Committee on Health Care of the Oregon Legislative Assembly

Mental Health Provider Reimbursement Carrier Data Call

As required by 2017 Senate Bill 860

Volume III – Utilization Management Procedures

Prepared for:

Oregon Department of Consumer and Business Services

Division of Financial Regulation

March 31, 2020

Report by: Risk & Regulatory Consulting, LLC

TABLE OF CONTENTS

B. Data Call Analysis and Observations – Utilization Management Procedures

This section addresses each carrier's utilization management procedures as they relate to SB 860, Section 1, Subsection (2)(b).

The Contractor requested and reviewed information regarding each carrier's utilization management (UM) policies and procedures to determine whether each carrier imposes utilization management procedures for BH Providers that are more restrictive than the UM procedures for Medical Providers as indicated by the time-based outpatient office visit procedure codes. This review entailed obtaining a list from each carrier that stated the procedure codes that were subject to prior authorization, concurrent review, retrospective review and outlier management. Through this review, the Contractor also determined if the carriers restrict the use of longer office visits for BH Providers more than for Medical Providers. The analysis also included a review of the factors considered by each carrier when designing prior authorization, concurrent review, retrospective review and outlier management procedures for participating providers in an outpatient office-based setting. Finally, information regarding the evidentiary standards, national treatment guidelines or other considerations that were relied upon to establish prior authorization, concurrent review, retrospective review and outlier management procedures and requirements were also requested and reviewed.

In many instances, the carriers did not provide the requested information or the information supplied was insufficient or incomplete. As such, follow-up requests were issued to carriers. Two Report Charts are presented further below that summarize key points regarding the carrier UM policy and procedure analysis. The first chart, Report Chart B1, includes information regarding each carrier's utilization management requirements for Medical Providers and BH Providers. The second chart, Report Chart B2, includes information regarding the factors that each carrier considered when designing prior authorization, concurrent review, retrospective review and outlier management requirements. Other detailed information that was reviewed, including information regarding variances in the BH Provider and Medical Provider utilization management requirements, is included in the individual carrier Utilization Management Analysis section that follows the two charts.

Eleven carriers (collectively, Carriers) and 22 plans (Plans) were included in the review. Although four carriers had more than one plan, the utilization management programs were the same for all plans. As such, the utilization management analysis is presented at a carrier level.

The following analysis of utilization management policies and procedures is segmented by utilization management transactions such as prior authorization, concurrent review, retrospective review and outlier management requirements that each carrier had in effect during the Period of Review. The information is presented in this manner because the utilization management requirements varied by carrier. Finally, two of the 11 carriers (carriers 8 and 10) stated they did not have any prior authorization, concurrent review, retrospective review or outlier management requirements during the Period of Review for the procedure codes under review. However, the remaining nine carriers had some type of utilization management requirement. As such, the analysis below is based on the review of utilization management requirements for the nine carriers.

Report Chart B1 below provides details by carrier regarding the procedure codes that are subject to prior authorization, concurrent review, retrospective review or outlier management requirements. For reference,

the table below summarizes each of the Reports' 35 procedure codes within their respective procedure code groupings:

Procedure Code Group	Procedure Codes
Psychotherapy	90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90846, 90847, 90863, 90875, 90876
Psychological Testing	96101, 96102, 96116, 96118
Health and Behavior Assessment	96150, 96151, 96152, 96153, 96154, 96155
Evaluation and Management - New Patient	99201, 99202, 99203, 99204, 99205
Evaluation and Management - Established Patient	99211, 99212, 99213, 99214, 99215
Prolonged Office Visits	99354 and 99355

Prior Authorization Requirements

In terms of prior authorization requirements, eight of the nine carriers (carriers 1, 2, 3, 4, 6, 7, 9 and 11) had some type of prior authorization requirement during the Period of Review, unless a different period is noted. Five carriers (carriers 2, 6, 7, 9 and 11) had prior authorization requirements that applied to BH Providers only; one carrier (carrier 1) had requirements that pertained to both Medical Providers and BH Providers that are not employees of the carrier, and 2 carriers (carriers 3 and 4) did not indicate the providers that were subject to the requirement. The following summary provides details regarding each carrier's prior authorization requirements by procedure code group:

- Carrier 1 - Requirements existed for the following code groups:
    - Psychotherapy
    - Psychological testing
    - Evaluation and management - new patient
    - Evaluation and management - established patient

- Carrier 2 – Requirements existed for the following code groups:
    - Psychotherapy
    - Psychological testing

- Carrier 3 – Requirements existed for the following code group:
    - Psychotherapy

- Carrier 4 – Requirements existed for the following code group:
    - Prolonged office visits

- Carrier 6 – Requirements existed for the following code group:
    - Psychotherapy

- Carrier 7 – Requirements existed for the following code groups:
    - Psychological testing
    - Health and behavior assessment

- Carrier 9 – Requirements existed for the following code groups:
    - Psychotherapy testing during 2015 only
    - Psychological testing during 2015 – 2017

- Carrier 11 – Requirements existed for the following code group:
    - Psychotherapy

Concurrent Review Requirements

Regarding concurrent reviews, five of the nine carriers (carriers 2, 4, 5, 6 and 11) had some type of concurrent review requirement during the Period of Review, unless noted otherwise. Four carriers (carriers 2, 5, 6 and 11) had concurrent review requirements that applied to BH Providers only; one carrier (carrier 4) did not indicate the providers that were subject to the requirement. The following summary provides details regarding each carrier's concurrent review requirements by procedure code group:

- Carrier 2 – Requirements existed for the following code groups:
    - Psychotherapy
    - Psychological testing

- Carrier 4 – Requirements existed for the following code groups:
    - Psychotherapy during 2015 only
    - Psychological testing during 2015 only

- Carrier 5 – Requirements existed for the following code group:
    - Psychotherapy during 2015 only

- Carrier 6 – Requirements existed for the following code groups:
    - Psychotherapy
    - Psychological testing

- Carrier 11 – Requirements existed for the following code groups:
    - Psychotherapy
    - Psychological testing

Retrospective Review Requirements

Regarding retrospective reviews, five of the nine carriers (carriers 2, 4, 6, 7 and 11) had some type of retrospective review requirement during the Period of Review, unless noted otherwise. Four carriers (carriers 2, 6, 7 and 11) had retrospective review requirements that applied to BH Providers only; one carrier (carrier 4) did not indicate the providers that were subject to the requirement. The following summary provides details regarding each carrier's retrospective review requirements by procedure code group:

- Carrier 2 – Requirements existed for the following code groups:
    - Psychotherapy
    - Psychological testing

- Carrier 4 – Requirements existed for the following code groups:
    - Psychotherapy
    - Psychological testing
    - Health and behavior assessment
    - Evaluation and management - new patient
    - Evaluation and management - established patient
    - Prolonged office visits
    - Carrier noted that all medical and behavioral health services were subject to retrospective review

- Carrier 6 – Requirements existed for the following code groups:
    - Psychotherapy
    - Psychological testing

- Carrier 7 – Requirements existed for the following code group:
    - Psychological testing

- Carrier 11 – Requirements existed for the following code groups:
    - Psychotherapy
    - Psychological testing

Outlier Management Requirements

In terms of outlier management requirements, five of the nine carriers (carriers 2, 4, 6, 7 and 11) had some type of outlier management requirement during the Period of Review, unless noted otherwise. Four carriers (carriers 2, 6, 7 and 11) had outlier management requirements that applied to BH Providers only; one carrier (carrier 4) did not indicate the providers that were subject to the requirements. The following summary provides details regarding each carrier's outlier management requirements by procedure code group:

- Carrier 2 – Requirements existed for the following code groups:
    - Psychotherapy
    - Psychological testing
    - Health and behavior assessment

- Carrier 4 – Requirements existed for the following code groups:
    - Psychotherapy
    - Psychological testing
    - Health and behavior assessment
    - Evaluation and management - new patient
    - Evaluation and management - established patient
    - Prolonged office visits
    - Carrier noted that outpatient mental health treatment was subject to treatment plan review for medical necessity based on claim reports identifying outlier treatment episodes. This procedure was discontinued after April 2015

- Carrier 6 – Requirements existed for the following code groups:
    - Psychotherapy
    - Health and behavior assessment

- Carrier 7 – Requirements existed for the following code groups:
    - Psychotherapy
    - Health and behavior assessment

- Carrier 11 – Requirements existed for the following code groups:
    - Psychotherapy
    - Health and behavior assessment

Report Chart B1 - Utilization Management Requirements by Carrier

Carrier and Plan	Procedure Code	Utilization Management Requirement	Requirement Effective/ Term Date	Providers Subject to Requirement
1-A **1-B** **1-C**	90832, 90834, 90837, 90846, 90847, 90875, 90876, 96101, 96102, 96116, 96118	Prior Authorization	2015 -2018	All contracted Provider types, does not apply to Providers that are employees of the carrier

Carrier and Plan	Procedure Code	Utilization Management Requirement	Requirement Effective/ Term Date	Providers Subject to Requirement
1-A **1-B** **1-C**	99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215	Prior Authorization	2015 -2018	All contracted Provider types, does not apply to Providers that are employees of the carrier
2-D **2-E** **2-F** **2-G** **2-H** **2-I**	90837, 96116	Concurrent Review Prior Authorization Retrospective Reviews	2015 -2018	BH Providers only
2-D **2-E** **2-F** **2-G** **2-H** **2-I**	90832, 90833, 90834, 90837, 90838, 90839, 90846, 90847, 90863, 96116, 96150, 96151, 96152, 96153, 96154, 96155	Outlier Management – BH Providers Outlier Management – Medical/Surgical Service* **Specific CPT codes were not identified by the carrier*	2015 -2018 – BH & MH Providers only 2017-2018 – Medical/Surgical Service*	BH Providers only, the carrier noted that outlier management applies to Medical Providers but did not specify the applicable procedure codes
3-J	90875, 90876	Prior Authorization – only for diagnoses of Dyssynergia-type constipation in adults	2015 – 2018	Not specified by carrier
4-K	90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90846, 90847, 90863, 90875, 90876, 96101, 96102	Concurrent Review Retrospective Review	2015	Not specified by carrier
4-K	99354, 99355	Prior Authorization – when provider contract did not provide an allowable reimbursement for the code	2015 – 2018	Not specified by carrier

Carrier and Plan	Procedure Code	Utilization Management Requirement	Requirement Effective/ Term Date	Providers Subject to Requirement
4-K	90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90846, 90847, 90863, 90875, 90876, 96101, 96102, 96116, 96118, 96150, 96151, 96152, 96153, 96154, 96155, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99354, 99355	Outlier Management - Outpatient mental health treatment was subject to treatment plan review for medical necessity based on claim reports identifying outlier treatment episodes. This procedure was discontinued after April 2015	January 2015 - April 2015	Not specified by carrier
4-K	90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90846, 90847, 90863, 90875, 90876, 96101, 96102, 96116, 96118, 96150, 96151, 96152, 96153, 96154, 96155, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99354, 99355	Retrospective Review	2015 – 2018	Medical Providers and BH Providers
4-K	90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840,	Outlier Management	2015 - 2018	Not specified by carrier

