NQTL: Concurrent Review

Classification(s): Inpatient In-Network & Out-Of-Network

Step 1 – Identify the specific plan or coverage terms or other relevant terms regarding Prior Authorization and a description of all mental health or substance use disorder and medical or surgical benefits to which each such term applies in each respective benefits classification

Provide a clear description of the specific NQTL, plan terms, and policies at issue:
Wellfleet delegates its non-Pharmacy Utilization Management to Hines and Associates(Hines) for our Reference Based Pricing (True Choice plans). Concurrent Review is a decision made during the course of care that the Covered Services are Medically Necessary.

Concurrent review means Utilization review conducted during a patient's stay or course of treatment in a facility, the office of a health care professional or other inpatient or outpatient health care setting.

Identify the M/S benefits/services for which Prior Authorization is required:

INPATIENT IN & OUT OF NETWORK
M/S
Acute Inpatient Services Subacute Inpatient Services, i.e. Skilled Nursing Care, physical rehabilitation hospitals including habilitation, etc. Inpatient Professional Services

Identify the MH/SUD benefits/services for which Prior Authorization is required:

INPATIENT IN & OUT OF NETWORK
MHSUD
Mental Health Acute Inpatient Services SUD Inpatient Professional Services Mental Health Subacute Residential Treatment Mental Health Inpatient Professional Services SUD Acute Inpatient Services SUD Acute Inpatient Detoxification SUD Subacute Residential Treatment

Step 2 – Identify the factors used to determine that Prior Authorization will apply to mental health or substance use disorder benefits and medical or surgical benefits

Medical/Surgical:
FACTOR: Same for M/S and MH/SUD for all classifications listed in this NQTL

1. *Ongoing assessment to establish medical necessity of continued inpatient services and appropriate level of care*
2. *Complexity of the condition and if extension, expansion, or reduction of services is appropriate based on nationally recognized guidelines*
3. *Expected timeframe for clinical response/outcomes based on literature for efficacy of the treatment modality, progress towards goals and discharge/transition planning*
4. *Step therapy and/or fail first requirement*
5. *Return of Investment*

MH/SUD:
FACTOR: Same for M/S and MH/SUD for all classifications listed in this NQTL

1. *Ongoing assessment to establish medical necessity of continued inpatient services and appropriate level of care*
2. *Complexity of the condition and if extension, expansion, or reduction of services is appropriate based on nationally recognized guidelines*
3. *Expected timeframe for clinical response/outcomes based on literature for efficacy of the treatment modality, progress towards goals and discharge/transition planning*
4. *Step therapy and/or fail first requirement*
5. *Return of Investment*

