NQTL: Prior Authorization

Classification(s): Inpatient In-Network & Out-Of-Network, Outpatient All Other – 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 True Choice Plans. Prior Authorization (Preauthorization or "PA") for Medical is a decision prior to a member's receipt of a covered service, procedure, or device that the covered service, procedure or device is Medically Necessary.

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

The PA list for our utilization review agent Hines (Medical) is located on Wellfleet's website https://wellfleetstudent.com/providers/. Search Other Provider Resources - Prior Authorization Requirements – Hines Precertification Code Listing. There is no separate Prior Authorization code list for MH/SUD. All services subjected to Prior Authorization are reviewed at the CPT/HCPCS level for in network and out of network outpatient- all other benefit classification. The Inpatient out of network and in network benefit classification is reviewed for the number of days stays, and codes applicable to the stay. No MH/SUD inpatient benefits are subject to fail first and/or step therapy requirements.

The PA process is included in the member's Certificate of Coverage and can be found @ https://wellfleetstudent.com/ by searching for the plan under "Search for Your School". To initiate a PA, Wellfleet has links on their website https://wellfleetstudent.com/providers/ for electronic and alternative submission methods.

INPATIENT IN & OUT OF NETWORK	OUTPATIENT ALL OTHER IN & OUT OF NETWORK
M/S	**M/S**
Acute Inpatient Services Subacute Inpatient Services, i.e. Skilled Nursing Care, physical rehabilitation hospitals including habilitation, etc. Inpatient Professional Services	Surgeries Home Health Care Rehabilitative & Habilitative Therapies Chiropractic Acupuncture Diagnostic Imaging High Rad Scans Infusions & Injections DME Infertility Treatment Prosthetic Devices

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

The PA list for our utilization review agent Hines (Medical) is located on Wellfleet's website https://wellfleetstudent.com/providers/. Search Other Provider Resources - Prior Authorization Requirements – Hines Precertification Code Listing. There is no separate Prior Authorization code list for MH/SUD. All services subjected to Prior Authorization are reviewed at the CPT/HCPCS level for in network and out of network outpatient- all other benefit classification. The Inpatient out of network and in network benefit classification is reviewed for the number of days stays, and codes applicable to the stay. No MH/SUD inpatient benefits are subject to fail first and/or step therapy requirements.

The PA process is included in the member's Certificate of Coverage and can be found @ https://wellfleetstudent.com/ by searching for the plan under "Search for Your School". To initiate a PA, Wellfleet has links on their website https://wellfleetstudent.com/providers/ for electronic and alternative submission methods.

