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 Cigna Health Management, Inc., an affiliate of CHLIC (Cigna). Concurrent Review is a decision made during the course of care that the Covered Services are Medically Necessary.

Concurrent Review is applied to all inpatient benefits, based upon high cost, high risk and complexity for members receiving the service with the exception of any services reimbursed to the provider on a case rate/Diagnostic Resource Group (DRG) basis, including non-emergent M/S and MH/SUD services rendered by a hospital or other facility to plan enrollees who are confined overnight to the hospital or other facility.

Note: Cigna performs utilization reviews for most medical/surgical (M/S) benefits. A separate entity, eviCore, reviews certain M/S services for Cigna; American Specialty Health, reviews physical therapy and occupational therapy on behalf of CHLIC and both national and regional vendors to perform UM. All entities adhere to Cigna's policies and procedures when performing utilization reviews, and the data provided is inclusive of utilization reviews of certain M/S services. Evernorth Behavioral Health ("Evernorth," "EBH" or "Behavioral Health" formerly Cigna Behavioral Health), an affiliate of Cigna, performs utilization reviews for MH/SUD benefits.

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

INPATIENT IN & OUT OF NETWORK
<u>**M/S**</u>
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
<u>**MHSUD**</u>
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*

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.

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.

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: 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
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). Cigna 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

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
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). Cigna typically authorizes 1-6 MH/SUD

guidelines by physician peer reviewers licensed in the same or similar specialty area as the treating provider. Cigna 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 that are not addressed in a Cigna medical, or co-branded coverage policy.

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; Cigna Coverage Policies*
   Evidentiary Standards: 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). Cigna typically authorizes 1-4 M/S inpatient days upon concurrent care review. 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. Cigna 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 that are not addressed in a Cigna medical, or co-branded coverage policy.
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; Cigna Coverage Policies; CMS*
   Evidentiary Standard: Cigna typically authorizes 1-4 M/S inpatient days upon concurrent care review. 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. Cigna 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 that are not addressed in a Cigna medical, or co-branded coverage policy. DRG Variation - Inpatient services reimbursed on the basis of a DRG/case rate and otherwise authorized pursuant to a prior authorization review are not subject to concurrent review because, for the duration of the period for which the DRG/case rate applies, the amount of benefits the plan is obligated to pay for a facility stay does not depend on the duration of time that the individual received care
   in the facility.
4. **Factor 4:** *Step therapy and/or fail first requirement*

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. Cigna uses MCG for non-SUD primary diagnosis of behavioral health level of care and Cigna uses ASAM Criteria for coverage guidance in utilization review level of care of SUD services.

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; Cigna Coverage Policies*
   Evidentiary Standard: 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). Cigna 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. Cigna uses MCG for non-SUD primary diagnosis of behavioral health level of care and Cigna uses ASAM 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; MCG Guidelines; Cigna Coverage Policies; CMS*
   Evidentiary Standard: Cigna typically authorizes 1-6 MH/SUD inpatient days upon concurrent care review. 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. Cigna uses MCG Guidelines for non SUD primary diagnosis of behavioral health level of care and Cigna uses ASAM Criteria for coverage guidance in utilization review level of care of SUD services. DRG Variation-Inpatient services reimbursed on the basis of a DRG/case rate and otherwise authorized pursuant to a prior authorization review are not subject to concurrent review because, for the duration of the period for which the DRG/case rate applies, the amount of benefits the plan is obligated to pay for a facility stay does not depend on the duration of time that the individual received care in the facility. DRG- based reimbursement creates incentives for hospitals to actively manage utilization but DRG-based fees do not exist for psychiatric

***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; Cigna Coverage Policies*

Evidentiary Standard: Cigna imposes 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 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; Cigna Coverage Policies

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 Cigna-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. Cigna 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 services.

hospitalizations. The lack of correlation between the length of stay and the plan's obligation to pay benefits for the same means that assessing the ongoing medical necessity of a continued facility stay for coverage/benefit purposes is unnecessary for such period of time.

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 M/S benefits is whether application of Concurrent Review produces positive financial savings, as measured in the aggregate across the Cigna-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. Cigna 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 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.