Carrier and Plan	Procedure Code	Utilization Management Requirement	Requirement Effective/ Term Date	Providers Subject to Requirement
	90846, 90847, 90863, 90875, 90876, 96101, 96102, 96116, 96118, 96150, 96151, 96152, 96153, 96154, 96155, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99354, 99355			
5-L **5-M** **5-N** **5-O**	90823, 90833, 90843, 90836, 90837, 90838, 90839, 90840, 90846, 90847, 90863	Concurrent Review	2015	BH Providers only
5-L **5-M** **5-N** **5-O**	Not Applicable	No Prior Authorization, Concurrent/ Retrospective Review, or Outlier Management Requirements	2016 - 2018	Not Applicable
6-P	90837	Prior Authorizations	2015 -2018	BH Providers only
6-P	90837, 96116	Concurrent and Retrospective Reviews	2015 -2018	BH Providers only
6-P	90832, 90833, 90834, 90836, 90837, 90838, 90839, 90846, 90847, 90863, 96150, 96151, 96152, 96153, 96154, 96155	Outlier Management Program – third party entity only, this program is explained above	2015 -2018	BH Providers only

Carrier and Plan	Procedure Code	Utilization Management Requirement	Requirement Effective/ Term Date	Providers Subject to Requirement
7-Q 7-R	96101, 96102, 96116, 96118, 96152	Prior Authorizations	2015 - 2018	BH Providers only
7-Q 7-R	96101, 96102, 96116, 96118	Retrospective Review	2015 - 2018	BH Providers only
7-Q 7-R	90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90846, 90847, 90863, 90875, 90876, 96150, 96151	Outlier Management	2015 - 2018	BH Providers only
8-S	Not Applicable	No Prior Authorization, Concurrent/ Retrospective Review, or Outlier Management Requirements	2015 - 2018	Not Applicable
9-T	90875, 90876	Prior Authorization	2015	Medical Providers and BH Providers
9-T	96101, 96102, 96118	Prior Authorization	2015 – 2017	BH Providers only
10-U	Not Applicable	No Prior Authorization, Concurrent/ Retrospective Review, or Outlier Management Requirements	2015 - 2018	Not Applicable
11-V	90837	Prior Authorizations	2015 -2018	BH Providers only
11-V	90837, 96116	Concurrent and Retrospective Reviews	2015 -2018	BH Providers only
11-V	90832, 90833, 90834, 90836, 90837, 90838,	Outlier Management Program – third party entity only	2015 -2018	BH Providers only

Carrier and Plan	Procedure Code	Utilization Management Requirement	Requirement Effective/ Term Date	Providers Subject to Requirement
	90839, 90846, 90847, 90863, 96150, 96151, 96152, 96153, 96154, 96155			

For the Contractor to determine the total utilization of the 35 procedure codes, in addition to the utilization management policies, procedures and methodologies, the Carriers were required to provide the total number of times each procedure code was received by the carrier during the year for each plan during the Period of Review, and whether the benefits were processed to pay. Please refer to Appendix VIII, Charts C1 to C35, Procedure Code Utilization by Year for Carrier and Plan, to learn the exact number of times each of the 35 procedure codes were processed to pay, the number of times each was received and the percentage that were processed to pay. This information is presented by carrier, plan and year.

The Carriers were also requested to provide information on the factors considered when designing utilization management requirements for Medical Providers and BH Providers. As stated above in the carrier utilization management summary, two of the 11 carriers (carriers 8 and 10) did not have any utilization management requirements that were relevant to the procedure codes under review. As such, the analysis in this section is focused on nine carriers. Below are the results of the analysis:

- Three of the nine carriers (carriers 3, 4 and 5) considered the same factors when designing utilization management requirements for Medical Providers and BH Providers.

- Three of the nine carriers (carriers 1, 6 and 11) considered different factors when designing utilization management requirements for Medical Providers and BH Providers. There were more factors considered for BH Providers than for Medical Providers.
    - Carrier 1 indicated three factors were considered for establishing Medical Providers' UM requirements, which focused on the availability of services and the needs of patients. However, there were 10 factors considered for establishing BH Providers' UM requirements, which focused on clinical guidelines and medical necessity.
    - Carriers 6 and 11 provided a summary of the factors for Medical Provider requirements such as cost effectiveness and quality of care. However, for BH Providers, the carrier noted six factors that were considered, including service or treatment variation, high cost treatments and supply and demand options.

- Two of the nine carriers (carriers 2 and 7) did not provide sufficient information that would allow for an analysis of the factors considered when designing utilization management requirements for Medical Providers.

See Report Chart B2 below for additional information on the above analysis. As noted above, the information in Report Chart B2 summarizes the factors that each carrier considered when designing prior authorization, concurrent review, retrospective review and outlier management requirements.

Report Chart B2 - Factors Considered When Designing Utilization Management Requirements for BH Providers and Medical Providers

Carrier and Plan	Utilization Management Requirement	Factors Considered When Designing Utilization Management Requirements for BH Providers	Factors Considered When Designing Utilization Management Requirements for Medical Providers
1-A **1-B** **1-C**	Prior Authorization Concurrent Review Retrospective Review Outlier Management	1. Authorization of payment for treatment must be for a recognized diagnosis. 2. The treatment must be medically necessary. 3. Authorization of the treatment must not be for convenience of the member or the clinician 4. Services must be most clinically appropriate and cost-effective means of treating members to prevent further deterioration 5. All treatment and interventions must be reviewed and approved by the carrier 6. For personality disorders, treatment must focus on targeted symptoms. 7. Treatment for children or adolescents, behavior must be evaluated for cause. 8. Treatments for geriatric patients with dementia, delirium must be ruled out to apply mental health benefits. 9. A thorough medical evaluation is recommended, to rule out underlying medical issues. 10. Treatment for geriatric patient, considering voluntary inpatient hospitalization, must consider the carrier owned treatment facility first	1. Availability of internal services within the carrier 2. Appropriate needs of the patient. 3. Patients with language or cultural needs that cannot be met internally by available language/interpreter services.

Carrier and Plan	Utilization Management Requirement	Factors Considered When Designing Utilization Management Requirements for BH Providers	Factors Considered When Designing Utilization Management Requirements for Medical Providers
2-D **2-E** **2-F** **2-G** **2-H** **2-I**	Prior Authorization Concurrent Review Retrospective Review	1. Service or treatment variation / variability by: a. level of care, b. geographic region, c. diagnosis, d. provider/facility 2. Disparate or high cost drivers: a. Service/treatment is a significant driver of cost trend in the classification of benefits i. High volume ii. High Cost 3. Outlier performance against established benchmarks 4. Disproportionate utilization 5. Preference/System driven care: a. Consideration of clinical evidence to support care preferences grounded in specific customer or health system request. b. Supply/demand factors related to specific care options 6. Value of review of service/treatment cases as represented by: a. Clinical Outcomes vs. Administrative Burden/Cost	No Information Provided
2-D **2-E** **2-F** **2-G** **2-H** **2-I**	Outlier Management	1. Clinical algorithms based solely on members' Wellness Assessment responses that do not result in utilization review; 2. Algorithms that analyze both Wellness Assessment responses and claims data, some of which can result in utilization review;	1. Utilization that exceeded national standards and/or claimed benefit limits

Carrier and Plan	Utilization Management Requirement	Factors Considered When Designing Utilization Management Requirements for BH Providers	Factors Considered When Designing Utilization Management Requirements for Medical Providers
		3. Algorithms that rely solely on claims data and can result in utilization review	
3-J	Prior Authorization Concurrent Review Retrospective Review Outlier Management	The carrier stated that prior authorization or concurrent review is not required for the listed behavioral health codes and no outlier management is being done involving these codes	The carrier stated that prior authorization or concurrent review is not required for the listed behavioral health codes and no outlier management is being done involving these codes
4-K	Prior Authorization Concurrent Review Retrospective Review Outlier Management	1. How well-established or new the service is in the provider community 2. How long the service has been a covered service 3. Utilization patterns including typical frequency of visits and duration of treatment episodes 4. Variability in provider practices 5. Preference sensitivity of the service 6. Maturity of the evidence basis for the service 7. Feasibility of establishing utilization management requirements 8. Anticipated provider and member response to utilization management requirements 9. Regulatory issues including any prohibitions, risks, or limitations and Cost of service	1. How well-established or new the service is in the provider community 2. How long the service has been a covered service 3. Utilization patterns including typical frequency of visits and duration of treatment episodes 4. Variability in provider practices 5. Preference sensitivity of the service 6. Maturity of the evidence basis for the service 7. Feasibility of establishing utilization management requirements 8. Anticipated provider and member response to utilization management requirements 9. Regulatory issues including any prohibitions, risks, or limitations and Cost of service
5-L **5-M** **5-N**	Prior Authorization Concurrent Review Retrospective Review	Outpatient patient services 1. Follows state licensure and credentialing requirements	Outpatient patient services 1. Follows state licensure and credentialing requirements

Carrier and Plan	Utilization Management Requirement	Factors Considered When Designing Utilization Management Requirements for BH Providers	Factors Considered When Designing Utilization Management Requirements for Medical Providers
5-O	Outlier Management	2. Service and provider type 3. Scope of practice 4. Timeline 5. Medical necessity guidelines 6. Benefit design Outlier Management 1. Network adequacy standards 2. Out of pocket expenses 3. Network plan 4. Geographic location 5. Federal laws	2. Service and provider type 3. Scope of practice 4. Timeline 5. Medical necessity guidelines 6. Benefit design Outlier Management 1. Network adequacy standards 2. Out of pocket expenses 3. Network plan 4. Geographic location 5. Federal laws
6-P	Prior Authorization Concurrent Review Retrospective Review Outlier Management	1. Service or treatment variation/variability by: a. level of care, b. geographic region, c. diagnosis, d. provider/facility 2. Disparate or high cost drivers: a. Service/treatment is a significant driver of cost trend in the classification of benefits i. High volume ii. High Cost 3. Outlier performance against established benchmarks 4. Disproportionate utilization 5. Preference/System driven care: a. Consideration of clinical evidence to support care preferences grounded in specific customer or health system request. b. Supply/demand factors related to specific care options 6. Value of review of service/treatment cases as represented by:	*Carrier 6* developed our prior authorization list by performing a thorough financial and non-financial analysis of services and procedures. *Carrier 6* considers cost-effectiveness and quality of care (whether there is potential for variance in care) when recommending prior authorization of services. *Carrier 6* requires prior authorization for procedures where we see the highest variation in outcomes. *Carrier 6* regularly reviews trends and patterns of utilization to ensure our utilization management practices continue to deliver the greatest value to our customers and members. *Carrier 6* reviews the standard prior authorization list at least annually to ensure that services meet various criteria.