INPATIENT IN & OUT OF NETWORK	OUTPATIENT ALL OTHER IN & OUT OF NETWORK
MHSUD	**MHSUD**
Mental Health Acute Inpatient Services	Surgeries
Mental Health Subacute Residential Treatment SUD Acute Inpatient Services SUD Acute Inpatient Detoxification SUD Subacute Residential Treatment Mental Health Inpatient Professional Services SUD Inpatient Professional Services	Rehailitative & Habilitative Therapies Diagnostic Imaging High Rad Scans Infusions & Injections Infertility 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. *Experimental/Investigational/Unproven service* 2. *Potential benefit exclusion* 3. *Serious safety risk* 4. *Significant variation in Evidence-based practice* 5. *Potential for Fraud, Waste or Abuse* 6. *Estimated average cost of review* **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 used to perform Prior Authorization	**MH/SUD**: **FACTOR:** Same for M/S and MH/SUD for all classifications listed in this NQTL 1. Experimental/Investigational/Unproven service 2. Potential benefit exclusion 3. Serious safety risk 4. Significant variation in Evidence-based practice 5. Potential for Fraud, Waste or Abuse 6. Estimated average cost of review **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 used to perform Prior Authorization
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**: *Experimental/Investigational/Unproven service* **SOURCE:** FDA clearance/approval; peer-reviewed publications; clinical trials and studies; professional opinion; publications by professional societies or government agencies **Evidentiary Standards**: Inadequate volume of existing peer-reviewed, evidence-based, scientific literature to establish whether or not a technology, supplies, treatments, procedures, or devices is safe and effective for treating or diagnosing the condition or sickness for which its use is proposed; When subject to U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency review, not approved to be lawfully marketed for the proposed use; The subject of review or approval by an Institutional Review Board for the proposed use except as provided in a clinical trial; The subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials. 2.**Factor 2**: *Potential benefit exclusion -* **SOURCE:** Plan documents **Evidentiary Standard:** CMS.gov: "CMS PUB. 100-02 Medicare Benefit Policy Manual, Chapter 16 – General Exclusions from Coverage" support the general exclusions listed in the plan documents. This may not be exhaustive list. Not reasonable and necessary (§20);No legal obligation to pay for or provide (§40); Paid for by a governmental entity (§50); Not provided within United States (§60); Resulting from war (§70); Personal comfort	**MH/SUD**: 1. **Factor 1:** *Experimental/Investigational/Unproven service* - Inadequate volume of existing peer-reviewed, evidence-based, scientific literature to establish whether or not a technology, supplies, treatments, procedures, or devices is safe and effective for treating or diagnosing the condition or sickness for which its use is proposed; When subject to U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency review, not approved to be lawfully marketed for the proposed use; The subject of review or approval by an Institutional Review Board for the proposed use except as provided in a clinical trial; The subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials. **SOURCE**: FDA clearance/approval; peer-reviewed publications; clinical trials and studies; professional opinion; publications by professional societies or government agencies 2. **Factor 2:** *Potential benefit exclusion* **SOURCE**: Plan documents **Evidentiary Standards**: CMS.gov: "CMS PUB. 100-02 Medicare Benefit Policy Manual, Chapter 16 – General Exclusions from Coverage"support the general exclusions listed in the plan documents. This may not be exhaustive list. Not reasonable and necessary (§20);No legal obligation to pay for or provide (§40); Paid for by a governmental entity (§50); Not provided within United States (§60); Resulting from war (§70); Personal comfort (§80); Routine services and appliances (§90); Custodial care (§110); Cosmetic surgery (§120); Charges by immediate relatives or members of household (§130); Dental services (§140); Paid or expected to be paid under workers'

(§80); Routine services and appliances (§90); Custodial care (§110); Cosmetic surgery (§120); Charges by immediate relatives or members of household (§130); Dental services (§140); Paid or expected to be paid under workers' compensation (§150); Non-physician services provided to a hospital inpatient that were not provided directly or arranged for by the hospital (§170);

3. **Factor 3***: Serious safety risk* -

SOURCE: FDA clearance/approval; peer-reviewed publications; clinical trials and studies; professional opinion; publications by professional societies (e.g. NCCN guidelines) or government agencies

Evidentiary Standard: Inadequate volume of existing peer-reviewed, evidence-based, scientific literature to establish whether or not a technology, supplies, treatments, procedures, or devices is safe and effective for treating or diagnosing the condition or sickness for which its use is proposed. Study detail is scrutinized using the scientific method of evidence review which is defined by the U.S. General Services Administration as: systematic evidence review attempts to find all published and unpublished evidence related to a specific research or policy question, using literature search methodologies designed to be transparent, unbiased, and reproducible

4. **Factor 4***: Significant variation in Evidence-based practice* -

SOURCE: Greater frequency of deviation from evidence-based practice compared to Wellfleet book of business

Evidentiary Standard: Variation(s) measured against a documented baseline or standard for the specific service or service bundle of codes. Significant variation should be assessed at the service bundle level, and not necessarily in the variation between individual code(s).

5. **Factor 5***: Potential for Fraud, Waste or Abuse* -

SOURCE: Dedicated Data-Mart (Healthcare Fraud Shield); Geospatial Analytics; Social Media Monitoring; Link Analysis; Multiple Control Models; Special Investigation Resource and Intelligence System (SIRIS); Member, Pharmacy and Prescriber Analytics; Wellfleet claims data

Evidentiary Standards: An automated peer-based model that compares a provider's billing behavior to their peers and those who score differently are reviewed to determine if an investigation is warranted, as evidenced by increased volume.