M/S:

To ensure that Cigna's policies are consistently applied, Cigna conducts a thorough review of policies and procedures at least annually. The annual review includes an analysis of applicable M/S policies and procedures to identify potential gaps or inconsistencies. In its 2023 review as set forth in the policy comparison tables below, Cigna identified opportunities for adjustments to ensure comparability and equivalent stringency in application the Concurrent Review NQTL. The below examples of Cigna's Utilization Management policies used in the application of the Concurrent Review demonstrate comparability and consistency. These Cigna policies were

MH/SUD:

To ensure that Cigna's policies are consistently applied, Cigna conducts a thorough review of policies and procedures at least annually. The annual review includes an analysis of applicable MH/SUD policies and procedures to identify potential gaps or inconsistencies. In its 2023 review as set forth in the policy comparison tables below, Cigna identified opportunities for adjustments to ensure comparability and equivalent stringency in application the Concurrent Review NQTL. The below examples of Cigna's Utilization Management policies used in the application of the Concurrent Review demonstrate comparability and consistency. These Cigna 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. Cigna 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 that are not addressed in a Cigna medical or co-branded policy.
Additionally, Cigna 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.

The *UM-12: Qualified Health Professionals Render UM Decisions* policy is reflective of Cigna's consistent parameters to identify medical directors' and other licensed clinicians' roles and responsibilities. Both policies require reviewers to be appropriately licensed and act within the scope of their license. As noted in the scope of this policy in 4(b)below, indicate accountability in the review and determination of denials.

M/S
UM-12: Qualified Health Professionals Render UM Decisions
1. Qualified health professionals assess the clinical information used to support UM decisions. Non-clinical staff may provide assistance by performing administrative tasks only. 2. RN's provides clinical oversight to non-clinical and LPN/LVN staff and/or reviews inpatient and outpatient UM services using established, approved, medical criteria, tools and references as well as own clinical training and education in making medical necessity coverage "approval" decisions. RN staff includes Inpatient Case Manager (IPCM) and Pre-service/Post Service Utilization Review Nurse (UM) roles. 3. Licensed Physician (i.e. Medical Director) – provides clinical oversight to pharmacist staff where indicated, nurse staff and makes medical necessity UM decisions using medical necessity guidelines, new technologies information and board-certified specialty (same or similar) consultants for additional medical expertise as required as well as own clinical training and education in making medical necessity coverage decisions. Medical Director qualification requirements include: o Hold an active unrestricted license or certification to practice medicine in a state or territory of the United States

developed and reviewed in accordance with URAC and NCQA standards, as well as state mandates.
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. Cigna uses MCG Guidelines for non SUD behavioral health care for coverage guidance in utilization review of services that are not addressed in a Cigna medical or co-branded policy. Cigna uses ASAM Criteria for coverage guidance in utilization review level of care of SUD services.
With respect to MH/SUD benefits, and in contrast to the process for performing M/S benefit reviews, Cigna 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.
Additionally, Cigna 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.

HM-CLN-039: Utilization Management Decisions – Appropriate Professional Assessment policies is reflective of Cigna's consistent parameters to identify medical directors' and other licensed clinicians' roles and responsibilities. Both policies require reviewers to be appropriately licensed and act within the scope of their license. As noted in the scope of this policy in 4(b)below, indicate accountability in the review and determination of denials.

MH/SUD
HM-CLN-039: Utilization Management Decisions – Appropriate Professional Assessment
1. Behavioral Health's policy requires that appropriately licensed behavioral health professionals assess and supervise utilization management decisions. Only psychologists, addictionologists or board-certified psychiatrists are allowed to assess and make medical necessity denial decisions. To ensure that qualified licensed health professionals assess the clinical information used to make appropriate utilization management decisions. 2. Care managers collect data for pre-service, concurrent, and post-service utilization decisions and have the authority to approve but not to deny medical necessity services. In the event that a care manager cannot approve the utilization request, the

- Unless expressly allowed by state or federal regulations, are located in a state or territory of the United States when conducting a peer clinical review
  - Are qualified as determined by the Senior Medical Director to render a clinical opinion about the medical condition, procedure and treatment under review
  - Hold a current and valid license in the same category as the ordering provider or as a Doctor of Medicine, or as a Doctor of Osteopathic Medicine.
- Medical Director Areas of Responsibility for UM Decisions; includes, but not limited to the following:
  - Review and render all medical necessity denials.
  - Make medical necessity decisions in accordance with state licensure requirements as applicable.
  - Provide specific reason(s) for denials in case documentation and letter content.
  - Provide oversight and ongoing consultation to clinical and non-clinical staff.
  - Complete ongoing education to maintain licensure and update professional skills.

