NQTL: MEDICAL NECESSITY CRITERIA DEVELOPMENT

Classification(s): Inpatient In Network & Out of Network , Outpatient Office In Network & Out of Network, Outpatient All Other In Network & Out of Network and Emergency 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). Cigna employs the same definition of medical necessity to (M/S) and mental health/substance use disorder (MH/SUD) benefits. Cigna Medical Directors apply the definition of "medical necessity" set forth in the governing plan instrument or the definition required by state law. Notwithstanding the above, Cigna's standard definition of "medical necessity" is as follows:

Cigna defines "Medically Necessary/Medical Necessity" as follows: Health care services, supplies and medications provided for the purpose of preventing, evaluating, diagnosing, or treating a Sickness, Injury, condition, disease, or its symptoms, which are all of the following as determined by a Medical Director or Review Organization:

- required to diagnose or treat an illness, Injury, disease, or its symptoms.
- in accordance with generally accepted standards of medical practice.
- clinically appropriate in terms of type, frequency, extent, site, and duration.
- not primarily for the convenience of the patient, Physician, or other health care provider.
- not more costly than an alternative service(s), medication(s) or supply(ies) that is at least as likely to produce equivalent therapeutic or diagnostic results with the same safety profile as to the prevention, evaluation, diagnosis or treatment of your Sickness, Injury, condition, disease, or its symptoms; and
- rendered in the least intensive setting that is appropriate for the delivery of the services, supplies or medications. Where applicable, the Medical Director or Review
- Organization may compare the cost-effectiveness of alternative services, supplies, medications, or settings when determining least intensive setting.

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 all of 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. No separate entities review MH/SUD services for Cigna.

Identify the M/S benefits/services for which Prior Authorization is required:	***Identify the MH/SUD benefits/services for which Prior Authorization is required***:
All M/S and MH/SUD services, whether in-network or out-of-network must be medically necessary. Services determined by Cigna not to be medically necessary would be excluded under the terms of the plan unless otherwise dictated by regulatory requirement or specific plan design.	All M/S and MH/SUD services, whether in-network or out-of-network must be medically necessary. Services determined by Cigna not to be medically necessary would be excluded under the terms of the plan unless otherwise dictated by regulatory requirement or specific plan design.

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: 1. Clinical efficacy 2. Safety of services and technologies **3.** Appropriateness of the proposed service and technology **Factors Considered but rejected (same for M/S and MH/SUD):** No other factors were considered and rejected. **Weight (same for M/S and MH/SUD):** There is no differentiation of weight between the factors. There is no Artificial Intelligence application utilized for the NQTL design.	**MH/SUD**: 1. Clinical efficacy 2. Safety of services and technologies 3. Appropriateness of the proposed service and technology **Factors Considered but rejected (same for M/S and MH/SUD):** No other factors were considered and rejected. **Weight (same for M/S and MH/SUD):** There is no differentiation of weight between the factors. There is no Artificial Intelligence application utilized for the NQTL design.
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. · *Analyses should explain whether any factors 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.*	
Medical/Surgical: **1. Factor 1**: Clinical Efficacy **SOURCE:** Cigna Coverage Policies Incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia including peer-reviewed, evidence-based scientific literature or guidelines. **SOURCE:** Cigna MCG Guidelines MCG Care Guidelines are created by clinical editors that analyze and classify peer reviewed papers and research studies each year to develop the care guidelines in strict accordance with the principles of evidence based medicine. **EVIDENTIARY STANDARDS:** Peer-reviewed published medical literature Evidence-based consensus statements Evidence-based guidelines from nationally recognized professional healthcare organizations and public health agencies Technology assessments and structured evidence reviews Clinical training, experience, and judgment of HMAC clinical reviewers **2. Factor 2:** Safety of services and technologies **SOURCE**: Cigna Coverage Policies Incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia including peer-reviewed, evidence-based scientific literature or guidelines. **SOURCE**: Cigna MCG Guidelines	**MH/SUD**: 1. Clinical Efficacy **SOURCE:** Cigna Coverage Policies Incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia including peer-reviewed, evidence-based scientific literature or guidelines. **SOURCE:** Cigna MCG Guidelines MCG Care Guidelines are created by clinical editors that analyze and classify peer reviewed papers and research studies each year to develop the care guidelines in strict accordance with the principles of evidence based medicine. **SOURCE:** ASAM Criteria Cigna uses the criteria published by the American Society of Addiction Medicine (ASAM), 3rd Edition, to guide clinicians in evaluating the medical necessity of levels and types of care for substance use disorders. ASAM criteria are generally accepted, national standards for SUD treatment decisions and are recognized as such by many courts and regulators. Some states, notably New York and California, require state-specific SUD level of care criteria. In those states, Cigna uses the criteria required by law. **EVIDENTIARY STANDARDS:** Peer-reviewed published medical literature Evidence-based consensus statements Evidence-based guidelines from nationally recognized professional healthcare organizations and public health agencies Technology assessments and structured evidence reviews Clinical training, experience, and judgment of HMAC clinical reviewer 2. **Factor 2:** Safety of services and technologies **SOURCE**: Cigna Coverage Policies