6. **Factor 6:** *Estimated average cost of review*

SOURCE: Wellfleet claims data

Evidentiary Standards:

- Any service where the average unit cost, based on an assessment of Wellfleet historical paid claims, exceeds $500
- Return of Investment <1.0

compensation (§150); Non-physician services provided to a hospital inpatient that were not provided directly or arranged for by the hospital (§170);

3. **Factor 3***: Serious safety risk* -

SOURCE: FDA clearance/approval; peer-reviewed publications; clinical trials and studies; professional opinion; publications by professional societies or government agencies

Evidentiary Standards: Inadequate volume of existing peer-reviewed, evidence-based, scientific literature to establish whether or not a technology, supplies, treatments, procedures, or devices is safe and effective for treating or diagnosing the condition or sickness for which its use is proposed. Study detail is scrutinized using the scientific method of evidence review which is defined by the U.S. General Services Administration as: systematic evidence review attempts to find all published and unpublished evidence related to a specific research or policy question, using literature search methodologies designed to be transparent, unbiased, and reproducible.

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SOURCE: Greater frequency of deviation from evidence-based practice compared to Wellfleet book of business

Evidentiary Standard: Variation(s) measured against a documented baseline or standard for the specific service or service bundle of codes. Significant variation should be assessed at the service bundle level, and not necessarily in the variation between individual code(s).

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6.**Factor 6**: *Estimated average cost of review* -

SOURCE: Wellfleet claims data

Evidentiary Standards:

- Any service where the average unit cost, based on an assessment of Wellfleet historical paid claims, exceeds $500
- Return of Investment <1.0

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.*

M/S	**MH/SUD**
To ensure that Wellfleet's plan documents are consistently applied, Wellfleet conducts a thorough review of its plans utilization review data performed by Hines and claims data at least annually. The annual review includes an analysis of applicable M/S and MH/SUD procedures to identify potential gaps or inconsistencies. Wellfleet also conducts Return of Investment(ROI) calculation annually based off the precertification list. ROI exhibiting <1 are presented to the Benefits Committee to be removed from the prior authorization practices. The below examples of Hines' Utilization Management policies used in the application of the Prior Authorization demonstrate comparability and consistency. Hines' policies were developed and reviewed in accordance with Department of Labor standards, URAC and NCQA standards, as well as state mandates. Hines first level reviewers will utilize industry recognized Milliman Care Guidelines (MCG) as their primary criteria set for validating medical necessity of medical/surgical requests. MCG Inpatient & Surgical Care Guidelines offers evidence-based criteria, goals, care pathways, and other decision- support tools, making it a valuable resource for determining medical necessity of care requests. First level reviewers will defer the request to second level physician review when they cannot validate the clinical provided with MCG. Hines first level reviewers will utilize industry recognized NCCN guidelines, as the criteria set for validating medical necessity of an oncology treatment request. These guidelines are the recognized standard for clinical policy in oncology, covering 97 percent of all patients with cancer and updated on a continual basis, the NCCN Guidelines® are developed through an explicit review of evidence (clinical trials, existing treatment protocol, etc.) integrated with expert medical judgment and recommendations by panels that are made up of representatives from the 25 NCCN Member Institutions. First level reviewers will defer the request to second level review when they cannot validate the clinical provided with NCCN. Policy II-A2-4.1 Prospective Review (Precert) Prospective 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	To ensure that Wellfleet's plan documents are consistently applied, Wellfleet conducts a thorough review of its plans utilization review data and claims data at least annually. The annual review includes an analysis of applicable M/S and MH/SUD procedures to identify potential gaps or inconsistencies. Wellfleet also conducts Return of Investment(ROI) calculation annually based off the precertification list. ROI exhibiting <1 are presented to the Benefits Committee to be removed from the prior authorization practices. The below examples of Hines' Utilization Management policies used in the application of the Prior Authorization demonstrate comparability and consistency. Hines' policies were developed and reviewed in accordance with URAC and NCQA standards, as well as state mandates. Hines first level reviewers will utilize industry recognized LOCUS and CALOCUS guidelines, as the criteria set for validating medical necessity of mental health and/or substance abuse treatment requests. Deerfield Behavioral Health, Inc.'s LOCUS and CALOCUS guidelines were developed by members of the American Association of Community Psychiatrists (AACP). Both are a level of care assessment tool used by behavioral health managers and clinicians throughout the country to support accurate level of care recommendations. These tools assess the current clinical needs of the individual to establish the intensity of services found along the continuum of care. Policy II-A2-4.1 Prospective Review (Precert) Prospective 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. The prospective review process should be completed, including verbal and written notification, within 72 hours of the request for precertification for urgent pre-service requests and within 15 calendar days of the request for precertification for non-urgent pre-service requests, unless a shorter time is mandated by applicable state law. The first level reviewer assumes responsibility for validating information taken at Intake and for updating each case file. Hines second and third level reviewers will be provided the criteria as well, however, the criteria will be used as a guideline only and individual patient characteristics must be considered. Physician