UM-09: Precertification of Inpatient, Outpatient and Ambulatory Services outline the responsibilities of administrative staff in the application of the Prior Authorization NQTL. As noted below, this policy outlines the scope of administrative staff who perform administrative tasks only. The scope of responsibilities are comparable and include pre-review screening. Additionally, *UM-09: Precertification of Inpatient, Outpatient and Ambulatory Services* reflects the role of non-physician clinicians (i.e. nurses or care managers) in the application of the Concurrent Review NQTL. These policies outline the comparable roles and responsibilities of Cigna's M/S nurses and MH/SUD care managers each of which are independently licensed clinicians with the ability to approve utilization management decisions. The denial of a utilization management decision, including Concurrent Review requires medical director/peer review for both M/S and MH/SUD benefits. Prior to issuance of a denial, a peer-to-peer is available and offered for any MH/SUD coverage request.

M/S
UM-09: Precertification of Inpatient, Outpatient and Ambulatory Services
The purpose of this policy is to establish a consistent process for responding to precertification of inpatient, outpatient, and ambulatory service requests that: • Proactively reviews requested medical services and/or supplies to determine whether they are covered based upon application of appropriate clinical criteria

case is forwarded to an appropriate peer reviewer for assessment and the decision to approve or deny services.

3. Behavioral Peer Reviewers are Board Certified Psychiatrists, Licensed Clinical Psychologists and Certified Addictionologists who may have the following job titles:
   - Senior Medical Director
   - Medical Officer
   - Medical Director
   - Medical Principal

   a. Qualifications: Board certified psychiatrist, addictionologists, or doctoral level psychologists with current unrestricted license in the United States or its territories.

   b. Responsibilities include:
      - Conducting Pre-service
      - Concurrent reviews
      - Post-service
      - Medical necessity determinations including:
        - Approvals including cases not meeting criteria guidelines and
        - Denials

HM-CLN-002: Advocates and Care Coordinators outline the responsibilities of administrative staff in the application of the Prior Authorization NQTL. As noted below, this policy outlines the scope of administrative staff who perform administrative tasks only. The scope of responsibilities are comparable and include pre-review screening. Additionally, *HM-CLN-012: Clinical Review* reflect the role of non-physician clinicians (i.e. nurses or care managers) in the application of the Concurrent Review NQTL. These policies outline the comparable roles and responsibilities of Cigna's M/S nurses and MH/SUD care managers each of which are independently licensed clinicians with the ability to approve utilization management decisions. The denial of a utilization management decision, including Concurrent Review requires medical director/peer review for both M/S and MH/SUD benefits. Prior to issuance of a denial, a peer-to-peer is available and offered for any MH/SUD coverage request.

MH/SUD
HM-CLN-002: Advocates and Care Coordinators; HM-CLN-012: Clinical Review
HM-CLN-002 Advocates and Care Coordinators Non-clinical staff: Any staff of Behavioral Health who do not hold a license or certification for independent clinical practices in a behavioral health profession. Examples of non-clinical staff include Personal Advocates and Care Coordinators among others. The roles of the Advocate and Care Coordinator can include assisting customers and practitioners with information related to service requests,

and other benefit plan provisions (refer to Cigna National Coverage and Benefit Policy);

Non-Clinical Staff scope of responsibilities (Pre-Review Screening)

1. Non-clinical staff is responsible for the initial intake process, which includes creation of the system file, collection of basic demographic information and documenting information regarding the service being requested into the system. The central system provides guidance to the non-clinical staff as to the information necessary to be collected.
2. Cases are reviewed to evaluate if the provider is in the network if the customer is currently eligible for coverage and if coverage is available for the service under the terms of the plan. The non-clinical teams have access to a Benefit Specialist to support eligibility and benefit reviews and to the prior authorization nurses for any clinical questions that may arise in the process.

Initial clinical review scope of responsibilities:

Cases requiring medical necessity/precertification review are reviewed by a nurse, using the clinical information provided at the time of the request, to the appropriate guideline as defined in the Cigna Benefit and Coverage Tool policy.