MCG Care Guidelines are created by clinical editors that analyze and classify peer reviewed papers and research studies each year to develop the care guidelines in strict accordance with the principles of evidence based medicine **EVIDENTIARY STANDARDS:** Peer-reviewed published medical literature Evidence-based consensus statements Evidence-based guidelines from nationally recognized professional healthcare organizations and public health agencies Technology assessments and structured evidence reviews Clinical training, experience, and judgment of HMAC clinical reviewers **3. Factor 3:** Appropriateness of the proposed service and technology **SOURCE**: Cigna Coverage Policies Incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia including peer-reviewed, evidence-based scientific literature or guidelines. **SOURCE**: Cigna MCG Guidelines MCG Care Guidelines are created by clinical editors that analyze and classify peer reviewed papers and research studies each year to develop the care guidelines in strict accordance with the principles of evidence based medicine. **EVIDENTIARY STANDARDS:** Peer-reviewed published medical literature Evidence-based consensus statements Evidence-based guidelines from nationally recognized professional healthcare organizations and public health agencies Technology assessments and structured evidence reviews Clinical training, experience, and judgment of HMAC clinical reviewers	Incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia including peer-reviewed, evidence-based scientific literature or guidelines. **SOURCE:** Cigna MCG Guidelines MCG Care Guidelines are created by clinical editors that analyze and classify peer reviewed papers and research studies each year to develop the care guidelines in strict accordance with the principles of evidence based medicine. **SOURCE:** ASAM Criteria Cigna uses the criteria published by the American Society of Addiction Medicine (ASAM), 3rd Edition, to guide clinicians in evaluating the medical necessity of levels and types of care for substance use disorders. ASAM criteria are generally accepted, national standards for SUD treatment decisions and are recognized as such by many courts and regulators. Some states, notably New York and California, require state-specific SUD level of care criteria. In those states, Cigna uses the criteria required by law. **EVIDENTIARY STANDARDS:** Peer-reviewed published medical literature Evidence-based consensus statements Evidence-based guidelines from nationally recognized professional healthcare organizations and public health agencies Technology assessments and structured evidence reviews Clinical training, experience, and judgment of HMAC clinical reviewers 3. **Factor 3:** Appropriateness of the proposed service and technology **SOURCE:** Cigna Coverage Policies Incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia including peer-reviewed, evidence-based scientific literature or guidelines. **SOURCE:** Cigna MCG Guidelines MCG Care Guidelines are created by clinical editors that analyze and classify peer reviewed papers and research studies each year to develop the care guidelines in strict accordance with the principles of evidence based medicine. **SOURCE:** ASAM Criteria Cigna uses the criteria published by the American Society of Addiction Medicine (ASAM), 3rd Edition, to guide clinicians in evaluating the medical necessity of levels and types of care for substance use disorders. ASAM criteria are generally accepted, national standards for SUD treatment decisions and are recognized as such by many courts and regulators. Some states, notably New York and California, require state-specific SUD level of care criteria. In those states, Cigna uses the criteria required by law. **EVIDENTIARY STANDARDS**: Peer-reviewed published medical literature Evidence-based consensus statements