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. The prospective review process should be completed, including verbal and written notification, within 72 hours of the request for precertification for urgent pre-service requests and within 15 calendar days of the request for precertification for non-urgent pre-service requests, unless a shorter time is mandated by applicable state law. The first level reviewer assumes responsibility for validating information taken at Intake and for updating each case file. Hines second and third level reviewers will be provided the criteria as well, however, the criteria will be used as a guideline only and individual patient characteristics must be considered. Physician reviewers have the medical and scientific knowledge base, along with experience to apply the guidelines and recognize individual patient characteristics, the geographic area and care resources, and application of scientific data from evidenced based, physician peer reviewed journals. When a physician must adapt the guidelines as per the product description, justification will be provided via clinical rationale and additional resources as indicated. Again, this process is the same whether medical or behavioral in nature. The Medical Directors (internal medicine) and /or other physician panel members will review the criteria sets at least annually to update and approve the practice standards therein. New technology will be reviewed by a content expert, then the appropriate medical director, and presented to the Quality and Physician Advisory Committee as soon as possible. Consistent application of criteria is a necessary component of Utilization Review for both behavioral health, including Substance Abuse/ Mental Health and Medical/Surgical cases. Inter- rater reliability testing enables Hines to identify consistent application and provide additional education to staff when necessary. For inter-rater reliability, sample cases are sent quarterly to nursing first level review staff, and scored individually to determine if the criteria was accurately applied. Those who are not consistent in their case assessment receive additional training. The Hines Medical Director (Internal Medicine) reviews physician review determinations conducted for medical/surgical cases and the Behavioral Health Medical Director (Psychiatrist) reviews physician review determinations for substance abuse/mental health cases for accurate application of criteria guidelines and rationale for adjusting given individual patient characteristics, the geographic area and care resources, and application of scientific data from evidenced based, physician peer reviewed journals. Concurrent quality assurance audits of utilization review cases are conducted by the Quality Assurance Supervisor (or designee) for both medical/surgical and substance abuse/mental health cases. The focus will be on the process of UR including but not limited to timeliness or reviews, appropriate application of criteria, referral to physician review when criteria are not met, screening and referral for case management. The same tool and volume of cases reviewed by nurse is used for behavioral health and medical-surgical nurse	reviewers have the medical and scientific knowledge base, along with experience to apply the guidelines and recognize individual patient characteristics, the geographic area and care resources, and application of scientific data from evidenced based, physician peer reviewed journals. When a physician must adapt the guidelines as per the product description, justification will be provided via clinical rationale and additional resources as indicated. Again, this process is the same whether medical or behavioral in nature. The Medical Directors (psychiatrist) and /or other physician panel members will review the criteria sets at least annually to update and approve the practice standards therein. New technology will be reviewed by a content expert, then the appropriate medical director, and presented to the Quality and Physician Advisory Committee as soon as possible. Consistent application of criteria is a necessary component of Utilization Review for both behavioral health, including Substance Abuse/ Mental Health and Medical/Surgical cases. Inter- rater reliability testing enables Hines to identify consistent application and provide additional education to staff when necessary. For inter-rater reliability, sample cases are sent quarterly to nursing first level review staff, and scored individually to determine if the criteria was accurately applied. Those who are not consistent in their case assessment receive additional training. The Hines Medical Director (Internal Medicine) reviews physician review determinations conducted for medical/surgical cases and the Behavioral Health Medical Director (Psychiatrist) reviews physician review determinations for substance abuse/mental health cases for accurate application of criteria guidelines and rationale for adjusting given individual patient characteristics, the geographic area and care resources, and application of scientific data from evidenced based, physician peer reviewed journals. Concurrent quality assurance audits of utilization review cases are conducted by the Quality Assurance Supervisor (or designee) for both medical/surgical and substance abuse/mental health cases. The focus will be on the process of UR including but not limited to timeliness or reviews, appropriate application of criteria, referral to physician review when criteria are not met, screening and referral for case management. The same tool and volume of cases reviewed by nurse is used for behavioral health and medical-surgical nurse reviewers. All reviewers are expected to attain and maintain a monthly score of 90% or better in all categories. It is of note, all Hines Reviewers passed IRR for 2024.

reviewers. All reviewers are expected to attain and maintain a monthly score of 90% or better in allcategories. It is of note, all Hines Reviewers passed IRR for 2024.	

