

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.”

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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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- *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 (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-RV-2018-HeritagePlus-LG-GA, SBN23-Medical-INS-RV-2018-HeritagePlus-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, or failure to provide or make payment (in whole or in part), 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 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.””

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 Schedule of Benefits 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

Factor - Services that are EIU

Factor - Patient Safety

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

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 an 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, 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.

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

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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.

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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 (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-RV-2018-HeritagePlus-LG-GA, SBN23-Medical-INS-RV-2018-HeritagePlus-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, or failure to provide or make payment (in whole or in part), 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, 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 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 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.””

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 Schedule of Benefits 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 (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.

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 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

Factor - Consistency

Factor - Low Volume

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

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 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.

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 (UHC)
- UnitedHealthcare of Georgia, Inc. (UHCGA)
- UnitedHealthcare Insurance Company of the River Valley (UHCIRV)
- 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.

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.

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 (NQT) Analysis

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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

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 – 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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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

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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
12/29/2023



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
12/29/2023



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-IE-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/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-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
- *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
12/29/2023



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](https://www.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
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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.

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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."

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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 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-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-RV-2018-HeritagePlus-LG-GA, SBN23-Medical-INS-RV-2018-HeritagePlus-SG-GA*) - 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, 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, or failure to provide or make payment (in whole or in part), 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 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.

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 of the River Valley (UHICRV)

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, 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”

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'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.

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 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:

- Outpatient Electroconvulsive Therapy
- Applied Behavioral Analysis for the treatment of Autism
- Transcranial Magnetic Stimulation (TMS) (for MDs only)
- Psychological Testing

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)
- Psychological/Neuropsychological Testing
 - Optum Psychological and Neuropsychological Testing Request Form (electronic submission for Optum Behavioral Health)
- 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 (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.
 - 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

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

The evidentiary standard and the source apply to M/S and MH/SUD INN outpatient services and are defined in a quantitative manner.

Factor -

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

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

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

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

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.

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-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-RV-2018-HeritagePlus-LG-GA, SBN23-Medical-INS-RV-2018-HeritagePlus-SG-GA*) - 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, 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, or failure to provide or make payment (in whole or in part), 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 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, 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 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 of the River Valley (UHICRV)

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, 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”

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'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) 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.

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 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. 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-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-RV-2018-HeritagePlus-LG-GA, SBN23-Medical-INS-RV-2018-HeritagePlus-SG-GA*) - 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, 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, or failure to provide or make payment (in whole or in part), 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 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, 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 of the River Valley (UHICRV)

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, 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.

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'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) 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.

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)

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

- 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

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

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 - Consistency

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 and
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)

Process

Reimbursement Policy-Coding Edits Non-Quantitative Treatment Limitation (NQTL) Analysis

GA – UnitedHealthcare Insurance Company, UnitedHealthcare of
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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

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.

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GA – UnitedHealthcare Insurance Company, UnitedHealthcare of
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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
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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.

Retrospective Review In-Network Inpatient Non-Quantitative Treatment Limitations (NQTL) Analysis

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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).

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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 (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
- *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, or failure to provide or make payment (in whole or in part), 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, or failure to provide or make payment (in whole or in part), 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 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
- 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 (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 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.”

Retrospective Review Out-of-Network Inpatient Non-Quantitative Treatment Limitations (NQTL) Analysis

GA -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.

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: *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

Commented [RA1]: Ensure appropriate year's policy is pulled and attached (i.e., if request is for PY2021 ensure document used in 2021 is provided)

Commented [KC2]: A comparable document is not listed in the other UM NQTLs. Is it unique to RR? Otherwise, it should be treated consistently.

Commented [JSB3R2]: This is specific to retro review

Commented [KC4]: This document is not listed in the PA NQTLs. Should it be or should it be removed here?

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



Retrospective Review Out-of-Network Inpatient Non-Quantitative Treatment Limitations (NQTL) Analysis

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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.

Commented [RA5]: OBH to review MH/SUD clinical criteria to ensure accuracy

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 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"

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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

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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.

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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

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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.

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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 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

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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, 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

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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 the M/S codes that may be subject to Retrospective Review
- *Certificates of Coverage (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
- *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

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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, or failure to provide or make payment (in whole or in part), 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, or failure to provide or make payment (in whole or in part), of a benefit. Adverse

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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 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
- 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 (AAPCP) 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.

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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.

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

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 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

GA – UnitedHealthcare Insurance Company, UnitedHealthcare of Georgia, Inc.

and UnitedHealthcare Insurance Company of the River Valley

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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

GA – UnitedHealthcare Insurance Company, UnitedHealthcare of Georgia,
Inc. and UnitedHealthcare Insurance Company of the River Valley
12/29/2023



- 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

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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-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-RV-2018-HeritagePlus-LG-GA, SBN23-Medical-INS-RV-2018-HeritagePlus-SG-GA*) - 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, 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, or failure to provide or make payment (in whole or in part), 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, 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 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 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 Clinical Quality & Operations Committee 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 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 of the River Valley (UHICRV)

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, 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*, 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’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.

