Non-Quantitative Treatment Limitation (NQTL) Reporting Submission Form

Instructions: This NQTL reporting submission form includes the required five elements as specified by 42 U.S.C. Section 300gg-26(a)(8)(A); 29 U.S.C. Section 1185a(a)(8)(A); and 26 U.S.C. Section 9812(a)(8)(A). Plans and issuers (or a department) can choose to submit a different form for each classification of benefits (recommended approach) or duplicate the prompts below for each classification of benefits. It is not recommended that a plan or issuer submit multiple NQTLs in the same document.

In-Network Reimbursement: Facility Based

Step 1:

Specify the specific Plan or coverage terms or other relevant terms regarding the NQTL, that applies to such Plan or coverage, and provide a description of all MH or SUD and medical or surgical benefits to which the NQTL applies or for which it does not apply.

FAQ 45 Guidance: The FAQ 45 (Q2, #'s 1 and 2) guidance stipulate that a sufficient analysis should include:

A clear description of the specific NQTL, plan terms, and policies at issue; and

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.

Plan(s) at Issue

- UnitedHealthcare of Illinois, Inc.
- UnitedHealthcare Plan of the River Valley, Inc.
- UnitedHealthcare Insurance Company of Illinois
- UnitedHealthcare Insurance Company of the River Valley

Inpatient, in-network:

Negotiation

For both M/S and MH/SUD facilities, the Plan uses a substantially similar process to negotiate and establish reimbursement rates for INN facility services. The Plan delegates negotiation of reimbursement rates for MH/SUD facility providers to United Behavioral Health d/b/a Optum Behavioral Health (OBH), it's delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor.

Key steps in the INN facility reimbursement negotiation process for both M/S and MH/SUD services include:

[redacted]

Detailed process for the INN facility reimbursement negotiation:

[redacted]

[redacted]

Inpatient M/S -- General Acute Care, Children's, and Long-Term Acute Care Facilities

[redacted]

The following provides an overview of the inpatient reimbursement methodologies used by the Plan:

- [redacted]
- [redacted]
- [redacted]
- [redacted]

[redacted]

Inpatient MH/SUD – Inpatient and Residential

The Plan contracts for inpatient MH/SUD services using the following methodology:

- [redacted]

[redacted]

Outpatient M/S -- General Acute Care, Children's, and Long-Term Acute Care Facilities

[redacted]

[redacted]

The following provides an overview of the outpatient reimbursement methodologies used:

- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]

[redacted]

Outpatient MH/SUD – Intensive Outpatient Programs and Partial Hospitalization Programs

[redacted]

- [redacted]

[redacted]

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.

Plan Terms

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

Inpatient, out-of-network:
Not Applicable

Outpatient, in-network:
Same as Inpatient, in-network

Outpatient, out-of-network:
Not Applicable

Emergency:
Same as Inpatient, in-network

Prescription drug:
Not Applicable

Step 2:

Identify all the factors (quantitative and qualitative and label as appropriate) used to determine that the NQTL will apply to MH/SUD benefits and medical or surgical benefits.

FAQ 45 Guidance: The FAQ 45 (Q2, #3) guidance stipulates that a sufficient analysis includes:

Identification of any factors, evidentiary standards or sources, 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.

Inpatient, in-network:
The Plan relies on the following factors to establish reimbursement rates for M/S and MH/SUD facilities.

[redacted]

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)

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.

Inpatient, out-of-network:
Not Applicable

Outpatient, in-network:
Same as Inpatient, in-network

Outpatient, out-of-network:
Not Applicable

Emergency:
Same as Inpatient, in-network

Prescription drug:
Not Applicable

Step 3:

Provide the evidentiary standards used for the factors identified in Step 2, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTL to MH/SUD benefits and medical or surgical benefits.

FAQ 45 Guidance: The FAQ 45 (Q 2, # 4) guidance stipulates that a sufficient response includes:

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.

The FAQ 45 guidance (Q 3, # 5) states that the following is insufficient:

Reference to factors and evidentiary standards that were defined or applied in a quantitative manner, without the precise definitions, data, and information necessary to assess their development or application.

Inpatient, in-network:
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:

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.

Inpatient, out-of-network:

Not Applicable

Outpatient, in-network:
Same as Inpatient, in-network

Outpatient, out-of-network:
Not Applicable

Emergency:
Same as Inpatient, in-network

Prescription drug:
Not Applicable

Step 4:

Provide the comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits, **as written and in operation**, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical or surgical benefits.

FAQ 45 Guidance: The FAQ 45 guidance states that the following is necessary for a sufficient response:

Q2, #5) 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 mental health or substance use disorder and medical or surgical benefits and, if so, describe the process and factors used for establishing that variation.

(Q 2, # 6) 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).

(Q2, #7) 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 mental health or substance use disorder and medical or surgical benefits.

The FAQ 45 guidance states that the following constitutes an insufficient response:

(Q 3, # 1) Production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analysis.

(Q3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.

(Q 3, # 3) Identification of processes, strategies, sources, and factors without the required or clear and detailed comparative analysis.

(Q 3, # 4) Identification of factors, evidentiary standards, and strategies without a clear explanation of how they were defined and applied in practice.

Inpatient, in-network:

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 [redacted].

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, a comparative analysis with MH/SUD is inherently complex. [redacted].

Inpatient, out-of-network:

As written:
Not Applicable

In operation:
Not Applicable

Outpatient, in-network:

As written:
Same as Inpatient, in-network

In operation:
Same as Inpatient, in-network

Outpatient, out-of-network:

As written:
Not Applicable

In operation:
Not Applicable

Emergency:

As written:
Same as Inpatient, in-network

In operation:
Same as Inpatient, in-network

Prescription drug:

As written:
Not Applicable

In operation:
Not Applicable

Step 5:

The specific findings and conclusions reached by the Plan or issuer with respect to the health insurance coverage, including any results of the analyses described in the previous steps that indicate that the Plan or issuer is or is not in compliance with the MHPAEA NQTL requirements.

FAQ 45 Guidance: The FAQ 45 guidance states that a sufficient response should include:

(Q 2, # 8) 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.

The FAQ 45 guidance states that the following constitutes an insufficient response:

(Q 3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.

Inpatient, in-network:

Findings
"as Written"
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, [redacted]

The findings of that analysis confirmed the strategies, processes, factors, evidentiary standards, and source information used to negotiate and establish reimbursements for MH/SUD INN facility services and/or programs were comparable to, and applied no more stringently than, the strategies, processes, factors, evidentiary standards, and source information used to negotiate and establish facility reimbursement for M/S INN facility services and/or programs "as written."

"in Operation"
The Plan determined that M/S facility-based services are reimbursed under a variety of different reimbursement models, [redacted].

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

"as Written"
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."

"in Operation"
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."

Inpatient, out-of-network:
Not Applicable

Outpatient, in-network:
Same as Inpatient, in-network

Outpatient, out-of-network:
Not Applicable

Emergency:
Same as Inpatient, in-network

Prescription drug:
Not Applicable

In-Network Reimbursement: Professional Services

Step 1:

Specify the specific Plan or coverage terms or other relevant terms regarding the NQTL, that applies to such Plan or coverage, and provide a description of all MH or SUD and medical or surgical benefits to which the NQTL applies or for which it does not apply.

FAQ 45 Guidance: The FAQ 45 (Q2, #'s 1 and 2) guidance stipulate that a sufficient analysis should include:

A clear description of the specific NQTL, plan terms, and policies at issue; and

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.

Plan(s) at Issue

- UnitedHealthcare of Illinois, Inc.
- UnitedHealthcare Plan of the River Valley, Inc.
- UnitedHealthcare Insurance Company of Illinois
- UnitedHealthcare Insurance Company of the River Valley

Inpatient, in-network:

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:

[redacted]

Detailed process for the INN professional services reimbursement negotiation:

[redacted]

[redacted]

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.

Plan Terms

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.

Inpatient, out-of-network:
Not Applicable

Outpatient, in-network:
Same as Inpatient, in-network

Outpatient, out-of-network:
Not Applicable

Emergency:
Same as Inpatient, in-network

Prescription drug:
Not Applicable

Step 2:

Identify all the factors (quantitative and qualitative and label as appropriate) used to determine that the NQTL will apply to MH/SUD benefits and medical or surgical benefits.

FAQ 45 Guidance: The FAQ 45 (Q2, #3) guidance stipulates that a sufficient analysis includes:

Identification of any factors, evidentiary standards or sources, 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.

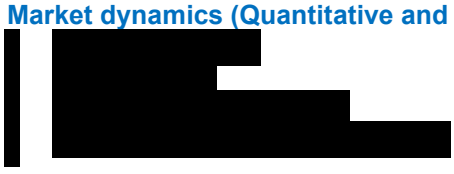
Inpatient, in-network:
The Plan relies on the following factors to **establish** reimbursement rates for M/S and MH/SUD professionals:

- **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:



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.

Inpatient, out-of-network:
Not Applicable

Outpatient, in-network:
Same as Inpatient, in-network

Outpatient, out-of-network:
Not Applicable

Emergency:
Same as Inpatient, in-network

Prescription drug:
Not Applicable

Step 3:

Provide the evidentiary standards used for the factors identified in Step 2, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTL to MH/SUD benefits and medical or surgical benefits.

FAQ 45 Guidance: The FAQ 45 (Q 2, # 4) guidance stipulates that a sufficient response includes:

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.

The FAQ 45 guidance (Q 3, # 5) states that the following is insufficient:

Reference to factors and evidentiary standards that were defined or applied in a quantitative manner, without the precise definitions, data, and information necessary to assess their development or application.

Inpatient, in-network:
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):

[redacted]

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:

[redacted]

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.

Inpatient, out-of-network:
Not Applicable

Outpatient, in-network:
Same as Inpatient, in-network

Outpatient, out-of-network:
Not Applicable

Emergency:
Same as Inpatient, in-network

Prescription drug:
Not Applicable

Step 4:

Provide the comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits, **as written and in operation**, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical or surgical benefits.

FAQ 45 Guidance: The FAQ 45 guidance states that the following is necessary for a sufficient response:

(Q2, #5) 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 mental health or substance use disorder and medical or surgical benefits and, if so, describe the process and factors used for establishing that variation.

(Q 2, # 6) 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).

(Q2, #7) 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 mental health or substance use disorder and medical or surgical benefits.

The FAQ 45 guidance states that the following constitutes an insufficient response:

(Q 3, # 1) Production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analysis.

(Q3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.

(Q 3, # 3) Identification of processes, strategies, sources, and factors without the required or clear and detailed comparative analysis.

(Q 3, # 4) Identification of factors, evidentiary standards, and strategies without a clear explanation of how they were defined and applied in practice.

Inpatient, in-network:

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, [redacted]

In operation:
[redacted]

Data Included in Analysis
07/01/2022 through 06/30/2023 INN provider allowed amounts derived from claims reporting.

Provider Type
[redacted]

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

The Plan concludes the above testing and comparison is sufficient to demonstrate comparability in operation.

Inpatient, out-of-network:

As written:
Not Applicable

In operation:
Not Applicable

Outpatient, in-network:

As written:
Same as Inpatient, in-network

In operation:
Same as Inpatient, in-network

Outpatient, out-of-network:

As written:
Not Applicable

In operation:
Not Applicable

Emergency:

As written:
Same as Inpatient, in-network

In operation:
Same as Inpatient, in-network

Prescription drug:

As written:
Not Applicable

In operation:
Not Applicable

Step 5:

The specific findings and conclusions reached by the Plan or issuer with respect to the health insurance coverage, including any results of the analyses described in the previous steps that indicate that the Plan or issuer is or is not in compliance with the MHPAEA NQTL requirements.

FAQ 45 Guidance: The FAQ 45 guidance states that a sufficient response should include:

(Q 2, # 8) 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.

The FAQ 45 guidance states that the following constitutes an insufficient response:

(Q 3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.

Inpatient, in-network:

Findings

"as Written"
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."

"in Operation"
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 Illinois 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 [redacted] were applied in a consistent manner.

Conclusions

"as Written"
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."

"in Operation"
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."

Inpatient, out-of-network:
Not Applicable

Outpatient, in-network:
Same as Inpatient, in-network

Outpatient, out-of-network:
Not Applicable

Emergency:
Same as Inpatient, in-network

Prescription drug:
Not Applicable

Out-of-Network Reimbursement

Step 1:

Specify the specific Plan or coverage terms or other relevant terms regarding the NQTL, that applies to such Plan or coverage, and provide a description of all MH or SUD and medical or surgical benefits to which the NQTL applies or for which it does not apply.

FAQ 45 Guidance: The FAQ 45 (Q2, #'s 1 and 2) guidance stipulate that a sufficient analysis should include:

A clear description of the specific NQTL, plan terms, and policies at issue; and

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.

Plan(s) at Issue
- UnitedHealthcare of Illinois, Inc.
- UnitedHealthcare Plan of the River Valley, Inc.
- UnitedHealthcare Insurance Company of Illinois
- UnitedHealthcare Insurance Company of the River Valley

Inpatient, in-network:
Not Applicable

Inpatient, out-of-network:

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.

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* and are described in the factors below.

Plan Terms

Applies to UnitedHealthcare of Illinois, Inc UnitedHealthcare Plan of the River Valley, Inc. (Small Group)

- You must see a Designated Network or Network Physician in order to obtain Benefits. Except as specifically described in this Schedule of Benefits, Benefits are not available for services provided by out-of-Network providers. This Benefit plan does not provide an out-of-Network level of Benefits.

Applies to UnitedHealthcare Plan of the River Valley, Inc. (Large Group)

- 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.

Applies to UnitedHealthcare Insurance Company of Illinois and UnitedHealthcare Insurance Company of the River Valley

- 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.
- WARNING, LIMITED BENEFITS WILL BE PAID WHEN OUT-OF-NETWORK PROVIDERS ARE USED. You should be aware that when you elect to utilize the services of an out-of-Network provider for a covered service in non-Emergency situations, Benefit payments to such out-of-Network providers are not based upon the amount billed. The basis of your Benefit payment will be determined according to your Certificate's fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the Certificate. YOU CAN EXPECT TO PAY MORE THAN THE CO-INSURANCE AMOUNT DEFINED IN THE CERTIFICATE AFTER THE PLAN HAS PAID ITS REQUIRED PORTION. Out-of-Network providers may bill members for any amount up to the billed charge after the plan has paid its portion of the bill,

except as provided in Section 356z.3a of the Illinois Insurance Code for Covered Health Care Services received at a Network health care facility from an out-of-Network provider that are: (a) ancillary services, (b) items or services furnished as a result of unforeseen, urgent medical needs that arise at the time the item or service is furnished, or (c) items or services received when the facility or the out-of-Network provider fails to satisfy the notice and consent criteria specified under Section 356z.3a. Network providers have agreed to accept discounted payments for services with no additional billing to the member other than Co-insurance and deductible amounts. You may obtain further information about the participating status of professional providers and information on out-of-pocket expenses by calling us at the telephone number on your ID card.

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

- OON inpatient and outpatient services

Outpatient, in-network:
Not Applicable

Outpatient, out-of-network:
Same as Inpatient, out-of-network

Emergency:
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 Plan determines reimbursements for OON emergency care services in accordance with state and federal regulatory requirements. The methodology used to reimburse OON emergency care services applies to emergency services rendered for the treatment of both M/S conditions and MH/SUD. OON reimbursement exists as a singular structure (it is sold as one structure and applied as one structure) and is the same for M/S and MH/SUD.

Plan Terms - Applies to all Plans

Emergency Health Care Services - with respect to an Emergency:

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

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

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

Prescription drug:
Not Applicable

Step 2:

Identify all the factors (quantitative and qualitative and label as appropriate) used to determine that the NQTL will apply to MH/SUD benefits and medical or surgical benefits.

FAQ 45 Guidance: The FAQ 45 (Q2, #3) guidance stipulates that a sufficient analysis includes:

Identification of any factors, evidentiary standards or sources, 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.

Inpatient, in-network:
Not Applicable

Inpatient, out-of-network:
The Plan relies on the following factors to determine OON reimbursement rates for M/S and MH/SUD inpatient and outpatient services. These factors apply to both M/S and MH/SUD benefits in the following classifications:

I. M/S OON Inpatient/Outpatient Services
II. MH/SUD OON Inpatient/Outpatient Services

- **Federal and State Regulations (Qualitative)**
  - State or federal law may impact permissible out of network reimbursement options available to customers. This factor is applicable to:
    - OON non-emergency inpatient or outpatient services provided in an In-Network (INN) or OON facility rendered for the treatment of M/S or MH/SUD conditions

    Applies to both M/S and MH/SUD services

- **Extended Non-Network Reimbursement Program (ENRP) methodology (Quantitative)** This factor is applicable to:
  - OON non-emergency inpatient or outpatient services provided in an OON facility rendered for the treatment of M/S or MH/SUD conditions processed at the INN benefit level

    Applies to both M/S and MH/SUD services

- **MNRP (Quantitative)**. This factor is applicable to:
  - OON non-emergency inpatient or outpatient services provided in an OON facility rendered for the treatment of M/S or MH/SUD conditions
  - OON inpatient and outpatient services rendered for the treatment of M/S or MH/SUD conditions

    Applies to both M/S and MH/SUD services

- **Shared Savings (Quantitative)** This factor is applicable to:
  - OON non-emergency inpatient or outpatient services provided in an INN or OON facility rendered for the treatment of M/S or MH/SUD conditions
  - OON inpatient and outpatient services rendered for the treatment of M/S or MH/SUD conditions

  Applies to both M/S and MH/SUD services

- **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.