Carrier and Plan	Utilization Management Requirement	Factors Considered When Designing Utilization Management Requirements for BH Providers	Factors Considered When Designing Utilization Management Requirements for Medical Providers
		a. Clinical Outcomes vs. Administrative Burden/Cost	
7-Q **7-R**	Prior Authorization Retrospective Review Outlier Management	Specific factors were not enumerated; but the Carrier stated that factors considered in the determination process were supported by internal data reports, internal medical records review, credible medical literature, peer-reviewed journals and other scientific evidence.	Not applicable
9-T	Prior Authorization	1. Medical costs 2. Incidence of occurrence 3. Potential for overutilization 4. *Carrier 9* policy provisions (i.e. Clinical Policy Bulletins)	1. Medical costs 2. Incidence of occurrence 3. Potential for overutilization 4. *Carrier 9* policy provisions (i.e. Clinical Policy Bulletins) 5. Claim management to minimize member and provider impact
11-V	Prior Authorization Concurrent Review Retrospective Review Outlier Management	1. Service or treatment variation/ variability by: a. level of care, b. geographic region, c. diagnosis, d. provider/facility 2. Disparate or high cost drivers: a. Service/treatment is a significant driver of cost trend in the classification of benefits i. High volume ii. High Cost 3. Outlier performance against established benchmarks 4. Disproportionate utilization 5. Preference/System driven care: a. Consideration of clinical evidence to support care	*Carrier 11* developed our prior authorization list by performing a thorough financial and non-financial analysis of services and procedures. *Carrier 11* considers cost-effectiveness and quality of care (whether there is potential for variance in care) when recommending prior authorization of services. *Carrier 11* requires prior authorization for procedures where we see the highest variation in outcomes. *Carrier 11* regularly reviews trends and patterns of utilization to ensure our utilization management practices continue to deliver the greatest value to our customers and members. *Carrier 11* reviews the standard prior authorization list at

Carrier and Plan	Utilization Management Requirement	Factors Considered When Designing Utilization Management Requirements for BH Providers	Factors Considered When Designing Utilization Management Requirements for Medical Providers
		preferences grounded in specific customer or health system request. b. Supply/demand factors related to specific care options 6. Value of review of service/treatment cases as represented by: a. Clinical Outcomes vs. Administrative Burden/Cost	least annually to ensure that services meet various criteria.

Carrier Utilization Management Analysis

Carrier 1 - Plans A-C

Please note that the information presented in this section pertains to the carrier's three plans, unless noted otherwise. The carrier provided several documents from the Period of Review regarding their utilization management program. The documents provided included the following statement:

> "All requests for services subject to a utilization review process for medical necessity determinations will have established regional policies and procedures applied outlining the accountabilities, timeliness, processes, and documentation of same, which are consistent with all regulatory requirements and accrediting standards and have been approved by the Utilization Review Oversight Committee. Staff and physicians involved in approval or denial processes will review appropriate clinical information for the individual patient involved, for example, the clinical information sent with the request, by accessing the patient's electronic record, and/or by consultation with the ordering clinician. Information may include but is not limited to lab results, consultations, history and physical examination reports, medication history and imaging reports. Physicians involved in medical necessity determinations will utilize clinical expertise, knowledge of availability of resources/services in the local delivery system, and supporting clinical information related to the patient's individual needs and safety (age, co-morbidity, complications, and progress of treatment, psychosocial and home environment, as applicable). The organization will consult with board-certified specialists, when appropriate, for assistance with UM decision making."

Although the utilization management documents noted above pertain to medical necessity determinations for Medical/Surgical (Med/Surg) and Mental Health/Substance Use Disorder (MH/SUD), the carrier also provided other documents that were specific to MH/SUD medical necessity determinations. The following statement was included in these documents:

> "The purpose of this policy is to provide a guide for the consistent application of plan mental health benefits through the use of formal medical necessity criteria. The Utilization Management Department is responsible for the application of benefits as the health plan representative. All mental Health UR medical necessity criteria are applied no more restrictively than those for medical/surgical care in accordance with the Mental Health Parity and Addiction Equity Act (MHPEA) (sic – MHPAEA)."

The carrier provided a document titled, UR 14 C Mental Health Protocols for Triage and Appointment Access that addresses how members are assisted on a pre-service basis regarding outpatient, inpatient and emergency services. The document includes the following statement:

> "*Carrier 1* seeks to assure appropriate care for members with mental health or addiction problems and to document that services are appropriately provided, monitored and professionally managed. It is the Department's policy to ensure that members gain access to appropriate care based on the urgency of their needs. Primary care referral is not required for mental health services. Licensed mental health clinicians are available 24/7 to assist members in urgent or emergent need of access to services. Most member requests are triaged through the Mental Health appointment line during business hours."

In terms of outpatient services for new members, the document noted the following:

> "For all mental health outpatient services, new members are screened by a licensed therapist. Protocols address the urgency of the member's clinical circumstances, define the appropriate care settings and treatment resources that are to be used for services, and address all relevant mental health situations."

The carrier noted that regarding inpatient and emergency services, a Mental Health Triage Clinician will speak with the member to evaluate the situation. The Contractor requested that the carrier provide information regarding triage procedures for Med/Surg services and treatments. The carrier provided the following response:

> "There is not a comparable Med/Surg policy to UR 14C because *carrier 1* does not have a dedicated Triage Department for Med/Surg specialty visits. Prior Authorization is typically required for access to Med/Surg specialists, which provided the opportunity for the Referring Provider to communicate the diagnoses, acuity, urgency, etc., so that the appropriate appointing can occur. As Prior Authorization is not required for MH/SUD, members call in to speak directly to licensed MH staff who determine diagnoses, acuity, urgency, etc. based on what members self-report. This allows the MH staff triagers to assure that members are appointed appropriately."

The carrier provided information regarding the factors considered when designing prior authorization requirements for participating providers in an outpatient office-based setting. In terms of Medical Providers, BH Providers and MH Providers with prescribing privileges, the carrier noted that for all three plans during 2015 through 2018, the following factors were considered:

Medical Providers

"i. Availability of internal services within *carrier 1*.
ii. Appropriate needs of the patient.
iii. Patients with language or cultural needs that cannot be met internally by available language/interpreter services."

Behavioral Mental Health Providers and Mental Health Providers with Prescribing Privileges

"i. Authorization of payment for treatment must be for a recognized diagnosis.
ii. The treatment must be medically necessary.
iii. Authorization of the treatment must not be for convenience of the member or the clinician
iv. Services must be most clinically appropriate and cost-effective means of treating members to prevent further deterioration
v. All treatment and interventions must be reviewed and approved by *carrier 1*
vi. For personality disorders, treatment must focus on targeted symptoms.
vii. Treatment for children or adolescents, behavior must be evaluated for cause.
viii. Treatments for geriatric patients with dementia, delirium must be ruled out to apply mental health benefits.
ix. A thorough medical evaluation is recommended, to rule out underlying medical issues.
x. Treatment for geriatric patient, considering voluntary inpatient hospitalization, must consider *carrier 1* owned treatment facility first."

The carrier was requested to submit the analysis performed to support the factors considered when designing prior authorization requirements for participating providers in an outpatient office-based setting. The carrier provided the following response for Medical Providers:

"*Carrier 1* has no document to provide for this response. For *carrier 1*'s plan C an initial evaluation is completed by the clinical provider for outpatient out of network level of care at one of five portals of entry for care (Triage, UM, Hospital, Emergency, or Primary care Behavioral Health). The clinical provider assesses care needs and determines if external services are needed, just like medical/surgical. If the patient needs a service (internal or external) based on MCG and medical necessity guidelines, we provide the service if we can (ie: the service exists or there is no waiting list)."

The carrier was requested to submit the analysis performed to support the factors considered when designing prior authorization requirements for participating providers in an outpatient office-based setting. The carrier provided the following response for BH Providers and MH Providers with Prescribing Privileges:

"These factors are evaluated by the provider making the determination of the level of service needed to treat the condition they have diagnosed. Upon request of the clinical provider, a level of service review is made (sic - by) the Utilization Management team or Emergency clinical provider and preauthorization is completed for external services for higher levels of care than routine outpatient. Otherwise, it is determined and authorized by

> the clinical provider at the time of the evaluation. This is true for I through X and for all CPT codes referenced."

As illustrated above, the factors considered when designing prior authorization requirements for BH Providers and MH Providers with prescribing privileges are more extensive than the factors considered for Medical Providers. As such, the Contractor requested that the carrier explain this matter. The carrier provided the following response:

> "In review of the response to C.5, we acknowledge it did not include the full list of criteria that is found in our internal Utilization Review policies. Please refer to UR 1 – Utilization Review Policy and UR 4 - Medical Necessity Determinations Policy, which addresses criteria used in prior authorization decisions for Med/Surg."

The Contractor reviewed the policies noted by the carrier above, and could not locate nor verify the factors considered when designing prior authorization requirements for participating providers in an outpatient office-based setting. As such, the carrier considers fewer factors when designing prior authorization requirements for Medical Providers in comparison to the factors considered for BH Providers and MH Providers with Prescribing Privileges. Finally, when asked for the carrier's comparative analysis that supports the factors utilized for Medical Providers, BH Providers and MH Providers with Prescribing Privileges, the carrier provided the following response:

> "*Carrier 1* does not have a comparative analysis that supports the factors utilized for behavior and mental health providers and medical providers."

The carrier also provided information regarding the evidentiary standards, national treatment guidelines or other considerations that were relied upon to establish the utilization management requirements noted above. For Medical Providers, the carrier provided the following response:

> "For all plan designs *carrier 1* utilized the most recent approved edition of the nationally recognized and researched MCG Health Care Guidelines for all levels of care. Additionally, the *carrier 1* Proprietary criteria, Medicare National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs) were used. Medical necessity criteria were applied to all benefit requests in the absence of a contracted benefit exclusion. Medical necessity criteria were reviewed and approved annually by the Regional Utilization Review Oversight Committee (UROC)."

Regarding BH Providers and MH Providers with prescribing privileges, the carrier provided the following response:

> "For the period of 1/1/15 to 6/30/18, and for all plan designs, *carrier 1* utilized the most recent approved edition of the nationally recognized and researched MCG Health Care Guidelines for all levels of care. Medical necessity criteria were applied to all benefit requests in the absence of a contracted benefit exclusion. Medical necessity criteria were reviewed and approved annually by the Regional Utilization Review Oversight Committee (UROC)."

The carrier further noted that they did not consider any other standards that were rejected.

Carrier 2 - Plans D – I

The carrier stated, "In order to ensure compliance with MHPAEA, the carrier assembled an internal Mental Health Parity (MHP) compliance project team, composed of network, regulatory, clinical and legal subject matter experts. The project team conducted a thorough review of the impact of MHPAEA on all key organizational functions covering our benefits, including clinical management processes. Working collaboratively, *carrier 1* and *carrier 1*'s *third party entity* performed a review of policies and procedures, including those policies and procedures that apply to Utilization Management. *Carrier 1* coordinated with *carrier 1's third party entity* to assess how NQTLs are addressed from the Medical/Surgical perspective and Behavioral Health perspective, and documented this analysis in a public disclosure document. When either *carrier 1* or *carrier 1's third party entity* updates policies or procedures impacting NQTLs, an analysis is done to ensure continued compliance with MHPAEA."