The nurse approves services for those customers whose clinical information meets the guidelines and generates an authorization notification within the timelines and notification requirements outlined in the Timeliness policy.

All services that do not meet the criteria in the guideline and cannot be approved are referred to the Medical Director for review and determination.

The above referenced policy is illustrative of the annual review conducted to ensure comparability in writing of the application of the Concurrent Review NQTL to M/S and MH/SUD services in all benefit classifications. The process by which services are considered for application of Concurrent Review is comparable in writing across MH/SUD and M/S benefits. As reflected in its written policies, a committee of Cigna-employed Medical Directors determines which M/S and MH/SUD services are subject to Concurrent Review. Cigna utilizes a single Healthcare Medical Assessment Committee("HMAC") in the development of clinical guidelines and medical necessity criteria (collectively "Coverage Policies") of M/S and MH/SUD services. HMAC reviews Coverage Policies, annually to ensure their continued appropriateness based on prevailing clinical standards of care. The team is made up of 13 board certified medical doctors, which 4 members are dedicated to MH/SUD.

Internal subject matter experts include, but are not limited to orthopedists, neurologists, neurosurgeons, OBGYNs, oncologists, primary care physicians, internist, surgeons, urologists, pulmonologists, cardiologists, psychologists and psychiatrists.

collecting non-clinical data, acquiring structured clinical data and offering supplemental educational materials that do not require evaluation or interpretation of clinical information. All Advocate and Care Coordinator staff shall have access to a clinical resource with at least a Master's degree and an unrestricted clinical license to practice from a licensing agency within the United States.

The Advocate Department and Care Coordinators associated with Outpatient and Inpatient behavioral service provision are permitted to make authorization determinations based upon clinical rules and/or logic developed by a licensed behavioral health care clinician with a minimum of a Master's degree and five years of post- Master's clinical experience.

HM-CLN-012 Clinical Review

Behavioral Health's care managers shall be responsible for documenting the results of their Clinical Reviews in Behavioral Health's care management intake system documenting sufficient clinical and administrative information to support their care management determinations including referencing relevant plan document language used in making any adverse determinations in accord with Clinical and Administrative Information for Making a Determination of Coverage. Behavioral Health's care managers/consultants shall notify provider staff and specify last covered day (LCD) in the case notes. The care manager shall also include the number of extended days, the next review date, the new total number of days or services approved and the date of admission or onset of any new services. See Policy and Procedure on Continuity and Coordination of Behavioral Care.

During review of a case, Behavioral Health shall discuss the relevant information and guidelines upon which decisions are based and upon request by a customer, practitioner or provider shall make written copies of the guidelines available.

Whenever a Behavioral Health care manager is unable to approve a request for service based on medical necessity the care manager shall refer the case to a peer reviewer as per the Peer Review Policy.

The above referenced policy is illustrative of the annual review conducted to ensure comparability in writing of the application of the Concurrent Review NQTL to M/S and MH/SUD services in all benefit classifications. The process by which services are considered for application of Concurrent Review is comparable in writing across MH/SUD and M/S benefits. As reflected in its written policies, a committee of Cigna-employed Medical Directors determines which M/S and MH/SUD services are subject to Concurrent Review. Cigna utilizes a single Healthcare Medical Assessment Committee("HMAC") in the development of clinical guidelines and medical necessity criteria (collectively "Coverage Policies") of M/S and MH/SUD services. HMAC reviews Coverage Policies, annually to ensure their continued appropriateness based on prevailing

