

NQL: 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 NQL, plan terms, and policies at issue: Wellfleet delegates its non-Pharmacy Utilization Management to Cigna Health Management, Inc., an affiliate of CHLIC (Cigna). 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. <i>Note:</i> 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: The PA list for our utilization review agent Cigna (Medical) is located on Wellfleet’s website https://wellfleetstudent.com/providers/. Search Other Provider Resources - Prior Authorization Requirements – Cigna 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.	Identify the MH/SUD benefits/services for which Prior Authorization is required: The PA list for our utilization review agent Cigna (Medical) is located on Wellfleet’s website https://wellfleetstudent.com/providers/. Search Other Provider Resources - Prior Authorization Requirements – Cigna 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	INPATIENT IN & OUT OF NETWORK	OUTPATIENT ALL OTHER IN & OUT OF NETWORK
M/S	M/S	MHSUD	MHSUD
Acute Inpatient Services	Surgeries	Mental Health Acute Inpatient Services	Surgeries
Subacute Inpatient Services, i.e. Skilled Nursing Care, physical rehabilitation hospitals including habilitation, etc. Inpatient Professional Services	Home Health Care Rehabilitative & Habilitative Therapies Chiropractic Acupuncture Diagnostic Imaging High Rad Scans Infusions & Injections DME Infertility Treatment Prosthetic Devices	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	Rehabilitative & 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. <i>Experimental/Investigational/Unproven service</i> 2. <i>Potential benefit exclusion</i> 3. <i>Serious safety risk</i> 4. <i>Significant variation in Evidence-based practice</i> 5. <i>Potential for Fraud, Waste or Abuse</i> 6. <i>Estimated average cost of review and return of investment</i> 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. <i>Experimental/Investigational/Unproven service</i> 2. <i>Potential benefit exclusion</i> 3. <i>Serious safety risk</i> 4. <i>Significant variation in Evidence-based practice</i> 5. <i>Potential for Fraud, Waste or Abuse</i> 6. <i>Estimated average cost of review and return of investment</i> 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
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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 (§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 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 -*

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 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' 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.

4. **Factor 4:** *Significant variation in Evidence-based practice -*
SOURCE: Greater frequency of deviation from evidence-based practice compared to Cigna's book of business

SOURCE: Greater frequency of deviation from evidence-based practice compared to Cigna's 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 & Cigna 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 and return of investment. SOURCE: Wellfleet & Cigna claims data Evidentiary Standards: Any service where the average unit cost, based on an assessment of Cigna Healthcare's historical paid claims, exceeds \$500 and the average cost of review calculation for return of investment is less than 1.0.	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 & Cigna 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 & Cigna claims data Evidentiary Standards: Any service where the average unit cost, based on an assessment of Cigna Healthcare's historical paid claims, exceeds \$500
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. <i>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.</i> ☐ <i>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).</i> ☐ <i>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.</i>	
All information below is applicable to both M/S and MH/SUD classifications 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 and MH/SUD policies and procedures to identify potential gaps or inconsistencies. The below examples of Cigna's Utilization Management policies used in the application of the Prior Authorization demonstrate comparability and consistency. These Cigna policies were developed and reviewed in accordance with URAC and NCQA standards, as well as state mandates. The UM-12: <i>Qualified Health Professionals Render UM Decisions</i> 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	All information below is applicable to both M/S and MH/SUD classifications 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 and MH/SUD policies and procedures to identify potential gaps or inconsistencies. The below examples of Cigna's Utilization Management policies used in the application of the Prior Authorization demonstrate comparability and consistency. These Cigna policies were developed and reviewed in accordance with URAC and NCQA standards, as well as state mandates. HM-CLN-039: <i>Utilization Management Decisions – Appropriate Professional Assessment</i> 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

the scope of their license. As noted in the scope of these policies in 4(b)below, both 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 o 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 o Are qualified as determined by the Senior Medical Director to render a clinical opinion about the medical condition, procedure and treatment under review o 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. • <u>Medical Director Areas of Responsibility for UM Decisions; includes, but not limited to the following:</u> o Review and render all medical necessity denials. o Make medical necessity decisions in accordance with state licensure requirements as applicable. o Provide specific reason(s) for denials in case documentation and letter content.