Outpatient, in-network:
Not Applicable

Outpatient, out-of-network:
Same as Inpatient, out-of-network

Emergency:
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.

Prescription drug:
Not Applicable

Step 3:

Provide the evidentiary standards used for the factors identified in Step 2, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTL to MH/SUD benefits and medical or surgical benefits.

FAQ 45 Guidance: The FAQ 45 (Q 2, # 4) guidance stipulates that a sufficient response includes:

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.

The FAQ 45 guidance (Q 3, # 5) states that the following is insufficient:

Reference to factors and evidentiary standards that were defined or applied in a quantitative manner, without the precise definitions, data, and information necessary to assess their development or application.

Inpatient, in-network:

Not Applicable

Inpatient, out-of-network:

Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factors used in determining OON reimbursement for inpatient and outpatient services. These evidentiary standards and sources apply to the following benefit classifications:

I. M/S OON Inpatient/Outpatient Services
II. MH/SUD OON Inpatient/Outpatient Services

Factor – Federal and State Laws and Regulations is defined as a set of rules to establish standards for healthcare transactions.

- The Plan's evidentiary standards and sources that define and/or trigger the identification of the factor:
  - State or federal law may impact the range of permissible out of network reimbursement options.
    - An amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act;
    - If there is no such applicable All-Payer Model Agreement, an amount determined by a specified state law; or
    - If there is no such applicable All-Payer Model Agreement or specified state law, the lesser of the billed charge or the Plan's or issuer's median contracted rate (a/k/a qualifying payment amount (QPA)) for the same or similar item or service in the relevant geographic region
  - Applicable state law
  - Reimbursement amount determined by applicable All-Payer Model Agreement
  - Reimbursement amount determined by applicable state law
  - Contracted rates for the same or similar items or services provided by facilities of the same or similar facility type in the relevant geographic region

This evidentiary standard and source applies to both M/S and MH/SUD OON inpatient/outpatient services. This evidentiary standard and source is defined in a qualitative manner.

Factor – ENRP methodology is defined as a program that can be used to determine eligible expense(s) when an OON provider is processed under the network benefits. Reimbursement under ENRP is based on a percentage of the Medicare rate.

- The Plan's evidentiary standards and sources that define and/or trigger the identification of the factor:
  - The ENRP reimbursements are based on a percentage of the Centers for Medicare & Medicaid Services (CMS) benchmark rate (e.g., Physician Fee Schedule or CMS diagnosis related group (DRG) rate) for a procedure or service type within a given geographic region
    - CMS Standards and Fee Schedules in relevant geographic market
    - CMS DRG rates allowed by CMS
    - When a rate is not published by CMS for the service, the Plan uses a gap methodology established by OptumInsight and/or a third-party vendor that uses a relative value scale or similar methodology

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

Factor – MNRP is defined as a Medicare-based methodology to reimburse the provider/facility. MNRP reimbursements are based upon a percentage of the Centers for Medicare & Medicaid Services (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.

Outpatient, in-network:
Not Applicable

Outpatient, out-of-network:
Same as Inpatient, out-of-network

Emergency:
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 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.

Prescription drug:
Not Applicable

Step 4:

Provide the comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits, **as written and in operation**, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical or surgical benefits.

FAQ 45 Guidance: The FAQ 45 guidance states that the following is necessary for a sufficient response:

(Q2, #5) 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 mental health or substance use disorder and medical or surgical benefits and, if so, describe the process and factors used for establishing that variation.

(Q 2, # 6) 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).

(Q2, #7) 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 mental health or substance use disorder and medical or surgical benefits.

The FAQ 45 guidance states that the following constitutes an insufficient response:

(Q 3, # 1) Production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analysis.

(Q3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.

(Q 3, # 3) Identification of processes, strategies, sources, and factors without the required or clear and detailed comparative analysis.

(Q 3, # 4) Identification of factors, evidentiary standards, and strategies without a clear explanation of how they were defined and applied in practice.

Inpatient, in-network:

As written:
Not Applicable

In operation:
Not Applicable

Inpatient, out-of-network:

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 same strategies, processes, factors, sources, and evidentiary standards for each reimbursement methodology for both M/S and MH/SUD services. Both use one or more of the following: state, or federal requirements, ENRP, MNRP, Shared Savings, or OCM to establish OON reimbursement rates.

In operation:
The Plan compared the strategies, processes, factors, evidentiary standards, and source information used to determine M/S and MH/SUD ONN inpatient/outpatient services reimbursement "in operation."

Both M/S and MH/SUD use the same methodology for determining OON provider reimbursements for services and treatments.

Outpatient, in-network:

As written:
Not Applicable

In operation:
Not Applicable

Outpatient, out-of-network:

As written:
Same as Inpatient, out-of-network

In operation:
Same as Inpatient, out-of-network

Emergency:

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 same factor, sources, and evidentiary standards for each reimbursement methodology for 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 same methodology is used for determining provider reimbursements for OON emergency care for M/S and MH/SUD conditions.

Prescription drug:

As written:
Not Applicable

In operation:
Not Applicable

Step 5:

The specific findings and conclusions reached by the Plan or issuer with respect to the health insurance coverage, including any results of the analyses described in the previous steps that indicate that the Plan or issuer is or is not in compliance with the MHPAEA NQTL requirements.

FAQ 45 Guidance: The FAQ 45 guidance states that a sufficient response should include:

(Q 2, # 8) 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.

The FAQ 45 guidance states that the following constitutes an insufficient response:

(Q 3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.

Inpatient, in-network:
Not Applicable

Inpatient, out-of-network:
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."

Outpatient, in-network:
Not Applicable

Outpatient, out-of-network:
Same as Inpatient, out-of-network

Emergency:
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."

Prescription drug:
Not Applicable

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. 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." 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
- *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. 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, 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. 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:

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.

[redacted]

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, or failure to provide or make payment (in whole or in part), of a benefit. Adverse benefit determinations are recorded as a clinical denial when it is based on clinical criteria and member clinical information.

Ongoing Concurrent Review. INN providers may request coverage for additional days by contacting the Plan prior to the expiration of the last covered day of an approved MH/SUD inpatient admission. The Plan's INN MH/SUD general acute care facilities are reimbursed on a per diem basis. The Plan conducts ongoing Concurrent Review for INN MH/SUD admissions depending on the applicable clinical criteria and the member's clinical presentation. Upon receipt of a request for coverage of additional days, the Plan reviews the medical necessity of inpatient admissions. Clinical reviewers and peer clinical reviewers follow the initial Concurrent Review process.

Clinical Criteria. Initial clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based behavioral clinical policies or use clinical criteria from third party sources such as American Society of 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.

[redacted]

[redacted]

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 Insurance Company of Illinois (UHIC IL)
- UnitedHealthcare of Illinois, Inc. (UHC IL)
- UnitedHealthcare Plan of the River Valley, Inc. (UHCP RV)
- UnitedHealthcare Insurance Company of the River Valley (UHIC RV)

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. Sometimes called "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 *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.

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.

[redacted]

[redacted]

[redacted]

Step 5 – Findings and Conclusions

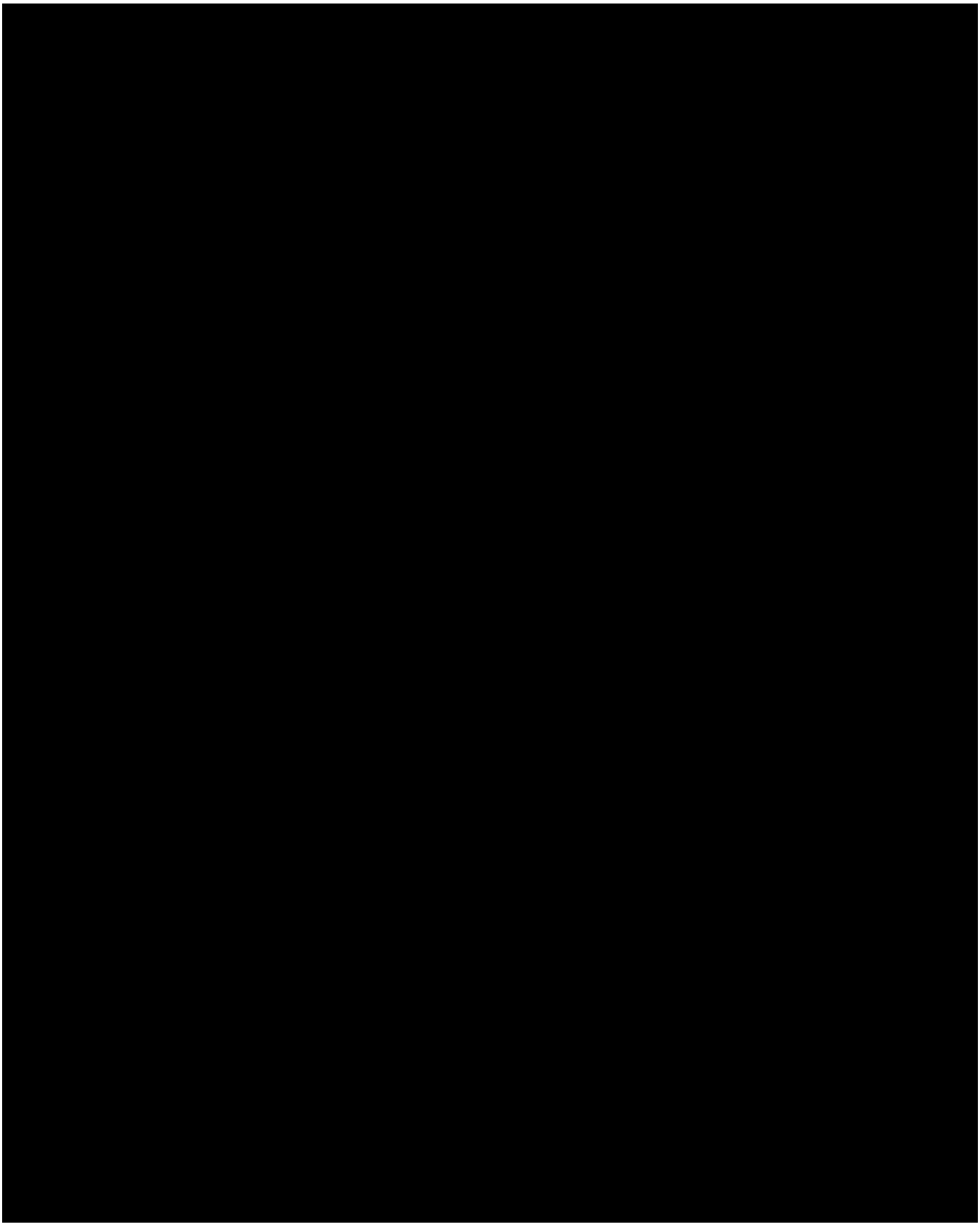
FAQ 45: A reasoned discussion of the Plan or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion 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.

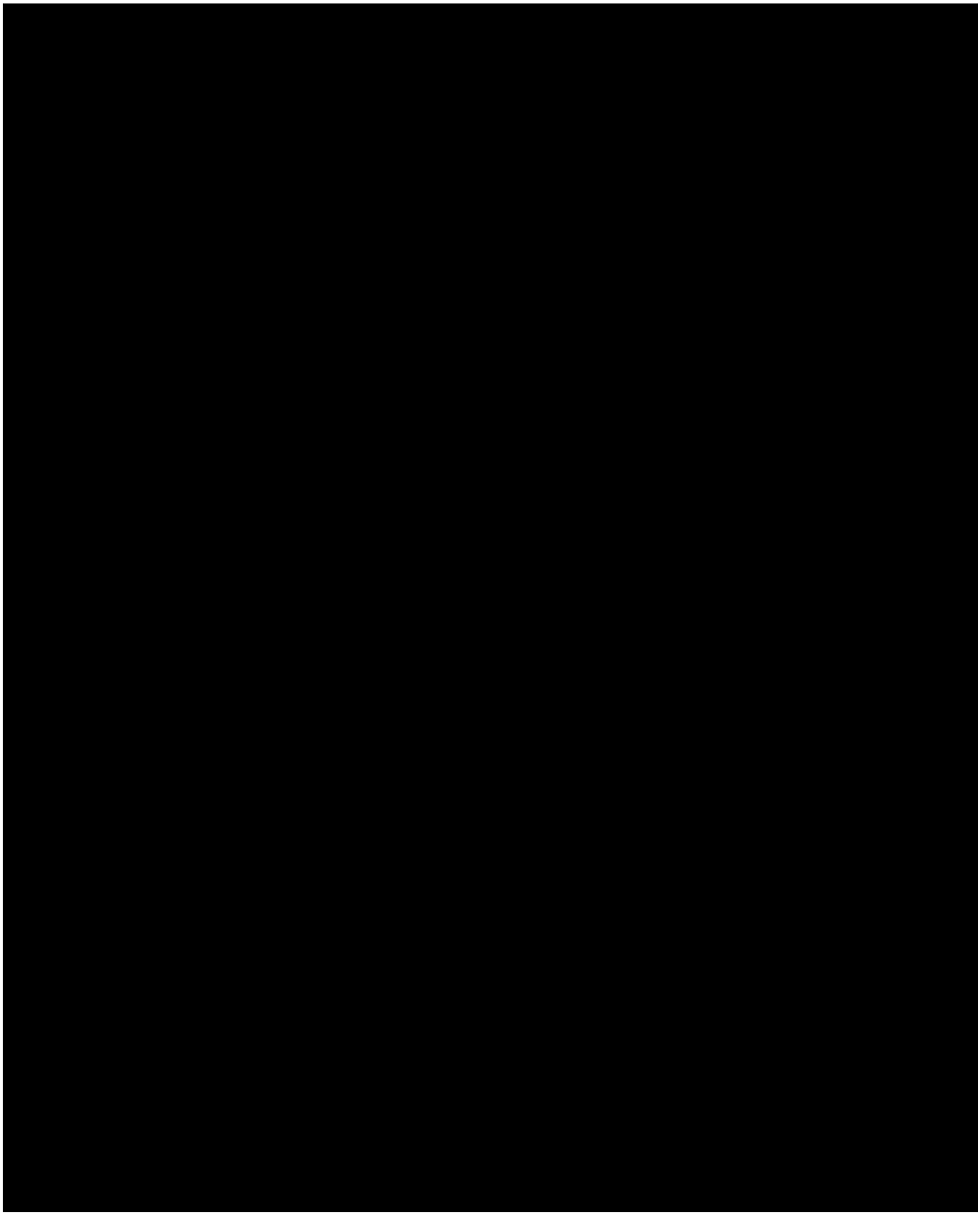
Findings

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."

[redacted]

[redacted]





Conclusions

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

The Plan reviewed the M/S and MH/SUD processes, including responsibility for submission, timeframes for submission and review, notification to members and providers, clinical standards for review, 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.

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. 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."

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

This document includes the following information:

- The description of the NQTL and process

This analysis refers to the following attachments:

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

Process

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

The Plan structures outpatient Concurrent Review processes to be compliant with all applicable federal and state laws, 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.

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

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

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

Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is "parity" between mental health and substance use disorder (MH/SUD) benefits and medical/surgical (M/S) benefits. This generally means that 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. 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." 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

- *Utilization Management Program Description (UMPD) of United HealthCare Services, Inc. and UnitedHealthcare Insurance Company* - summarizes the philosophy, structure and standards that govern UHC's medical management, UM and utilization review responsibilities and functions
- *Management of Behavioral Health Benefits Policy* - Describes the mechanisms and processes designed to promote consistency in the management of behavioral health benefits and to ensure that members receive appropriate, high quality behavioral health services in a timely manner
- *Schedule of Benefits* (SBN) - (*SBN24-Medical-INS-2018-[Choice Plus][Select Plus][Doctors Plus]-LG-IL* and *SBN24-Medical-INS-RV-2018-HeritagePlus-LG-IL*) – 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. 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).

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, 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. 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:

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.

[redacted]

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

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

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

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

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

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

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.

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. [redacted]

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.

[redacted]

[redacted]

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 Illinois (UHIC IL)
- UnitedHealthcare Insurance Company of the River Valley (UHIC RV)

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 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.
  - 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 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

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.

[redacted]

[redacted]

[redacted]

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."

[redacted]

[redacted]

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.

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. 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."

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

This document includes the following information:

- The description of the NQTL and process

This analysis refers to the following attachments:

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

Process

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

The Plan structures outpatient Concurrent Review processes to be compliant with all applicable federal and state laws, 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.
Concurrent Review of M/S and MH/SUD outpatient services consists of the following:

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

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

Overview

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

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

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

Specific NQTL

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

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

This document includes the following information:

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

The analysis refers to the following attachments:

- *Certificate of Coverage* (COC) - (*COC24-HMO-2018-LG-IL, COC24-HMO-RV-2018-LG-IL, COC24-INS-2018-LG-IL,* and *COC24-INS-RV-2018-LG-IL)* - Plan document that explains covered services, terms, conditions, and limitations of the member's policy

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

Process

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

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

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

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

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

Credentialing Plan

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

Credentialing Plan Approval

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

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

For MH/SUD, the Plan delegates credentialling of behavioral health network providers to its affiliate UBH d/b/a Optum Behavioral Health (OBH). The Quality Improvement Committee (QIC) has oversight of the Credentialing Committee and delegates overall responsibility and authority to its standing Credentialing Committee for credentialing. The QIC also delegates

to the Credentialing Committee the authority to administer the *UBH Credentialing Plan*. The Credentialing Committee is responsible for administering the *UBH Credentialing Plan* and reviewing and approving policies related to credentialing activities on behalf of OBH, subject to oversight by the QIC. The *UBH Credentialing Plan* can be referenced on the website https://www.providerexpress.com/content/dam/ope-provexpr/us/pdfs/clinResourcesMain/guidelines/credPlans/credPlanUBH.pdf.