The carrier provided the following concerning medical necessity:

> "When determining the issue of medical necessity as it relates to reimbursement, the Plan looks to several criteria. The fact that a physician has performed or prescribed a service or the fact that it may be the only treatment for a particular injury, sickness, or mental illness does not mean that it is medically necessary for purposes of reimbursement. An intervention may be medically indicated yet not be a covered benefit or meet this contractual definition of medical necessity. The Plan may choose to cover interventions that do not meet this contractual definition of medical necessity. Health care services may include medical, surgical, diagnostic, substance abuse, other health care technologies, supplies, treatments, procedures, drug therapies or devices. Health care services are determined to be medically necessary if they meet all of the following criteria, at the time the Plan makes a determination regarding coverage in a particular case:
> 1. The service is medically appropriate according to the following criteria:
>   - The service is necessary to meet the basic health needs of the covered person.
>   - The expected health benefits from the service are clinically significant and exceed the expected health risks by a sufficiently wide margin. The service is of demonstrable value and is superior to other health services, including no service.
>   - Expected health benefits can include: 1) Increased life expectancy, 2) Improved functional capacity, 3) Prevention of complications and Relief of pain.
> 2. The service is recommended by the treating physician.
> 3. The service is rendered in the most cost-efficient manner and type of setting consistent with nationally recognized standards of care, with consideration for potential benefits and harms to the patient.
> 4. The service is consistent in type, frequency, and duration of treatment with scientifically based guidelines of national medical research, or health care coverage organizations or governmental agencies that are accepted by the Plan.
> 5. In the case of a life threatening sickness, services that would not meet the criteria above may be considered medically necessary for purposes of reimbursement, If:
>   - It is considered to be safe with promising efficacy, as demonstrated by accepted clinical evidence reported by generally recognized medical professionals or publications; and

- The treatment is provided in a clinically controlled research setting using a specific research protocol that meets standards equivalent to that as defined by The National Institutes of Health for a life threatening condition.
- For the purpose of this definition, the term "life threatening" is used to describe sicknesses or conditions, which are more likely than not to cause death within one year of the date of request for treatment."

The carrier's vendor policy on management of behavioral health benefits was applicable only to MH and BH benefits. The carrier's vendor provided its services relating to concurrent and retrospective reviews, and prior authorization requirements for the outpatient office-based procedure codes that were part of this review, and the two procedure codes noted below had these requirements and were only applicable to MH Providers and BH Providers:

90837	Psychotherapy, 60 min
96116	Neurobehavioral status exam with interpretation & report per hour

The carrier stated, "The analyses and determinations are made by both *carrier 2*s' *third party entity*'s CTAC ("Clinical Technology Assessments Committee"), and the MTAC ("Medical Technology Assessments Committee" which is the medical/surgical equivalent." The carrier also stated, "The ongoing analysis and evolution of the Prior Authorization requirement process has consistently involved a review of historical and benchmark data, therefore a simple claims-based analysis cannot be displayed. Having said that, please be assured that the requirement to request prior authorization is grounded not only in a desire to gauge clinical necessity, but also to confirm that the treatment being requested is outcome-driven, evidence-based, and provided in the least restrictive environment possible. Further, in terms of administrative process, it provides *carrier 2*s' *third party entity* the opportunity to confirm member coverage/eligibility, and assist with preservice needs and follow-up planning." Additionally, the carrier stated, "The prior authorization for CPT 90837 (which has been waived for network providers as of December 2018) was based on the finding that benefits may be conclusively proven for certain treatments, but unproven for others, and that may have a negative impact on cost, quality and/or utilization of other treatment options. The determination that 90837 require prior authorization was based on a desire to confirm the sufficiency of clinical evidence, taking into account the availability of well-conducted randomized controlled trials or cohort studies in the prevailing published, peer-reviewed medical literature."

The carrier stated the following were a list of factors considered when designing its prior authorization requirements:

1. "Service or treatment variation/variability by:
   a) Level of care,
   b) Geographic region,
   c) Diagnosis,
   d) Provider/facility
2. Disparate or high cost drivers:
   a) Service/treatment is a significant driver of cost trend in the classification of benefits
      i. High volume
      ii. High Cost
3. Outlier performance against established benchmarks

4. Disproportionate utilization
5. Preference/System driven care:
   a) Consideration of clinical evidence to support care preferences grounded in specific customer or health system request.
   b) Supply/demand factors related to specific care options
6. Value of review of service/treatment cases as represented by:
   a) Clinical Outcomes vs. Administrative Burden/Cost"

The carrier had a separate policy for neuropsychological testing which was only applicable to medical conditions. For cases where mental health conditions were present, the determination for this testing was made by a third party entity.

The third party entity established an outlier management program for outpatient services that was applied to CPT codes 90832, 90833, 90834, 90837, 90838, 90839, 90846, 90847, 90863, 96116, 96150, 96151, 96152, 96153, 96154 and 96155. It was an outlier management algorithm program which utilized individual outpatient services provided to members, using member-completed wellness assessments and/or claims data. The carrier's outlier management algorithm program was used to identify members with risk factors, atypical utilization patterns and/or atypical treatment responses.

The carrier's outlier management algorithm program was specifically applied to the behavioral health/mental health conditions and services. The carrier stated:

> "The outpatient psychotherapy services to which *carrier's outlier management algorithm program* applied included the noted CPT codes concerning 30-minute psychotherapy sessions, 45-minute psychotherapy sessions, group psychotherapy, and family psychotherapy. The *carrier's outlier management algorithm program* used approximately thirty (30) algorithms, and only nine (9) of the algorithms had the potential to result in utilization review. There are three main types of *carrier outlier management algorithm*s: (1) clinical algorithms based solely on members' Wellness Assessment responses that do not result in utilization review; (2) algorithms that analyze both Wellness Assessment responses and claims data, some of which can result in utilization review; and (3) algorithms that rely solely on claims data and can result in utilization review. However, the carrier noted it also monitored outpatient Medical/Surgical services treatment progress and pharmacy adherence, to identify risk factors and utilization outliers. The carrier's outlier management efforts looked for utilization that exceeded national standards and/or claimed benefit limits in order to achieve comparable management of outlier cases. For example, clinical reviews were conducted on outpatient practitioners/services for physical therapy to determine medical necessity of services received. These reviews were conducted for members with more than 20 episodes of physical therapy services for musculoskeletal and surgical procedures only and excluded pediatric members and members with strokes. The carrier launched this program during 2017."

Carrier 3 - Plan J

During the Period of Review, the carrier did not require prior authorization or concurrent review for any of the 35 procedure codes under review, with the exception of procedure codes 90875 and 90876 for individual

psychophysiological therapy incorporating biofeedback training by any modality, 30 minutes and 45 minutes, respectively. The carrier stated the following:

> "For CPT codes 90875 and 90876, there are prior authorization requirements for medical conditions as described below:
>
> > Pre-authorization is required for diagnoses of Dyssynergia-type constipation in adults. We do not review for diagnoses of migraines and tension headaches. Neurofeedback and Biofeedback for all other indications is considered investigational (including for Behavioral Health diagnoses)."

The carrier's procedure code data for the Period of Review reflects that procedure code 90875 was received 122 times and procedure code 90876 was received 26 times; however, neither procedure code was processed to pay.

Based upon the carrier's data call information, there was no outlier management involving any of the 35 codes under review.

Carrier 4 - Plan K

The carrier provided several documents from the Period of Review, which were described as a Policy Statement and labeled, Healthcare Services Resources and Clinical Decision Tools. The documents related to the use of clinical support tools by the carrier during the clinical review process. These documents were applicable to medical and behavioral health treatments and services. The Policy Statement noted the following,

> "Third party entity staff uses clinical support tools based on evidence-based guidelines and written policies for applying the criteria based on individual needs and an assessment of the local delivery system to support clinical interventions and access to current healthcare resources for assistance in providing services to members in all lines of *carrier 4*'s business."

The documents included links to the carrier's on-line resources, such as medical necessity criteria and a link to the Centers for Medicare & Medicaid Services (CMS) guidelines and tools. The carrier also provided several documents during the Period of Review labeled, Medical Necessity Criteria Development Policy and Procedure, which provided a high-level overview regarding the policy and the Medical Providers that are involved in the process. The Policy Statement notes the following:

> "*Carrier 4* develops medical necessity criteria which are applied to review of service authorization requests and retrospective claim review. *Carrier 4* follows a consistent procedure in developing and adopting criteria across medical and behavioral conditions."

The document also notes resources, such as the National Institutes of Health, Medicare Program Manuals and medical journals that were utilized in the development of the medical necessity criteria. The carrier also provided several documents, such as the Uniform Application of Medical Necessity Definition and Utilization Management Parity documents, where *carrier 4* stated that their "utilization management procedures are no more restrictive for behavioral health services than for other medical services."

The carrier provided information regarding the factors considered when designing prior authorization requirements, concurrent and retrospective reviews and outlier management for participating providers in an outpatient office-based setting. In terms of Medical Providers, BH Providers and MH Providers with prescribing privileges, the carrier noted that during 2015 through 2018, the following factors were considered:

> "How well-established or new the service is in the provider community, How long the service has been a covered service, Utilization patterns including typical frequency of visits and duration of treatment episodes, Variability in provider practices, Preference sensitivity of the service, Maturity of the evidence basis for the service, Feasibility of establishing utilization management requirements, Anticipated provider and member response to utilization management requirements, Regulatory issues including any prohibitions, risks, or limitations and Cost of service."

The carrier also provided information regarding the evidentiary standards that were relied upon to establish the UM requirements noted above. For Medical Providers, BH providers and MH providers with prescribing privileges, the carrier provided the following response:

> "Evidentiary standards: The evidentiary standards applied by *carrier 4* were:
> Applies to: 2015, 2016, 2017: Medically Necessary means those services and supplies that are required for diagnosis or treatment of a medical condition and are:
>
> (a) Appropriate and consistent with the symptoms or diagnosis of a member's condition
> (b) Established as the standard treatment by the medical community in the service area in which they are received
> (c) Not primarily for the convenience of a member or a provider
> (d) The least costly of the alternative supplies or levels of service that can be safely provided to a member. For example, care rendered in a hospital inpatient setting is not medically necessary if it could have been provided in a less expensive setting, such as a skilled nursing facility or by a nurse in the member's home, without harm to the member
>
> Applies to 2018: Medically Necessary means healthcare services, medications, supplies or interventions that a treating licensed healthcare provider recommends and all of the following are met:
>
> (a) It is consistent with the symptoms or diagnosis of a member's condition and appropriate considering the potential benefit and harm to the patient
> (b) The service, medication, supply or intervention is known to be effective in improving health outcomes
> (c) The service, medication, supply or intervention is cost-effective compared to the alternative intervention, including no intervention"

Finally, regarding the national treatment guidelines and other considerations that were relied upon to establish prior authorization requirements, concurrent and retrospective reviews and outlier management for participating providers in an outpatient office-based setting, the carrier stated that during 2015 through 2018, the following were considered: "MCG Care Guidelines (formerly Milliman Care Guidelines), Noridian Local Coverage Determination Jurisdiction F (LCDs), National Coverage Determinations (NCDs), National

Committee for Quality Assurance (NCQA) standards and UptoDate®". The carrier further noted that "none" of the standards that were considered were rejected from 2015 through 2018.

Carrier 5 - Plans L-O

During the Period of Review, the carrier stated:

> "*Carrier 5* does not require routine review of outpatient behavioral health services. We have established parameters and guidelines based on medical necessity to identify those members with significant care needs. When care needs are identified, concurrent review of continuing outpatient services may be conducted in order to determine medical necessity and appropriate case management support".

