NQTL: RETROSPECTIVE REVIEW

Classification(s): Inpatient In Network & Out of Network and Outpatient Office In Network & Out of Network and All Other In Network and 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 retrospective review to Hines and Associates (Hines) and Advanced Medical Reviews (AMR). These utilization management(UM) vendors rely on Wellfleet's definitions of retrospective review, medical necessity and experimental and investigational to assist in the decision making for UM.

Wellfleet's standard definition of "retrospective review" is as follows:

Retrospective Review is a review of a claim after a service has already been provided, but before the claim for that service has been paid. Specifically, these are reviews of coverage authorizations that were not approved prior to the service being rendered.
All services must be medically necessary to be a covered benefit. **Medically Necessary** or **Medical Necessity** means health care services that a Physician, exercising prudent clinical judgment, would provide for the purpose of preventing, evaluating, diagnosing or treating an illness, Injury, disease or its symptoms, and that are:

1. In accordance with generally accepted standards of medical practice;
2. Clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective for an illness, Injury or disease; and
3. Not primarily for the convenience of an Insured Person, Physician or other health care provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or Treatment of an Insured Person's illness, Injury or disease.

The fact that any particular Physician may prescribe, order, recommend or approve a service or supply does not, of itself, make the service or supply Medically Necessary.

All non-emergent M/S and MH/SUD inpatient and outpatient services are theoretically subject to a medical necessity review.

Identify the M/S benefits/services for which Retrospective Review is required:	***Identify the MH/SUD benefits/services for which Retrospective Review is required***:
Retrospective review is a utilization review service performed by licensed healthcare professionals to determine coverage after treatment has been given. The intent is to determine medical necessity, appropriateness of treatment, and benefits and eligibility. Wellfleet performs retrospective review on services that were not precertified that are on the member precertification list and for circumstances on services that may be inconsistent with the member's coverage or identified on Wellfleet Payment Guidelines to determine if it is medically appropriate and consistent with evidence based guidelines.	Retrospective review is a utilization review service performed by licensed healthcare professionals to determine coverage after treatment has been given. The intent is to determine medical necessity, appropriateness of treatment, and benefits and eligibility. Wellfleet performs retrospective review on services that were not precertified that are on the member precertification list and for circumstances on services that may be inconsistent with the member's coverage or identified on Wellfleet Payment Guidelines to determine if it is medically appropriate and consistent with evidence based guidelines.

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: **FACTORS:** 1. Determined to be experimental, investigational, unproven or safety concern 2. Service may be excluded from coverage 3. Service demonstrates significant variations from evidence based care 4. High incidence of fraud waste and/or abuse 5. Service is associated with a high average cost 6. Performing coverage reviews for a service is projected to meet or exceed a certain return on investment ratio 7. School preference/selection (used only to remove retrospective review) **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**: **FACTORS:** 1. Determined to be experimental, investigational, unproven or safety concern 2. Service may be excluded from coverage 3. Service demonstrates significant variations from evidence based care 4. High incidence of fraud waste and/or abuse 5. Whether the service is associated with a high average cost 6. Performing coverage reviews for a service is projected to meet or exceed a certain return on investment ratio 7. School preference/selection (used only to remove retrospective review) **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 Retrospective Review 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: **FACTORS:** 1. Determined to be experimental, investigational, unproven or safety concern **SOURCE:** US FDA (U.S. Food and Drug Administration) • 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:** 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:** • 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; or	**MH/SUD**: **FACTORS:** 1.Determined to be experimental, investigational, unproven or safety concern **SOURCE:** US FDA (U.S. Food and Drug Administration) • 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:** 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:** • 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; or