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

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

Detailed Process for Credentialing

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

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

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

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

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

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

For MH/SUD, credentialing decisions and actions of OBH will be guided primarily by (a) consideration of each applicant's potential contribution to the objective of providing effective and efficient health care services to UBH's members, (b) UBH's

need for clinicians and organizational providers within its service area, and (c) judging each applicant for credentialing and recredentialing without discrimination due to age, race, gender, color, religion, ethic/national identity, ancestry, disability, marital status, covered veteran status, sexual orientation, status with respect to public assistance, blindness or partial blindness, handicap, physical or mental impairment, victims of domestic violence, types of patients seen, or any other characteristic protected under state, federal, or local law.

The Credentialing Committee is responsible for making credentialing decisions about inclusion of providers and facilities in the network. Applications that meet all the credentialing criteria and require no further review by the Credentialing Committee are sent to the Medical Director for approval. Applications that require additional review are presented to the Credentialing Committee. In this instance the Credentialing Committee has the sole discretion to make a credentialing exception to the required criteria, such as network need. Decisions to make exceptions based on appropriate factors are done in compliance with state and federal regulations. The Credentialing Committee may also at its sole discretion and determination, make the decision to deny the application for network participation.

Step 1 – NQTL and Application

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

Specific NQTL

- Credentialing

Benefit Classification(s)

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

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHIC)
- UnitedHealthcare Insurance Company of Illinois (UHIC IL)
- UnitedHealthcare of Illinois, Inc. (UHC IL)
- UnitedHealthcare Plan of the River Valley, Inc. (UHCP RV)
- UnitedHealthcare Insurance Company of the River Valley (UHIC RV)

Plan Terms

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

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

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

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

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

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

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

- The provider or facility completes and attests to the accuracy of the content of the application (Qualitative)
  - Applies to both M/S and MH/SUD

- The Plan verifies certain information (Qualitative)
  - Applies to both M/S and MH/SUD

- The provider or facility continues to meet the applicable requirements (Qualitative)
  - Applies to both M/S and MH/SUD

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

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

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

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

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

Factor – Completed Application is defined as the provider or facility completes and attests to the accuracy of the content of the application.

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

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

Factor – The Plan verifies certain information is defined as primary source verification in the application.

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

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

Factor – The provider or facility continues to meet the applicable requirements is defined as what is set forth in the credentialing plans while they are contracted with the Plan.

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

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

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

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

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

As Written

The Plan conducted a comparative analysis of the strategies, processes, factors, evidentiary standards, and source information used to determine if a provider or facility meets standards to join (credential) or maintain (recredential) their status in the Plan's network of participating providers for M/S and MH/SUD "as written."

For M/S, the NCC is responsible for implementing the *UHC Credentialing Plan*. The NCC is comprised of PLIPs, UHC Medical Directors, and a designated Medical Director Chairperson, unless a different committee composition is otherwise required by applicable credentialing authorities. The NCC makes the credentialing decision and informs providers within applicable state or federally mandated timeframes.

For MH/SUD, the Plan delegates credentialing of behavioral health network providers to its affiliate OBH.

The OBH Credentialing Committee is responsible for implementing its *UBH Credentialing Plan*. The OBH Credentialing Committee is multi-disciplinary and must have at least two Optum Medical Directors as members. At least two of the 12 members must be external participating clinicians from each major discipline (i.e., MD, PhD, and MSW). The OBH Credentialing Committee informs providers of credentialing decisions within applicable state or federally mandated timeframes.

The M/S and MH/SUD credentialing committees have similar composition, in that they both include licensed providers with expertise in the relevant disciplines as well as Medical Directors. They also both follow applicable state or federal regulations for response timeframes. In addition, the *UHC* and *UBH Credentialing Plans* are both accredited by NCQA and are reviewed annually.

At times, UHC and OBH may delegate credentialing to third parties. The Plan performs oversight of delegated credentialing as outlined in the *UHC* and *UBH Credentialing Plans*.

The Plan conducted a comparative analysis of the application criteria and required documentation for both M/S and MH/SUD providers.

Crosswalk of M/S and MH/SUD Credentialing Application and Required Documentation Professional	
M/S credentialing application requirements (*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 or care, (signed attestation form may be used).
Applicant's current professional liability insurance policy, including the name of insurer, policy number, expiration date, and coverage limits; (Note: M/S standard liability is $1million/$3million or an amount or type as otherwise specified by applicable state law)	Professional liability malpractice insurance with liability limits of $1/$3 million for physicians and $1/$1 million for non-physician Clinicians, or in an amount or type as otherwise specified by applicable state law. This can include evidence of participation in state patient compensation or catastrophic loss funds, if applicable.
Limitations on ability to perform functions of the position with or without accommodation;	Reasons for any inability to perform the essential functions of the position, with or without accommodation.
History of loss or limitation of privileges or disciplinary activity;	Disclosure of any and all loss or limitation of professional privileges or disciplinary activity.
Absence of current, illegal drug use;	Presence of illegal drug use.
History of loss of license and felony convictions;	Disclosure of any and all loss of professional license(s). Disclosure of any and all felony convictions.
Completeness and accuracy of the information provided in the Application.	A signed attestation regarding the correctness and completeness of the application.

(Page 9, section 4.2) Affirmative responses to Disclosure Questions on the Credentialing Application. Applicant is required to provide details on all affirmative responses to Disclosure Questions on the Credentialing Application, which may be reviewed by a Medical Director, and at the discretion of the Medical Director, may be reviewed by Credentialing Committee for a determination of LIP's acceptance into Credentialing Entity's Network.	Completed disclosure statements including questions on license disciplinary actions; criminal felony convictions or civil judgments that involved dishonesty, fraud, deceit or misrepresentation; disciplinary actions by any federal programs; any other disciplinary actions or restrictions; and responses to applicable "Yes" answers
M/S Required Documentation (Pages 7-9, section 4.2 unless noted otherwise)	MH/SUD Required Documentation (Pages 5-6, sections 4.1)
Insurance or State-approved alternative. The Applicant must maintain errors and omissions (malpractice) insurance through insurers licensed in their State, or show similar financial commitments made through an appropriate State approved alternative, in the minimum amounts required by UnitedHealth Group's Provider Guidelines. The Credentialing Entity may require a copy of the Applicant's current Certificate of Coverage or may allow the Applicant's attestation to current, adequate insurance of State-approved alternative. The pertinent Participation Agreement may require coverage that 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, verify reported information from the Office of Inspector General (OIG), the CMS Preclusion list and Medicare Opt Out.	Proof of participation and meeting CMS Medicare and Medicaid requirements.
Crosswalk of M/S and MH/SUD Credentialing Application Facility/Organizational Providers	
M/S credentialing application requirements (*UHC Credentialing Plan*, uhcprovider.com/content/dam/provider/docs/public/resources/join- network/Credentialing-Plan.pdf, page 12, Section 7)	MH/SUD credentialing application requirements (*UBH Credentialing Plan*, providerexpress.com/content/dam/ope-provexpr/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	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

program and must be without any sanctions levied by the Office of Inspector General (OIG), the General Services Administration (GSA) and the CMS Preclusion list or other disciplinary action by any Federal or State entities identified by CMS. Exceptions to this requirement may only be granted when there are issues of network adequacy and an OIG waiver has been granted.	(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.
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*.

[redacted]

[redacted]

Step 5 – Findings and Conclusions

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

Findings

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

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

that credentialing application requirements for MH/SUD network providers are comparable to, and applied no more stringently than, the application requirements for M/S network providers.

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

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

Conclusions

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

Overview

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

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

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

Specific NQTL

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

This document includes the following information:

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

This analysis refers to the following attachments:

- *2023 UnitedHealthcare Provider Administrative Guide* - Informs providers of the EIU limitation. The *UnitedHealthcare Provider Administrative Guide* can be accessed on the website https://www.uhcprovider.com/en/admin-guides.html
- September 2023 *Optum National Network Manual* - Informs providers of the EIU limitation. The *Optum National Network Manual* can be accessed on the website https://public.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/optum-network-manual.html
- *Certificates of Coverage* (COC) - (*COC24-HMO-2018-LG-IL, COC24-HMO-RV-2018-LG-IL, COC24-INS-2018-LG-IL,* and *COC24-INS-RV-2018-LG-IL*) - Plan document that explains covered services, terms, conditions, and limitations of the member's policy
- *Schedule of Benefits* (SBN) - (*SBN24-Medical-HMO-2018-[Charter][Navigate][Nexus [N]R]-LG-IL*, *SBN24-Medical-HMO-RV-2018-HeritageSelect-LG-IL*, *SBN24-Medical-INS-2018-[Choice Plus][Select Plus][Doctors Plus]-LG-IL*, *SBN24-Medical-INS-RV-2018-HeritagePlus-LG-IL*) - Plan document that outlines member responsibilities

- M/S medical clinical polices 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
- *Utilization Management Program Committee Charter* – document that outlines the purpose, responsibility, functions, and composition of the committee that oversees the M/S utilization management program
- *Applying Benefit Plan and Review Criteria* Standard Operating Procedure - outlines the hierarchy of authorities to be reviewed (i.e., state/federal laws and regulations followed by Benefit Plan criteria) when making coverage determinations
- *Utilization Management Program Description (UMPD) of United HealthCare Services, Inc. and UnitedHealthcare Insurance Company* – M/S summarizes the philosophy, structure and standards that govern UHC's medical management, utilization management (UM) and utilization review responsibilities and functions
- *Clinical Review Criteria Operational* Policy - The purpose of this operational policy is to document that UHC will use evidence-based clinical review criteria to support clinical review decisions for UM programs, and to ensure that the clinical review process is applied consistently
- *Clinical Criteria Development Selection and Application* Policy - addresses Optum's selection, development, and use of clinical criteria in making benefit determinations
- *UnitedHealthcare Commercial Omnibus Codes* – M/S policy that outlines technologies that are considered EIU

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

Process

[redacted]

[redacted]

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 Insurance Company of Illinois (UHIC IL)
- UnitedHealthcare of Illinois, Inc. (UHC IL)
- UnitedHealthcare Plan of the River Valley, Inc. (UHCP RV)
- UnitedHealthcare Insurance Company of the River Valley (UHIC RV)

Plan Terms/Source Document(s)

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

UHIC, UHIC IL, UHC IL, UHCP RV, UHIC RV

"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.

Where a drug prescribed for the treatment of a type of cancer has not been approved by the FDA for this particular purpose, the Policy will include coverage of such drug, provided:

- The drug was approved by the *FDA* for the treatment of some kind of cancer; and
- The drug has been recognized for the treatment of the specific type of cancer for which it was prescribed in any one of the following established reference compendia:
  - The *American Hospital Formulary Service Drug Information*.
  - The *National Comprehensive Cancer Network's Drugs & Biologics Compendium*.
  - The *Thomson Micromedex's DrugDex*.
  - The *Elsevier Gold Standard's Clinical Pharmacology*.

- Other authoritative compendia as identified by the *Federal Secretary of Health and Human Services*.

- Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase I, II or III clinical trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.
- Only obtainable, with regard to outcomes for the given indication, within research settings.

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

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

"Unproven Service(s) - services, including medications and devices, regardless of *U.S. Food and Drug Administration (FDA)* approval, that are not determined to be effective for treatment of the medical condition or not determined to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies from more than one institution. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

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

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

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 polices 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)

[redacted]

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

[redacted]

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

[redacted]

[redacted]

The Plan's evidentiary standards and sources that trigger and/or define the M/S and MH/SUD Committee Considerations factor:

[redacted]

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 [redacted]

[redacted]

[redacted]

Step 5 – Findings and Conclusions

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

Findings

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

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

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

Conclusions

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

Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is "parity" between mental health and substance use disorder (MH/SUD) benefits and medical/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) Criteria®[1], Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System-Child and Adolescent Service Intensity Instrument (CALOCUS-CASII), and Early Childhood Service Intensity Instrument (ECSII) guidelines as well as internally developed objective, evidence-based, medical/behavioral clinical policies.

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

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

This document includes the following information:

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

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

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

This analysis refers to the following attachments:

- *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions* - M/S policy that defines Medical Necessity
- *Optum National Policy Definitions List* - MH/SUD policy that defines Medical Necessity
- *UnitedHealthcare (UHC) Hierarchy of Clinical Evidence* – M/S policy that defines the hierarchy of clinical evidence to ensure a transparent and consistent approach within UnitedHealthcare
- *Behavioral Health Hierarchy of Clinical Evidence* – MH/SUD policy that defines the hierarchy of clinical evidence to ensure a transparent and consistent approach to the review and development of Optum's Clinical Technology Assessments and Behavioral Clinical Policies
- *2023 UnitedHealthcare Provider Administrative Guide* - Informs providers of the Prior Authorization process. The *UnitedHealthcare Provider Administrative Guide* can be accessed on the website https://www.uhcprovider.com/en/admin-guides.html
- *September 2023 Optum National Network Manual* - Informs providers of the Prior Authorization process. The *Optum National Network Manual* can be accessed on the website https://public.providerexpress.com/content/ope-provexpr/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* (COC) - (*COC24-HMO-2018-LG-IL, COC24-HMO-RV-2018-LG-IL, COC24-INS-2018-LG-IL,* and *COC24-INS-RV-2018-LG-IL*) - Plan document that explains covered services, terms, conditions, and limitations of the member's policy
- *Schedule of Benefits* (SBN) - (*SBN24-Medical-HMO-2018-[Charter][Navigate][Nexus [N]R]-LG-IL*, *SBN24-Medical-HMO-RV-2018-HeritageSelect-LG-IL*, *SBN24-Medical-INS-2018-[Choice Plus][Select Plus][Doctors Plus]-LG-IL*, *SBN24-Medical-INS-RV-2018-HeritagePlus-LG-IL*) - Plan document that outlines member responsibilities
- *Utilization Management Program Committee Charter* – document that outlines the purpose, responsibility, functions, and composition of the committee that oversees the M/S utilization management program
- *Clinical Technology Assessment Committee (CTAC) Charter* – document that outlines the purpose, structure, responsibility and membership of the committee that develops internal medical criteria and reviews and approves externally developed criteria for MH/SUD
- *Clinical Quality and Operations Committee (CQOC) Charter* – document that outlines the purpose, structure, responsibility, and membership of the committee that oversees CTAC
- *Applying Benefit Plan and Review Criteria Standard Operating Procedure* - outlines the hierarchy of authorities to be reviewed (i.e., state/federal laws and regulations followed by Benefit Plan criteria) when making coverage determinations
- *Clinical Review Criteria Operational Policy* - The purpose of this operational policy is to document that UHC will use evidence-based clinical review criteria to support clinical review decisions for UM programs, and to ensure that the clinical review process is applied consistently
- *Clinical Criteria Development Selection and Application Policy* - addresses Optum's selection, development, and use of clinical criteria in making benefit determinations

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

Process

[redacted]

[redacted]

[redacted]

[redacted]

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 Insurance Company of Illinois (UHIC IL)
- UnitedHealthcare of Illinois, Inc. (UHC IL)

- UnitedHealthcare Plan of the River Valley, Inc. (UHCP RV)
- UnitedHealthcare Insurance Company of the River Valley (UHIC RV)

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:

UHIC, UHIC IL, UHCP RV, UHIC RV

"Medically Necessary – health care services that are all of the following:

- In accordance with *Generally Accepted Standards of Medical Practice*.
- 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 Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We may also consult expert opinion in determining whether health care services are Medically Necessary.

We develop and maintain clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by us and revised when needed), are available to Covered Persons through www.myuhc.com or the telephone number on your ID card. They are also available to Physicians and other health care professionals on UHCprovider.com."