The carrier also indicated that when it identified a need for retrospective or concurrent review of care, the provider was notified and a current treatment plan was requested. In addition, prior authorization was not required on any of the 35 outpatient procedure codes during the Period of Review.

The carrier provided information on concurrent and retrospective review requirements. The procedure codes listed as requiring concurrent review were 90823, 90833, 90843, 90836, 90837, 90838, 90839, 90840, 90846, 90847 and 90863. During 2015, the concurrent review of such procedure codes was relevant to BH Providers and MH Providers, but not Medical Providers. Concurrent review was required after 20 sessions of extended psychotherapy services. The carrier's response concerning those codes stated:

> "Concurrent and Retrospective reviews were not required on any of the codes listed in Exhibit 1 from 2016 to present. In 2015, a treatment plan review was required after 20 outpatient visits in a calendar year were exhausted for codes 90823, 90833, 90843, 90836, 90837, 90838, 90839, 90840, 90846, 90847 and 90863 from Exhibit 1. This concurrent review was utilized to assess for medical necessity, care coordination and appropriate plan of care. The treatment plan requests were not subjected to retrospective review in 2015. Please reference Behavioral Health Outpatient Treatment Adults and Children Policy. This requirement was retired in 1/2016."

The carrier's document, Behavioral Health Outpatient Treatment Adults and Children, stated:

> "We have established parameters and guidelines based on medical necessity in order to identify those members with significant care needs. When these care needs are identified, concurrent review of continuing outpatient services may be conducted in order to determine medical necessity and appropriate case management support."

The carrier was requested to define "significant care needs." The carrier's response stated:

> "In 2015, the clinicians utilized national guidelines to define the acuity of care needs and the care level most appropriate to treat presenting symptoms. MCG was utilized for all mental health requests and ASAM criteria was used for all substance use disorder requests." (Note - MCG represents Milliman Clinical Guidelines; ASAM represents the American Society of Addiction Medicine.)

The same carrier document referenced directly above, also stated there was an expectation that the provider and member/patient would collaborate to establish mutually agreed upon treatment objectives and that when the objectives were met, the treatment sessions would end. The carrier's response stated:

> "This policy occurred for the year of 2015. At that time, there was not a policy to address medical and surgical conditions. This policy was not applied to medical or surgical conditions in 2015. This verbiage and policy was retired at the end of 2015."

In addition, in the same document noted above, the carrier stated:

> "Frequency of visits greater than once weekly would generally not be considered medically necessary, except for brief increases in frequency, occasioned by acute crises."

The carrier's initial data call response stated:

> "This policy occurred for the year of 2015. At that time, there was not a policy to address medical and surgical conditions. This policy was not applied to medical or surgical conditions in 2015."

Lastly, the carrier's document stated the following:

> "Routine monitoring of members with ongoing and chronic behavioral health issues allows coordinated case management. Such monitoring is typically accomplished by a review of a current treatment plan and authorization of coverage for visits in 3 to 6 month intervals".

The carrier's initial data call response stated:

> "When the policy was effective in 2015, the frequency of visits and acuity determined the interval for concurrent review. For the time period of 2016 through 2018, concurrent review for outpatient treatment for mental health and substance use disorders was retired and no oversight management was performed for these services. The policy Behavioral Health Outpatient Treatment Adults and Children was utilized as well as MCG for mental health requests and ASAM for substance use disorder requests to standardized review practices and interrater reliability. This policy occurred for the year of 2015. At that time, there was not a policy to address medical and surgical conditions. This verbiage and policy was retired at the end of 2015."

Carrier 6 - Plan P

The carrier provided several documents from the Period of Review, which described their policies and procedures regarding the carrier's UM program. The carrier provided a document labeled, *Carrier 6* Clinical Services Medical Management Operational Policy, which includes information regarding the clinical review criteria utilized during the benefit determination process. The Policy includes the following statement:

> "The utilization management program will use evidence-based, clinical review criteria to support clinical review decisions. Staff will apply the clinical review criteria consistently in

accordance with written procedures and with consideration for individual consumer needs. Qualified physicians, appropriate providers or prescribers will develop the clinical review criteria based on current clinical principles and knowledge relevant to the criteria under review. The organization and actively practicing physicians, pharmacists and other providers with knowledge relevant to the clinical review criteria will evaluate them at least annually, and the utilization management program medical director (or equivalent designee) or clinical oversight body will approve them. Providers will have access to clinical review criteria upon request and will be advised in writing how to obtain criteria."

Also, the carrier's third party entity provided a document labeled, Management of Behavioral Health Benefits, which includes information regarding the benefit determination process. The policy statement of this document is noted as follows:

> "The purpose of this policy is to describe the mechanisms and processes designed: To promote consistency in the management of behavioral health benefits; To ensure that members receive appropriate, high quality behavioral health services in a timely manner and *carrier 6s' third party entity* has formal systems and workflows designed to process pre-service, concurrent and post-service requests for benefit coverage of services, for both in-network and out-of-network (OON) practitioners and facilities."

The carrier's third party entity also provided a state specific addendum to this policy that included Oregon statutes regarding the benefit determination process including information regarding experimental, investigational or unproven services.

The carriers' third party entity's document labeled, Management of Behavioral Health Benefits, as described above, contained a reference to the carrier's outlier management algorithm program that serves the following purposes as stated within the document:

> "*Carrier 6's outlier management algorithm program* is used to manage individual outpatient services provided to members, using member-completed Wellness Assessments and/or claims data. The *carrier's outlier management algorithm program* identifies members with risk factors, atypical utilization patterns and/or atypical treatment responses. Care Advocates conduct clinical reviews with outpatient practitioners for members identified by the *carrier's outlier management program's* algorithms."

The Contractor requested additional information regarding the carrier's outlier management algorithm program. Additional information was requested relative to whether the carrier's outlier management algorithm program pertained to Medical Providers, MH Providers and BH Providers. The following response was provided:

> "Medical/Surgical does not use the carrier's outlier management algorithm program's clinical reviews and/or prior authorization reviews when therapies are requested that exceed national standards and/or claimed benefit limits in order to achieve comparable management of outlier cases."

The carrier further noted that claims processed by the carrier are not subject to the carrier's outlier management algorithm program; only claims processed by its third party entity are subject to the *carrier's*

outlier management algorithm program. In terms of the 35 procedure codes under this review that are subject to the *carrier's outlier management algorithm program*, the carrier provided the following information:

> "The outpatient psychotherapy services to which *carrier 6's outlier management algorithm program* applies include the suite of CPT codes concerning 30-minute psychotherapy sessions, 45-minute psychotherapy sessions, group psychotherapy, and family psychotherapy."

The carrier also provided a list of the procedure codes that are subject to the carrier's outlier management algorithm program, which includes the following procedure codes under this review: 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90846, 90847, 90863, 96150, 96151, 96152, 96153, 96154, and 96155.

The carrier was requested to provide the underlying triggers and equations in determining whether a member has frequency utilization, risk factors, atypical utilization patterns, or atypical treatment responses (include any thresholds or margins) within the carrier's outlier management algorithm program. The carrier provided the following response:

> "The *carrier's outlier management algorithm program* uses approximately 30 algorithms; only nine of the algorithms have the potential to result in utilization review. There are three main types of *outlier management algorithms*: (1) clinical algorithms based solely on members' Wellness Assessment responses that do not result in utilization review; (2) algorithms that analyze both Wellness Assessment responses and claims data, some of which can result in utilization review; and (3) algorithms that rely solely on claims data and can result in utilization review.
>
> - Patients incurred 12 or more outpatient visits (defined by 90791, 90832, 90834, 90837, 90839, 90845, 90846, 90847, 90849, 90853, 90857, 90863, 90880, 90901, 99510, 90792, 90833, 90836, 90838, CPT codes) and with place of service not in (31, 32) in (sic) six weeks with the same clinician. Last session must be within last 45 days.
> - Patients incurred 21 or more outpatient services visits defined by CPT codes in (90791, 90832, 90834, 90837, 90839, 90845, 90846, 90847, 90849, 90853, 90857, 90863, 90880, 90901, 99510, 90792, 90833, 90836, 90838) and with a single provider by Tax ID within the past 6 months. Last session must be within last 45 days. – See below for update as of 5/13/2019
> - Patients incurring more than 48 services in past 6 months (Defined by CPT codes 96150, 96151, 96152, 96153, 96154, 96155). Last session of health and behavioral assessments must be within last 45 days.
> - Patients incurring 9 or more services in past 6 months (Defined by CPT codes 99304, 99305, 99306, 99307, 99308, 99309, 99310, 90816, 90822, 90791, 90792, 90832, 90834, 90837, 90839, 90853, 90857, 90833, 90836, 90838) and with place of service in (31, 32) (sic). Last session of nursing home service in the last 45 days or the last 75 days for ISNP only. See below for update as of 2/19/2018
> - Patients incurred 31 or more outpatient, or EAP visits with a single preferred network clinician within the past 6 months with at least one sessions (sic) within the past 45 days. (Defined by CPT codes 99304, 99305, 99306, 99307, 99308, 99309, 99310,

90816, 90822, 90791, 90792, 90832, 90834, 90837, 90839, 90853, 90857, 90833, 90836, 90838) See below for change as of 5/13/2019

- At least one claim from ANY provider in last 12 months has a primary, secondary or tertiary diagnosis category in Neurocognitive Disorders AND Patients incurring 3 or more services regardless of AMA place of service in past 3 months (Defined by CPT codes 90816-90822, 90791, 90792, 90832, 90834, 90837, 90839, 90853, 90857, 90833, 90836, 90838). Last service must be within last 45 days. No removal from history (one trigger per member and provider only)."

The carrier provided information regarding the factors considered when designing prior authorization, concurrent and retrospective review requirements and outlier management for participating providers in an outpatient office-based setting. In terms of Medical Providers, the carrier noted that the following factors were considered:

> "*Carrier 6* developed our prior authorization list by performing a thorough financial and non-financial analysis of services and procedures. *Carrier 6* considers cost-effectiveness and quality of care (whether there is potential for variance in care) when recommending prior authorization of services. *Carrier 6* requires prior authorization for procedures where we see the highest variation in outcomes. *Carrier 6* regularly reviews trends and patterns of utilization to ensure our utilization management practices continue to deliver the greatest value to our customers and members. *Carrier 6* reviews the standard prior authorization list at least annually to ensure that services meet various criteria."

Regarding BH Providers and MH Providers with prescribing privileges, the carrier's third party entity noted that the following factors were considered:

1. "Service or treatment variation/variability by:
   a) level of care,
   b) geographic region,
   c) diagnosis,
   d) provider/facility
2. Disparate or high cost drivers:
   a) Service/treatment is a significant driver of cost trend in the classification of benefits
      i. High volume
      ii. High Cost
3. Outlier performance against established benchmarks
4. Disproportionate utilization
5. Preference/System driven care :
   a) Consideration of clinical evidence to support care preferences grounded in specific customer or health system request.
   b) Supply/demand factors related to specific care options
6. Value of review of service/treatment cases as represented by:
   a) Clinical Outcomes vs. Administrative Burden/Cost"

Based on the above, the factors considered when designing prior authorization requirements, concurrent and retrospective reviews and outlier management for participating Medical Providers in an outpatient office-based setting varies from that for BH Providers and MH Providers with prescribing privileges. As such, the

Contractor requested the carrier provide additional information regarding the variances. The following response was provided:

> "The Company apologizes for any confusion caused by the previous response. Although different terminology was used (the MH/SUD version being more of an outline than a narrative), it is actually the same process that is used for both Medical/Surgical (M/S) and Mental Health/Substance Use Disorder (MH/SUD) providers."