• the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials. • Whether a service presents a serious risk to enrollee safety is determined through an assessment of available Clinical Evidence for the service. Examples of safety issues considered to be potentially life-threatening include a service such as rapid detoxification under anesthesia, or the use of a service that is the subject of a serious warning or recall 2. Service may be excluded from coverage **SOURCE:** Certificates of Coverage • All plans located on Wellfleet Student website https://wellfleetstudent.com/ with exclusions may be based on CMS.gov: "CMS PUB. 100-02 Medicare Benefit Policy Manual, Chapter 16 – General Exclusions from Coverage" **EVIDENTIARY STANDARDS:** • Certificate of Coverage; plan exclusions - Specifically, a service may be rendered for one or more uses covered by a benefit plan and one or more uses that are excluded by the benefit plan, or the intended use of the service cannot be identified based on the information provided in a submitted benefit claim. For example, benefit plan may exclude a service if it is rendered for cosmetic purposes, but the benefit plan may cover a service if it is rendered to treat a covered condition. The clinically appropriate uses for a service are determined through an assessment of available Clinical Evidence for the service. 3. Service demonstrates significant variations from evidence based care **SOURCE**: 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:** • A variation in evidence-based care must reflect a statistically significant standard deviation from the standard frequency or duration in treatment using the service, while accounting for operational and knowledge variations that may exist across providers and geographic areas. What is considered statistically significant will vary by the type of service, as the frequency or duration in treatment standard may vary by service type. 4. High incidence of fraud waste and/or abuse **SOURCE**: Federal Drug Administration FDA; Centers for Medicare & Medicaid Services (CMS), National Institutes of Health(NIH); National Healthcare Anti-Fraud Association (NHCAA) **EVIDENTIARY STANDARDS:** identified in publications by organizations that track trends regarding fraud waste, and abuse in utilization of healthcare services; • CMS performs Provider Screening: CMS uses rigorous screening processes to identify and exclude potentially fraudulent providers. Predictive Modeling: CMS utilizes predictive modeling technology, similar to credit card companies, to identify patterns of potential fraud and abuse.	• the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials. • Whether a service presents a serious risk to enrollee safety is determined through an assessment of available Clinical Evidence for the service. Examples of safety issues considered to be potentially life-threatening include a service such as rapid detoxification under anesthesia, or the use of a service that is the subject of a serious warning or recall 2. Service may be excluded from coverage **SOURCE:** Certificates of Coverage • All plans located on Wellfleet Student website https://wellfleetstudent.com/ with exclusions may be based on CMS.gov: "CMS PUB. 100-02 Medicare Benefit Policy Manual, Chapter 16 – General Exclusions from Coverage" **EVIDENTIARY STANDARDS:** • Certificate of Coverage; plan exclusions - Specifically, a service may be rendered for one or more uses covered by a benefit plan and one or more uses that are excluded by the benefit plan, or the intended use of the service cannot be identified based on the information provided in a submitted benefit claim. 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- Enforcement Authorities: CMS has implemented new enforcement authorities to strengthen its ability to stop fraud before it happens, including the ability to deny or revoke provider enrollment. Fraud Prevention System (FPS): The FPS performs post-payment analysis on claims, using predictive models and algorithms to identify potential fraud.
- NIH - Maintaining a strong private-public partnership in combating health care fraud and abuse; Providing unparalleled learning opportunities related to combating health care fraud and abuse; Providing opportunities for private and public-sector information sharing related to health care fraud and abuse; Serving as a national resource for health care anti-fraud information and professional assistance to government, industry and media; and recognizing and advancing professional specialization in the detection, investigation and/or prosecution of health care fraud and abuse through accreditation of health care anti-fraud professionals.

5. Whether the service is associated with a high average cost

SOURCE: Wellfleet claims data

EVIDENTIARY STANDARDS: Based on an assessment of historical paid claims for the service across its book of business, the average unit cost of the service must exceed five hundred dollars ($500), unless either:

- The service is an unlisted or non-specific code where the unit cost may vary from far less than $500 to far more than $500; or
- The service is associated with serial use where the cumulative average use of the services may be represented by a single prior authorization and therefore exceed the dollar threshold.

6. Performing coverage reviews for a service is projected to meet or exceed a certain return on investment ratio

SOURCE: Wellfleet claims data

EVIDENTIARY STANDARDS: The ROI ratio is calculated using the following formula:

- The actual or anticipated denial rate of the service multiplied by the average unit cost (or, as applicable, cumulative cost) of the service, with the resulting figure divided by the estimated cost to review the total number of services.
- For services for which Wellfleet maintains historic claims data, Wellfleet calculates the denial rate by reference to the actual denial rate as reflected in the historic book-of-business claims data it maintains. The average unit cost of the service is calculated based on Cigna's historical paid claims for the service across its commercial book of business. The estimated cost to perform a coverage review is $100 per review, which is informed by costs/expenses such as personnel salaries and time.

7. School preference/selection (used only to remove retrospective review)

SOURCE: School (client) decision to remove a benefit from the precertification list or Wellfleet Payment Guidelines

provider enrollment. Fraud Prevention System (FPS): The FPS performs post-payment analysis on claims, using predictive models and algorithms to identify potential fraud.

- NIH - Maintaining a strong private-public partnership in combating health care fraud and abuse; Providing unparalleled learning opportunities related to combating health care fraud and abuse; Providing opportunities for private and public-sector information sharing related to health care fraud and abuse; Serving as a national resource for health care anti-fraud information and professional assistance to government, industry and media; and recognizing and advancing professional specialization in the detection, investigation and/or prosecution of health care fraud and abuse through accreditation of health care anti-fraud professionals.