UHC IL

"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 Medical Practice*.
- 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 Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

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

We develop and maintain clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by us and revised when needed), are available to Covered Persons through www.myuhc.com or the telephone number on your ID card. They are also available to Physicians and other health care professionals on 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 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:

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

- [redacted]

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:

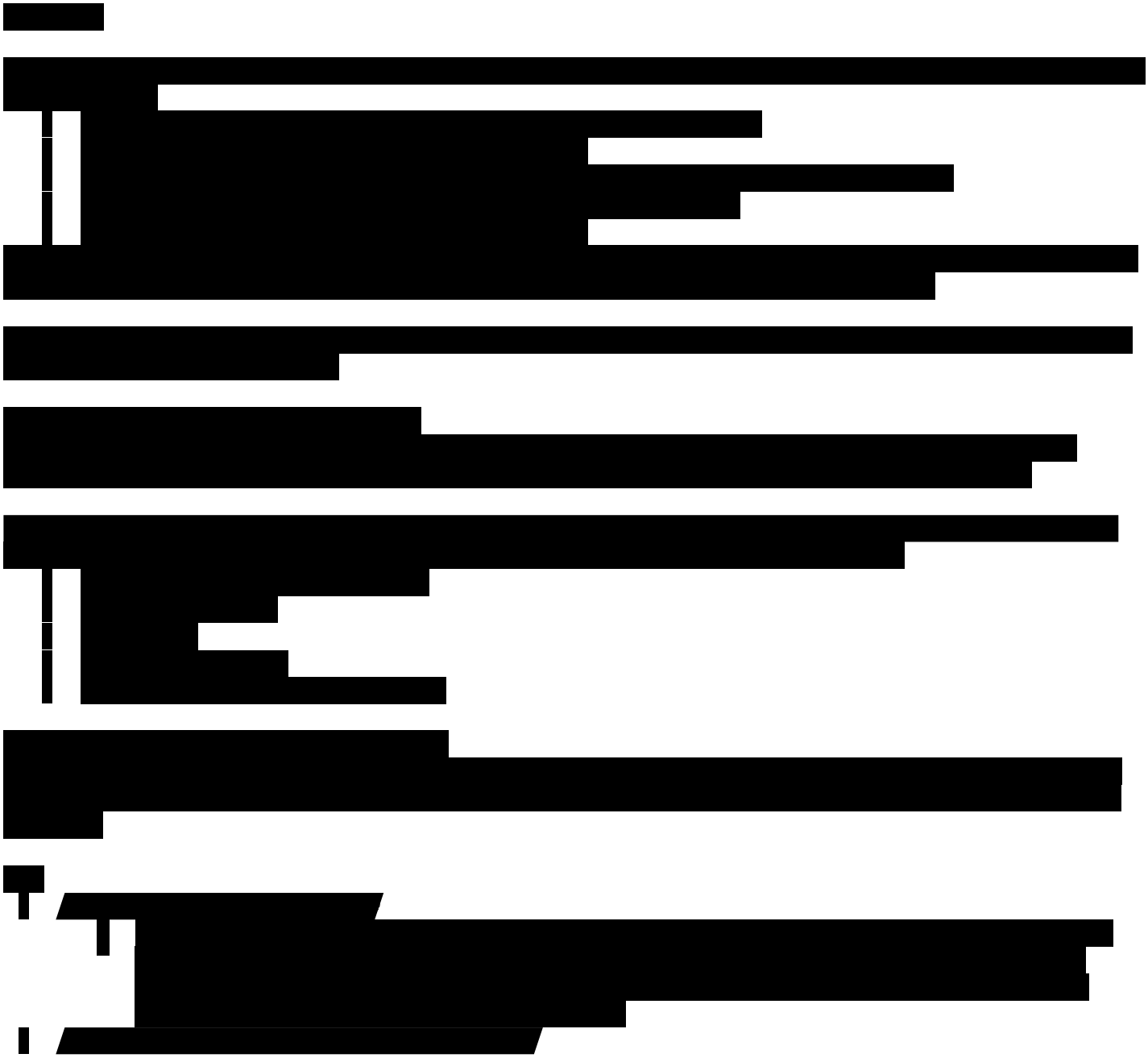
I. All M/S INN inpatient, OON inpatient, INN outpatient, and OON outpatient services and technologies subject to UM
II. All MH/SUD INN inpatient, OON inpatient, INN outpatient, and OON outpatient services and technologies subject to UM

- [redacted]

[redacted]

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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[redacted]

[redacted]

[redacted]

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

[redacted]

Step 1 – NQTL and Application

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

Specific NQTL

- Network Management – Network Adequacy

Benefit Classification(s)

- Applies to all INN, inpatient and outpatient services

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHIC)
- UnitedHealthcare Insurance Company of Illinois (UHIC IL)
- UnitedHealthcare of Illinois, Inc. (UHC IL)
- UnitedHealthcare Plan of the River Valley, Inc. (UHCP RV)
- UnitedHealthcare Insurance Company of the River Valley (UHIC RV)

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.

[redacted]

Step 5 – Findings and Conclusions

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

Findings

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

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

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

Conclusions

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

Overview

Pursuant to 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.

[redacted]

[redacted]

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 Insurance Company of Illinois (UHIC IL)
- UnitedHealthcare of Illinois, Inc. (UHC IL)
- UnitedHealthcare Plan of the River Valley, Inc. (UHCP RV)
- UnitedHealthcare Insurance Company of the River Valley (UHIC RV)

Plan Terms

"Coverage Policies and Guidelines

Our Prescription Drug List (PDL) Management Committee makes tier placement changes on our behalf. The PDL Management Committee places *FDA*-approved Prescription Drug Product into tiers by considering a number of factors including clinical and economic factors. Clinical factors may include review of the place in therapy or use as compared to other similar product or services, site of care, relative safety or effectiveness of the Prescription Drug Product, as well as if certain supply limits or [notification] [prior authorization] requirements should apply. Economic factors may include the Prescription Drug Product's total cost including any rebates and evaluations of the cost effectiveness of the Prescription Drug Product.

Some Prescription Drug Products are more cost effective for treating specific conditions as compared to others; therefore, a Prescription Drug Product may be placed on multiple tiers according to the condition for which the Prescription Drug Product was prescribed to treat, or according to whether it was prescribed by a Specialist.

We may change the placement of a Prescription Drug Product among the tiers. These changes generally will happen quarterly, but no more than six times per calendar year and notice will be provided at least 60 days prior to this change.

When considering a Prescription Drug Product for tier placement, the PDL Management Committee reviews clinical and economic factors regarding Covered Persons as a general population. Whether a particular Prescription Drug Product is appropriate for you is a determination that is made by you and your prescribing Physician.

NOTE: The tier placement of a Prescription Drug Product may change based on the process described above. As a result of such changes, you may be required to pay more or less for that Prescription Drug Product. Please contact us at [www.myuhc.com] or the telephone number on your ID card for the most up-to-date tier placement.

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at either a Network Pharmacy or an out-of-Network Pharmacy and are subject to Co-payments 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. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for applicable Co-payments and/or Co-insurance requirements."

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.

[redacted]

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.

[redacted]

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

UHIC, UHIC IL, UHC IL

The *Certificate of Coverage* defines Covered Health Care Service as "health care services, including supplies or Pharmaceutical Products, which are determined 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."

"Pharmaceutical Products - Outpatient

[[3]Certain Pharmaceutical Products are subject to step therapy requirements. This means that in order to receive Benefits for such Pharmaceutical Products, you must use a different Pharmaceutical Product and/or prescription drug product first. You may find out whether a particular Pharmaceutical Product is subject to step therapy requirements by contacting us at [www.myuhc.com] or the telephone number on your ID card.]

[[4]Benefits for certain Pharmaceutical Products are subject to the supply limits that are stated in the *Schedule of Benefits*. For a single Co-payment and/or Co-insurance, you may receive Pharmaceutical Products 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 to our review and change. This may limit the amount dispensed per order or refill and/or the amount dispensed per month's supply.

You may find out whether a Pharmaceutical Product has a supply limit for dispensing by contacting us at [www.myuhc.com] or the telephone number on your ID card.]"

UHCP RV

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.

How Do Supply Limits Apply?

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Co-payment, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits or dose restrictions based on criteria that we have developed and subject to [notification] [prior authorization]. Supply limits are subject 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.

Does Step Therapy Apply?

Certain Prescription Drug Products for which Benefits are described under *Section 10: Outpatient Prescription Drugs* in the *Certificate* 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. [Notification] [Prior authorization] coverage criteria for step therapy is also located on www.uhcprovider.com.

You may have the right to request an exception. Refer to *Your Right to Request an Exclusion Exception* in *Section 10: Outpatient Prescription Drugs* of the *Certificate* for additional information.

In the case of *FDA*-approved drugs for the treatment of stage 4 advanced, metastatic cancer, Benefits will not be subject to step therapy requirements if the use of the drug is consistent with best practices for the treatment and is supported by peer-reviewed medical literature."

The *Certificate of Coverage* defines Covered Health Care Service as "health care services, including supplies or Pharmaceutical Products, which are determined 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."

UHIC RV

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.

How Do Supply Limits Apply?

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Co-payment 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 or dose restrictions based on criteria that we have developed and subject to [Notification] [Prior Authorization]. Supply limits are subject 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. This limitation does not apply to prescription inhalants when suffering from asthma or other life-threatening bronchial ailments based upon restrictions on the number of days before an inhaler refill may be obtained.

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.

Does Step Therapy Apply?

Certain Prescription Drug Products for which Benefits are described under *Section 11: Outpatient Prescription Drugs* in the *Certificate* 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. [Notification] [Prior authorization] coverage criteria for step therapy is also located on www.uhcprovider.com.

You may have the right to request an exception. Refer to *Your Right to Request an Exclusion Exception* in *Section 11: Outpatient Prescription Drugs* of the *Certificate* for additional information.

In the case of *FDA*-approved drugs for the treatment of stage 4 advanced, metastatic cancer, Benefits will not be subject to step therapy requirements if the use of the drug is consistent with best practices for the treatment and is supported by peer-reviewed medical literature."

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

- Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms.
- Medically Necessary
- Described as a Covered Health Care Service in the Certificate under Section 1: Covered Health Care Services and in the Schedule of Benefits

Not excluded in the Certificate under Section 2: Exclusions and Limitations."

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

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

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

Prior Authorization, Step Therapy, and Quantity Limits for prescription drugs begin after a provider or member requests 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) - Informs providers of the Prior Authorization process
- *Certificate of Coverage* (COC) - (*COC24-HMO-2018-LG-IL, COC24-HMO-RV-2018-LG-IL, COC24-INS-2018-LG-IL,* and *COC24-INS-RV-2018-LG-IL*) - Plan document that explains covered services, terms, conditions, and limitations of the member's policy
- *Schedule of Benefits* (SBN) – (*SBN24-Pharmacy-INS-RV-2018-NET-OON-Hybrid-LG-IL* and *SBN24-Pharmacy-HMO-RV-2018-NET-Hybrid-LG-IL*) - Plan document that outlines member responsibilities
- Drugs with Clinical Programs-Commercial dated 11/01/2023

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.

[redacted]

[redacted]

[redacted]

UHIC, UHIC IL, UHC IL

The *Certificate of Coverage* defines Covered Health Care Service as "health care services, including supplies or Pharmaceutical Products, which are determined 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."

"Pharmaceutical Products - Outpatient

[[3]Certain Pharmaceutical Products are subject to step therapy requirements. This means that in order to receive Benefits for such Pharmaceutical Products, you must use a different Pharmaceutical Product and/or prescription drug product first. You may find out whether a particular Pharmaceutical Product is subject to step therapy requirements by contacting us at [www.myuhc.com] or the telephone number on your ID card.]

[[4]Benefits for certain Pharmaceutical Products are subject to the supply limits that are stated in the *Schedule of Benefits*. For a single Co-payment and/or Co-insurance, you may receive Pharmaceutical Products 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 to our review and change. This may limit the amount dispensed per order or refill and/or the amount dispensed per month's supply.

You may find out whether a Pharmaceutical Product has a supply limit for dispensing by contacting us at [www.myuhc.com] or the telephone number on your ID card.]"

UHCP RV

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.

How Do Supply Limits Apply?

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Co-payment, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits or dose restrictions based on criteria that we have developed and subject to [notification] [prior authorization]. Supply limits are subject 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.

Does Step Therapy Apply?

Certain Prescription Drug Products for which Benefits are described under *Section 10: Outpatient Prescription Drugs* in the *Certificate* 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. [Notification] [Prior authorization] coverage criteria for step therapy is also located on www.uhcprovider.com.

You may have the right to request an exception. Refer to *Your Right to Request an Exclusion Exception* in *Section 10: Outpatient Prescription Drugs* of the *Certificate* for additional information.

In the case of *FDA*-approved drugs for the treatment of stage 4 advanced, metastatic cancer, Benefits will not be subject to step therapy requirements if the use of the drug is consistent with best practices for the treatment and is supported by peer-reviewed medical literature."

The *Certificate of Coverage* defines Covered Health Care Service as "health care services, including supplies or Pharmaceutical Products, which are determined 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."

UHIC RV

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.

How Do Supply Limits Apply?

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Co-payment 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 or dose restrictions based on criteria that we have developed and subject to [Notification] [Prior Authorization]. Supply limits are subject 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. This limitation does not apply to prescription inhalants when suffering from asthma or other life-threatening bronchial ailments based upon restrictions on the number of days before an inhaler refill may be obtained.

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.

Does Step Therapy Apply?

Certain Prescription Drug Products for which Benefits are described under *Section 11: Outpatient Prescription Drugs* in the *Certificate* 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. [Notification] [Prior authorization] coverage criteria for step therapy is also located on www.uhcprovider.com.

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Not excluded in the Certificate under Section 2: Exclusions and Limitations."

The Plan structures prescription drug Prior Authorization processes to be compliant with all applicable federal and state laws, as well as the National Committee for Quality Assurance (NCQA) accreditation standards. NCQA confirms that Plan operations and policies identify appropriate time frames for decisions, requires decision-making by appropriate personnel, and governs communication of adverse benefit determinations. In addition, Prior Authorization is governed at both the state and federal level, which includes consumer protections such as external review for adverse benefit determinations after internal appeals options are exhausted, as applicable.

Prior Authorization, Step Therapy and Quantity Limits review of M/S and MH/SUD prescription drugs consists of the following:

Prior Authorization, Step Therapy, and Quantity Limits for prescription drugs begin after a provider or member requests coverage for a prescription drug and receipt of clinical information. The provider or member's submission of a request (notification) triggers the Prior Authorization, Step Therapy, and Quantity Limits process. Quantity Limits trigger a Prior Authorization if the member is seeking more than the quantity limit set. A Prior Authorization (including Quantity Limits) or Step Therapy request may be submitted by telephone or electronically. The Plan confirms receipt of the Prior Authorization, Step Therapy or Quantity Limit request. Non-clinical staff confirm member eligibility and benefit plan coverage. The Plan can administratively deny cases for lack of eligibility or benefit coverage.

Determinations. Clinical reviewers (Medical Director or healthcare professional) consult clinical drug policies when making clinical coverage benefit determinations. The clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical drug policies in the case review to assess whether a prescription drug should be covered. The Prior Authorization, Step Therapy, or Quantity Limit request is approved based on whether the member's clinical condition meets criteria for coverage as determined by the application of clinical drug policies. Only qualified clinical reviewers (e.g., physicians or pharmacists) can issue adverse benefit determinations. If an adverse benefit determination is issued, then the adverse benefit determination and appeal rights are communicated to the member and provider.

Adverse Benefit Determinations. For prescription drugs, an adverse benefit determination is an administrative or clinical review decision resulting in a reduction or termination, non-coverage or non-certification of a prescription drug. Adverse benefit determinations are recorded as administrative denials when member eligibility and benefit coverage cannot be confirmed, or benefits are exhausted. Adverse benefit determinations are recorded as clinical denials when they are based on clinical drug policies and member clinical information

Clinical Criteria. Clinical reviewers base Prior Authorization clinical coverage benefit determinations on objective, evidence-based clinical drug policies.

Step 1 – NQTL and Application

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

Specific NQTL

- Prescription Drug Prior Authorization, Step Therapy, and/or Quantity Limits

Benefit Classification(s)

- Prescription Drugs

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHIC)
- UnitedHealthcare Insurance Company of Illinois (UHIC IL)
- UnitedHealthcare of Illinois, Inc. (UHC IL)
- UnitedHealthcare Plan of the River Valley, Inc. (UHCP RV)
- UnitedHealthcare Insurance Company of the River Valley (UHIC RV)

Plan Terms/Source Document(s)

The Plan's Outpatient Prescription Drug *Schedule of Benefits* notify members of the Prior Authorization requirements. Members or providers are required to comply with UM protocols established by the Plan.

UHIC, UHIC IL, UHC IL

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- Not excluded in the Certificate under Section 2: Exclusions and Limitations."

"Pharmaceutical Products - Outpatient

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UHIC RV

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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. [Notification] [Prior authorization] coverage criteria for step therapy is also located on www.uhcprovider.com.

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In the case of *FDA*-approved drugs for the treatment of stage 4 advanced, metastatic cancer, Benefits will not be subject to step therapy requirements if the use of the drug is consistent with best practices for the treatment and is supported by peer-reviewed medical literature."

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

- Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms.
- Medically Necessary
- Described as a Covered Health Care Service in the Certificate under Section 1: Covered Health Care Services and in the Schedule of Benefits

Not excluded in the Certificate under Section 2: Exclusions and Limitations."

The *2023 UnitedHealthcare Care Provider Administrative Guide* notifies providers of the Prior Authorization requirements. In-network providers are required to comply with UM protocols established by the Plan.

> "We develop medical policies, medical benefit drug policies, coverage determination guidelines, and utilization review guidelines to support the administration of medical benefits. You may request a copy of our medical policies and guidelines by calling our care management team at 1-877-842-3210 or 1-888-478-4760 (Individual Exchange Plans). They are only for informational purposes; they are not medical advice. You are responsible for deciding what care to give our members. Members should talk to their health care providers before making medical decisions. Drug policies for commercial members covered under the pharmacy benefit are on uhcprovider.com/pharmacy.
>
> Benefit coverage is determined by the following:
> • Laws that may require coverage
> • The member's benefit plan document
> – Summary Plan Description
> – Schedule of Benefits
> – Certificate of Coverage
>
> The member's benefit plan document identifies which services are covered, which are excluded, and which are subject to limitations. If there is a conflict, the member's benefit plan document supersedes our policies and guidelines.
>
> We develop our policies and guidelines as needed. We regularly review and update them. They are subject to change. We believe the information in these policies and guidelines is accurate and current as of the publication date. We also use tools developed by third parties, such as InterQual criteria, to help us manage health benefits. If you believe we should consider new or additional clinical evidence pertaining to a specific medical policy, complete this form for UnitedHealthcare medical policy review. Do not submit protected health information using this form. If you have questions or concerns about a specific service for a member, refer to the appropriate benefits, claims or prior authorization/notification process."