In addition, the carrier was requested to provide the comparative analysis that was performed regarding the factors considered while designing precertification and prior authorization, concurrent and retrospective review requirements, and outlier management requirements for participating Medical Providers, BH Providers and MH Providers with prescribing privileges in an outpatient office-based setting. The following response was provided:

> "The Company is unable to provide the requested documentation as we do not have the historical data as the prior authorization requirements were established years ago and pre-parity; however, the same analysis was applied for both M/S and MH/SUD."

The carrier was requested to provide evidentiary standards, national treatment guidelines or other considerations (including standards considered but rejected) that were relied upon to establish precertification and prior authorization, concurrent and retrospective review requirements, and outlier management for participating providers in an outpatient office-based setting. In terms of Medical Providers, the carrier provided the following information:

> "The medical plan determines when prior authorization and other management interventions may be required by evaluating the potential administrative cost of these interventions when compared to their potential benefit. The following strategies, processes, evidentiary standards and other factors are used as part of this analysis:
>
> 1) Practice Variation/variability by
>   a. Level of care
>   b. Geographic region
>   c. Diagnosis
>   d. Provider/facility
> 2) Significant drivers of cost trend
> 3) Outlier performance against established benchmarks
> 4) Disproportionate Utilization
> 5) Preference/System driven care
>   a. Preference driven
>   b. Supply/demand factors
> 6) Gaps in Care that negatively impact cost, quality and/or utilization
> 7) Outcome yield from the Utilization Management activity/Administrative cost analysis"

Regarding BH Providers and MH Providers with prescribing privileges, the carrier provided the following information:

"The evidentiary standards used include *the carrier's third party entity*'s historical data, as well as evidence-based guidelines (i.e. clinical evidence and peer-reviewed literature)

Claims based analysis:
We review services for requirements and variation analysis based on:
a) Volume of services
b) Use Frequency distribution, to establish variation from evidence based practice
i. While some variation in utilization may exist for all outpatient services, review is considered where the magnitude of the variation materially exceeds the variation for other outpatient services within the classification. *Carrier 6s' third party entity* and *carrier 6* consider "materially exceeds" on a cost or utilization metric to be where the range of the metric exceed the mean by 2X.
c) Examination of trends

Benchmark based analysis:
We also apply benchmark based analysis based on:
a) Miliman (sic - Milliman) Guidelines or other nationally-recognized benchmarks
b) Review of trusted literature:
a. The totality of clinical evidence suggests the use of the service requires specified qualifying criteria for safe and effective treatment outcomes as required by national practice guidelines
b. Deviation from established practice evidenced in literature, audits, claims review (including evidence that the diagnosis has not proven to respond to the treatment)."

Based upon the above information, the evidentiary standards, national treatment guidelines or other considerations (including standards considered but rejected) that were relied upon to establish precertification and prior authorization, concurrent and retrospective review requirements, and outlier management varies for participating Medical Providers, BH Providers and MH Providers with prescribing privileges in an outpatient office-based setting. As such, the Contractor requested additional information regarding the variances. The following response was provided:

"The Company apologizes for any confusion caused by the previous response. The process used for M/S and MH/SUD is the same. Still, the difference in numbers of M/S versus MH/SUD conditions, and especially the different rate at which treatment options and related findings change for M/S versus MH/SUD, means that the factors considered will vary. Still, those evidentiary standards are no more stringent for MH/SUD."

In addition, the carrier was requested to provide the comparative analysis that was performed regarding the evidentiary standards, national treatment guidelines or other considerations (including standards considered but rejected) that were relied upon to establish precertification and prior authorization, concurrent and retrospective review requirements, and outlier management for participating Medical Providers, BH Providers and MH Providers with prescribing privileges in an outpatient office-based setting. The following response was provided:

"Prior to implementation of the MHPAEA, *carrier 6s' third party entity* already had procedures in place that we then determined were compliant with the newly adopted law. The Company is unable to

provide evidence of any efforts to move into compliance because the data set was already being properly controlled, and no further action was needed or undertaken. Again, we review and maintain parity compliance on an ongoing basis."

Carrier 7 - Plans Q-R

The carrier stated its utilization management decisions were guided by objective, evidence-based criteria. It also stated its decisions required both knowledge and consistent application of its third party entity's (a behavioral health entity) policies and clinical guidelines, which were based on scientific evidence, industry standards, and regulatory requirements. The carrier stated that all decisions were based upon its:

> *"*Change Healthcare InterQual Level of Care Criteria"; *carrier 7s' third party entity*'s evidence-based internal criteria; and the Centers for Medicare and Medicaid Services (CMS) National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs). *Carrier 7s' third party entity*'s evidence-based internal criteria guidelines were based on a variety of clinical sources such as the evidence-based American Psychiatric Association Practice Guidelines, American Psychological Association standards of practice (Ethical Principles of Psychologists and Code of Conduct), and Psychological Test Usage: Implications in Professional Psychology, by W. J. Camara, J. S. Nathan, and A. E. Puente, 2000, Professional Psychology: Research and Practice, 31, 141-154."

In addition, the carrier stated:

> "The underlying processes, strategies, and evidentiary standards considered by *carrier 7s' third party entity* and the carrier when determining if a non-quantitative treatment limitation (NQTL) applied to a service, were conducted in an equitable manner across all M/S and MH/SUD benefits."

The carrier also stated:

> "Factors considered in the determination process were supported by internal data reports, internal medical records review, credible medical literature, peer-reviewed journals and other scientific evidence."

In addition, the carrier stated:

> "Further, the underlying processes, strategies, and evidentiary standards, considered by *carrier 7s' third party entity* and *carrier 7* when determining if a NQTL applied to a service, was conducted in an equitable manner across all M/S and MH/SUD benefits. Factors considered in the determination process were supported by internal data reports, internal medical records review, credible medical literature, peer-reviewed journals and other scientific evidence. Outpatient psychiatry and medication management services did not require Prior Authorization, concurrent review or retrospective review. Outlier management was a sub-category of utilization management techniques. The prior authorization list assessment and implementation team completed a comprehensive review of NQTL requirements to determine the appropriateness for inclusion and potential deletions to the list. The team consisted of medical and behavioral health clinical leadership. In determining

what benefits would be subject to a NQTL, the team evaluated the current list of services subject to NQTLs and potential new categories for each market using established inputs and factor criteria. *Carrier 7s' third party entity*/*carrier 7* applied NQTLs for only those services/procedures which met one or more of the factors identified by the team and for which the quality of care could be favorably influenced by medical necessity or appropriateness review. The evidentiary standards considered in developing utilization management techniques included consideration of a wide array of recognized medical literature and professional standards and protocols, as well as state and federal parity regulations. There were no standards considered but rejected."

The carrier provided a listing, which was applicable for both plan types and for the entire Period of Review, of the outpatient office-based procedure codes which were subject to prior authorization requirements:

- 96101 - Psychological Testing
- 96102 - Psychological Testing
- 96116 - Neuropsychological Testing
- 96118 - Neuropsychological Testing
- 96152 - Health& Behavior Intervention-ABA Therapy

The carrier stated:

> "Nothing comparable on medical/surgical side. This requirement is specific to psychological testing and behavioral health providers. In the rare event *carrier 7's* Prior Authorization receives a request from a Medical/Surgical provider for psychological testing the requesting provider is contacted and redirected to submit to the carrier's *third party entity* for Prior Authorization review."

Relative to concurrent review, the carrier stated, "None of the office based procedure codes were subject to concurrent review."

For the procedure codes that were subject to prior authorization and retrospective review, the carrier noted that medical outpatient office visits of a similar nature were not subject to either retrospective review or prior authorization.

The carrier provided a listing, which was applicable for both plan types and for the entire Period of Review, of BH and MH outpatient office-based procedure codes which were subject to outlier management, as follows:

- 90832 - 90834 - Psychotherapy
- 90836 - 90840 - Psychotherapy
- 90846 - 90847 - Family Psychotherapy
- 90863 - Pharmacologic Management
- 90875 - 90876 - Individual Psychophysiological Therapy
- 96150 - 96151 - Health and Behavior Assessment

However, the carrier stated that the carrier does not have outlier management for Medical Provider outpatient office visits.

Carrier 8 - Plan S

The carrier did not subject routine outpatient office-based services for the treatment of medical or behavioral health conditions to medical necessity review. The carrier stated, "*Carrier 8* does not impose treatment limitations to medical or behavioral outpatient time-based office visits/services." In addition, the carrier noted prior authorization, concurrent and retrospective reviews were not required on any of the 35 outpatient procedure codes reviewed during the Period of Review. There was no outlier management for participating providers in an outpatient office-based setting during the Period of Review.

Carrier 9 - Plan T

From 2015 to 2018, in regards to treatment limitations applied to outpatient time-based office visits and services, the carrier stated the following:

> "The coverage plans do not limit the number of outpatient time based office visit services a covered person may obtain provided that the services were medically necessary and appropriate for the care and treatment of the covered person. Out-patient time-based office visits are not subject to prior authorization under our utilization management program."

Specific to Exhibit 1 of the original data request letter, which is the listing of the 35 outpatient time-based office visit procedure codes inclusive of evaluation and management office visits and prolonged services (procedure codes 99201-99205, 99211-99215 or 99354-99355), the carrier stated:

> "No precertification/prior authorization requirements currently exist for any of the procedures listed in exhibit 1. Additionally, no concurrent and retrospective reviews, or outlier management currently exists for any of the evaluation and management (E&M) or prolonged visit codes listed in exhibit 1 (99201-99205, 99211-99215 or 99354-99355)."

In designing precertification/prior authorization requirements and the procedures included on the carrier national precertification list (NPL), the carrier stated the following factors were considered and analyzed by an internal committee for medical/surgical and mental health/substance use disorder services:

- "Medical costs
- Incidence of occurrence
- Potential for overutilization
- Carrier policy provisions (i.e. Clinical Policy Bulletins)."

Within the 2015 internal committee meeting minutes, specific to mental health and substance use disorder benefits, the carrier also stated the following factor was considered:

- "Claim management to minimize member and provider impact."

The carrier further noted that they establish clinical policy bulletins based on:

- "Peer-reviewed, published medical journals
- A review of available studies on a particular topic
- Evidence-based consensus statements

- Expert opinions of health care professionals
- Guidelines from nationally recognized health care organizations."

The carrier provided information regarding other treatments and services that are subject to precertification/ prior authorization, concurrent and retrospective reviews and outlier management under the carrier's UM program.

A team of the carrier's Medical Directors and department representatives complete periodic re-evaluations of the national precertification list to determine if there should be any adjustments. From 2015 through 2017, the carrier required precertification for psychological and neuropsychological testing within the outpatient office-based setting (procedure codes 96101, 96102, and 96118). Neuropsychological testing could be performed for either a medical/surgical condition or behavioral health condition. In those instances where the service was performed for a medical or surgical condition, the carrier noted, it was a medical and surgical benefit, per federal parity definitions. After a review of medical costs, return-on-investment (ROI), and behavioral health parity requirements, the carrier noted the "same codes do not require precertification on medical benefits" and that this represented a "parity risk." Therefore, per the carrier, the precertification requirement for these services was recommended for removal on July 9, 2018. The effective date of the removal was not provided.