Factors considered but rejected: There are no factors that were considered but rejected. **Weight (same for M/S and MH/SUD):** There is no differentiation of weight between factors. There is no artificial intelligence application utilized for the NQTL.	**Factors considered but rejected:** There are no factors that were considered but rejected. **Weight (same for M/S and MH/SUD):** There is no differentiation of weight between factors. There is no artificial intelligence application utilized for the NQTL.
Step 3 – Identify 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 Prior Authorization to mental health or substance use disorder benefits and medical or surgical benefits. (The evidentiary standards are numerically defined to the factors noted above)	
Medical/Surgical: 1. **Factor 1***: Ongoing assessment to establish medical necessity of continued inpatient services and appropriate level of care-* **SOURCE: I**ndustry accepted procedures codes developed by: o American Medical Association (AMA) publication of the Current Procedural Terminology (CPT) book o American Hospital Association (AHA) publication of revenue codes o American Formulary Association (AFA) publication of codes o Centers for Medicare and Medicaid Services (CMS) publication of codes **Evidentiary Standards:** For M/S benefits, the Nurse Reviewer collects the updated clinical information and/or reviews it for medical necessity. If the Nurse Reviewer determines the enrollee meets criteria for continued inpatient care, he/she authorizes the services at issue. If the Nurse Reviewer assesses the enrollee does not appear to meet medical necessity criteria for continued inpatient care, he/she refers the case to a Peer Reviewer (e.g. Medical Director) who reviews the clinical information and determines whether the enrollee meets criteria for continued inpatient care (i.e. Peer Reviewer may authorize or deny benefit authorization depending upon the information provided by the treating provider). Hines typically authorizes 1-4 M/S inpatient days upon concurrent care review. (See Peer to Peer Variation Analysis in Medical Necessity Section). UM coverage determinations of M/S services are made in accordance with evidence-based treatment guidelines by physician peer reviewers licensed in the same or similar specialty area as the treating provider. Hines uses MCG Guidelines for ambulatory care, inpatient and surgical care, recovery facility care and home care for coverage guidance in utilization review of services performed by the Nurse Reviewer. 2. **Factor 2:** *Complexity of the condition and if extension, expansion, or reduction of services is appropriate based on nationally recognized guidelines* ***SOURCE:** Expert Medical Review of Clinical Criteria; MCG Guidelines;* **Evidentiary Standards**: **:** For M/S benefits, the Nurse Reviewer collects the updated clinical information and/or reviews it for medical necessity. If the Nurse Reviewer determines the	**MH/SUD**: 1. **Factor 1:** *Ongoing assessment to establish medical necessity of continued inpatient services and appropriate level of care-* **SOURCE:** Industry accepted procedures codes developed by: O American Medical Association (AMA) publication of the Current Procedural Terminology (CPT) book o American Hospital Association (AHA) publication of revenue codes o American Formulary Association (AFA) publication of codes o Centers for Medicare and Medicaid Services (CMS) publication of codes **SOURCE:** LOCUS/CALOCUS Guidelines **Evidentiary Standard:** For MHSUD benefits, the Care Manager (Licensed Behavioral Health Clinician) collects the updated clinical information and/or reviews it for medical necessity. They engage telephonically a day or two before the last covered/authorized day. If the Care Manager determines the enrollee meets criteria for continued inpatient care, he/she authorizes the services at issue. If the Care Manager assesses the enrollee does not appear to meet medical necessity criteria for continued inpatient care, he/she refers the case to a Peer Reviewer (e.g. Medical Director) who conducts a peer to peer review the clinical information and determines whether the enrollee meets criteria for continued inpatient care (i.e. Peer Reviewer may authorize or deny benefit authorization depending upon the information provided by the treating provider). Hines typically authorizes 1-6 MH/SUD inpatient days upon concurrent care review. (See Peer to Peer Variation Analysis in Medical Necessity Section). UM coverage determinations of MH/SUD services are made in accordance with evidence-based treatment guidelines by physician peer reviewers licensed in the same or similar specialty area as the treating provider. Hines Care Managers use MCG for non-SUD primary diagnosis of behavioral health level of care and uses ASAM & LOCUS/CALOCUS Criteria for coverage guidance in utilization review level of care of SUD services.

enrollee meets criteria for continued inpatient care, he/she authorizes the services at issue. If the Nurse Reviewer assesses the enrollee does not appear to meet medical necessity criteria for continued inpatient care, he/she refers the case to a Peer Reviewer (e.g. Medical Director) who reviews the clinical information and determines whether the enrollee meets criteria for continued inpatient care (i.e. Peer Reviewer may authorize or deny benefit authorization depending upon the information provided by the treating provider). Hines typically authorizes 1-4 M/S inpatient days upon concurrent care review. (See Peer to Peer Variation Analysis in Medical Necessity Section). UM coverage determinations of M/S services are made in accordance with evidence-based treatment guidelines by physician peer reviewers licensed in the same or similar specialty area as the treating provider. Hines uses MCG Guidelines for ambulatory care, inpatient and surgical care, recovery facility care and home care for coverage guidance in utilization review of services performed by the Nurse Reviewer.