List of M/S and MH/SUD Services Subject to NQTL
See list of Drugs with Clinical Programs-Commercial dated 11/01/2023:

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
        - FDA-approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off-label use, and claims data analysis as relevant

These evidentiary standards and sources apply to both M/S and MH/SUD prescription drugs. These evidentiary standards and sources are defined in a quantitative manner.

Factor – Value to implement Prior Authorization/Step Therapy - Goal is to evaluate whether inclusion of contingency edits or inclusion in Diagnosis to Prescription match (Dx2Rx) or Silent Authorization is appropriate or whether a coverage review is required to determine whether conditions of coverage are met. Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.

- The Plan's evidentiary standards and sources that define and/or trigger the value to implement Prior Authorization/Step Therapy factor:
    - State and/or Federal regulations and guidelines
        - FDA-approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off-label use, and claims data analysis as relevant

- Review of external clinical evidence
  - FDA-approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off-label use, and claims data analysis as relevant
- Nationally recognized evidence-based guidelines and benchmarks
  - FDA-approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off-label use, and claims data analysis as relevant

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

Factor – Relative safety and efficacy - Goal is to promote optimal drug use by performing a comprehensive efficacy comparison as well as reviewing the type and frequency of side effects and potential drug interactions among alternative drug products.

- The Plan's evidentiary standards and sources that define and/or trigger the Relative safety and efficacy factor:
  - State and/or Federal regulations and guidelines
    - FDA-approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off-label use, and claims data analysis as relevant
  - Review of external clinical evidence
    - FDA-approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off-label use, and claims data analysis as relevant
  - Nationally recognized evidence-based guidelines and benchmarks
    - FDA-approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off-label use, and claims data analysis as relevant

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

Factor – Prevention of off-label use or unproven uses - Goal is to promote optimal drug use by evaluating the potential for the drug to be used for indications other than what is included on FDA approved product labeling.

- The Plan's evidentiary standards and sources that define and/or trigger the Prevention of off-label use or unproven uses factor:
  - State and/or Federal regulations and guidelines
    - FDA-approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off-label use, and claims data analysis as relevant
  - Review of external clinical evidence
    - FDA-approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice

guidelines, comparisons of efficacy, side effects, potential for off-label use, and claims data analysis as relevant

- Nationally recognized evidence-based guidelines and benchmarks
  - FDA-approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off-label use, and claims data analysis as relevant

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

These are the factors and evidentiary standards used in designing or applying the Plan's Prior Authorization, Step Therapy, or Quantity Limits requirement to prescription drugs. The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL.

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

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

[redacted]

[redacted]

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."

[redacted]

In addition, both M/S and MH/SUD utilize the same generally accepted types of data, evidentiary sources, and trend analysis in order to create and maintain a Prior Authorization, Step Therapy, or Quantity Limit requirement.

The findings of the prescription drug Prior Authorization, Step Therapy, or Quantity Limits outcomes analysis for each Plan (see data below) indicated the percentage of prescription drugs subject to Prior Authorization, Step Therapy, and/or Quantity Limits for MH/SUD prescription drugs were comparable to the percentage of prescription drugs subject to Prior Authorization, Step Therapy, and/or Quantity Limits for M/S prescription drugs. Data is for January, May, and September 2022. The Plan notes that the U.S. Department of Labor has indicated generally that outcomes data are not dispositive of parity compliance.

Conclusions

The Plan reviewed the M/S and MH/SUD processes and noted the Plan uses a single P&T committee which follows a standard process to create clinical criteria and develop clinical drug policies for M/S and MH/SUD prescription drugs. From review of the Prior Authorization Step Therapy, or Quantity Limit policies and procedures, the Plan concluded the methodology used to determine which MH/SUD prescription drugs are subject to Prior Authorization Step Therapy, or Quantity Limits “as written” were comparable to, and applied no more stringently than, the methodology used to determine which M/S prescription drugs are subject to Prior Authorization, Step Therapy, or Quantity Limits “as written.” Additionally, the Plan concluded how Prior Authorization, Step Therapy, or Quantity Limits is applied to MH/SUD prescription drugs was comparable to, and applied no more stringently than, how Prior Authorization, Step Therapy, or Quantity Limits was applied to M/S prescription drugs “as written.”

The Plan notes that the percentage of MH/SUD drugs subject to Prior Authorization, Step Therapy, and/or Quantity Limits is higher than the percentage of M/S drugs subject to Prior Authorization, Step Therapy, and/or Quantity Limits. The Plan concluded this was due to the following contributing factors: a smaller pool of MH/SUD products to evaluate, a broader range of strengths for MH/SUD products, and an increased risk of abuse and diversion of MH/SUD products explain the variance. The Plan concluded this does not indicate a parity concern, but rather is an indicator of patient safety in disbursing MH/SUD drugs.

The Plan reviewed the M/S and MH/SUD processes and noted the Plan uses the same policies and procedures to create clinical criteria and develop clinical drug policies for both M/S and MH/SUD prescription drugs. The Plan also reviewed the percentage of M/S and MH/SUD prescription drugs which are subject to Prior Authorization, Step Therapy, or Quantity Limits and concluded the methodology used to determine which MH/SUD prescription drugs are subject to Prior Authorization, Step Therapy, or Quantity Limits and how Prior Authorization, Step Therapy, or Quantity Limits were applied were comparable to, and applied no more stringent than, the methodology used to determine which M/S prescription drugs were subject to Prior Authorization, Step Therapy, or Quantity Limits “in operation.”

Overview

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

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

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

Specific NQTL

Per the *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions,* Prior Authorization is defined as: "A required or mandatory clinical assessment for proposed service(s) based on clinical information provided and the terms of the health plan benefits before the service(s) are performed or delivered. Clinical and medical necessity requirements, level of care appropriateness, and the terms of the health plan benefits must be met in order for services to be covered by the member's plan." The *Optum National Policy Definitions List* defines pre-authorization (aka Prior Authorization) as "a form of prospective utilization review of health care services proposed to be provided to a member."

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

Prior Authorization for inpatient services commences prior to a service being delivered. Prior Authorization is a UM process that involves applying the benefit plan language and/or clinical criteria to make the most appropriate clinical coverage benefit determination.

This document includes the following information:

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

This analysis refers to the following attachments:

- *Addendum A* - Identifies the M/S and MH/SUD inpatient services that are subject to Prior Authorization
- *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions* - M/S policy that defines Prior Authorization
- *Optum National Policy Definitions List* - MH/SUD policy that defines Prior Authorization

- *Utilization Management Program Description (UMPD) of United HealthCare Services, Inc. and UnitedHealthcare Insurance Company* - Summarizes the philosophy, structure and standards that govern UHC's medical management, UM and utilization review responsibilities and functions
- *Management of Behavioral Health Benefits Policy* - Describes the mechanisms and processes designed to promote consistency in the management of behavioral health benefits and to ensure that members receive appropriate, high quality behavioral health services in a timely manner
- *Prior Authorization_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
- *Schedule of Benefits* (SBN) - *(SBN24-Medical-HMO-2018-[Charter][Navigate][Nexus [N]R]-LG-IL, SBN24-Medical-HMO-RV-2018-HeritageSelect-LG-IL, SBN24-Medical-INS-2018-[Choice Plus][Select Plus][Doctors Plus]-LG-IL,* and *SBN24-Medical-INS-RV-2018-HeritagePlus-LG-IL)* - 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.

[redacted]

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.

[redacted]

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 (UHIC)
- UnitedHealthcare Insurance Company of Illinois (UHIC IL)
- UnitedHealthcare of Illinois, Inc. (UHC IL)
- UnitedHealthcare Plan of the River Valley, Inc. (UHCP RV)
- UnitedHealthcare Insurance Company of the River Valley (UHIC RV)

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:

UHIC, UHIC IL, UHCP RV, UHIC RV

"Medically Necessary – health care services that are all of the following:

- In accordance with *Generally Accepted Standards of Medical Practice*.
- 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 Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We may also consult expert opinion in determining whether health care services are Medically Necessary.

We develop and maintain clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by us and revised when needed), are available to Covered Persons through www.myuhc.com or the telephone number on your ID card. They are also available to Physicians and other health care professionals on UHCprovider.com."

UHC IL

"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 Medical Practice*.
- 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 Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

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

We develop and maintain clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by us and revised when needed), are available to Covered Persons through www.myuhc.com or the telephone number on your ID card. They are also available to Physicians and other health care professionals on 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. Previously also known as Pre-Authorization, or Pre-Review. Note: Certain states continue to use the term Pre-Certification."

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:

UHIC, UHIC IL, UHIC RV

"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."

UHC IL

"We require prior authorization for certain Covered Health Care Services. Your Primary Care Physician and other Network providers are responsible for obtaining prior authorization before they provide these services to you.

Please note that prior authorization is required even if you have an electronic referral submitted online to UnitedHealthcare of Illinois, Inc. by your Primary Care Physician to seek care from another Network Physician.

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."

UHCP RV

"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."

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 services have not been rendered and the specified date of service or date range has passed, you must contact us to update the date of service or date range. When you contact us, we will advise if we will require a new submission.

Giving us advance notification, or receiving prior authorization from us, is not a guarantee of payment, unless required by law or Medicare guidelines. This includes regulations about health care providers on a sanctions or excluded list, the Medicare preclusion list and/or care providers not included in the Medicare Provider Enrollment Chain and Ownership System (PECOS)* list. Payment of covered services is based on:

- The member's benefit plan
- If you are eligible for payment
- Claim processing requirements
- Your Agreement

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 subject to change. We will inform you of changes on uhcprovider.com/news. Sign up to receive email updates at uhcprovider.com/subscribe.

If you need a paper copy of the requirements, contact your UnitedHealthcare Network Management representative or provider advocate at uhcprovider.com > Contact us."

The September 2023 *Optum National Network Manual* notifies providers of the Prior Authorization requirements. INN providers are required to comply with UM protocols established by the Plan:

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

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

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

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

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

For mental health, substance-related disorder services, and wraparound services, UBH uses its Clinical Criteria (see below), behavioral clinical policies, 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.

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)

  [redacted]

  Applies to M/S and MH/SUD services.

- Value (Quantitative)

  [redacted]

  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:

III. M/S: INN inpatient services
IV. MH/SUD: INN inpatient services

Factor – Clinical Appropriateness

[redacted]

Factor – Value

[redacted]

[redacted]

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.

[redacted]

[redacted]

[redacted]

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

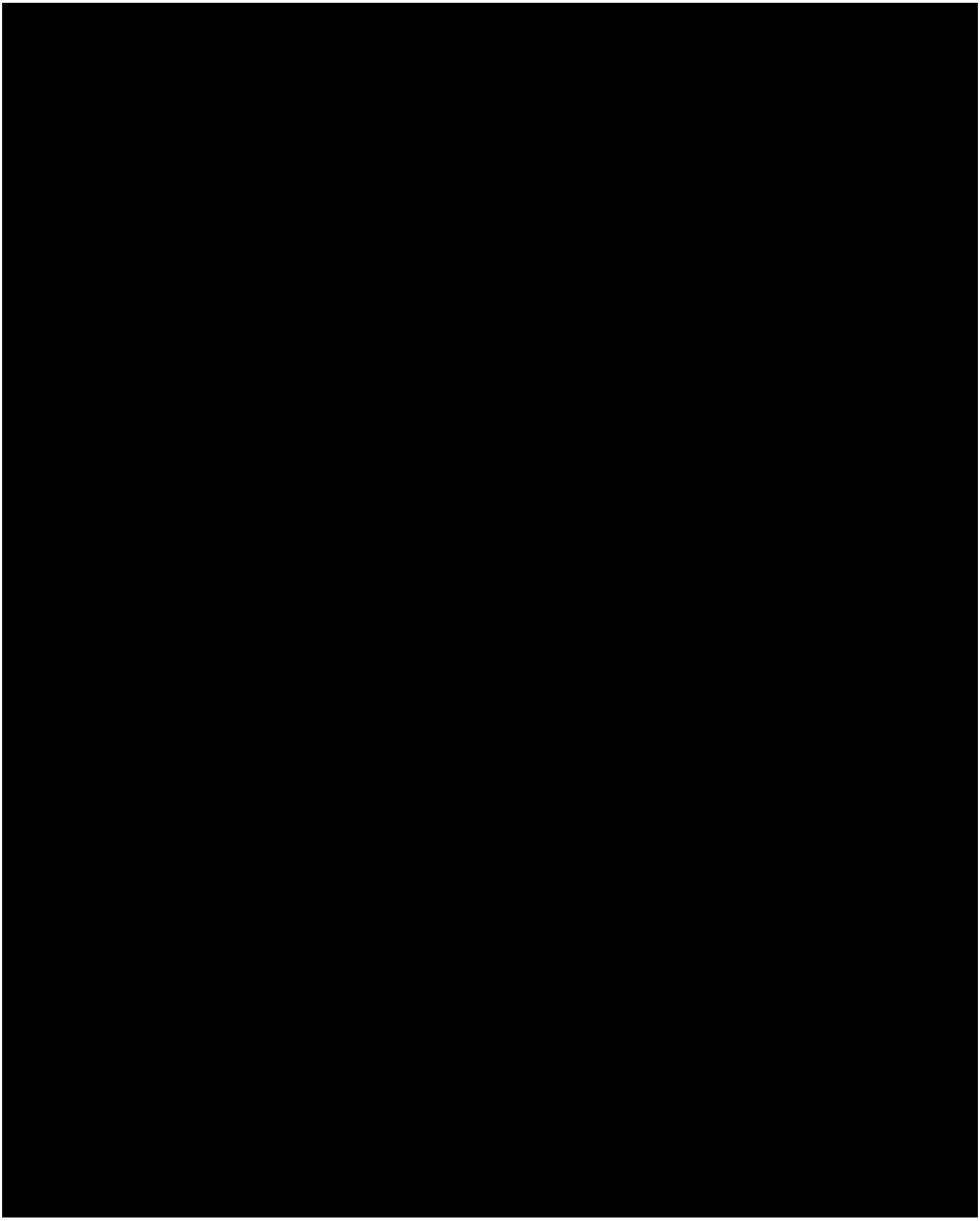
The findings of the Plan's comparative analyses confirmed the strategies, processes, factors, evidentiary standards, and source information used to determine the MH/SUD INN inpatient services subject to Prior Authorization were comparable to, and applied no more stringently than, the strategies, processes, 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.

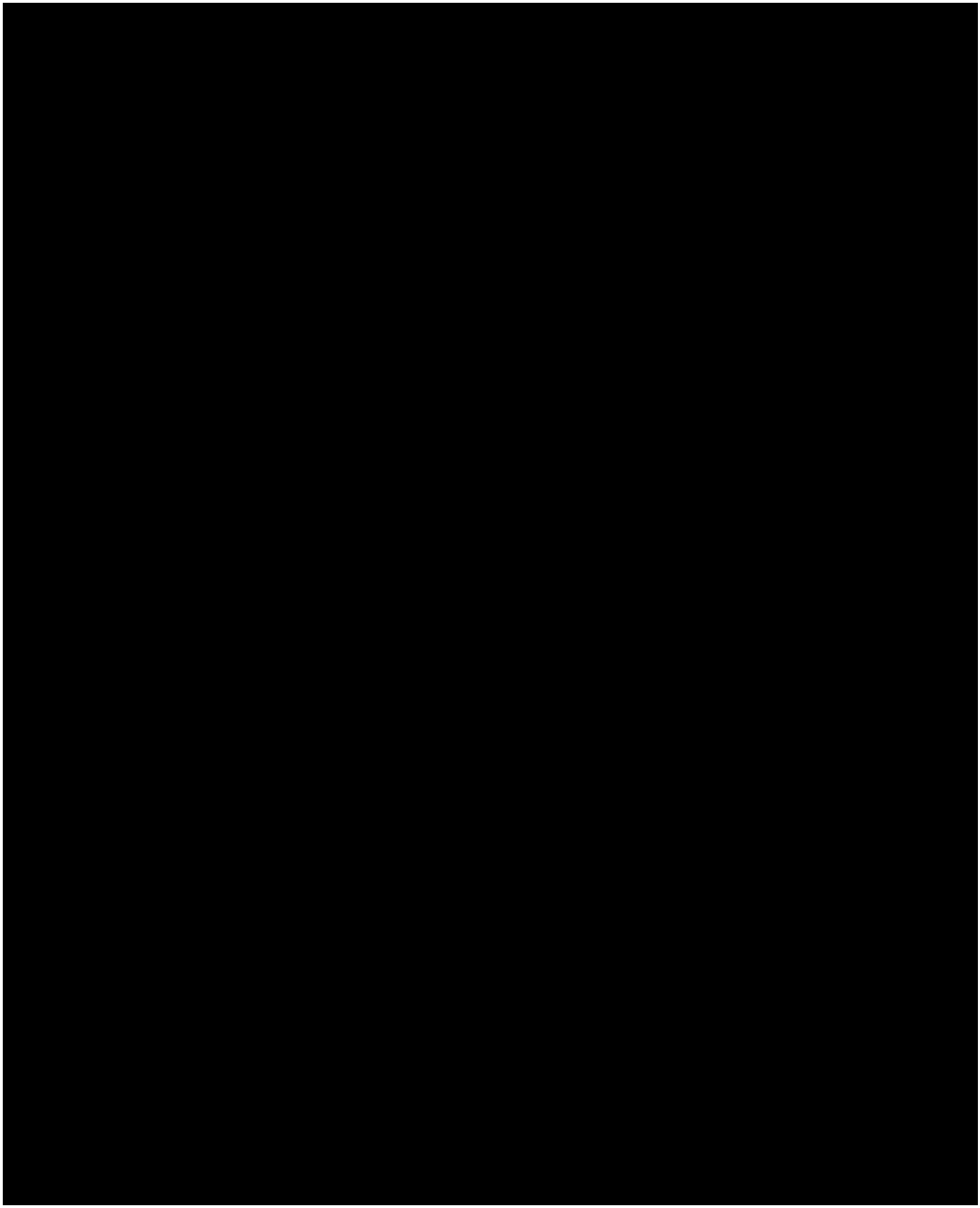
The Plan found the factors used to determine the MH/SUD INN inpatient services subject to Prior Authorization were comparable to, and applied no more stringently than, the factors used to determine the M/S INN inpatient services subject to Prior Authorization. INN M/S and MH/SUD inpatient services that 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.