	Evidence-based guidelines from nationally recognized professional healthcare organizations and public health agencies Technology assessments and structured evidence reviews Clinical training, experience, and judgment of HMAC clinical reviewers
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. *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.*	
All information below is applicable to M/S classifications Healthcare Medical Assessment Committee (HMAC) is the committee responsible for the process of evaluating clinical efficacy. HMAC is composed of physicians and nurses and includes specialists from both medical and behavioral health disciplines. 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. HMAC establishes and maintains the clinical guidelines and medical necessity criteria in the form of published Cigna Coverage Policies pertaining to the various medical and behavioral health services, therapies, procedures, devices, technologies, and pharmaceuticals to be used for utilization management purposes. This includes Coverage Policies that address M/S services determined to be experimental and investigational. Cigna's Coverage Policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia including MCG Guidelines for both MS and MHSUD, ASAM Criteria for SUD. Cigna's HMAC reviews clinical research and guidelines for new clinical procedures and technologies to determine whether these services have demonstrated clinical efficacy or are still deemed experimental/investigational. Cigna reviews medical and behavioral health national clinical practice guidelines on an annual and bi-annual basis to inform medical necessity criteria and the clinical decision process. The Cigna-employed Medical Directors that are on the HMAC are responsible for the development and/or review of medical necessity criteria of M/S and MH/SUD services include:	All information below is applicable to MH/SUD classifications Healthcare Medical Assessment Committee (HMAC) is the committee responsible for the process of evaluating clinical efficacy. HMAC is composed of physicians and nurses and includes specialists from both medical and behavioral health disciplines. 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. HMAC establishes and maintains the clinical guidelines and medical necessity criteria in the form of published Cigna Coverage Policies pertaining to the various medical and behavioral health services, therapies, procedures, devices, technologies, and pharmaceuticals to be used for utilization management purposes. This includes Coverage Policies that address M/S services determined to be experimental and investigational. Cigna's Coverage Policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia including MCG Guidelines for both MS and MHSUD, ASAM Criteria. Cigna's HMAC reviews clinical research and guidelines for new clinical procedures and technologies to determine whether these services have demonstrated clinical efficacy or are still deemed experimental/investigational. Cigna reviews medical and behavioral health national clinical practice guidelines on an annual and bi-annual basis to inform medical necessity criteria and the clinical decision process. The Cigna-employed Medical Directors that are on the HMAC are responsible for the development and/or review of medical necessity criteria of M/S and MH/SUD services include:

Coverage Policy Author: The medical professionals who review and draft medical necessity coverage policies, in consultation with Coverage Policy SMEs, as part of the annual clinical review. These recommendations are offered to HMAC for discussion and ultimately require a vote of the majority to be accepted to go in to effect. The Committee may send it back for further review, reject recommendations, or propose an alternative, or any combination of those outcomes. The committee also discusses relevant health equity concerns. Coverage Policy SME: These are clinical subject matter experts representing a range of clinical specialties. The team is made up of 13 board certified medical doctors, of which 4 members are dedicated to MH/SUD. These specialties currently include Internal Medicine, Neuropsychiatry, Family Medicine, Surgery, Thoracic and Cardiac Surgery, Pediatrics and Clinical Genetics, Physical Medicine and Rehabilitation, Nephrology, Addiction Psychiatry, Child and Adolescent Psychiatry, and Forensic Psychiatry accreditations. The HMAC's evidence-based medicine approach ranks the categories of evidence and assigns greater weight to categories with higher levels of scientific evidence as set forth below in Cigna's "Levels of Scientific Evidence Table" adapted from the Centre for Evidence Based Medicine, University of Oxford, March 2009 and evidenced in Cigna's Medical Technology Assessment and Coverage Process for "*Determination of Medical Necessity Coverage Criteria Recommendations Policy (OPS-48)":* Level 1: Randomized Controlled Trials (RCT). Randomized, blinded, placebo- controlled, clinical trials and systematic reviews of RCTs and meta-analysis of RCTs. Level 2: Non-randomized controlled trials (an experimental study, but not an ideal design). Also, systematic reviews and meta- analyses of non-randomized controlled trials. Level 3: Observational studies – e.g., cohort, case-control studies (non-experimental studies). Also, systematic reviews and meta- analyses of observational studies. Level 4: Descriptive studies, case reports, case series, panel studies (non-experimental studies), and retrospective analyses of any kind. Also systematic reviews and meta- analyses of retrospective studies. Level 5: Professional/organizational recommendations when based upon a valid evidence-based assessment of the available literature. While Cigna's Coverage Policies and vendor guidelines are reviewed at least once annually, re-review of Coverage Policies and/or topics for new Coverage Policies are identified through multiple channels including requests from the provider community, customers, frontline reviewers, CPU, and the impetus of new, emerging, and evolving technologies. The company's routine (occurring no less frequently than annually) Inter-Rater Reliability (IRR) process is used to evaluate consistency of clinical decision-making across reviewers and to identify any potential revisions to coverage policies that may be warranted. Of note, the company's most recent M/S &MH/SUD IRR exercise did not reveal a need to revise its coverage policies governing reviews of M/S & MHSUD benefits. IRR reviews are conducted according to accreditation standards and are intended to ensure consistency in decision-making across reviewers making medical necessity determinations based on clinical review literature and Cigna Coverage Policies	Coverage Policy Author: The medical professionals who review and draft medical necessity coverage policies, in consultation with Coverage Policy SMEs, as part of the annual clinical review. These recommendations are offered to HMAC for discussion and ultimately require a vote of the majority to be accepted to go in to effect. The Committee may send it back for further review, reject recommendations, or propose an alternative, or any combination of those outcomes. The committee also discusses relevant health equity concerns. Coverage Policy SME: These are clinical subject matter experts representing a range of clinical specialties. The team is made up of 13 board certified medical doctors, of which 4 members are dedicated to MH/SUD. These specialties currently include Internal Medicine, Neuropsychiatry, Family Medicine, Surgery, Thoracic and Cardiac Surgery, Pediatrics and Clinical Genetics, Physical Medicine and Rehabilitation, Nephrology, Addiction Psychiatry, Child and Adolescent Psychiatry, and Forensic Psychiatry accreditations. The HMAC's evidence-based medicine approach ranks the categories of evidence and assigns greater weight to categories with higher levels of scientific evidence as set forth below in Cigna's "Levels of Scientific Evidence Table" adapted from the Centre for Evidence Based Medicine, University of Oxford, March 2009 and evidenced in Cigna's Medical Technology Assessment and Coverage Process for "*Determination of Medical Necessity Coverage Criteria Recommendations Policy (OPS-48)":* Level 1: Randomized Controlled Trials (RCT). Randomized, blinded, placebo- controlled, clinical trials and systematic reviews of RCTs and meta-analysis of RCTs. 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IRR reviews are conducted according to accreditation standards and are intended to ensure consistency in decision-making across reviewers making medical necessity determinations based on clinical review literature and Cigna Coverage Policies