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 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 pre-authorization 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, psychological/neuropsychological guidelines, 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 (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.

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)*.

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.
- 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 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. 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.

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 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)

Prior Authorization – Inpatient In-Network Non-Quantitative Treatment Limitation (NQTL) Analysis

GA –UnitedHealthcare Insurance

Company of the River Valley

12/29/2023



- 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)

UHICRV

Outcomes Data Prior Authorization Review Analysis:		In-Network Inpatient	
		M/S	MH/SUD
Total # of Requests Received		63	21
Total # of Requests Approved		57	20
Total # of Requests Clinically Denied		6	1
Approval Rate %		90.48%	95.24%
Clinical Denial Rate %		9.52%	4.76%
Total # of Clinical Denials reviewed upon appeal-Total (Internal & External)		2	0
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)		2	0
Clinical Denial Uphold Rate %--Total (Internal & External)		100.00%	-
Total # of Clinical Denials reviewed upon internal appeal only		2	0
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		2	0
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		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-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-RV-2018-HeritagePlus-LG-GA, SBN23-Medical-INS-RV-2018-HeritagePlus-SG-GA*) - 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, 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, or failure to provide or make payment (in whole or in part), 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 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.

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 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, 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 of the River Valley (UHICRV)

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, 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”

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'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.

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 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:

- Outpatient Electroconvulsive Therapy

- Applied Behavioral Analysis for the treatment of Autism
- Transcranial Magnetic Stimulation (TMS) (for MDs only)
- Psychological Testing

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)
- Psychological/Neuropsychological Testing
 - Optum Psychological and Neuropsychological Testing Request Form (electronic submission for Optum Behavioral Health)
- 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, psychological/neuropsychological guidelines, 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 (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, 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 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.
- **Time frame 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. 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.

- 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 of the River Valley (UHCVRV), M/S had a clinical denial rate of 10.58% and MH/SUD had a clinical denial rate of 3.60%. 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)

Prior Authorization – Outpatient In-Network Non-Quantitative Treatment Limitation (NQTL) Analysis

GA –UnitedHealthcare Insurance Company of the River Valley
12/29/2023



UHCIRV

Outcomes Data Prior Authorization Review Analysis:

	In-Network Outpatient	
	M/S	MH/SUD
Total # of Requests Received	2,551	139
Total # of Requests Approved	2,282	134
Total # of Requests Clinically Denied	270	5
Approval Rate %	89.46%	96.40%
Clinical Denial Rate %	10.58%	3.60%
Total # of Clinical Denials reviewed upon appeal-Total (Internal & External)	19	0
Total # of Clinical Denials Overturned upon appeal--Total (Internal & External)	7	0
Clinical Denial Overturn Rate %- Total (Internal & External)	36.84%	-
Total # of Clinical Denials Upheld-Total (Internal & External)	12	0
Clinical Denial Uphold Rate %--Total (Internal & External)	63.16%	-
Total # of Clinical Denials reviewed upon internal appeal only	18	0
Total # of Clinical Denials Overturned upon internal appeal only	7	0
Clinical Denial Overturn Rate %, internal appeal only	38.89%	-
Total # of Clinical Denials Upheld upon internal appeal	11	0
Clinical Denial Uphold Rate %, internal appeal only	61.11%	-
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	1	0
Clinical Uphold Denial Rate %, external appeal only	100.00%	-

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-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-RV-2018-HeritagePlus-LG-GA, SBN23-Medical-INS-RV-2018-HeritagePlus-SG-GA*) - 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, 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, or failure to provide or make payment (in whole or in part), 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, 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 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 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 Clinical Quality & Operations Committee 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 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 of the River Valley (UHICRV)

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, 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”

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'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, psychological/neuropsychological guidelines, 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 (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.

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. 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.

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 (UHCIRV).

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)

UHCIRV

Outcomes Data Prior Authorization Review Analysis:	Out-of-Network Inpatient	
	M/S	MH/SUD
Total # of Requests Received	1	25
Total # of Requests Approved	0	23
Total # of Requests Clinically Denied	1	1
Approval Rate %	0.00%	92.00%
Clinical Denial Rate %	100.00%	4.00%
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	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-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-RV-2018-HeritagePlus-LG-GA, SBN23-Medical-INS-RV-2018-HeritagePlus-SG-GA*) - 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, 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, or failure to provide or make payment (in whole or in part), 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 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 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, 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 of the River Valley (UHICRV)

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, 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.

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'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, psychological/neuropsychological guidelines, 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, 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 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.
- 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.

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 outpatient cases from 01/01/2022-12/31/2022 to support an analysis of clinical outcomes data for UnitedHealthcare Insurance Company of the River Valley (UHCIRV).