[redacted]

[redacted]

Prior Authorization – Inpatient In-Network Non-Quantitative Treatment Limitation (NQTL) Analysis
IL - UnitedHealthcare Insurance Company, UnitedHealthcare Insurance Company of Illinois, UnitedHealthcare of Illinois, Inc., UnitedHealthcare Plan of the River Valley, Inc., and UnitedHealthcare Insurance Company of the River Valley
12/01/2023





Conclusions

The Plan reviewed the M/S and MH/SUD Prior Authorization operational policies and procedures and concluded the methodology used to determine which MH/SUD 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_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
- *Schedule of Benefits* (SBN) - (*SBN24-Medical-HMO-2018-[Charter][Navigate][Nexus [N]R]-LG-IL*, *SBN24-Medical-HMO-RV-2018-HeritageSelect-LG-IL*, *SBN24-Medical-INS-2018-[Choice Plus][Select Plus][Doctors Plus]-LG-IL*, and *SBN24-Medical-INS-RV-2018-HeritagePlus-LG-IL)* - 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.

[redacted]

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.

[redacted]

Per the MH/SUD policy entitled, *Core Principles and Practices*, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse clinical coverage benefit determinations (clinical denials) for financial reasons.
MH/SUD generally structures UM processes to comply with federal ERISA requirements, NCQA UM standards, and state law where applicable.

Step 1 – NQTL and Application

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

Specific NQTL

- Prior Authorization

Benefit Classification(s)

- INN, outpatient

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHIC)
- UnitedHealthcare Insurance Company of Illinois (UHIC IL)
- UnitedHealthcare of Illinois, Inc. (UHC IL)
- UnitedHealthcare Plan of the River Valley, Inc. (UHCP RV)
- UnitedHealthcare Insurance Company of the River Valley (UHIC RV)

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:

UHIC, UHIC IL, UHCP RV, UHIC RV

"Medically Necessary – health care services that are all of the following:

- In accordance with *Generally Accepted Standards of Medical Practice*.
- 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 Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We may also consult expert opinion in determining whether health care services are Medically Necessary.

We develop and maintain clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by us and revised when needed), are available to Covered Persons through www.myuhc.com or the telephone number on your ID card. They are also available to Physicians and other health care professionals on UHCprovider.com."

UHC IL

"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 Medical Practice*.
- 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 Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

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

We develop and maintain clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by us and revised when needed), are available to Covered Persons through www.myuhc.com or the telephone number on your ID card. They are also available to Physicians and other health care professionals on 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. Previously also known as Pre-Authorization, or Pre-Review. Note: Certain states continue to use the term Pre-Certification."

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:

UHIC, UHIC IL, UHIC RV

> "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."

UHC IL

"We require prior authorization for certain Covered Health Care Services. Your Primary Care Physician and other Network providers are responsible for obtaining prior authorization before they provide these services to you.

Please note that prior authorization is required even if you have an electronic referral submitted online to UnitedHealthcare of Illinois, Inc. by your Primary Care Physician to seek care from another Network Physician.

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."

UHCP RV

"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."

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 services have not been rendered and the specified date of service or date range has passed, you must contact us to update the date of service or date range. When you contact us, we will advise if we will require a new submission.

Giving us advance notification, or receiving prior authorization from us, is not a guarantee of payment, unless required by law or Medicare guidelines. This includes regulations about health care providers on a sanctions or excluded list, the Medicare preclusion list and/or care providers not included in the Medicare Provider Enrollment Chain and Ownership System (PECOS)* list. Payment of covered services is based on:

- The member's benefit plan
- If you are eligible for payment
- Claim processing requirements
- Your Agreement

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 subject to change. We will inform you of changes on uhcprovider.com/news. Sign up to receive email updates at uhcprovider.com/subscribe.

If you need a paper copy of the requirements, contact your UnitedHealthcare Network Management representative or provider advocate at uhcprovider.com > Contact us."

The September 2023 *Optum National Network Manual* 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 may include, but are not limited to, the following:

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

Authorization for some non-routine services may be requested through either the Provider Express website, or the Provider Express Secure Portal:

- ABA services: Provider Express > Autism Corner: Autism/ABA Information
  - ABA Assessment Portal (electronic authorization request submissions)
  - ABA Treatment Request Documents (please review webpage for specific forms)
- Psychological/Neuropsychological Testing: Provider Express > Clinical Resources > Forms > Psychological Testing Request Forms:
  - Optum Psychological and Neuropsychological Testing Request Form (electronic submission for most memberships)
  - Paper forms for specific memberships, available for download, are to be faxed in
- TMS services (electronic submission) Provider Express > Clinical Resources > Forms > Transcranial Magnetic Stimulation (TMS) Form

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.
    - 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:

III. M/S INN outpatient services
IV. MH/SUD INN outpatient services

- Clinical Appropriateness (Qualitative)
  [redacted]

  Applies to M/S and MH/SUD services.

- Value (Quantitative)

  [redacted]

  Applies to M/S and MH/SUD services.

- Variation (Quantitative)

  [redacted]

  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)

  [redacted]

  Applies to M/S and MH/SUD services.

- Consistency (Quantitative)

  [redacted]

  Applies to M/S and MH/SUD services.

- Low Volume (Quantitative)

  [redacted]

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)

  [redacted]

  Applies to M/S and MH/SUD services.

- Patient Safety (Qualitative)

  [redacted]

  Applies to M/S and MH/SUD services.

- Level of Care (Quantitative)

  [redacted]

  Applies to M/S and MH/SUD services.

- High-Cost Drugs and Services that are greater than $100,000 (Quantitative)

  [redacted]

  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 [redacted]

[redacted]

Factor – Value [redacted]

Factor – Variation [redacted]

[redacted]

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 [redacted]

Factor - Consistency [redacted]

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 [redacted]

- [redacted]
- [redacted]

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 [redacted]

- [redacted]
- [redacted]

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 [redacted]

- [redacted]
- [redacted]

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 [redacted]

[redacted]

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 [redacted]

[redacted]

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.

[redacted]

[redacted]

[redacted]

Prior Authorization – Outpatient In-Network Non-Quantitative Treatment Limitation (NQTL) Analysis
IL - UnitedHealthcare Insurance Company, UnitedHealthcare Insurance Company of Illinois, UnitedHealthcare of Illinois, Inc., UnitedHealthcare Plan of the River Valley, Inc., and UnitedHealthcare Insurance Company of the River Valley
12/01/2023

[redacted]

Prior Authorization – Outpatient In-Network Non-Quantitative Treatment Limitation (NQTL) Analysis
IL - UnitedHealthcare Insurance Company, UnitedHealthcare Insurance Company of Illinois, UnitedHealthcare of Illinois, Inc., UnitedHealthcare Plan of the River Valley, Inc., and UnitedHealthcare Insurance Company of the River Valley
12/01/2023

[redacted]

[redacted]

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."

[redacted]

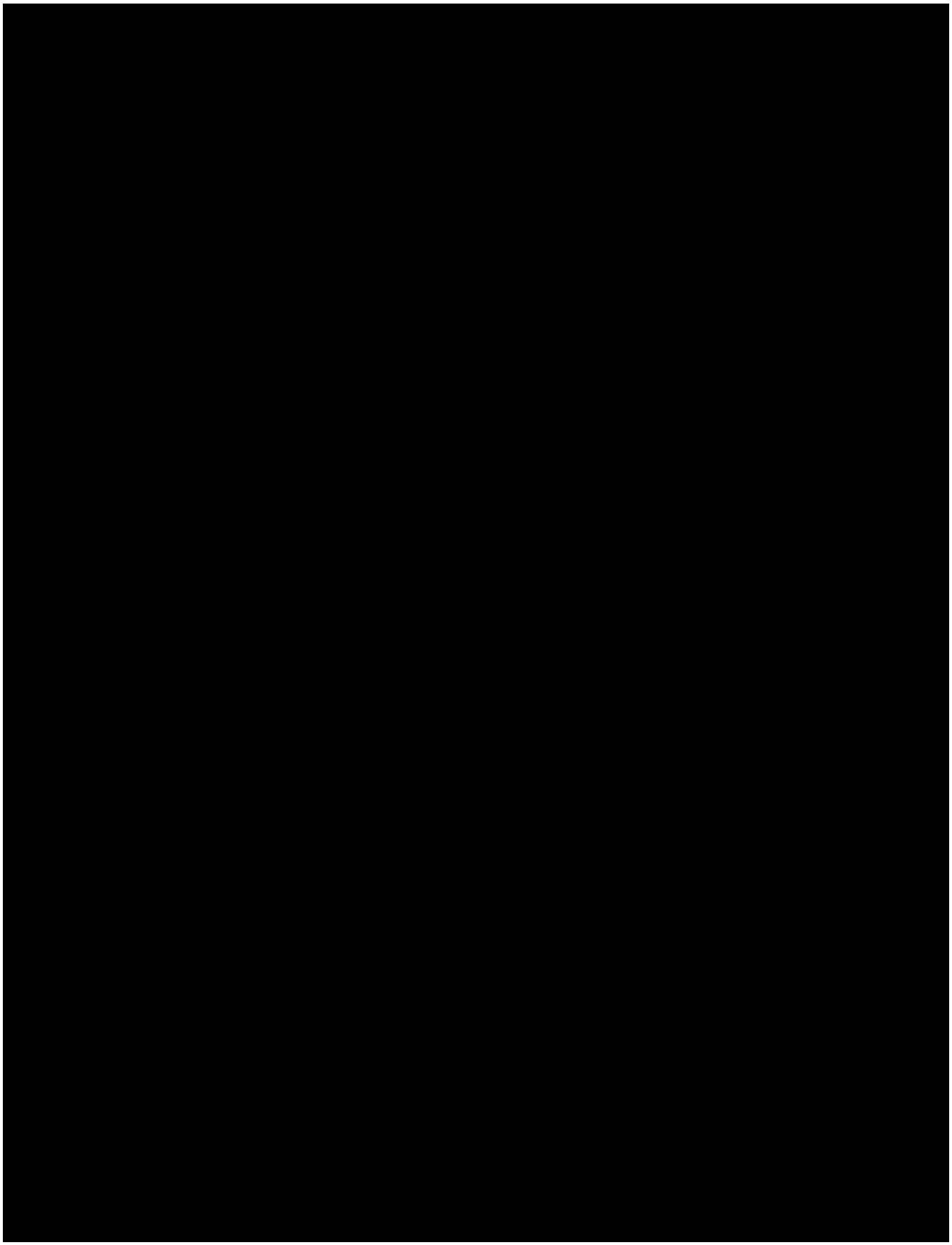
Prior Authorization – Outpatient In-Network Non-Quantitative Treatment Limitation (NQTL) Analysis
IL - UnitedHealthcare Insurance Company, UnitedHealthcare Insurance Company of Illinois, UnitedHealthcare of Illinois, Inc., UnitedHealthcare Plan of the River Valley, Inc., and UnitedHealthcare Insurance Company of the River Valley
12/01/2023

[redacted]

Prior Authorization – Outpatient In-Network Non-Quantitative Treatment Limitation (NQTL) Analysis
IL - UnitedHealthcare Insurance Company, UnitedHealthcare Insurance Company of Illinois, UnitedHealthcare of Illinois, Inc., UnitedHealthcare Plan of the River Valley, Inc., and UnitedHealthcare Insurance Company of the River Valley
12/01/2023

[redacted]

Prior Authorization – Outpatient In-Network Non-Quantitative Treatment Limitation (NQTL) Analysis
IL - UnitedHealthcare Insurance Company, UnitedHealthcare Insurance Company of Illinois, UnitedHealthcare of Illinois, Inc., UnitedHealthcare Plan of the River Valley, Inc., and UnitedHealthcare Insurance Company of the River Valley
12/01/2023



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. Previously also known as Pre-Authorization, or Pre-Review. Note: Certain states continue to use the term Pre-Certification." 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_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
- *Schedule of Benefits* (SBN) - (*SBN24-Medical-INS-2018-[Choice Plus][Select Plus][Doctors Plus]-LG-IL* and *SBN24-Medical-INS-RV-2018-HeritagePlus-LG-IL*) - 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. Previously also known as Pre-Authorization, or Pre-Review. Note: Certain states continue to use the term Pre-Certification." 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.

[redacted]

[redacted]

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.

[redacted]

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

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

Step 1 – NQTL and Application

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

Specific NQTL

- Prior Authorization

Benefit Classification(s)

- OON, inpatient

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHIC)
- UnitedHealthcare Insurance Company of Illinois (UHIC IL)
- UnitedHealthcare Insurance Company of the River Valley (UHIC RV)

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:

UHIC, UHIC IL, UHIC RV

"Medically Necessary – health care services that are all of the following:

- In accordance with *Generally Accepted Standards of Medical Practice*.
- 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 Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We may also consult expert opinion in determining whether health care services are Medically Necessary.

We develop and maintain clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by us and revised when needed), are available to Covered Persons through www.myuhc.com or the telephone number on your ID card. They are also available to Physicians and other health care professionals on 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. Previously also known as Pre-Authorization, or Pre-Review. Note: Certain states continue to use the term Pre-Certification."

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:

UHIC, UHIC IL, UHIC RV

> "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 (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.

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)

  [redacted]

  Applies to M/S and MH/SUD services.

- Value (Quantitative)

  [redacted]

Applies to M/S and MH/SUD services.

For M/S meeting Clinical Appropriateness is determinative in imposing the limitation. For MH/SUD meeting Clinical Appropriateness and Value is determinative in imposing the limitation. The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL. All Prior Authorization reviews are subject to Clinical Appropriateness and must have medical necessity criteria.

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

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

Below are the evidentiary standards and sources and used to define, trigger, and/or implicate the factors used to add services to the Plan's Prior Authorization requirement for OON inpatient services. These evidentiary standards and sources apply to benefits for the following:

I. M/S: OON inpatient services
II. MH/SUD: OON inpatient services

Factor – Clinical Appropriateness [redacted]

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

Factor – Value [redacted]

[redacted]

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.

[redacted]

Prior Authorization – Inpatient Out-of-Network Non-Quantitative Treatment Limitation (NQTL) Analysis
IL - UnitedHealthcare Insurance Company, UnitedHealthcare Insurance Company of Illinois, and
UnitedHealthcare Insurance Company of the River Valley
12/01/2023

[redacted]

Prior Authorization – Inpatient Out-of-Network Non-Quantitative Treatment Limitation (NQTL) Analysis
IL - UnitedHealthcare Insurance Company, UnitedHealthcare Insurance Company of Illinois, and
UnitedHealthcare Insurance Company of the River Valley
12/01/2023

[redacted]

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."

[redacted]

Prior Authorization – Inpatient Out-of-Network Non-Quantitative Treatment Limitation (NQTL) Analysis
IL - UnitedHealthcare Insurance Company, UnitedHealthcare Insurance Company of Illinois, and
UnitedHealthcare Insurance Company of the River Valley
12/01/2023

Prior Authorization – Inpatient Out-of-Network Non-Quantitative Treatment Limitation (NQTL) Analysis
IL - UnitedHealthcare Insurance Company, UnitedHealthcare Insurance Company of Illinois, and
UnitedHealthcare Insurance Company of the River Valley
12/01/2023

[redacted]

[redacted]

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_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 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/ope-provexpr/us/en/clinical-resources/guidelines-policies/optum-network-manual.html
- *Schedule of Benefits* (SBN) - (*SBN24-Medical-INS-2018-[Choice Plus][Select Plus][Doctors Plus]-LG-IL* and *SBN24-Medical-INS-RV-2018-HeritagePlus-LG-IL*) - 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.

[redacted]

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.

[redacted]

[redacted]

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

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

Step 1 – NQTL and Application

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

Specific NQTL

- Prior Authorization

Benefit Classification(s)

- OON, outpatient

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHIC)
- UnitedHealthcare Insurance Company of Illinois (UHIC IL)
- UnitedHealthcare Insurance Company of the River Valley (UHIC RV)

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:

UHIC, UHIC IL, UHIC RV

"Medically Necessary – health care services that are all of the following:

- In accordance with *Generally Accepted Standards of Medical Practice*.
- 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 Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on

controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We may also consult expert opinion in determining whether health care services are Medically Necessary.

We develop and maintain clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by us and revised when needed), are available to Covered Persons through www.myuhc.com or the telephone number on your ID card. They are also available to Physicians and other health care professionals on 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. Previously also known as Pre-Authorization, or Pre-Review. Note: Certain states continue to use the term Pre-Certification."