3. **Factor 3:** *Expected timeframe for clinical response/outcomes based on literature for efficacy of the treatment modality, progress towards goals and discharge/transition planning*
   SOURCE: *Expert Medical Review of Clinical Criteria; MCG Guidelines;*
   Evidentiary Standard: For M/S benefits, the Nurse Reviewer collects the updated clinical information and/or reviews it for medical necessity. If the Nurse Reviewer determines the enrollee meets criteria for continued inpatient care, he/she authorizes the services at issue. If the Nurse Reviewer assesses the enrollee does not appear to meet medical necessity criteria for continued inpatient care, he/she refers the case to a Peer Reviewer (e.g. Medical Director) who reviews the clinical information and determines whether the enrollee meets criteria for continued inpatient care (i.e. Peer Reviewer may authorize or deny benefit authorization depending upon the information provided by the treating provider). Hines typically authorizes 1-4 M/S inpatient days upon concurrent care review. (See Peer to Peer Variation Analysis in Medical Necessity Section). UM coverage determinations of M/S services are made in accordance with evidence-based treatment guidelines by physician peer reviewers licensed in the same or similar specialty area as the treating provider. Hines uses MCG Guidelines for ambulatory care, inpatient and surgical care, recovery facility care and home care for coverage guidance in utilization review of services performed by the Nurse Reviewer.

4. **Factor 4:** *Step therapy and/or fail first requirement*
   ***SOURCE**: Expert Medical Review of Clinical Criteria; MCG guidelines (MRI, Gastric Bypass, lumbar spine fusion) where higher cost therapies may be denied unless lower cost therapy in not effective;*
   Evidentiary Standard: Step therapy and/or fail first requirements on certain M/S services including for example, MRI, gastric bypass, lumbar spine fusion where higher-cost therapies

2. ***Factor 2:** Complexity of the condition and if extension, expansion, or reduction of services is appropriate based on nationally recognized guidelines*
   ***SOURCE**: Expert Medical Review of Clinical Criteria; MCG Guidelines;*
   Evidentiary Standard: For MHSUD benefits, the Care Manager (Licensed Behavioral Health Clinician) collects the updated clinical information and/or reviews it for medical necessity. They engage telephonically a day or two before the last covered/authorized day. If the Care Manager determines the enrollee meets criteria for continued inpatient care, he/she authorizes the services at issue. If the Care Manager assesses the enrollee does not appear to meet medical necessity criteria for continued inpatient care, he/she refers the case to a Peer Reviewer (e.g. Medical Director) who conducts a peer to peer review the clinical information and determines whether the enrollee meets criteria for continued inpatient care (i.e. Peer Reviewer may authorize or deny benefit authorization depending upon the information provided by the treating provider). Hines typically authorizes 1-6 MH/SUD inpatient days upon concurrent care review. (See Peer to Peer Variation Analysis in Medical Necessity Section). UM coverage determinations of MH/SUD services are made in accordance with evidence-based treatment guidelines by physician peer reviewers licensed in the same or similar specialty area as the treating provider. Hines Care Managers use MCG for non-SUD primary diagnosis of behavioral health level of care and uses ASAM & LOCUS/CALOCUS Criteria for coverage guidance in utilization review level of care of SUD services.