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

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- 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)

UHCIRV

Outcomes Data Prior Authorization Review Analysis:

	Out-of-Network Outpatient		
	M/S	MH/SUD	
Total # of Requests Received	77	43	Low volume (of some classifications) is not sufficient for analysis. (quantity of 100 each, is required for a valid sample)
Total # of Requests Approved	71	42	
Total # of Requests Clinically Denied	6	1	
Approval Rate %	92.21%	97.67%	
Clinical Denial Rate %	7.79%	2.33%	
Total # of Clinical Denials reviewed upon appeal--Total (Internal & External)	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 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	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	-	-	
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	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	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
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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

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

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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,

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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; 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, ([2023 UnitedHealthcare Care Provider Administrative Guide \(uhcprovider.com\)](https://uhcprovider.com/content/uhc-provider-administrative-guide/us/en/clinical-resources/guidelines-policies/optum-network-manual.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>).

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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://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

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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.

UHCRA

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.

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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 (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
- *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, or failure to provide or make payment (in whole or in part), 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, or failure to provide or make payment (in whole or in part), 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 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

- Retrospective Review

Benefit Classification(s)

- INN, outpatient

Plan(s) at Issue

- 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
- 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, psychological/neuropsychological guidelines, 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.
- 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, 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 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 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 of the River Valley (UHCIRV).

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
- 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)

UHCIRV

Outcomes Data Retrospective Review Analysis:	In-Network Outpatient	
	M/S*	MH/SUD
Total # of Requests Received	66	2
Total # of Requests Approved	63	2
Total # of Requests Clinically Denied	3	0
Approval Rate %	95.45%	100.00%
Clinical Denial Rate %	4.55%	0.00%
Total # of Clinical Denials reviewed upon appeal-Total (Internal & External)	20	0
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)	20	0
Clinical Denial Uphold Rate %--Total (Internal & External)	100.00%	-
Total # of Clinical Denials reviewed upon internal appeal only	20	0
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	20	0
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	-	-

NOTE: Due to a system migration, not all M/S post claim retrospective review data is available at this time.

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.”

Retrospective Review Out-of-Network Inpatient Non-Quantitative Treatment Limitations (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

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 (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.

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

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

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



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

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



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)

UHIC

Outcomes Data Concurrent Review Analysis:

	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	-	-

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



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

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



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 (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-RV-2018-HeritagePlus-LG-GA, SBN23-Medical-INS-RV-2018-HeritagePlus-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, or failure to provide or make payment (in whole or in part), 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 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, 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 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.””

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 Schedule of Benefits 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, psychological/neuropsychological guidelines, 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 (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, 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 an 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, 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 of the River Valley (UHCIRV).

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 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

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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)

UHCIRV

Outcomes Data Concurrent Review Analysis:	In-Network Outpatient	
	M/S	MH/SUD
Total # of Requests Received	32	0
Total # of Requests Approved	29	0
Total # of Requests Clinically Denied	3	0
Approval Rate %	90.63%	-
Clinical Denial Rate %	9.38%	-
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	-	-

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	-	-

UHC RV

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 (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-RV-2018-HeritagePlus-LG-GA, SBN23-Medical-INS-RV-2018-HeritagePlus-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, or failure to provide or make payment (in whole or in part), 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 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, 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 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.””

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 Schedule of Benefits 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, psychological/neuropsychological guidelines, 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, 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.
- **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 of the River Valley (UHICRV).

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)

UHCRCV

Outcomes Data Concurrent Review Analysis:	Out-of-Network Outpatient		
	M/S	MH/SUD	
Total # of Requests Received	0	1	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	1	
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	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	1	
Clinical Denial Uphold Rate %--Total (Internal & External)	-	100.00%	
Total # of Clinical Denials reviewed upon internal appeal only	0	1	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	1	
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
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 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

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
12/29/2023



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

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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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 (UHC Credentialing Plan, uhcprovider.com/content/dam/provider/docs/public/resources/join-network/Credentialing-Plan.pdf , page 22, Attachment A, 11)	MH/SUD credentialing application requirements (UBH Credentialing Plan, 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 (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;

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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.

Geographic Restrictions Non-Quantitative Treatment Limitation (NQTL) Analysis

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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

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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

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- 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)
- 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.

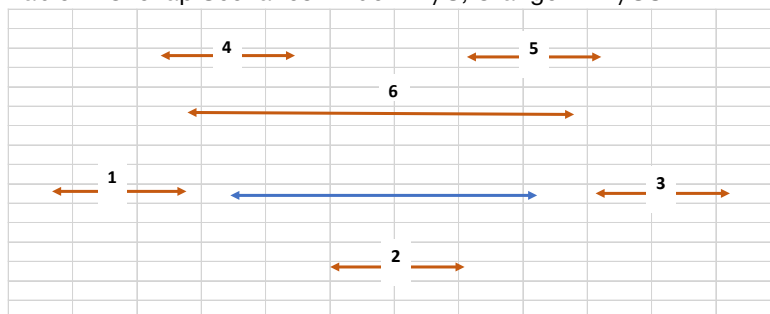
Testing for Comparability

- 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
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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 BH w/n Med	2 BH w/n Med
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
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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)
- 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.

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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/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.”

Medical Necessity Non-Quantitative Treatment Limitation (NQTL) 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 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 (UHICRV)
- 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 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

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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

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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.

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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 OON 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.”