-of-Network provider and us.
 - The amount determined by *Independent Dispute Resolution (IDR)*.

IMPORTANT NOTICE: You are not responsible, and an out-of-Network provider may not bill you, for amounts in excess of your Co-payment which is based on the rates that would apply if the service was provided by a Network provider which is based on the Recognized Amount as defined in the *Certificate*.

- For Emergency ground ambulance transportation provided by an out-of-Network provider, the Allowed Amount, which includes mileage, is a rate agreed upon by the out-of-Network provider or, unless a different amount is required by applicable law, determined based upon the median amount negotiated with Network providers for the same or similar service.

IMPORTANT NOTICE: Out-of-Network providers may bill you for any difference between the provider's billed charges and the Allowed Amount described here.

When Covered Health Care Services are received from an out-of-Network provider, except as described above, Allowed Amounts are determined based on either of the following:

[\[MNRP payment option.\]](#)

- [\[Negotiated rates agreed to by the out-of-Network provider and either us or one of our vendors, affiliates or subcontractors.\]](#)
- [\[If rates have not been negotiated, then one of the following amounts:\]](#)
 - [\[Allowed Amounts are determined based on \[50 - 200\]% of the published rates allowed by the Centers for Medicare and Medicaid Services \(CMS\) for Medicare for the same or similar service within the geographic market.\]](#)
 - [\[When a rate is not published by CMS for the service, we use an available gap methodology to determine a rate for the service as follows:\]](#)
 - ♦ [\[For services other than Pharmaceutical Products, we use a gap methodology established by OptumInsight and/or a third-party vendor that uses a relative value scale or the amount typically accepted by a provider for the same or similar service. The relative value scale may be based on the difficulty, time, work, risk, location, and resources of the service. If the relative value scale\(s\) currently in use become no longer available, we will use a comparable scale\(s\). We and OptumInsight are related companies through common ownership by UnitedHealth Group.\]](#)

- ♦ For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems*, *Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.
- ♦ When a rate for a laboratory service is not published by CMS for the service and gap methodology does not apply to the service, the rate is based on the average amount negotiated with similar Network providers for the same or similar service.
- ♦ When a rate for all other services is not published by CMS for the service and a gap methodology does not apply to the service, the Allowed Amount is based on [10 - 50]% of the provider's billed charge.

We update the CMS published rate data on a regular basis when updated data from CMS becomes available. These updates are typically put in place within 30 to 90 days after CMS updates its data.

IMPORTANT NOTICE: Out-of-Network providers may bill you for any difference between the provider's billed charges and the Allowed Amount described here. This includes non-Ancillary Services when notice and consent is satisfied as described under section 2799B-2(d) of the *Public Health Service Act*.]

[Traditional OON payment option.]

- [Negotiated rates agreed to by the out-of-Network provider and either us or one of our vendors, affiliates or subcontractors.
- If rates have not been negotiated, then one of the following amounts:
 - For Covered Health Care Services other than Pharmaceutical Products, Allowed Amounts are determined based on available data resources of competitive fees in that geographic area.
 - When Covered Health Care Services are Pharmaceutical Products, Allowed Amounts are the average wholesale price of such Pharmaceutical Products as set forth in the *Red Book* drug pricing resource. The Pharmaceutical Product pricing information is updated annually.
 - When *Red Book* does not have a price for the product, an alternative pricing source such as, *RJ Health* or an internally developed pharmaceutical pricing resource to determine the average wholesale price for the covered Pharmaceutical Product will be used.
- When a rate is not available for the service, the Allowed Amount is based on [10 - 30]% of the billed charge.

IMPORTANT NOTICE: Out-of-Network providers may bill you for any difference between the provider's billed charges and the Allowed Amount described here. This includes non-Ancillary Services when notice and consent is satisfied as described under section 2799B-2(d) of the *Public Health Service Act*.]

Provider Network

We arrange for health care providers to take part in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to choose your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by [visiting benefits.surest.com] or] calling the telephone number on your ID card. A directory of providers is available by [visiting [\[benefits.surest.com\]](https://benefits.surest.com) or] calling the telephone number on your ID card to request a copy. If you receive a Covered Health Care Service from an out-of-Network provider and were informed incorrectly by us prior to receipt of the Covered Health Care Service that the provider was a Network provider, either through our database, our provider directory, or in our response to your request for such information (via telephone, electronic, web-

based or internet-based means), you may be eligible for cost sharing (Co-payment) that would be no greater than if the service had been provided from a Network provider.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If you are currently seeing a Network provider and that provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Network Benefits. However, if you are currently receiving treatment for Covered Health Care Services from a provider whose network status changes from Network to out-of-Network during such treatment due to termination (non-renewal or expiration) of the provider's contract, you may be eligible to request continued care from your current provider under the same terms and conditions that would have applied prior to termination of the provider's contract for specified conditions and timeframes. This provision does not apply to provider contract terminations for failure to meet applicable quality standards or for fraud. If you would like help to find out if you are eligible for continuity of care Benefits, please call the telephone number on your ID card.

If you are currently undergoing a course of treatment using an out-of-Network Physician or health care facility, you may be eligible to receive transition of care. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help to find out if you are eligible for transition of care Benefits, please call the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Care Services. Some Network providers contract with us to provide only certain Covered Health Care Services, but not all Covered Health Care Services. Some Network providers choose to be a Network provider for only some of our products. For assistance [\[visit \[benefits.surest.com\]\(https://benefits.surest.com\)\]](https://benefits.surest.com) or [\[call the telephone number on your ID card\]](#).

Designated Providers

If you have a medical condition that we believe needs special services, we may direct you to a Designated Provider chosen by us. If you require certain complex Covered Health Care Services for which expertise is limited, we may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Care Services from a Designated Provider, we may reimburse certain travel expenses.

In both cases, Network Benefits will only be paid if your Covered Health Care Services for that condition are provided by or arranged by the Designated Provider chosen by us.

You or your Network Physician must notify us of special service needs (such as transplants or cancer treatment) that might warrant referral to a Designated Provider. If you do not notify us in advance, and if you receive services from an out-of-Network facility (regardless of whether it is a Designated Provider) or other out-of-Network provider, Network Benefits will not be paid. Out-of-Network Benefits may be available if the special needs services you receive are Covered Health Care Services for which Benefits are provided under the Policy.

Health Care Services from Out-of-Network Providers Paid as Network Benefits

If specific Covered Health Care Services are not available from a Network provider, you may be eligible for Network Benefits when Covered Health Care Services are received from out-of-Network providers. In this situation, your Network Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Network Physician to coordinate care through an out-of-Network provider.

Limitations on Selection of Providers

If we determine that you are using health care services in a harmful or abusive manner, or with harmful frequency, your selection of Network providers may be limited. If this happens, we may require you to select a single Network Physician to provide and coordinate all future Covered Health Care Services.

If you don't make a selection within 31 days of the date we notify you, we will select a single Network Physician for you.

If you do not use the selected Network Physician, Covered Health Care Services will be paid as Out-of-Network Benefits.