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: (In Operation)

Authorizations

UR Service Level	Inpt	UR Service Level	Outpt
Auth Type	Precert	Auth Type	Precert
MED SURG		MED SURG	
Approvals	38	Approvals	565
Denials	3	Denials	43
MedSurg % Denied	7%	MedSurg % Denied	1%
MH		MH	
Approvals	27	Approvals	11
Denials	0	Denials	1
MH % Denied	0%	MH % Denied	8%
SUD		SUD	
Approvals	6	Approvals	0
Denials	3	Denials	0
SUD % Denied	33%	SUD % Denied	0%

APPEALS

UR Service Level	Inpt	UR Service Level	Outpt
Auth Type	Precert	Auth Type	Precert
MedSurg		MedSurg	
Denials Upheld	0	Denials Upheld	0
Denials Overturned	0	Denials Overturned	0
MedSurg % Upheld	0%	MedSurg % Upheld	0%
MH		MH	
Denials Upheld	0	Denials Upheld	0
Denials Overturned	0	Denials Overturned	0
MH % Upheld	0%	MH % Upheld	0%
SUD		SUD	
Denials Upheld	0	Denials Upheld	0
Denials Overturned	0	Denials Overturned	0
SUD % Upheld	0%	SUD % Upheld	0%

Wellfleet monitors the 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 and physicians use the medical necessity criteria from MCG Guidelines, and ASAM Criteria or state specific requirements to make their prior authorization determination.

The 2024 Wellfleet BoB UM data for Hines:
The number of PA decisions across the Wellfleet book of business data for Hines' reviews, reflects significantly higher volume of Medical Necessity reviews across all inpatient and outpatient benefit classifications for utilization management of prior authorizationfor M/S services which shows lower % of denial rate than medical necessity denials of MH/SUD services. MHSUD has significant less medical necessity reviews which skews the % higher. The MH/SUD denial was further evaluated and the service was a laboratory test that is excluded as experimental and investigational for genetic testing for medication management.
Appeals data includes the same time relating to the utilization management data metrics.

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

M/S and MH/SUD:

Wellfleet's Mental Health and Substance Use Disorder Parity Compliance Program sets the processes and procedures of establishing parity compliance and ensuring appropriate identification and remediation of improper practices internally and with its delegates. Wellfleet has established methodologies for the identification and testing, including a comparative analysis, of all NQTLs that are imposed on MH/SUD benefits. Wellfleet monitors for and detects improper practices by conducting ongoing and periodic reviews of Wellfleet's policies and procedures as well as the activities of any of Wellfleet's agents or representatives providing benefit management services or performing utilization reviews. Wellfleet has not identified any 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.

Wellfleet Delegation Oversight Committee performs oversight with our delegated vendor Hines. Utilization Management data received from Hines is reviewed no less than semiannually for comparability of M/S vs MH/SUD reviews. Variables in data analyzed are further reviewed for adequacy of literature, reviewer type, level of care reviewed, TAT and outcome. Any discrepancies of data are evaluated with Hines. If discrepancies are identified, and corrective action is needed for any opportunities identified, the Delegation Oversight Committee will apply a corrective action plan to the delegate.

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, the process for reviewing utilization management requests, and the process for applying coverage criteria. A review of Hines' written policies and processes reveals the comparable process by which MH/SUD and M/S services are selected for application of prior authorization within the applicable benefit classification that evidences comparability and equivalent stringency in-writing and in-operation is evidenced by the number of PA decisions across the Wellfleet book of business data, reflects significantly higher denial rates based upon Medical Necessity reviews across all inpatient & outpatient all other benefit classifications for utilization management of prior authorization, with medical necessity denials for M/S services higher than medical necessity denials of MH/SUD services.