DRG Variation Inpatient services reimbursed on the basis of a DRG/case rate and otherwise authorized pursuant to a prior authorization review are not subject to concurrent review because, for the duration of the period for which the DRG/case rate applies, the amount of benefits the plan is obligated to pay for a facility stay does not depend on the duration of time that the individual received care in the facility. DRG- based reimbursement creates incentives for hospitals to actively manage utilization but DRG-based fees do not exist for psychiatric hospitalizations. The lack of correlation between the length of stay and the plan's obligation to pay benefits for the same means that assessing the ongoing medical necessity of a continued facility stay for coverage/benefit purposes is unnecessary for such period of time. The case rate/DRG payment functions as payment in full for any and all services rendered to the individual for the pre-authorized course of treatment for the length of time covered by the case rate/DRG payment and over which the individual remains in the facility. The plan's liability for payment of benefits for services, and the individuals' cost-sharing obligation, does not increase or decrease depending on how long the individual remains in the facility receiving the pre-authorized treatment in question, unless the individual's stay extends beyond the time-period that the DRG/case rate payment covers.	clinical standards of care. The team is made up of 13 board certified medical doctors, of which 4 members are dedicated to MH/SUD. Internal subject matter experts include, but are not limited to orthopedists, neurologists, neurosurgeons, OBGYNs, oncologists, primary care physicians, internist, surgeons, urologists, pulmonologists, cardiologists, psychologists and psychiatrists. ***DRG Variation*** DRG-based reimbursement creates incentives for hospitals to actively manage utilization but DRG- based fees do not exist for psychiatric hospitalizations. Concurrent Review by Cigna is clinically appropriate and permissible for psychiatric hospitalizations as general medical hospitalizations that are not reimbursed based on DRGs are also subject to concurrent review. Differences in utilization management of inpatient behavioral health is not a more stringent application because DRG- based fees have not been established for psychiatric hospitalizations.

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-Cigna 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. Cigna's utilization management clinicians and physicians use the medical necessity criteria from Cigna Coverage Policies, MCG Guidelines, and ASAM Criteria or state specific requirements to make their prior authorization determination.

Authorizations			
UR Service Level	Inpt	Inpt	TOTAL CONCURRENT REVIEWS
NETWORK	INN	OON	
Auth Type	Concurrent	Concurrent	
MED SURG			
Approvals	580	18	598
Denials	164	8	172
MedSurg % Denied	22%	31%	24%
MH			
Approvals	594	158	752
Denials	4	2	6
MH % Denied	1%	1%	1%
SUD			
Approvals	44	57	101
Denials	5	0	5

SUD % Denied	10%	0%	5%
APPEALS			
UR Service Level	Inpt	Inpt	TOTAL CONCURRENT REVIEWS
Network	INN	OON	
Auth Type	Concurrent	Concurrent	
MedSurg			
Denials Upheld	0	0	0
Denials Overturned	0	0	0
MedSurg % Upheld	0%	0%	0%
MH			
Denials Upheld	0	0	0
Denials Overturned	0	0	0
MH % Upheld	0%	0%	0%
SUD			
Denials Upheld	0	0	0
Denials Overturned	0	0	0
SUD % Upheld	0%	0%	0%

The 2024 Wellfleet – Cigna BoB
The number of Concurrent Review decisions across the Wellfleet- Cigna book of business data, reflects medical necessity denials for M/S services higher than medical necessity denials of MH/SUD services. Appeals data includes the same time relating to the utilization management data metrics. Data reflected for Wellfleet – Cigna book of business shows zero SUD denial.
An "in operation" review of Cigna's application of the Concurrent Review NQTL, specifically approvals and denial information, in the "Inpatient, In-Network" classification revealed no statistically significant discrepancies in medical necessity denial rates as- between MH/SUD and M/S benefits.
A review of appeals data reveals comparable upheld and overturn rates and, on average, lower overturn rates for MH/SUD benefits in the inpatient classifications for the 2023 Cigna book of business. Specifically, an analysis of the total out-of-network appeal overturn rate as- between inpatient MH/SUD and M/S services shows a comparable denial rate (about 20% MH/SUD to about 16% M/S).

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 Cigna's application of the Concurrent Review NQTL, specifically approvals and denial information, in the "Inpatient, In-Network" classification revealed no statistically significant discrepancies in medical necessity denial rates as- between MH/SUD and M/S benefits. On average, denial rates for concurrent medical necessity review of In-Network Inpatient and Out-of-Network MH/SUD benefits were lower than M/S services.

Cigna'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, Cigna 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, the process for reviewing utilization management requests, and the process for applying coverage criteria. A review of Cigna's written policies and processes reveals the comparable process by which MH/SUD and M/S services are selected for application of concurrent review within the applicable benefit classification that evidences comparability and equivalent stringency in-writing. Moreover, comparability in-operation is evidenced by a higher volume of medical necessity denials for M/S services than medical necessity denials of MH/SUD services.