act within the scope of their license. As noted in the scope of these policies in 4(b)below, both 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 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: o Conducting Pre-service o Concurrent reviews o Post-service o Medical necessity determinations including: ▪ Approvals including cases not meeting criteria guidelines and ▪ Denials
UM-09: HM-CLN-002: Advocates and Care Coordinators outlines the responsibilities of administrative staff in the application of the Prior Authorization NQTL. As noted below, these policies outline 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 Prior Authorization 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 Prior Authorization requires medical director/peer review for both M/S and

- 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 outlines the responsibilities of administrative staff in the application of the Prior Authorization NQTL. As noted below, these policies outline 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 reflect the role of non-physician clinicians (i.e. nurses or care managers) in the application of the Prior Authorization 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 Prior Authorization 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 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:

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 <u>Non-clinical staff:</u> 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, 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.

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 policies are illustrative of the annual review conducted to ensure comparability in writing of the application of the Prior Authorization NQTL to M/S and MH/SUD services in all benefit classifications. The process by which services are considered for application of Prior Authorization 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 Prior Authorization. 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. Additionally, the Precertification Team, also known as the Precertification Workgroup, a committee of Cigna-employed Medical Directors for M/S (MDs with unrestricted license to practice medicine in a state or territory of the United States and 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) and MH/SUD professionals (Board certified psychiatrists, addictionologists, or doctoral level psychologists with current unrestricted license in the United States or its territories) may recommend additions/deletions of services requiring the application of Prior Authorization NQTL to HMAC based upon the factors of Experimental/Investigational/Unproven, benefit exclusions, safety risk, evidence based	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 policies are illustrative of the annual review conducted to ensure comparability in writing of the application of the Prior Authorization NQTL to M/S and MH/SUD services in all benefit classifications. The process by which services are considered for application of Prior Authorization 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 Prior Authorization. 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. Additionally, the Precertification Team, also known as the Precertification Workgroup, a committee of Cigna-employed Medical Directors for M/S (MDs with unrestricted license to practice medicine in a state or territory of the United States and 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) and MH/SUD professionals (Board certified psychiatrists, addictionologists, or doctoral level psychologists with current unrestricted license in the United States or its territories) may recommend additions/deletions of services requiring the application of Prior Authorization NQTL to HMAC based upon the factors of Experimental/Investigational/Unproven, benefit exclusions, safety risk, evidence based practice, FWA, and cost. These qualified professionals utilize the applicable thresholds and sources cited in Step 3 to make their recommendations. The committee has 7 members with 3 being MH/SUD. Internal subject matter experts include, but are not limited to surgeons, anesthesiologists, surgical oncology, family medicine, psychiatry & neurology, behavioral neurology & neuropsychiatry.
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practice, FWA, and cost/Return of investment. These qualified professionals utilize the applicable thresholds and sources cited in Step 3 to make their recommendations. The committee has 7 members with 3 being MH/SUD. Internal subject matter experts include, but are not limited to surgeons, anesthesiologists, surgical oncology, family medicine, psychiatry & neurology, behavioral neurology & neuropsychiatry.

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)

			PRIOR AUTHORIZATIONS				PRIOR AUTHORIZATIONS
UR Service Level	Inpt	Inpt	TOTAL INPT PA REVIEWS	UR Service Level	Outpt All Other	Outpt All Other	TOTAL OUTPT PA REVIEWS
NETWORK	INN	OON		NETWORK	INN	OON	
Auth Type	Precert	Precert		Auth Type	Precert	Precert	
M/S				M/S			
Approvals	46	6	52	Approvals	4,833	230	5063
Denials	21	0	21	Denials	1,476	353	1829
M/S % Denied	33%	0%	41%	M/S % Denied	45%	61%	36%
MH				MH			
Approvals	63	6	69	Approvals	57	16	73
Denials	1	0	1	Denials	17	11	28
MH % Denied	2%	0%	1%	MH % Denied	23%	41%	38%
SUD				SUD			
Approvals	5	2	7	Approvals	0	0	0
Denials	0	0	0	Denials	0	0	0
SUD % Denied	0%	0%	0%	SUD % Denied	0%	0%	0%
			APPEALS				APPEALS
UR Service Level	Inpt	Inpt	TOTAL INPT Appeals REVIEWS	UR Service Level	Outpt All Other	Outpt All Other	TOTAL OUTPT Appeals REVIEWS
Network	INN	OON		Network	INN	OON	
Auth Type	Precert	Precert		Auth Type	Precert	Precert	
M/S				M/S			
Denials Upheld	1	1	2	Denials Upheld	3	10	13
Denials Overturned	1	0	1	Denials Overturned	3	4	7
M/S % Upheld	50%	100%	50%	M/S % Upheld	50%	71%	54%