Appeals. Cigna follows the same single- level internal appeal process for resolving disputes regarding pre/post-service benefit coverage and medical necessity denials of requested benefits for both M/S and MH/SUD. For medical necessity reviews a second health care professional, who was not involved in any previous decision and is not a subordinate of the individual in the previous decision, performs a single level appeal, whether expedited or standard. Cigna also follows the same process for M/S and MH/SUD external appeals.	Appeals. Cigna follows the same single- level internal appeal process for resolving disputes regarding pre/post-service benefit coverage and medical necessity denials of requested benefits for both M/S and MH/SUD. For medical necessity reviews a second health care professional, who was not involved in any previous decision and is not a subordinate of the individual in the previous decision, performs a single level appeal, whether expedited or standard. Cigna also follows the same process for M/S and MH/SUD external appeals. Peer to Peer Variation: 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 from medical necessity denials. Cigna's medical necessity review of MH/SUD services is guided by the ASAM Criteria, MCG and Cigna's Coverage policies and plan documents approved for use in care management determinations. Cigna's Peer-to-Peer review program is triggered when a care manager receives clinical information that does not appear to meet the ASAM Criteria, MCG and Cigna's Coverage policies and plan documents for initial or prior authorization for level of care requested. In this instance, care managers may offer a lower level of review. The IRO will render a decision without deference to the previous decisions. Standard external appeals are completed within 45 days and expedited external appeals are completed within 72 hours.

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:

Authorizations													
UR Service Level	**Inpt**	**Inpt**	**Inpt**	**Inpt**	**Inpt**	**Inpt**	**TOTAL INPT REVIEWS**	**UR Service Level**	**Outpt All Other**	**Outpt All Other**	**Outpt All Other**	**Outpt All Other**	**TOTAL OUTPT REVIEWS**
NETWORK	**INN**	**OON**	**INN**	**OON**	**INN**	**OON**		**NETWORK**	**INN**	**OON**	**INN**	**OON**	
Auth Type	**Precert**	**Precert**	**Con current**	**Con current**	**Retro**	**Retro**		**Auth Type**	**Precert**	**Precert**	**Retro**	**Retro**	
M/S								**M/S**					
Approvals	46	6	580	18	372	17	1,039	Approvals	4,833	230	256	54	5,373
Denials	21	0	164	8	127	10	330	Denials	1,476	353	183	26	2,038