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:

UHIC, UHIC IL, UHIC RV

"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 (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.
    - 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)

  [redacted]

  Applies to M/S and MH/SUD services

- Value (Quantitative)

  [redacted]

  Applies to M/S and MH/SUD services

- Variation (Quantitative)

  [redacted]

  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:

III. M/S: OON outpatient services
IV. MH/SUD: OON outpatient services

- Low Value (Quantitative)

  [redacted]

  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:

III. M/S: OON outpatient services
IV. 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 [redacted]

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

Factor – Value [redacted]

This evidentiary standard and sources apply to M/S and MH/SUD OON outpatient services and are defined in a quantitative manner.

Factor – Variation [redacted]

[redacted]

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 [redacted]

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 [redacted]

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 [redacted]

- [redacted]
- [redacted]

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 [redacted]

- [redacted]
- [redacted]

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 [redacted]

- [redacted]
- [redacted]

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 [redacted]

- [redacted]
- [redacted]

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 [redacted]

- [redacted]
- [redacted]

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.

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

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."

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

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."

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)

[redacted]

[redacted]

Process

[redacted]

[redacted]

Step 1 – NQTL and Application

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

Specific NQTL

- Development and application of reimbursement policies

Benefit Classification(s)

- Applies to all benefit classifications

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHIC)
- UnitedHealthcare Insurance Company of Illinois (UHIC IL)
- UnitedHealthcare of Illinois, Inc. (UHC IL)
- UnitedHealthcare Plan of the River Valley, Inc. (UHCP RV)
- UnitedHealthcare Insurance Company of the River Valley (UHIC RV)

[redacted]

[redacted]

[redacted]

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.

[redacted]

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.

[redacted]

[redacted]

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.

[redacted]

[redacted]

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.

[redacted]

[redacted]

Conclusions

The Plan reviewed the M/S and MH/SUD reimbursement policies and procedures and concluded the methodology used to develop the MH/SUD reimbursement policies “as written” was comparable to, and applied no more stringently than, the methodology used to develop the M/S reimbursement policies “as written.” Additionally, the Plan concluded that the MH/SUD reimbursement policies were applied no more stringently than, the M/S reimbursement policies were applied “as written.”

The Plan reviewed the M/S and MH/SUD processes for applying the reimbursement policies and found they were comparable and no more stringently applied for MH/SUD. Additionally, from review of the M/S and MH/SUD processes for applying the reimbursement policies, including notification, timeframes for processing, determinations, and determination communications, the Plan concluded the methodology used to apply the MH/SUD reimbursement policies “in operation” was comparable to, and applied no more stringently than, the methodology used to apply the M/S reimbursement policies “in operation.”

Overview

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

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

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

Specific NQTL

Retrospective Review is a component of the Plan's Utilization Management (UM) program. Medical directors and other clinical staff review services in order to detect and better manage over- and under-utilization and determine whether the services reviewed are consistent with the member's coverage, medically appropriate, and consistent with evidence-based guidelines. Retrospective Review assesses the appropriateness of services on a case-by-case basis after the service has been provided but prior to payment for services. Retrospective Reviews are based on established review guidelines and may include:

- Review of medical necessity
- Appropriateness of level of care
- Identifying claims issues
- Eligibility determination
- Initiation of appropriate follow-up actions for utilization and quality issues

The Plan conducts medical necessity Retrospective Review of claims/requests for certain inpatient services that have not previously been reviewed as part of the Prior Authorization or Concurrent Review processes. The Plan may conduct Retrospective Review if the service or procedure codes do not match a diagnosis code, if services are experimental, investigational, or unproven (EIU), or if the services are subject to benefit limits/exclusions. The Plan conducts medical necessity Retrospective Review for inpatient services where Prior Authorization was required, but not obtained upon claim submission. INN M/S providers may also request Retrospective Review of inpatient claims that are denied.

This document includes the following information:

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

This comparative analysis refers to the following attachments:

- *Utilization Management Program Description (UMPD) of United HealthCare Services, Inc. and UnitedHealthcare Insurance Company* - Summarizes the philosophy, structure and standards that govern UHC's medical management, UM and utilization review responsibilities and functions
- *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions* - M/S policy that defines Retrospective Review
- *Optum National Policy Definitions List* - MH/SUD policy that defines Retrospective Review
- *M/S Retrospective Review Codes* – Excel document that lists M/S codes that may be subject to Retrospective Review
- *Certificates of Coverage* (COC) - (*COC24-HMO-2018-LG-IL, COC24-HMO-RV-2018-LG-IL, COC24-INS-2018-LG-IL,* and *COC24-INS-RV-2018-LG-IL*) - 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.

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, 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.

[redacted]

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, 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 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.

[redacted]

[redacted]

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 Insurance Company of Illinois (UHIC IL)
- UnitedHealthcare of Illinois, Inc. (UHC IL)
- UnitedHealthcare Plan of the River Valley, Inc. (UHCP RV)
- UnitedHealthcare Insurance Company of the River Valley (UHIC RV)

Plan Terms

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, 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.

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

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

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

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

- Services that have not previously been reviewed in Prior Authorization or Concurrent Review
- M/S Claims that are denied, if requested by an INN facility
- Services where the service or procedure codes do not match a diagnosis code
- EIU services
- Services that are subject to benefit limits/exclusions
- Codes identified by the Plan as subject to Retrospective Review
- Please see the file *M/S Retrospective Review Codes* for the list of M/S codes that may be subject to Retrospective Review
- MH/SUD claims/requests that include the following services are subject to Retrospective Review:
  - MH Non-Emergent Acute Inpatient
  - MH Subacute Residential Treatment
  - SUD Acute Inpatient Detoxification
  - SUD Acute Inpatient Rehabilitation
  - SUD Subacute Residential Treatment

Step 2 – Factors Used to Determine Retrospective Review Applies

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

The Plan relies on the following factor to determine which INN inpatient admissions are subject to Retrospective Review. This factor applies to M/S and MH/SUD for the following:

I. M/S INN inpatient admissions
II. MH/SUD INN inpatient admissions

- Consistency with Clinical Criteria (Qualitative):
  - Whether the application of Retrospective Review promotes optimal clinical outcomes

This factor applies to M/S and MH/SUD services. Meeting Consistency with Clinical Criteria is determinative in imposing the limitation.

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

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

Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factor used in designing or applying the Plan's Retrospective Review requirement to INN inpatient services. These evidentiary standards and sources apply to the following:

I. M/S INN inpatient admissions
II. MH/SUD INN inpatient admissions

Factor: Consistency with Clinical Criteria [redacted]

[redacted]

[redacted]

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.

[redacted]

[redacted]

[redacted]

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.

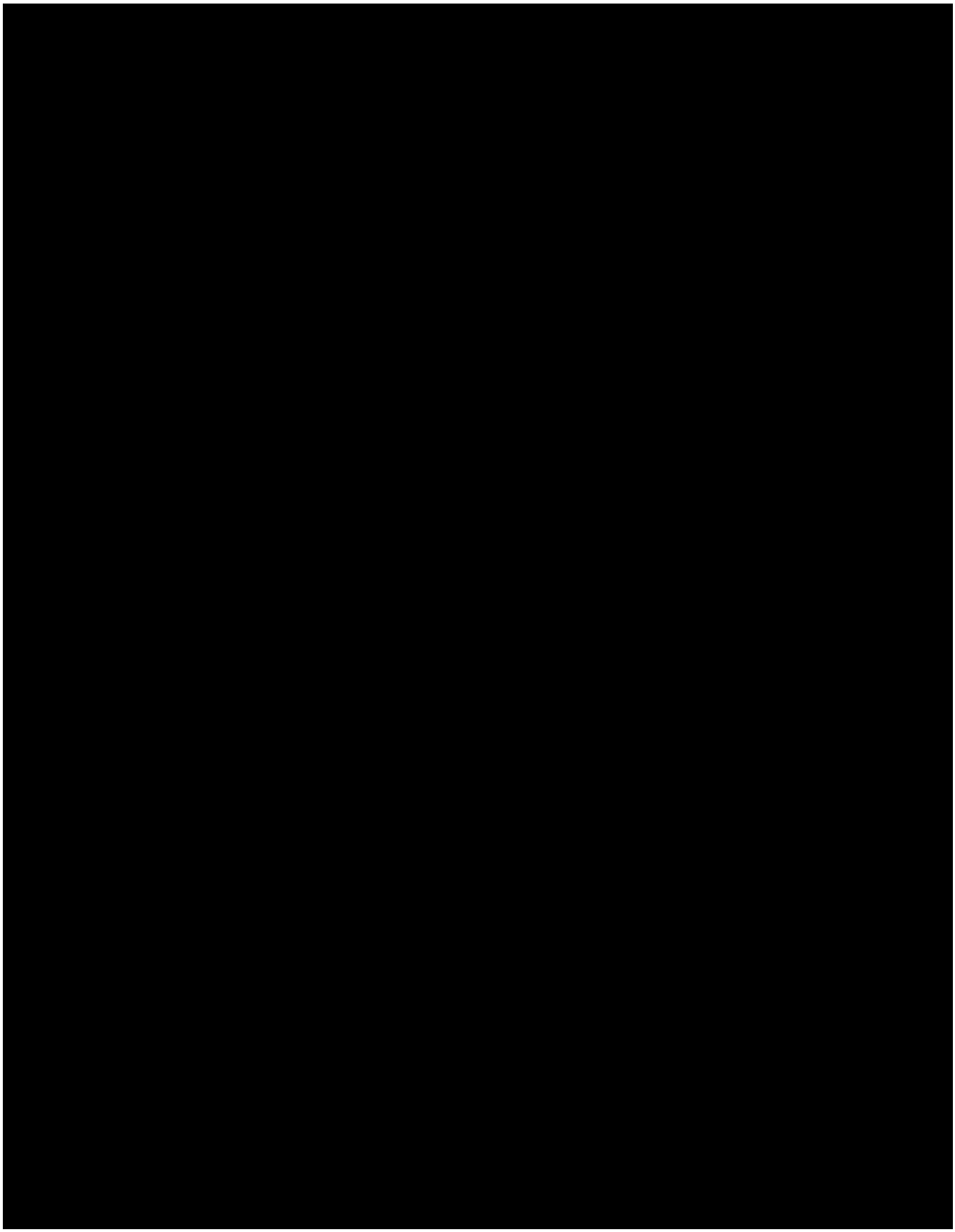
Findings

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.

[redacted]

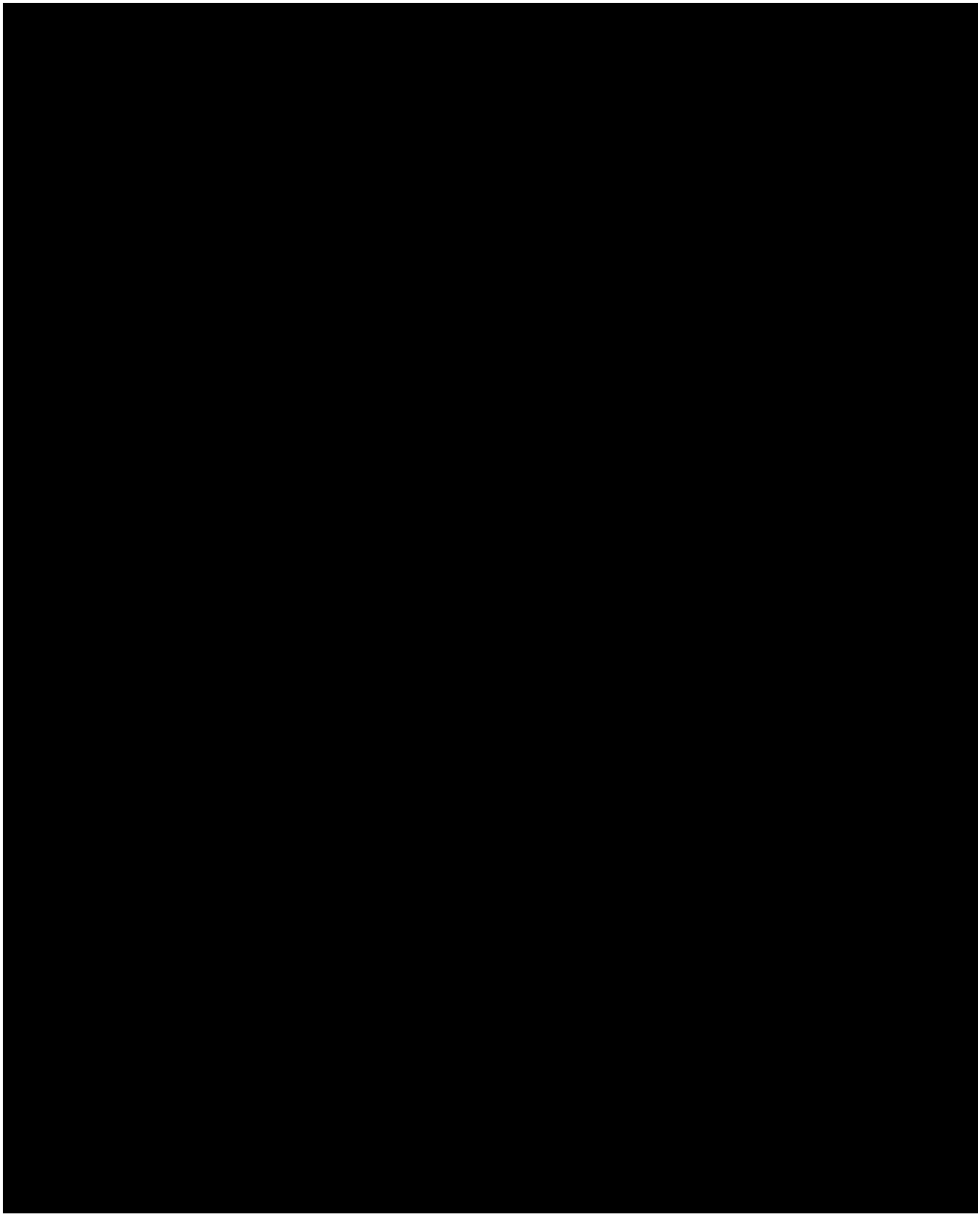
Retrospective Review In-Network Inpatient Non-Quantitative Treatment Limitations (NQTL) Analysis
IL - UnitedHealthcare Insurance Company, UnitedHealthcare Insurance Company of Illinois, UnitedHealthcare of Illinois, Inc., UnitedHealthcare Plan of the River Valley, Inc., and UnitedHealthcare Insurance Company of the River Valley
12/01/2023



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

IL - UnitedHealthcare Insurance Company, UnitedHealthcare Insurance Company of Illinois, UnitedHealthcare of Illinois, Inc., UnitedHealthcare Plan of the River Valley, Inc., and UnitedHealthcare Insurance Company of the River Valley

12/01/2023



Conclusions

The Plan concluded that how Retrospective Review is applied to MH/SUD INN inpatient services was comparable to, and applied no more stringently than, how Retrospective Review is applied to M/S INN inpatient services “as written.”

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

Overview

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

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

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

Specific NQTL

Retrospective Review is a component of the Plan's Utilization Management (UM) program. Medical directors and other clinical staff review services in order to detect and better manage over- and under-utilization and determine whether the services reviewed are consistent with the member's coverage, medically appropriate, and consistent with evidence-based guidelines. Retrospective Review assesses the appropriateness of services on a case-by-case basis after the service has been provided, but prior to payment for services. Retrospective Reviews are based on established review guidelines and may include:

- Review of medical necessity
- Appropriateness of level of care
- Identifying claims issues
- Eligibility determination
- Initiation of appropriate follow-up actions for utilization and quality issues

The Plan conducts medical necessity Retrospective Review of claims/requests for certain outpatient services that have not previously been reviewed as part of the Prior Authorization or Concurrent Review processes. The Plan may conduct Retrospective Review if the service or procedure codes do not match a diagnosis code, if services are experimental, investigational, or unproven (EIU), or if the services are subject to benefit limits/exclusion. The Plan conducts medical necessity Retrospective Review for outpatient services where Prior Authorization was required, but not obtained upon claim submission. INN M/S providers may also request Retrospective Review of outpatient claims that are denied.

This document includes the following information:

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

This comparative analysis refers to the following attachments:

- *Utilization Management Program Description (UMPD) of United HealthCare Services, Inc. and UnitedHealthcare Insurance Company* - Summarizes the philosophy, structure and standards that govern UHC's medical management, UM and utilization review responsibilities and functions
- UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions - M/S policy that defines Retrospective Review
- *Optum National Policy Definitions List* - MH/SUD policy that defines Retrospective Review
- *M/S Retrospective Review Codes* – Excel document that lists M/S codes that may be subject to Retrospective Review
- *Certificates of Coverage* (COC) - (*COC24-HMO-2018-LG-IL, COC24-HMO-RV-2018-LG-IL, COC24-INS-2018-LG-IL,* and *COC24-INS-RV-2018-LG-IL*) - 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.

[redacted]

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.

[redacted]

[redacted]

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

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

Step 1 – NQTL and Application

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

Specific NQTL

- Retrospective Review

Benefit Classification(s)

- INN, outpatient

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHIC)
- UnitedHealthcare Insurance Company of Illinois (UHIC IL)
- UnitedHealthcare of Illinois, Inc. (UHC IL)
- UnitedHealthcare Plan of the River Valley, Inc. (UHCP RV)
- UnitedHealthcare Insurance Company of the River Valley (UHIC RV)

Plan Terms

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-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.
  - 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/High-Intensity Outpatient
  - Intensive Outpatient Program (IOP)
  - Transcranial Magnetic Stimulation (TMS)
  - 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 [redacted]

[redacted]

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.