3. **Factor 3**: *Expected timeframe for clinical response/outcomes based on literature for efficacy of the treatment modality, progress towards goals and discharge/transition planning*
   ***SOURCE:** Expert Medical Review of Clinical Criteria; LOCUS/CALOCUS*
   Evidentiary Standard: For MHSUD benefits, the Care Manager (Licensed Behavioral Health Clinician) collects the updated clinical information and/or reviews it for medical necessity. They engage telephonically a day or two before the last covered/authorized day. If the Care Manager determines the enrollee meets criteria for continued inpatient care, he/she authorizes the services at issue. If the Care Manager assesses the enrollee does not appear to meet medical necessity criteria for continued inpatient care, he/she refers the case to a Peer Reviewer (e.g. Medical Director) who conducts a peer to peer review the clinical information and determines whether the enrollee meets criteria for continued inpatient care (i.e. Peer Reviewer may authorize or deny benefit authorization depending upon the information provided by the treating provider). Hines typically authorizes 1-6 MH/SUD inpatient days upon concurrent care review. (See Peer to Peer Variation Analysis in Medical Necessity Section). UM coverage determinations of MH/SUD services are made in accordance with evidence-based treatment guidelines by physician peer reviewers licensed in the same or similar specialty area as the treating provider. Hines Care Managers use MCG for non-SUD primary diagnosis of behavioral health level of care and uses ASAM &

may be denied unless it can be shown that a lower-cost therapy is not effective (also known as "fail-first" policies or " step therapy" protocols). **SOURCE**: Expert Medical Review of Clinical Criteria; MCG guidelines (MRI, Gastric Bypass, lumbar spine fusion) where higher cost therapies may be denied unless lower cost therapy in not effective; 5. **Factor 5:** *Return of Investment –* **SOURCE:** Internal claims data; Utilization management(UM) program operating costs; UM authorization data **Evidentiary Standard**: The evidentiary standard relied on to determine whether to apply Concurrent Review to inpatient M/S benefits is whether application of Concurrent Review produces positive financial savings, as measured in the aggregate across the Wellfleet administered book-of-business. The value associated with inpatient benefit reviews, as calculated by reference to the expected financial savings relative to the costs to review benefit claims, is assessed at the classification level and not at a service/procedure level. Wellfleet has determined the value of subjecting all inpatient In-Network and Out-of-Network M/S services to Concurrent Review must exceed the administrative costs by at least 1:1. The Concurrent Review NQTL applies to all M/S inpatient services	LOCUS/CALOCUS Criteria for coverage guidance in utilization review level of care of SUD services. 4. **Factor 4:** *Return of Investment –* **SOURCE**: Internal claims data; Utilization management(UM) program operating costs; UM authorization data **Evidentiary Standard**: The evidentiary standard relied on to determine whether to apply Concurrent Review to inpatient MH/SUD benefits is whether application of Concurrent Review produces positive financial savings, as measured in the aggregate across the Wellfleet administered book-of-business. The value associated with inpatient benefit reviews, as calculated by reference to the expected financial savings relative to the costs to review benefit claims, is assessed at the classification level and not at a service/procedure level. Wellfleet has determined the value of subjecting all inpatient In-Network and Out-of-Network M/S services to Concurrent Review must exceed the administrative costs by at least 1:1. The Concurrent Review NQTL applies to all MH/SUD inpatient services.
Step 4 – Provide the comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to mental health or substance use disorder 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 in the benefits classification. All information below is applicable to both M/S and MH/SUD classifications 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 MH/SUD and medical/surgical benefits.	
The examples below of Hines' Utilization Management policies used in the application of the Concurrent Review demonstrate comparability and consistency. These policies were developed and reviewed in accordance with URAC and NCQA standards, as well as state mandates. UM coverage determinations of M/S services are made in accordance with evidence-based treatment guidelines by physician peer reviewers licensed in the same or similar specialty area as the treating provider. Hines uses MCG Guidelines for ambulatory care, inpatient and surgical care, recovery facility care, home care, and behavioral health care for coverage guidance in utilization review of services. Additionally, Hines conducts routine (occurring no less frequently than annually) Inter- Rater Reliability (IRR) testing is used to evaluate consistency of clinical decision-making across reviewers and to identify any potential revisions to coverage policies that may be warranted. Corrective action is initiated if a score falls below 85% and if the results are below 90% the Medical Director will evaluate the scores and decide whether to convene a review process with the Medical Directors/Physician Reviewers. Of note, the company's most recent MH/SUD	The examples below of Hines' Utilization Management policies used in the application of the Concurrent Review demonstrate comparability and consistency. These policies were developed and reviewed in accordance with URAC and NCQA standards, as well as state mandates. Hines uses MCG Guidelines for ambulatory care, inpatient and surgical care, recovery facility care, home care, and behavioral health care for coverage guidance in utilization review of services. Hines uses ASAM Criteria for coverage guidance in utilization review level of care of SUD services. Additionally, Hines conducts routine (occurring no less frequently than annually) Inter- Rater Reliability (IRR) testing is used to evaluate consistency of clinical decision-making across reviewers and to identify any potential revisions to coverage policies that may be warranted. Corrective action is initiated if a score falls below 85% and if the results are below 90% the Medical Director will evaluate the scores and decide whether to convene a review process with the Medical Directors/Physician Reviewers. Of note, the company's most recent MH/SUD IRR exercise did not reveal a need to revise its coverage policies governing reviews of MH/SUD benefits.