The carrier's original documentation stated that there was a precertification requirement for family psychotherapy services (procedure codes 90846 and 90847), but their follow-up response indicated that this precertification application was for HMO plans only, which were not part of the scope of this review.

In 2015, the carrier required precertification for psychophysiological therapy with biofeedback within the outpatient office-based setting (procedure codes 90875 and 90876). Psychophysiological therapy with biofeedback could be performed for either a medical/surgical condition or mental health condition. In those instances where the service was performed for a medical or surgical condition, the carrier noted, it was a medical and surgical benefit, per federal parity definitions. The precertification requirement relied on the clinical policy bulletin, CPB 0132 Biofeedback, to determine whether the service was medically necessary. The carrier's policy specifically lists those medical/surgical conditions or behavioral conditions that would be deemed medically necessary (covered) and those conditions that would be deemed experimental and investigational (not covered). See Report Chart B3 below for those conditions covered for psychophysiological therapy with biofeedback and those that are excluded per the carrier's CPB 0132 bulletin. This precertification requirement was removed after 2016 but an explanation for the removal was not provided.

Report Chart B3: Covered and Not Covered Conditions Psychophysiological Therapy

Medically Necessary and Potentially Covered Conditions (Covered):	Experimental and Investigational for the Following Conditions (Not Covered):
• Cancer pain • Chronic constipation • Fecal incontinence • Irritable bowel syndrome • Levator ani syndrome (also known as anorectal pain syndrome) • Migraine and tension headaches • Neuromuscular rehabilitation of stroke and traumatic brain injury (TBI) • Refractory severe subjective tinnitus • Temporomandibular joint (TMJ) syndrome • Urinary incontinence	• Anterior shoulder instability or pain • Anxiety disorders • As a rehabilitation modality for spasmodic torticollis, spinal cord injury, or following knee surgeries • Attention deficit hyperactivity disorder (ADHD) • Autism • Balance training (with tongue-placed electrotactile biofeedback or visual interactive biofeedback) • Bell's palsy (idiopathic facial paralysis) • Cardiovascular diseases (e.g., heart failure) • Chemotherapy-induced peripheral neuropathy • Childhood apraxia of speech • Chronic abacterial prostatitis • Chronic fatigue syndrome • Chronic pain (e.g., back pain, fibromyalgia, neck pain) other than migraine and tension headache • Cleft palate speech (nasopharyngoscopic biofeedback) • Daytime syndrome of urinary frequency • Depression • Diabetes • Epilepsy • Essential hypertension (e.g., by means of the RESPeRATE Device) • Facial pain • Functional dysphonia • Home biofeedback (for any indication) • Improvement of anorectal/bowel functions after sphincter-saving surgery for rectal cancer • Insomnia • Ordinary muscle tension states • Pain associated with multiple sclerosis • Panic disorders (e.g., FreeSpira breathing system) • Pelvic floor dysfunction • Peripheral arterial disease (e.g., intermittent claudication) • Pre-term labor • Prophylaxis of medication overuse headache and pediatric migraine • Post-trauma stress disorder • Psychosis • Psychosomatic conditions

Medically Necessary and Potentially Covered Conditions (Covered):	Experimental and Investigational for the Following Conditions (Not Covered):
	• Raynaud's disease/phenomenon • Sleep bruxism • Spasticity secondary to cerebral palsy • Toe-out gait modification/retraining in people with knee osteoarthritis • Tourette's syndrome • Tremor • Type 2 diabetes • Urinary retention • Vaginal tear • Vaginismus • Vertigo/disequilibrium • Visual disorders • Vulvodynia

Carrier 10 - Plan U

From 2015 to 2018, in regards to utilization management of outpatient time-based office visits and services, the carrier stated the following:

> "*Carrier 10* does not require authorization for in-network outpatient services such as primary care and behavioral health care. Decisions regarding what services should require prior authorization are made to target services that are high risk (of complications or side effects), frequently overused, and high cost to members and the health plan. Services that are low risk, low cost, and not overused are generally not targeted to require prior authorization."

The carrier did not require prior authorization or outlier management and did not specifically state there was any requirement for concurrent reviews and retrospective reviews, for in-network outpatient services, such as primary care and behavioral health care. Specific to any requirement for prior authorization, concurrent reviews, or retrospective reviews of outpatient office time-based procedures, the carrier stated, "No Auth. required - objective is to remove barriers to care." Additionally, the carrier stated, "*Carrier 10* does not have an outlier management process for outpatient services."

The carrier was requested to provide any factors considered when designing precertification and prior authorization requirements, concurrent and retrospective reviews, or outlier management for participating providers in an outpatient office-based setting. Specific to Medical Providers, the carrier stated:

> "*Carrier 10* uses nationally recognized evidence-based criteria, local standards of care and availability of services within the network in the design of authorization requirements. Services with existing barriers to access generally do not require authorization."

The carrier's response to this request for BH Providers was:

> "*Carrier 10* recognizes the limited availability of behavioral health providers and thus have not required prior authorization in order to remove barriers in access to care."

In regards to this request specific to MH Providers with prescribing privileges, the carrier stated:

> "Recognizes there are extreme limitations in availability of behavioral health prescribers and thus have not required prior authorization in order to remove barriers in access to care."

The carrier provided its criteria for making UM decisions. The criteria was used for UM decision-making by the Chief Medical Officer/Medical Director, contracted physician reviewers, medical management (MM) staff, and the appeals team staff. Additionally, for all providers, the carrier stated:

> "*Carrier 10* establishes criteria for utilization management using nationally recognized evidence-based guidelines from MCG Health. Care guidelines from MCG provide evidence-based medicine best practices across the continuum of treatment and scope of providers."

The carrier provided the policy with the hierarchy of the Medical Necessity Guidelines for the various covered services. The carrier uses Medicare Guidelines, but also uses other industry and nationally recognized guidelines such as MCG Health and American Society of Addiction Medicine (ASAM), when appropriate for the service and condition. The carrier also indicated the use of internally-developed medical coverage policies as secondary and tertiary criteria. Secondary and tertiary criteria are only used if primary criteria do not exist, per the carrier's hierarchy. Regarding internally-developed medical coverage policies, the carrier refers to them as "*Carrier 10* Plan Operations developed guideline(s)" and defines them as:

> "A series of policies developed by *carrier 10* based on local, regional and national practice standards; literature researched, and consensus of appropriate *carrier 10* team members. Recommended policies must be approved by the Quality Improvement Committee (QIC) to be considered a *carrier 10* Plan Operations developed and approved policy."

The carrier's policy also lists the other specific factors utilized. The carrier's policy stated:

> "As nationally developed procedures for applying criteria are often designed for "uncomplicated" patients and for a comprehensive delivery system, they may not be appropriate for patients with complications or for a delivery system with insufficient alternatives to inpatient care. *Carrier 10* Plan Operations therefore considers the following when applying criteria to a given individual:
>
> i. Age
> ii. Comorbidities
> iii. Complications
> iv. Progress of treatment
> v. Psychosocial situation
> vi. Home environment, when applicable
> vii. Availability of skilled nursing facilities, subacute care facilities or home care in the service area (if needed to support the patient after hospital discharge)

viii. Coverage of benefits for skilled nursing facilities, subacute care facilities or home care where needed
ix. Local hospitals ability to provide all recommended services within the estimated length of stay."

Relative to how those factors are utilized and a coverage determination is made, the carrier stated:

> "These additional characteristics are reviewed and Medical Management staff are instructed to alert the reviewing physician when any of the above factors indicate that criteria guidelines may not be appropriate. These cases are reviewed individually by the Physician Reviewer for appropriate determinations."

Report Chart B4 below represents the carrier's commercial plans' criteria for utilization management decision making as provided by the carrier.

Report Chart B4: Utilization Management Decision-Making Criteria Hierarchy

Services	Primary Criteria	Secondary Criteria	Tertiary Criteria
Inpatient hospital stays	MCG criteria	*Carrier 10* Medical Coverage Policy	Medicare Coverage Guidelines or other evidence based guidance
Surgical services	MCG criteria	*Carrier 10* Medical Coverage Policy	Medicare Coverage Guidelines or other evidence based guidance
Imaging services	MCG criteria	*Carrier 10* Medical Coverage Policy	Medicare Coverage Guidelines or other evidence based guidance
Skilled Nursing Facility services	Medicare Coverage Guidelines	*Carrier 10* Medical Coverage Policy	N/A
Durable Medical Equipment and Supplies	MCG criteria	Medicare Coverage Guidelines	*Carrier 10* Medical Coverage Policy
Mental Health and Chemical Dependency	MCG criteria and ASAM	Medicare Coverage Guidelines	*Carrier 10* Medical Coverage Policy
Other outpatient services	MCG criteria	Medicare Coverage Guidelines	*Carrier 10* Medical Coverage Policy

The carrier was required to provide a comprehensive listing of any other treatment limitations applied to the 35 outpatient time-based procedure codes included in Exhibit 1 of the data call. The carrier stated the following for 2015 to 2018:

> "The services listed in Exhibit 1 are non-covered for the following provider types: midwife, registered nurse, certified first assistant, licensed practical nurse, certified alcohol and drug counselor, qualified mental health associate, qualified mental health

professional, bachelor's degree, certified genetic counselor, personal care RN, and private duty nurse.

Carrier 10 uses a claim editing system (CES) which reviews all claims for correct claim coding based on Medicare coding guidelines.

Carrier 10's Small Group Plans limit coverage of CPT codes 90875 and 90876 to 10 visits per lifetime for any covered service. No claims have been denied for these services."

The provider types listed in the carrier's response were excluded from review under SB 860. However, the carrier's small group plans limit the coverage of services for procedure codes 90875 and 90876, psychophysiological therapy incorporating biofeedback, to 10 visits per lifetime for any covered service. The procedure code 90876 was received by the carrier once in 2015 and the carrier reported that the procedure code 90876 was processed to pay once in 2015. The procedure code was not received by the Carrier from 2016 to 2018.

Carrier 11 - Plan V

The carrier provided several documents from the Period of Review, which described their policies and procedures regarding the UM program. The carrier provided a document labeled, Clinical Services Medical Management Operational Policy, which includes information regarding the clinical review criteria utilized during the benefit determination process. The Policy includes the following statement:

"The utilization management program will use evidence-based, clinical review criteria to support clinical review decisions. Staff will apply the clinical review criteria consistently in accordance with written procedures and with consideration for individual consumer needs. Qualified physicians, appropriate providers or prescribers will develop the clinical review criteria based on current clinical principles and knowledge relevant to the criteria under review. The organization and actively practicing physicians, pharmacists and other providers with knowledge relevant to the clinical review criteria will evaluate them at least annually, and the utilization management program medical director (or equivalent designee) or clinical oversight body will approve them. Providers will have access to clinical review criteria upon request and will be advised in writing how to obtain criteria."