[redacted]

[redacted]

[redacted]

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.

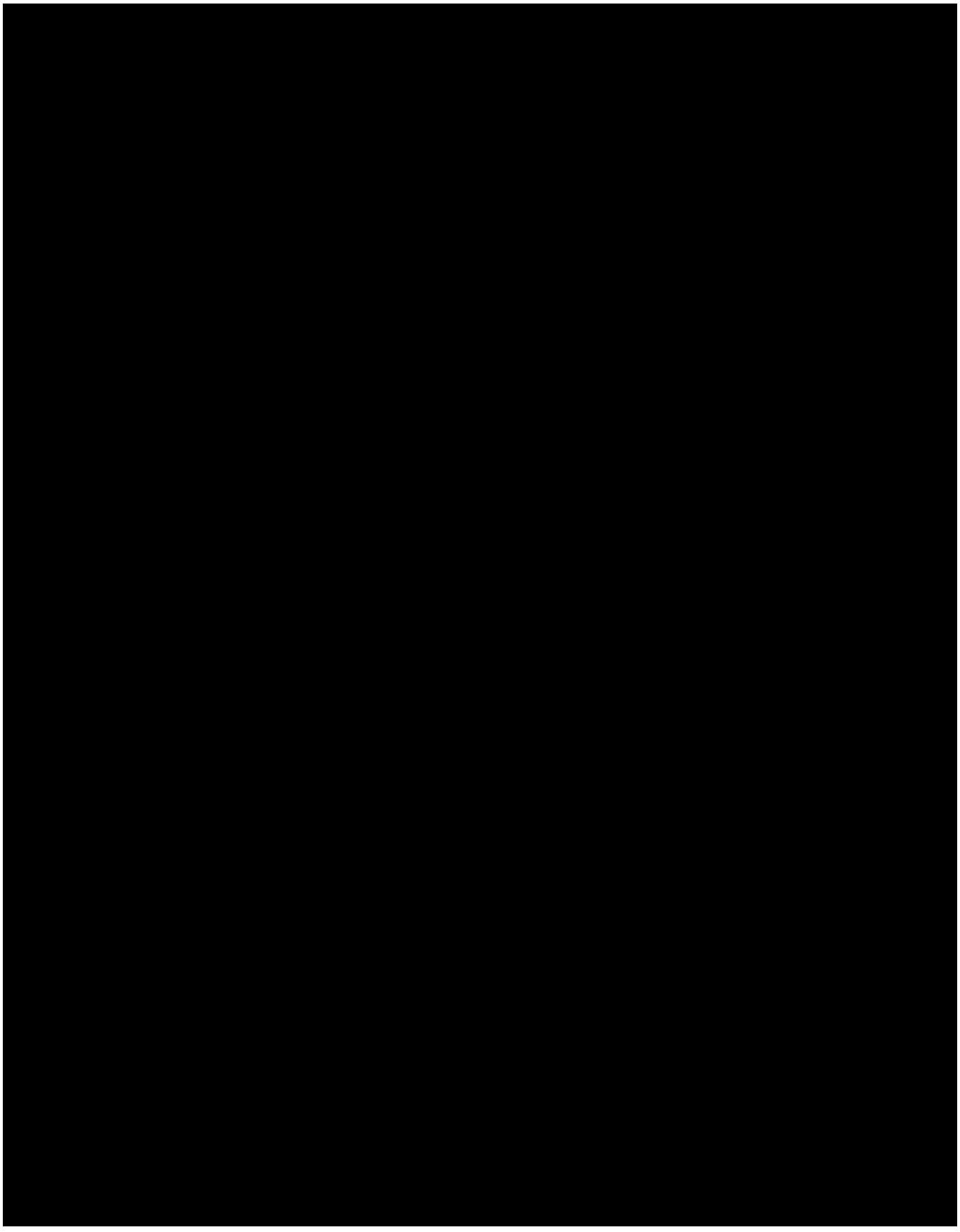
[redacted]

[redacted]

Review clinical external appeals received

[redacted]

Retrospective Review – Outpatient In-Network Non-Quantitative Treatment Limitations (NQTL) Analysis
IL - UnitedHealthcare Insurance Company, UnitedHealthcare Insurance Company of Illinois, UnitedHealthcare of Illinois, Inc., UnitedHealthcare Plan of the River Valley, Inc., and UnitedHealthcare Insurance Company of the River Valley
12/01/2023



Conclusions

The Plan concluded that how Retrospective Review is applied to MH/SUD INN outpatient services was comparable to, and applied no more stringently than, how Retrospective Review is applied to M/S INN outpatient services “as written.”

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

Overview

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

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

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

Specific NQTL

Retrospective Review is a component of the Plan's Utilization Management (UM) program. Medical directors and other clinical staff review services in order to detect and better manage over- and under-utilization and determine whether the services reviewed are consistent with the member's coverage, medically appropriate, and consistent with evidence-based guidelines. Retrospective Review assesses the appropriateness of services on a case-by-case basis after the service has been provided but prior to payment for services. Retrospective Reviews are based on established review guidelines and may include:

- Review of medical necessity
- Appropriateness of level of care
- Identifying claims issues
- Eligibility determination
- Initiation of appropriate follow-up actions for utilization and quality issues

The Plan conducts medical necessity Retrospective Review of claims/requests for certain inpatient services that have not previously been reviewed as part of the Prior Authorization or Concurrent Review processes. The Plan may conduct Retrospective Review if the service or procedure codes do not match a diagnosis code, if services are experimental, investigational, or unproven (EIU), or if the services are subject to benefit limits/exclusions. The Plan conducts medical necessity Retrospective Review for inpatient services where Prior Authorization was required but not obtained upon claim submission.

This document includes the following information:

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

This comparative analysis refers to the following attachments:

- *Utilization Management Program Description (UMPD) of United HealthCare Services, Inc. and UnitedHealthcare Insurance Company* - summarizes the philosophy, structure and standards that govern UHC's medical management, UM and utilization review responsibilities and functions

- *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions* - M/S policy that 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* (COC) - (*COC24-INS-2018-LG-IL* and *COC24-INS-RV-2018-LG-IL*) - Plan document that explains covered services, terms, conditions, and limitations of the member's policy
- *Core Principles and Practices* - MH/SUD policy that outlines the core principles and practices that should be used by personnel in their interactions with members, authorized member representatives, practitioners, and facilities, related to the management of behavioral health benefits, coverage determinations and appeals/grievances of non-coverage determinations
- *Performance Assessment and Incentives* - M/S policy confirming that clinical reviewers are not incented to make denials for financial reasons
- *Medical Necessity NQTL* – Comparative analysis that describes the processes, strategies, evidentiary standards and other factors used to apply medical necessity to M/S and MH/SUD services in accordance with MHPAEA and other regulatory guidance

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

Process

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

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

Retrospective Review of M/S Inpatient Admissions consist of the following:

Retrospective Review for certain inpatient services begins after the Plan receives claims or notification of an inpatient admission post discharge from an OON facility. The Plan conducts medical necessity Retrospective Review of claims/requests for certain inpatient services that have not previously been reviewed as part of the Prior Authorization or Concurrent Review processes. The Plan may conduct Retrospective Review if the service or procedure codes do not match a diagnosis code, if services EIU, or if the services are subject to benefit limits/exclusions. The Plan conducts medical necessity Retrospective Review for inpatient services where Prior Authorization was required but not obtained upon claim submission.

Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. If needed, non-clinical staff request medical records for claims containing services that are subject to Retrospective Review. When medical records are received, cases are referred to clinical reviewers to assess medical necessity.

First Level Clinical Review/Initial Review. The clinical reviewer (physicians or nurses) reviews the claim to determine if the inpatient service billed meets clinical criteria for coverage based on application of objective, evidence-based clinical criteria, nationally recognized guidelines, and the member's benefit plan documents. Clinical reviewers either approve claims for payment or refer claims to peer clinical reviewers (Medical Directors).

Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If a peer clinical reviewer determines that a service was not medically necessary, then an adverse benefit determination will be issued for the claim. The Plan communicates the adverse benefit determination, including applicable appeal rights, and offers a peer-to-peer conversation consistent with state, federal, and accreditation requirements. Appeal

rights are set forth in the member's benefit plan document (*Certificate of Coverage*). The Plan communicates results of 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.

[redacted]

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, 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 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.

[redacted]

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 Illinois (UHIC IL)
- UnitedHealthcare Insurance Company of the River Valley (UHIC RV)

Plan Terms

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, 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.

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

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

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

M/S and MH/SUD Services Subject to NQTL

- Services that have not previously been reviewed in Prior Authorization or Concurrent Review
- Services where the service or procedure codes do not match a diagnosis code
- EIU services
- Services that are subject to benefit limits/exclusions
- Codes identified by the Plan as subject to Retrospective Review
- Please see the file *M/S Retrospective Review Codes* for the list of M/S codes that may be subject to Retrospective Review
- MH/SUD claims/requests that include the following services are subject to Retrospective Review:
    - 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): [redacted]

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 [redacted]

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.

[redacted]

[redacted]

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.

[redacted]

[redacted]

Conclusions

The Plan concluded that how Retrospective Review is applied to MH/SUD OON inpatient services was comparable to, and applied no more stringently than, how Retrospective Review is applied to M/S OON inpatient services "as written."

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

Overview

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

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

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

Specific NQTL

Retrospective Review is a component of the Plan's Utilization Management (UM) program. Medical directors and other clinical staff review services in order to detect and better manage over- and under-utilization and determine whether the services reviewed are consistent with the member's coverage, medically appropriate, and consistent with evidence-based guidelines. Retrospective Review assesses the appropriateness of services on a case-by-case basis after the service has been provided but prior to payment for services. Retrospective Reviews are based on established review guidelines and may include:

- Review of medical necessity
- Appropriateness of level of care
- Identifying claims issues
- Eligibility determination
- Initiation of appropriate follow-up actions for utilization and quality issues

The Plan conducts medical necessity Retrospective Review of claims/requests for certain outpatient services that have not previously been reviewed as part of the Prior Authorization or Concurrent Review processes. The Plan may conduct Retrospective Review if the service or procedure codes do not match a diagnosis code, if services are experimental, investigational, or unproven (EIU), or if the services are subject to benefit limits/exclusions. The Plan conducts medical necessity Retrospective Review for outpatient services where Prior Authorization was required, but not obtained upon claim submission.

This document includes the following information:

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

This comparative analysis refers to the following attachments:

- *Utilization Management Program Description_UMPD_of United HealthCare Services, Inc. and UnitedHealthcare Insurance Company* - Summarizes the philosophy, structure and standards that govern UHC's medical management, UM and utilization review responsibilities and functions

- *UnitedHealthcare Clinical Services Medical Management Operational Policy: Approved Definitions* - M/S policy that defines Retrospective Review
- *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* (COC) - (*COC24-INS-2018-LG-IL* and *COC24-INS-RV-2018-LG-IL*) - Plan document that explains covered services, terms, conditions, and limitations of the member's policy
- *Core Principles and Practices* - MH/SUD policy that outlines the core principles and practices that should be used by personnel in their interactions with members, authorized member representatives, practitioners and facilities, related to the management of behavioral health benefits, coverage determinations and appeals/grievances of non-coverage determinations
- *Performance Assessment and Incentives* - M/S policy confirming that clinical reviewers are not incented to make denials for financial reasons
- *Medical Necessity NQTL* – Comparative analysis that describes the processes, strategies, evidentiary standards and other factors used to apply medical necessity to M/S and MH/SUD services in accordance with MHPAEA and other regulatory guidance

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

Process

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

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

Retrospective Review of M/S Outpatient Services consists of the following:

Retrospective Review for certain outpatient services begins after the Plan receives claims from OON providers. The Plan conducts medical necessity Retrospective Review of claims/requests for certain outpatient services that have not previously been reviewed as part of the Prior Authorization or Concurrent Review processes. The Plan may conduct Retrospective Review if the service or procedure codes do not match a diagnosis code, if services are EIU, or if the services are subject to benefit limits/exclusion. The Plan also conducts medical necessity Retrospective Review for outpatient services where Prior Authorization was required, but not obtained upon claim submission.

Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. If needed, non-clinical staff request medical records for claims containing services that are subject to Retrospective Review. When medical records are received, the case is referred to clinical reviewers to assess medical necessity.

First Level Clinical Review/Initial Review. The clinical reviewer (physicians or nurses) reviews the claim to determine if the outpatient service billed meets clinical criteria for coverage based on application of objective, evidence-based clinical criteria, nationally recognized guidelines, and the member's benefit plan documents. Clinical reviewers either approve claims for payment or refer claims to peer clinical reviewers (Medical Directors).

Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If a peer clinical reviewer determines that a service was not medically necessary, then an adverse benefit determination will be issued for the claim. The Plan communicates the adverse benefit determination, including applicable

appeal rights, and offers a peer-to-peer conversation consistent with state and federal requirements. Appeal rights are set forth in the member's benefit plan document (*Certificate of Coverage*). The Plan communicates results of Retrospective Review within 30 days of receipt of a claim. The OON provider may bill non-reimbursable charges to the member.

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.

[redacted]

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 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.

[redacted]

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

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

Step 1 – NQTL and Application

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

Specific NQTL

- Retrospective Review

Benefit Classification(s)

- OON, outpatient

Plan(s) at Issue

- UnitedHealthcare Insurance Company (UHIC)
- UnitedHealthcare Insurance Company of Illinois (UHIC IL)
- UnitedHealthcare Insurance Company of the River Valley (UHIC RV)

Plan Terms

The *Utilization Management Program Description (UMPD)* discusses Post-Service Reviews and indicates:

"Post-service review assesses the appropriateness of medical services on a case-by-case basis after the service has been provided but prior to payment for services. Post- service reviews are based on established review guidelines and includes:

- Review of medical necessity
- Appropriateness of level of care
- Identifying claims issues
- Eligibility determination
- Initiation of appropriate follow-up actions for utilization and quality issues; and
- Identifying appropriateness and administrative issues such as physician notification, emergency status of admission.

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

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

For mental health, substance-related disorder services, and wraparound services, UBH uses its Clinical Criteria (see below), behavioral clinical policies, 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.
  - Optum's Supplement to the APA Psychological and Neuropsychological Testing Billing and Coding Guide: Additional criteria used regarding provider qualifications, coverage rationale, limitations, and developmental testing.

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

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

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

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

- Services that have not previously been reviewed in Prior Authorization or Concurrent Review
- Services where the service or procedure codes do not match a diagnosis code
- EIU services
- Services that are subject to benefit limits
- Codes identified by the Plan as subject to Retrospective Review
  - Please see the file *M/S Retrospective Review Codes* for the list of M/S codes that may be subject to Retrospective Review

- MH/SUD claims that include the following services are subject to Retrospective Review:
  - Partial Hospitalization Program (PHP)/Day Treatment/High-Intensity Outpatient
  - Intensive Outpatient Program (IOP)
  - Transcranial Magnetic Stimulation (TMS)
  - Psychological Testing
  - Applied Behavioral Analysis (ABA)

Step 2 – Factors Used to Determine Retrospective Review Applies

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

The Plan relies on the following factor to determine which OON outpatient services are subject to Retrospective Review. This factor applies to M/S and MH/SUD for the following:

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

- Consistency with Clinical Criteria (Qualitative): [redacted]

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 [redacted]

The *Medical Necessity NQTL* describes the process for determining how internally developed medical/behavioral clinical policies are created and how externally developed third party guidelines are reviewed and approved.

The Plan's evidentiary standards and sources apply to M/S and MH/SUD services. The Consistency with Clinical Criteria factor, evidentiary standards, and sources are defined in a qualitative manner.

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

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

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

[redacted]

[redacted]

[redacted]

Step 5 – Findings and Conclusions

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

Findings

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

The Plan found the factor used to subject OON MH/SUD outpatient services to Retrospective Review was comparable to and applied no more stringently than the factor used to subject OON M/S outpatient services to Retrospective Review "in operation."

All M/S outpatient services were subject to Retrospective Review if they were not reviewed via Prior Authorization or Concurrent Review. Additionally, M/S claims for outpatient services submitted by OON providers were subject to Retrospective Review if the services or procedure codes did not match a diagnosis code, if services were EIU, or if the services had benefit limits. MH/SUD claims for outpatient services submitted by OON providers may be subject to Retrospective Review if the service or procedure code required Prior Authorization or Concurrent Review, but that review was not conducted and there is a mitigating circumstance. Additionally, claims may be subject to Retrospective Review if the billed services or procedure codes do not match the authorized codes or if services are EIU.

[redacted]

Retrospective Review Outpatient Out-of-Network Non-Quantitative Treatment Limitations (NQTL)Analysis
IL - UnitedHealthcare Insurance Company, UnitedHealthcare Insurance Company of Illinois, and
UnitedHealthcare Insurance Company of the River Valley
12/01/2023

Retrospective Review Outpatient Out-of-Network Non-Quantitative Treatment Limitations (NQTL)Analysis
IL - UnitedHealthcare Insurance Company, UnitedHealthcare Insurance Company of Illinois, and
UnitedHealthcare Insurance Company of the River Valley
12/01/2023

Retrospective Review Outpatient Out-of-Network Non-Quantitative Treatment Limitations (NQTL)Analysis
IL - UnitedHealthcare Insurance Company, UnitedHealthcare Insurance Company of Illinois, and
UnitedHealthcare Insurance Company of the River Valley
12/01/2023

[redacted]

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.”