MH				MH			
Denials Upheld	0	0	0	Denials Upheld	0	0	0
Denials Overturned	0	0	0	Denials Overturned	0	0	0
MH % Upheld	0%	0%	0%	MH % Upheld	0%	0%	0%
SUD				SUD			
Denials Upheld	0	0	0	Denials Upheld	0	0	0
Denials Overturned	0	1	1	Denials Overturned	0	0	0
SUD % Upheld	0%	0%	0%	SUD % Upheld	0%	0%	0%

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.

The 2024 Wellfleet – Cigna BoB

The number of PA decisions across the Wellfleet- Cigna book of business data, reflects significantly higher denial rates based upon Medical Necessity reviews across all inpatient 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. Outpatient medical necessity denials reflect a slightly higher % denial rate for MH (2%). However, 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 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

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 Cigna. Utilization Management data received from Cigna 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 Cigna. 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.

With regards to Cigna's sub-delegates (ASH and EviCore), Cigna promotes and applies systematic assessments and Continuous Quality Improvement (CQI) to internal processes and workflows. Cigna achieves this by adhering to common principles for the delivery of services and coverage to clients, members, and participating practitioners consistent with state and federal laws. The CQI process, a problem-solving approach, is applied when an opportunity for improvement is identified through monitoring performance indicators or from other sources. This process is applied consistently across M/S and MH/SUD services, and includes:

- collection of data
- systematic measurement of data
- analysis to identify opportunities for improvement
- identification of possible root causes or barriers
- selection of opportunities to pursue
- planning of interventions
- implementation of interventions
- remeasurement and analysis to determine effectiveness of interventions
- reviewing performance against key indicators as specifically identified in the quality work plan
- promoting quality clinical care and service, including both inpatient and outpatient services, provided by hospitals and providers
- evaluating and analyzing satisfaction information, including survey data and complaints and appeals
- evaluating access to services provided by the plan or its contracted providers
- identifying strategies to improve the health and reduce health care disparities of the members we serve

Moreover, Cigna has a Delegation Oversight program that is a methodical, comprehensive process to ensure Cigna customers receive the same high level of quality care and service regardless of whether Cigna or a delegated entity is providing the Prior Authorization medical necessity review.

Cigna retains the ultimate responsibility for ensuring that its delegated functions are carried out properly. Cigna delegates the application of Prior Authorization to

- (1) eviCore for the medical necessity review of M/S services for high tech imaging and cardiology, radiation and medical oncology, musculoskeletal management, and gastrointestinal endoscopic procedures; and
- (2) American Specialty Health ("ASH") for the medical necessity review of M/S and MH/SUD physical therapy and occupational therapy.
- (3) Evernorth for the medical necessity review of MH/SUD services.

Each of these delegated vendors adhere to Cigna's policies and procedures when performing utilization review. All of the data included in Cigna's Prior Authorization NQTL comparative analysis is inclusive of the Prior Authorization medical necessity reviews of the applicable delegated services.

Cigna maintains a robust Delegation Policy and Quality Programs to ensure Cigna's delegates are adhering to Cigna's policies and procedures when performing utilization review and the application of the Prior Authorization NQTL. The processes include regular monitoring and auditing, reviewing performance against key indicators, regular reporting through standardized committees, and root cause analysis.

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 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- Cigna 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.