Also, the carriers' third party entity provided a document labeled, Management of Behavioral Health Benefits, which includes information regarding the benefit determination process. The policy statement of this document is noted as follows:

"The purpose of this policy is to describe the mechanisms and processes designed: To promote consistency in the management of behavioral health benefits; To ensure that members receive appropriate, high quality behavioral health services in a timely manner and *carrier 11s' third party entity* has formal systems and workflows designed to process pre-service, concurrent and post-service requests for benefit coverage of services, for both in-network and out-of-network (OON) practitioners and facilities."

The carrier's third party entity also provided a state specific addendum to this policy that included Oregon statutes regarding the benefit determination process, including information regarding experimental, investigational or unproven services.

The third party entity document labeled, Management of Behavioral Health Benefits, as described above, contained a reference to the carrier's outlier management algorithm program that serves the following purposes as stated within the document:

> "*Carrier 11's outlier management algorithm program* is used to manage individual outpatient services provided to members, using member-completed Wellness Assessments and/or claims data. The *carrier's outlier management algorithm program* identifies members with risk factors, atypical utilization patterns and/or atypical treatment responses. Care Advocates conduct clinical reviews with outpatient practitioners for members identified by *carrier 11's outlier management program* algorithms."

The Contractor requested additional information regarding the carrier's outlier management algorithm program. Additional information was requested relative to whether the carrier's outlier management algorithm program pertained to Medical Providers, MH Providers and BH Providers. The following response was provided:

> "Medical/Surgical does not use the carrier's *outlier management algorithm program* clinical reviews and/or prior authorization reviews when therapies are requested that exceed national standards and/or claimed benefit limits in order to achieve comparable management of outlier cases."

The carrier further noted that claims processed by the carrier are not subject to the carrier's outlier management algorithm program; only claims processed by the third party entity are subject to the carrier's outlier management algorithm program. In terms of the 35 procedure codes under this review that are subject to the carrier's outlier management algorithm program, the carrier provided the following information:

> "The outpatient psychotherapy services to which *carrier 11's outlier management algorithm program* applies include the suite of CPT codes concerning 30-minute psychotherapy sessions, 45-minute psychotherapy sessions, group psychotherapy, and family psychotherapy."

The carrier also provided a list of the procedure codes that are subject to the carrier's outlier management algorithm program, which includes the following procedure codes under this review: 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90846, 90847, 90863, 96150, 96151, 96152, 96153, 96154, and 96155.

The carrier was requested to provide the underlying triggers and equations in determining whether a member has frequency utilization, risk factors, atypical utilization patterns, or atypical treatment responses (including any thresholds or margins) within the carrier's outlier management algorithm program. The carrier provided the following response:

"The carrier's *outlier management algorithm program* uses approximately 30 algorithms; only nine of the algorithms have the potential to result in utilization review. There are three main types of carrier *outlier management algorithm*s: (1) clinical algorithms based solely on members' Wellness Assessment responses that do not result in utilization review; (2) algorithms that analyze both Wellness Assessment responses and claims data, some of which can result in utilization review; and (3) algorithms that rely solely on claims data and can result in utilization review.

- Patients incurred 12 or more outpatient visits (defined by 90791, 90832, 90834, 90837, 90839, 90845, 90846, 90847, 90849, 90853, 90857, 90863, 90880, 90901, 99510, 90792, 90833, 90836, 90838, CPT codes) and with place of service not in (31, 32) in (sic) six weeks with the same clinician. Last session must be within last 45 days.
- Patients incurred 21 or more outpatient services visits defined by CPT codes in (90791, 90832, 90834, 90837, 90839, 90845, 90846, 90847, 90849, 90853, 90857, 90863, 90880, 90901, 99510, 90792, 90833, 90836, 90838) and with a single provider by Tax ID within the past 6 months. Last session must be within last 45 days. – See below for update as of 5/13/2019
- Patients incurring more than 48 services in past 6 months (Defined by CPT codes 96150, 96151, 96152, 96153, 96154, 96155). Last session of health and behavioral assessments must be within last 45 days.
- Patients incurring 9 or more services in past 6 months (Defined by CPT codes 99304, 99305, 99306, 99307, 99308, 99309, 99310, 90816, 90822, 90791, 90792, 90832, 90834, 90837, 90839, 90853, 90857, 90833, 90836, 90838) and with place of service in (31, 32) (sic). Last session of nursing home service in the last 45 days or the last 75 days for ISNP only. See below for update as of 2/19/2018
- Patients incurred 31 or more outpatient, or EAP visits with a single preferred network clinician within the past 6 months with at least one sessions (sic) within the past 45 days. (Defined by CPT codes 99304, 99305, 99306, 99307, 99308, 99309, 99310, 90816, 90822, 90791, 90792, 90832, 90834, 90837, 90839, 90853, 90857, 90833, 90836, 90838) See below for change as of 5/13/2019
- At least one claim from ANY provider in last 12 months has a primary, secondary or tertiary diagnosis category in Neurocognitive Disorders AND Patients incurring 3 or more services regardless of AMA place of service in past 3 months (Defined by CPT codes 90816-90822, 90791, 90792, 90832, 90834, 90837, 90839, 90853, 90857, 90833, 90836, 90838). Last service must be within last 45 days. No removal from history (one trigger per member and provider only)."

The carrier provided information regarding the factors considered when designing prior authorization, concurrent and retrospective review requirements and outlier management for participating providers in an outpatient office-based setting. In terms of Medical Providers, the carrier noted that the following factors were considered:

"*Carrier 11* developed our prior authorization list by performing a thorough financial and non-financial analysis of services and procedures. *Carrier 11* considers cost-effectiveness and quality of care (whether there is potential for variance in care) when recommending prior authorization of services. *Carrier 11* requires prior authorization for procedures where we

see the highest variation in outcomes. *Carrier 11* regularly reviews trends and patterns of utilization to ensure our utilization management practices continue to deliver the greatest value to our customers and members. *Carrier 11* reviews the standard prior authorization list at various criteria."

Regarding BH Providers and MH Providers with prescribing privileges, the carrier's third party entity noted that the following factors were considered:

1. "Service or treatment variation/variability by:
   a) level of care,
   b) geographic region,
   c) diagnosis,
   d) provider/facility
2. Disparate or high cost drivers:
   a) Service/treatment is a significant driver of cost trend in the classification of benefits
      i. High volume
      ii. High Cost
3. Outlier performance against established benchmarks
4. Disproportionate utilization
5. Preference/System driven care :
   a) Consideration of clinical evidence to support care preferences grounded in specific customer or health system request.
   b) Supply/demand factors related to specific care options
6. Value of review of service/treatment cases as represented by:
   a) Clinical Outcomes vs. Administrative Burden/Cost"

Based on the above, the factors considered when designing prior authorization requirements, concurrent and retrospective reviews and outlier management for participating Medical Providers in an outpatient office-based setting varies from that for BH Providers and MH Providers with prescribing privileges. As such, the Contractor requested the carrier provide additional information and clarification regarding the variances. The following clarifying response was provided:

"The Company apologizes for any confusion caused by the previous response. Although different terminology was used (the MH/SUD version being more of an outline than a narrative), it is actually the same process that is used for both Medical/Surgical (M/S) and Mental Health/Substance Use Disorder (MH/SUD) providers."

In addition, the carrier was requested to provide the comparative analysis that was performed regarding the factors considered while designing precertification and prior authorization, concurrent and retrospective review requirements, and outlier management requirements for participating Medical Providers, BH Providers and MH Providers with prescribing privileges in an outpatient office-based setting. The following response was provided:

"The Company is unable to provide the requested documentation as we do not have the historical data as the prior authorization requirements were established years ago and pre-parity; however, the same analysis was applied for both M/S and MH/SUD."

The carrier was requested to provide evidentiary standards, national treatment guidelines or other considerations (including standards considered but rejected) that were relied upon to establish precertification and prior authorization, concurrent and retrospective review requirements, and outlier management for participating providers in an outpatient office-based setting. In terms of Medical Providers, the carrier provided the following information:

> "The medical plan determines when prior authorization and other management interventions may be required by evaluating the potential administrative cost of these interventions when compared to their potential benefit. The following strategies, processes, evidentiary standards and other factors are used as part of this analysis:
>
> 1) Practice Variation/variability by
>   a. Level of care
>   b. Geographic region
>   c. Diagnosis
>   d. Provider/facility
> 2) Significant drivers of cost trend
> 3) Outlier performance against established benchmarks
> 4) Disproportionate Utilization
> 5) Preference/System driven care
>   a. Preference driven
>   b. Supply/demand factors
> 6) Gaps in Care that negatively impact cost, quality and/or utilization
> 7) Outcome yield from the Utilization Management activity/Administrative cost analysis"

Regarding BH Providers and MH Providers with prescribing privileges, the carrier provided the following information:

> "The evidentiary standards used include *carrier 11s' third party entity*'s historical data, as well as evidence-based guidelines (i.e. clinical evidence and peer-reviewed literature)
> Claims based analysis:
> We review services for requirements and variation analysis based on:
> a) Volume of services
> b) Use Frequency distribution, to establish variation from evidence based practice
> i. While some variation in utilization may exist for all outpatient services, review is considered where the magnitude of the variation materially exceeds the variation for other outpatient services within the classification. *Carrier 11s' third party entity* and *carrier 11* consider "materially exceeds" on a cost or utilization metric to be where the range of the metric exceed the mean by 2X.
> c) Examination of trends
>
> Benchmark based analysis:
> We also apply benchmark based analysis based on:
> a) Miliman (sic - Milliman) Guidelines or other nationally-recognized benchmarks
> b) Review of trusted literature:

a. The totality of clinical evidence suggests the use of the service requires specified qualifying criteria for safe and effective treatment outcomes as required by national practice guidelines
b. Deviation from established practice evidenced in literature, audits, claims review (including evidence that the diagnosis has not proven to respond to the treatment)."

Based upon the above information, the evidentiary standards, national treatment guidelines or other considerations (including standards considered but rejected) that were relied upon to establish precertification and prior authorization, concurrent and retrospective review requirements, and outlier management varies for participating Medical Providers, BH Providers and MH Providers with prescribing privileges in an outpatient office-based setting. As such, the Contractor requested additional information regarding the variances. The following response was provided:

"The Company apologizes for any confusion caused by the previous response. The process used for M/S and MH/SUD is the same. Still, the difference in numbers of M/S versus MH/SUD conditions, and especially the different rate at which treatment options and related findings change for M/S versus MH/SUD, means that the factors considered will vary. Still, those evidentiary standards are no more stringent for MH/SUD."

In addition, the carrier was requested to provide the comparative analysis that was performed regarding the evidentiary standards, national treatment guidelines or other considerations (including standards considered but rejected) that were relied upon to establish precertification and prior authorization, concurrent and retrospective review requirements, and outlier management for participating Medical Providers, BH Providers and MH Providers with prescribing privileges in an outpatient office-based setting. The following response was provided:

"Prior to implementation of the MHPAEA, *carrier 11s' third party entity* already had procedures in place that we then determined were compliant with the newly adopted law. The Company is unable to provide evidence of any efforts to move into compliance because the data set was already being properly controlled, and no further action was needed or undertaken. Again, we review and maintain parity compliance on an ongoing basis."