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 non-Pharmacy Utilization Management to Cigna Health Management, Inc., an affiliate of CHLIC (Cigna). Cigna employs the same definition of retrospective review to (M/S) and mental health/substance use disorder (MH/SUD) benefits. Cigna'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.
Cigna does not incorporate language related to Retrospective Review in its certificate or benefits booklet.
All non-emergent M/S and MH/SUD inpatient and outpatient services are theoretically subject to a medical necessity review.

Cigna Medical Directors apply the definition of "medical necessity" set forth in the governing plan instrument or the definition required by state law. In general, Cigna uses the following definition:
Medically Necessary/Medical Necessity are health care services, supplies and medications provided for the purpose of preventing, evaluating, diagnosing, or treating a Sickness, Injury, condition, disease, or its symptoms, which are all of the following as determined by a Medical Director or Review Organization:

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

Where applicable, the Medical Director or Review Organization may compare the cost-effectiveness of alternative services, supplies, medications or settings when determining least intensive setting. 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, the Medical Director or Review Organization may rely on the clinical coverage policies maintained by Cigna or the Review Organization.

Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines

Note: Cigna performs utilization reviews for most medical/surgical (M/S) benefits. A separate entity, eviCore, reviews certain M/S services for Cigna, American Specialty Health, reviews physical therapy and occupational therapy on behalf of CHLIC and both national and regional vendors to perform UM. All entities adhere to Cigna's policies and procedures when performing utilization reviews, and all of the data provided is inclusive of utilization reviews of certain M/S services. Evernorth Behavioral Health ("Evernorth," "EBH" or "Behavioral Health" formerly Cigna Behavioral Health) an affiliate of Cigna, performs utilization reviews for MH/SUD benefits. No separate entities review MH/SUD services for Cigna.

Identify the M/S benefits/services for which Prior Authorization is required: 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 limited circumstances on services that may be inconsistent with the member's coverage, to determine if it is medically appropriate and consistent with evidence based guidelines.	***Identify the MH/SUD benefits/services for which Prior Authorization 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 limited circumstances on services that may be inconsistent with the member's coverage, 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 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: **FACTORS:** 1. Determined to be experimental, investigational, unproven or safety concern **SOURCE:** Cigna Coverage Policies • Incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia including peer-reviewed, evidence-based scientific literature or guidelines. **SOURCE:** Cigna MCG Guidelines	**MH/SUD**: **FACTORS:** 1.Determined to be experimental, investigational, unproven or safety concern **SOURCE:** Cigna Coverage Policies • Incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia including peer-reviewed, evidence-based scientific literature or guidelines. **SOURCE:** Cigna MCG Guidelines

• MCG Care Guidelines are created by clinical editors that analyze and classify peer reviewed papers and research studies each year to develop the care guidelines in strict accordance with the principles of evidence based medicine. **SOURCE:** Cigna's Levels of Scientific Evidence Table **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:** Cigna Coverage Policies • Incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia including peer-reviewed, evidence-based scientific literature or guidelines. **SOURCE:** Cigna MCG Guidelines	• MCG Care Guidelines are created by clinical editors that analyze and classify peer reviewed papers and research studies each year to develop the care guidelines in strict accordance with the principles of evidence based medicine. **SOURCE:** Cigna's Levels of Scientific Evidence Table **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. 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• 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) • 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. • 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. **EVIDENTIARY STANDARDS:** identified in publications by organizations that track trends regarding fraud waste, and abuse in utilization of healthcare services 5. Whether the service is associated with a high average cost **SOURCE:** Cigna & Wellfleet claims data **EVIDENTIARY STANDARDS:** Based on an assessment of Cigna's historical paid claims for the service across its commercial 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.	**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. 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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. **EVIDENTIARY STANDARDS:** identified in publications by organizations that track trends regarding fraud waste, and abuse in utilization of healthcare services 5. 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6. Performing coverage reviews for a service is projected to meet or exceed a certain return on investment ratio **SOURCE:** Cigna & 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 Cigna maintains historic claims data, Cigna 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 list. Plans reviewed by Cigna have no Retrospective Review for any outpatient MH/SUD benefit as the ROI for RR by Cigna of all outpatient MH/SUD services is <1. **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.	• 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 Cigna maintains historic claims data, Cigna 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 list. Plans reviewed by Cigna have no Retrospective Review for any outpatient MH/SUD benefit as the ROI for RR by Cigna of all outpatient MH/SUD services is <1. **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.

Step 4 – Provide the comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to mental health or substance use disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical or surgical benefits in the benefits classification.

The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.

- *If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s).*
- *If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.*