IRR exercise did not reveal a need to revise its coverage policies governing reviews of MH/SUD benefits. Hines policies and procedures for Utilization Review Process for Concurrent/Continued Tay Review Section II; Page II-A2-5.1 illustrates the overall goal of all utilization management to provide timely and fair considerations for appropriate levels of care and validate medical necessity, which optimizes patient outcomes. Concurrent review determinations are made solely on the medical information obtained at the time of the review determination. First level review will be by a first level reviewer with scope of practice relevant to the clinical area(s) addressed in the initial clinical review. If the first level reviewer is unable to certify a case, then it will be sent for physician peer review. Concurrent or continued stay review must be completed at least 24 hours before expiration of the current certified period IF a request for continued services is made at least 24 hours before expiration of current certified period, to allow time for completion of expedited appeal, if necessary. For requests for concurrent review received less than 24 hours before the expiration of the current certified period, the decision will be rendered within 72 hours of the time of the request. Written notification of all review determinations will be mailed/ transmitted to the claim payer and patient within the same time frame allowed for the decision to be made. (i.e. within 72 hrs if the request was received less than 24 hours before the end of the currently certified period and within 24 hrs if the request was received more than 24 hours from the end of the currently certified period). The first certification letter to the patient advises the patient to assume all days of an inpatient confinement are certified unless the patient receives written notification from Hines of a non-certification decision. Therefore, recertification letters will not be generated to patients.	UM coverage determinations of MH/SUD services are made in accordance with evidence-based treatment guidelines by physician peer reviewers licensed in the same or similar specialty area as the treating provider. With respect to MH/SUD benefits, and in contrast to the process for performing M/S benefit reviews, Hines ensures that any potential denial of MH/SUD benefits is preceded by a proactive offer to the provider of a peer-to-peer review for certain services including Inpatient and Outpatient All Other benefit classifications. The objectives of proactively seeking a peer-to-peer review is to minimize the risk of issuing a denial where, in fact, the enrollee's clinical situation warrants an approval for medically necessary care yet the provider's request may have incompletely or imprecisely stated the case for medical necessity, or, if a denial is nonetheless issued, mitigating disruption if the loss of coverage results in the enrollee moving to a different treatment type or level of care. This process is beneficial for the enrollee and results in greater approvals and fewer appeals of medical necessity denials. Hines policies and procedures for Utilization Review Process for Concurrent/Continued Tay Review Section II; Page II-A2-5.1 illustrates the overall goal of all utilization management to provide timely and fair considerations for appropriate levels of care and validate medical necessity, which optimizes patient outcomes. Concurrent review determinations are made solely on the medical information obtained at the time of the review determination. First level review will be by a first level reviewer with scope of practice relevant to the clinical area(s) addressed in the initial clinical review. If the first level reviewer is unable to certify a case, then it will be sent for physician peer review. Concurrent or continued stay review must be completed at least 24 hours before expiration of the current certified period IF a request for continued services is made at least 24 hours before expiration of current certified period, to allow time for completion of expedited appeal, if necessary. For requests for concurrent review received less than 24 hours before the expiration of the current certified period, the decision will be rendered within 72 hours of the time of the request. Written notification of all review determinations will be mailed/ transmitted to the claim payer and patient within the same time frame allowed for the decision to be made. (i.e. within 72 hrs if the request was received less than 24 hours before the end of the currently certified period and within 24 hrs if the request was received more than 24 hours from the end of the currently certified period). The first certification letter to the patient advises the patient to assume all days of an inpatient confinement are certified unless the patient receives written notification from Hines of a non-certification decision. Therefore, recertification letters will not be generated to patients.
Step 4(b): Identify and define the factors and processes that are used to monitor and evaluate the application of Prior Authorization for M/S benefits:	
Wellfleet monitors the Wellfleet-Hines book of business (BoB)utilization management for prior authorization (PA) data. Utilization management is the process that evaluates the efficiency and appropriateness of the treatment, procedures, or service requested. Hines' utilization management clinicians use the medical necessity criteria from MCG Guidelines, and ASAM Criteria along	