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7. School preference/selection (used only to remove retrospective review)

SOURCE: School (client) decision to remove a benefit from the precertification list or Wellfleet Payment Guidelines

EVIDENTIARY STANDARDS: School (client) preference is only used to remove Retrospective Review from MH/SUD benefits, and is never used to apply Retrospective Review(RR) to MH/SUD benefits, thus this only serves to make MH/SUD benefits more accessible to members by potentially

EVIDENTIARY STANDARDS: School (client) preference is only used to remove Retrospective Review from MH/SUD benefits, and is never used to apply Retrospective Review(RR) to MH/SUD benefits, thus this only serves to make MH/SUD benefits more accessible to members by potentially eliminating RR from certain MH/SUD services. RR will be removed if the school (client) states that they do not want a certain benefit to be subject to RR and: • that preference is negotiated as part of the sales process, or • that preference is provided in writing in an independent decision by the school (client) at a later date. • Return of Investment is <1.0	eliminating RR from certain MH/SUD services. RR will be removed if the school (client) states that they do not want a certain benefit to be subject to RR and: • that preference is negotiated as part of the sales process, or • that preference is provided in writing in an independent decision by the school (client) at a later date. • Return of Investment is <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.*	
In determining whether health care services, supplies, or medications are Medically Necessary, all elements of Medical Necessity must be met as specifically outlined in the individual's benefit plan documents. Hines may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia including "Clinical evidence" as referenced above includes publications from professional societies that include nationally recognized specialists in the appropriate field (e.g., American College of Obstetricians and Gynecologists); guidance published by appropriate Government Regulatory Agencies (e.g., CMS, FDA, NIH); and other original research studies, publish in the English language, peer reviewed, published, evidence-based scientific studies or literature. Wellfleet reviews vendor guidelines and it's Payment Guidelines at least once annually, and applicable coding is identified through multiple channels including requests from the provider community, customers, frontline reviewers, and the impetus of new, emerging, and evolving technologies.	In determining whether health care services, supplies, or medications are Medically Necessary, all elements of Medical Necessity must be met as specifically outlined in the individual's benefit plan documents. Hines may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia including "Clinical evidence" as referenced above includes publications from professional societies that include nationally recognized specialists in the appropriate field (e.g., American College of Obstetricians and Gynecologists); guidance published by appropriate Government Regulatory Agencies (e.g., CMS, FDA, NIH); and other original research studies, publish in the English language, peer reviewed, published, evidence-based scientific studies or literature. Wellfleet reviews vendor guidelines and it's Payment Guidelines at least once annually, and applicable coding is identified through multiple channels including requests from the provider community, customers, frontline reviewers, and the impetus of new, emerging, and evolving technologies.

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:

Hines Authorizations		
UR Service Level	**Inpt**	**Outpt**
Auth Type	**Retro**	**Retro**
MED SURG		
Approvals	92	144
Denials	13	72
MedSurg % Denied	**12%**	**33%**
MH		
Approvals	33	3
Denials	2	1
MH % Denied	**6%**	**25%**
SUD		
Approvals	2	0
Denials	1	0
SUD % Denied	**33%**	**0%**
Hines APPEALS		
UR Service Level	**Inpt**	**Outpt**
Auth Type	**Retro**	**Retro**
MedSurg		
Denials Upheld	1	14
Denials Overturned	1	12
MedSurg % Upheld	**50%**	**46%**
MH		
Denials Upheld	4	0
Denials Overturned	2	0
MH % Upheld	**33%**	**0%**
SUD		
Denials Upheld	2	0
Denials Overturned	0	0
SUD % Upheld	**0%**	**0%**

The number of utilization review decisions across the Wellfleet- Hines book of business data reflects comparable average denial rates based upon Medical Necessity across all inpatient and outpatient benefit classifications for utilization management programs including retrospective review with medical necessity denials for M/S services higher than medical necessity denials of MH/SUD services. The SUD reviews are significantly lower and inpatient stays are reviewed per days stay. The denial was a portion of the total stay for the SUD review. There were significantly higher # of days approved.

AMR RETRO REVIEW TYPE	MS Approved	MS Denied	MHSUD Approved	MHSUD Denied
Benefit Coverage	1	6	0	0
Coding	1	5	0	0
Experimental/Investigational	1	1	0	0
Medical Necessity	9	28	0	0
Grand Total	12	40	0	0

The 2024 Wellfleet – AMR BoB
The number of utilization review decisions across the Wellfleet-AMR BoB data reflects all medical surgical reviews performed which resulted in 30% of reviews being approved and 70% denials.

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

Wellfleet 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.

Thus, Wellfleet has determined that Retrospective Review 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 Retrospective Review.