M/S % Denied	33%	0%	22%	31%	25%	37%	24%	M/S % Denied	45%	61%	42%	33%	27%
MH								MH					
Approvals	63	6	594	158	30	5	793	Approvals	57	16	1	0	74
Denials	1	0	4	2	2	1	9	Denials	17	11	0	3	31
MH % Denied	2%	0%	1%	1%	6%	17%	1%	MH % Denied	23%	41%	0%	100%	30%
SUD								SUD					
Approvals	5	2	44	57	5	0	113	Approvals	0	0	0	0	0
Denials	0	0	5	0	1	0	6	Denials	0	0	0	0	0
SUD % Denied	0%	0%	10%	0%	17%	0%	5%	SUD % Denied	0%	0%	0%	0%	0%
APPEALS													
UR Service Level	**Inpt**	**Inpt**	**Inpt**	**Inpt**	**Inpt**	**Inpt**	**TOTAL INPT REVIEWS**	**UR Service Level**	**Outpt All Other**	**Outpt All Other**	**Outpt All Other**	**Outpt All Other**	**TOTAL OUTPT REVIEWS**
Network	**INN**	**OON**	**INN**	**OON**	**INN**	**OON**		**Network**	**INN**	**OON**	**INN**	**OON**	
Auth Type	**Precert**	**Precert**	**Con current**	**Con current**	**Retro**	**Retro**		**Auth Type**	**Precert**	**Precert**	**Retro**	**Retro**	
M/S								**M/S**					
Denials Upheld	1	1	0	0	12	36	50	Denials Upheld	3	10	0	2	15
Denials Overturned	1	0	0	0	4	13	18	Denials Overturned	3	4	1	1	9
M/S % Upheld	50%	100%	0%	0%	75%	73%	74%	M/S % Upheld	50%	71%	0%	67%	63%
MH								MH					
Denials Upheld	0	0	0	0	0	0	0	Denials Upheld	0	0	0	0	0
Denials Overturned	0	0	0	0	0	0	0	Denials Overturned	0	0	0	0	0
MH % Upheld	0%	0%	0%	0%	0%	0%	0%	MH % Upheld	0%	0%	0%	0%	0%
SUD								SUD					
Denials Upheld	0	0	0	0	0	0	0	Denials Upheld	0	0	0	0	0
Denials Overturned	0	1	0	0	0	0	1	Denials Overturned	0	0	0	0	0

SUD % Upheld	0%	0%	0%	0%	0%	0%	0%	SUD % Upheld	0%	0%	0%	0%	0%

Wellfleet monitors the Wellfleet-Cigna book of business (BoB) utilization management 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 determination.

The 2024 Wellfleet – Cigna BoB
The number of utilization review decisions across the Wellfleet- Cigna book of business data reflects comparable average denial rates based upon Medical Necessity across all inpatient benefit classifications for utilization management programs including prior authorization, concurrent review, and retrospective review with medical necessity denials for M/S services higher than medical necessity denials of MH/SUD services. Outpatient medical necessity denials reflect a slightly higher % denial rate for MH, which is not determinative of NQTL compliance. The number of medical necessity reviews performed on MHSUD shows a vastly lower percentage of reviews than that of M/S benefits, which skews the percentage of denials in the analysis. Appeals data includes the same time period relating to the utilization management data metrics. Data reflected for Wellfleet – Cigna book of business shows one SUD denial that was overturned compared to the M/S appeals data.

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:
A review of Cigna's factors, evidentiary standards, sources, and as written and in operation processes reveals the comparable application of Medical Necessity to M/S and MH/SUD services within the applicable benefit classification. Cigna's Medical Necessity coverage policy development and application process is consistent between M/S and MH/SUD. Cigna applies comparable evidence- based guidelines to define established standards of effective care in both M/S and MH/SUD benefits. Compliance is further demonstrated through Cigna's uniform definition of Medical Necessity for M/S and MH/SUD benefits. Consistency in policy development, process, and application demonstrates that the medical necessity is applied comparably, and no more stringently, to MH/SUD services than to M/S services.

The only difference between the assessment of medical necessity for MH/SUD and M/S services is Cigna's peer-to-peer process described in Step 4. While this process is different for MH/SUD it is nonetheless more favorable for MH/SUD services.

Wellfleet has not identified any additional discrepancies in operational policies between MH/SUD and M/S benefits where the discrepancies present a comparability or stringency problem within the context of the NQTL requirement. 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.

Thus, Wellfleet has determined that Medical Necessity Criteria Development is applied for MH/SUD benefits in a manner that is comparable to and no more stringent than that of M/S services, both as written and in operation, based on the information presented above that describes in detail the evidentiary standards, processes, strategies, and factors used to impose Medical Necessity Criteria Development.