All information below is applicable to both M/S and MH/SUD classifications Where applicable, the Medical Director or Review Organization may compare the cost-effectiveness of alternative services, supplies, medications or settings when determining least intensive setting. 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, the Medical Director or Review Organization may rely on the clinical coverage policies maintained by Cigna or the Review Organization. Cigna's Coverage Policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia including "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. The HMAC's evidence-based medicine approach ranks the categories of evidence and assigns greater weight to categories with higher levels of scientific evidence as set forth below in Cigna's "Levels of Scientific Evidence Table" adapted from the Centre for Evidence Based Medicine, University of Oxford, March 2009 and evidenced in Cigna's Medical Technology Assessment and Coverage Process for "*Determination of Medical Necessity Coverage Criteria Recommendations Policy (OPS-48)":* Level 1: Randomized Controlled Trials (RCT). Randomized, blinded, placebo- controlled, clinical trials and systematic reviews of RCTs and meta-analysis of RCTs. Level 2: Non-randomized controlled trials (an experimental study, but not an ideal design). Also, systematic reviews and meta- analyses of non-randomized controlled trials. Level 3: Observational studies – e.g., cohort, case-control studies (non-experimental studies). Also, systematic reviews and meta- analyses of observational studies. Level 4: Descriptive studies, case reports, case series, panel studies (non-experimental studies), and retrospective analyses of any kind. Also systematic reviews and meta- analyses of retrospective studies. Level 5: Professional/organizational recommendations when based upon a valid evidence-based assessment of the available literature. While Cigna's Coverage Policies and vendor guidelines are reviewed at least once annually, re-review of Coverage Policies and/or topics for new Coverage Policies are identified through multiple channels including requests from the provider community, customers, frontline reviewers, CPU, and the impetus of new, emerging, and evolving technologies. The company's routine (occurring no less frequently than annually) Inter-Rater Reliability (IRR) process is used to evaluate consistency of clinical decision-making across reviewers and to identify any potential revisions to coverage policies that may be warranted. Of note, the company's most recent M/S &MH/SUD IRR exercise did not reveal a need to revise its coverage	All information below is applicable to both M/S and MH/SUD classifications Where applicable, the Medical Director or Review Organization may compare the cost-effectiveness of alternative services, supplies, medications or settings when determining least intensive setting. 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, the Medical Director or Review Organization may rely on the clinical coverage policies maintained by Cigna or the Review Organization. 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Level 4: Descriptive studies, case reports, case series, panel studies (non-experimental studies), and retrospective analyses of any kind. Also systematic reviews and meta- analyses of retrospective studies. Level 5: Professional/organizational recommendations when based upon a valid evidence-based assessment of the available literature. While Cigna's Coverage Policies and vendor guidelines are reviewed at least once annually, re-review of Coverage Policies and/or topics for new Coverage Policies are identified through multiple channels including requests from the provider community, customers, frontline reviewers, CPU, and the impetus of new, emerging, and evolving technologies. The company's routine (occurring no less frequently than annually) Inter-Rater Reliability (IRR) process is used to evaluate consistency of clinical decision-making across reviewers and to identify any potential revisions to coverage policies that may be warranted. Of note, the company's most recent M/S &MH/SUD IRR exercise did not reveal a need to revise its coverage

policies governing reviews of M/S & MHSUD benefits. IRR reviews are conducted according to accreditation standards and are intended to ensure consistency in decision-making across reviewers making medical necessity determinations based on clinical review literature and Cigna Coverage Policies.	policies governing reviews of M/S & MHSUD benefits. IRR reviews are conducted according to accreditation standards and are intended to ensure consistency in decision-making across reviewers making medical necessity determinations based on clinical review literature and Cigna Coverage Policies.

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:

UR Service Level	**Inpt**	**Inpt**	**TOTAL INPT REVIEWS**	**UR Service Level**	**Outpt All Other**	**Outpt All Other**	**TOTAL OUTPT REVIEWS**
NETWORK	**INN**	**OON**		**NETWORK**	**INN**	**OON**	
Auth Type	**Retro**	**Retro**		**Auth Type**	**Retro**	**Retro**	
M/S				**M/S**			
Approvals	372	17	389	Approvals	256	54	310
Denials	127	10	137	Denials	183	26	209
M/S % Denied	34%	59%	35%	M/S % Denied	71%	48%	67%
MH				MH			
Approvals	30	5	35	Approvals	1	0	1
Denials	2	1	3	Denials	0	3	3
MH % Denied	7%	20%	9%	MH % Denied	0%	100%	75%
SUD				SUD			
Approvals	5	0	5	Approvals	0	0	0
Denials	1	0	1	Denials	0	0	0
SUD % Denied	20%	0%	20%	SUD % Denied	0%	0%	0%

UR Service Level	**Inpt**	**Inpt**	**TOTAL INPT REVIEWS**	**UR Service Level**	**Outpt All Other**	**Outpt All Other**	**TOTAL OUTPT REVIEWS**
Network	**INN**	**OON**		**Network**	**INN**	**OON**	
Auth Type	**Retro**	**Retro**		**Auth Type**	**Retro**	**Retro**	
M/S				**M/S**			
Denials Upheld	12	36	48	Denials Upheld	0	2	2

Denials Overturned	4	13	17	Denials Overturned	1	1	2
M/S % Upheld	33%	36%	35%	M/S % Upheld	0%	50%	50%
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	0	1	Denials Overturned	0	0	0
SUD % Upheld	0%	0%	0%	SUD % Upheld	0%	0%	0%

The 2024 Wellfleet – Cigna BoB
The number of utilization review decisions across the Wellfleet- Cigna book of business data reflects comparable average denial rates based upon Medical Necessity across all inpatient 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.

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: 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 developing coverage criteria. Cigna'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.

A review of Cigna's factors, evidentiary standards, sources, and as written and in operation processes reveals the comparable application of Retrospective Review to M/S and MH/SUD services within the applicable benefit classification. Cigna's Medical Necessity coverage policy development and application process is consistent between M/S and MH/SUD.

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. Cigna conducts routine (occurring no less frequently than annually) Inter-Rater Reliability (IRR) testing is used to evaluate consistency of clinical decision-making across reviewers and to identify any potential revisions to coverage policies that may be warranted. Corrective action is initiated if a score falls below 85% and if the results are below 90% the Medical Director will evaluate the scores and decide whether to convene a review process with the Medical Directors/Physician Reviewers. Of note, the company's most recent MH/SUD IRR exercise did not reveal a need to revise its coverage policies governing reviews of MH/SUD benefits.

Thus, Wellfleet has determined that 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.