with LOCUS/CALOCUS or state specific requirements to make their prior authorization determination. Physicians will use the aforementioned tools output along with nationally recognized literature compendia.

Authorizations

UR Service Level	Concurrent
MED SURG	**117 auths**
Approvals	522
Denials	26
MedSurg % Denied	**5% of days**
MH	**75 auths**
Approvals	550
Denials	136
MH % Denied	**25% of days**
SUD	**13 auths**
Approvals	129
Denials	22
SUD % Denied	**17% of days**

The 2024 Wellfleet – Hines' BoB

The number of Concurrent Review decisions across the Wellfleet- Hines book of business data, reflects medical necessity denials for MS, MH & SUD services. Further analysis was performed for the concurrent review authorizations due to the higher percentage of days denied for MH/SUD. It is noted that the MH/SUD number of authorizations are significantly less than M/S authorizations, but the number of days involved in each authorization is significantly more than stays for M/S, which is common for the diagnoses. There were more days certified with each authorization than denied for MH/SUD. All days denied shown not medical necessity due to level of care applied. Hines process to offer peer to peer prior to issuing denials for MH/SUD, resulted in no appeals for the decisions. This demonstrates the overall process to identify medical necessity is applied no more stringently than that of M/S.

While operational outcomes are not determinative of NQTL compliance, and a plan may comply with the NQTL requirement notwithstanding a disparate outcome for an NQTL applied to MH/SUD benefits as compared to M/S benefits, comparable outcomes can help evidence compliance with the in-operation component of the NQTL requirement.

Step 5 – Provide the specific findings and conclusions reached by the group health plan or health insurance issuer with respect to the health insurance coverage, including any results that indicate that the plan or coverage is or is not in compliance with this section.

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

As written: An "in operation" review of Hines' application of the Concurrent Review NQTL, specifically approvals and denial information, in the inpatient classification revealed no statistically significant discrepancies in medical necessity denial rates as- between MH/SUD and M/S benefits

Wellfleet's methodology for determining which M/S services and which MH/SUD services within a classification of benefits are subject to concurrent care review as written and in operation, as well as its concurrent care medical necessity review processes applied to M/S services and for MH/SUD services as written and in operation reflect they are comparable and no more stringent for MH/SUD services within a classification of benefits than for M/S services within the same classification of benefits.

Wellfleet, along with its utilization review agent, Hines has assessed several components of its utilization management program for NQTL compliance, including the methodology for determining which services will be subject to utilization management and the process for reviewing utilization management requests. A review of Hines' written policies and processes reveals the comparable process by which MH/SUD and M/S services are reviewed for concurrent review within the applicable benefit classification that evidences comparability and equivalent stringency in-writing.