Instructions for Concurrent Review

General guidance applicable to all NQTL analyses: Every comparative analysis for each classification of benefits should be self-contained. In other words, it should not be necessary for the regulator to read through attachments or other separate policy documents to determine if the comparative analysis is sufficient. For any relevant document such as utilization management manuals, clinical policy bulletins, guidelines, criteria, etc., it is the responsibility of the plan/issuer to examine those documents and determine if there is comparability and no more stringent application between MH/SUD and medical/surgical. The is the fundamental expectation of comparative analysis: the plan/issuer examines all relevant materials and data, compares, contrasts, probes, and analyzes them and then explains what was revealed and how or why everything examined did or did not reveal compliance. Attachments and other documents may be submitted so that the regulator can corroborate the plan/issuer's findings and conclusions, but the plan/issuer should avoid responding to any step with "see attachments X, Y, and Z for proof of compliance". There will be select instances when the instructions for a particular step allow for the submission of attachments in lieu of analysis text.

Step 1: The specific plan or coverage terms or other relevant terms regarding the NQTL and a description of all mental health or substance use disorder (MH/SUD) and medical or surgical benefits to which each such term applies in each respective benefits classification.

Guidance: This Step requires that the plan/issuer provide the specific coverage terms and policies and procedures regarding concurrent review and a definitive identification of all MH/SUD and medical/surgical benefits to which each such term applies in each of the respective benefit classifications or subclassifications. The plan/issuer should identify all benefits to which concurrent review applies. If all benefits in the classification or subclassification are subject to concurrent review at some point in time, it is sufficient to state that and refrain from listing every benefit in the classification.

The plan/issuer should indicate and identify any delegate/vendor involvement with MH/SUD benefits. This includes if there are separate operating departments or divisions in the plan/issuer responsible for the management of covered MH/SUD benefits and any contractual arrangements with external entities. The plan/issuer should specifically provide the concurrent review requirements that are specific to the delegate or vendor and reference their policies and procedures.

Step 2: The factors used to determine that the NQTL will apply to MH/SUD benefits and medical or surgical benefits.

Guidance: The plan/issuer should provide an all-inclusive list of the factors it utilizes to determine if and when concurrent review will apply to medical/surgical and MH/SUD services. The plan/issuer should avoid using phrases such as "factors include…" or "factors may include…". The standard for this step is reporting the factors used to determine that the NQTL **will** apply. Phrasing that uses "include" or "may include" introduces uncertainty as to whether the listed factors actually were used or that there may be unlisted factors used to determine the NQTL will apply. It is recommended, but not required, that the plan/issuer have a grid or chart indicating which factor or factors led to the imposition of concurrent for each benefit.

If all benefits in a classification are subject to concurrent review it is not necessary to list or describe any factors with regards to ***whether*** concurrent review applies as it is understood that the imposition of concurrent review is a classification-wide occurrence. However, it is necessary to list factors that determine ***when*** concurrent review occurs. If there are no independent factors that determine the timing of concurrent review and the timing is based solely on clinical indicators revealed during prior authorization,

merely stating such is sufficient. However, this must be explained and delineated further in step 3 or step 4. In other words, stating that clinical presentation dictates the timing of concurrent review without further detailing how that works for MH/SUD and how it is comparable to and applied no more stringently than how it works for medical/surgical at some point in the analysis will result in the overall analysis being deemed insufficient.

As it is understood that all services must be medically necessary, medical necessity or clinical appropriateness does not need to be noted as a factor. Medical Necessity is a separate and distinct NQTL.

Step 3: The evidentiary standards used for the factors identified in step 2, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTL to MH/SUD benefits and medical or surgical benefits.

Guidance: The plan/issuer must define each factor set forth in Step 2 and identify the applicable evidentiary standard and source for each factor. For example, quantitative factors such as value or projected costs savings must be defined in an appropriate manner and documentation and/or an illustration of the calculation provided as supporting information. When defining a qualitative factor, it is not sufficient to indicate a factor or component of an evidentiary standard such as "opportunity to improve quality" without explaining specifically what that means or how it is determined. In addition, the plan/issuer should identify whether or not certain factors or components of an evidentiary standard are given more weight or value than others and explain the basis to assert they are not weighted. That is, if multiple factors are utilized to determine whether and/or when the NQTL will be applied, are any of them alone sufficient to determine the NQTL applies and/or when? Or are all or a combination of the factors required?

If a factor clearly involves some sort of threshold, such as "excessive utilization" or "high-cost admission", those thresholds must be defined and demonstrated to be comparable between MH/SUD and medical/surgical. For example, at what point does utilization reach the point of being "excessive"? At what dollar amount does a stay become "high cost"? Please note that there is no expectation that these threshold values must be or should be exactly the same for MH/SUD versus medical/surgical in order to be comparable. However, the plan/issuer must explain how and why the disparate values are in fact comparable. For example, excessive utilization involving evaluation and management billing codes will most likely be a lower numerical threshold than excessive utilization involving psychotherapy billing codes.

As noted in step 2, if clinical information revealed during prior authorization alone determines when concurrent review occurs, that must be explored and analyzed further either in this step, in step 4, or in both steps 3 and 4. Step 3 does not technically require a demonstration that the factors and evidentiary standards are comparable and applied no more stringently between MH/SUD and medical/surgical. But step 4 does. When clinical information alone determines the timing of concurrent review, further explanation of how that is structured for both MH/SUD and medical/surgical is required. Additionally, a demonstration of how its application to MH/SUD is comparable to and applied no more stringently than its application to medical/surgical is required. This can be done in this step alone, step 4 alone, or in a combination of the two steps.

Step 4: The comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to medical or surgical benefits in the benefits classification.

Guidance: This Step requires two distinct comparative analyses: a comparative analysis, as written, and comparative analysis, in operation. The first analysis concerns the plan/issuer's demonstration that its written protocols are comparable and applied no more stringently. The second analysis concerns the plan/issuer's demonstration that the NQTL is applied no more stringently in operation. The reporting must clearly address these two components separately and should not merely provide a conclusory statement that the plan/issuer has done an assessment and determined that the NQTL complies without providing the analysis and explanation as to how and why the plan/issuer has concluded it has met the tests of comparability and no more stringent application.

As Written: The comparative analysis concerning the "as written" component should be inclusive of all the plan/issuer's written policies, procedures, and utilization management manuals regarding concurrent review for MH/SUD and M/S services. These standards determine the basis for whether application of the NQTL is comparable and applied no more stringently with respect to MH/SUD and medical/surgical services. It is not necessary for the plan/issuer to produce an exhaustive dissection of all policies, procedures, UM manuals, etc. relied upon. However, the plan/issuer should provide persuasive analysis and reasoning that reveals how it concluded that these materials are comparable and applied no more stringently. If all written materials used in establishing and conducting concurrent review for MH/SUD and medical/surgical are the same, merely stating as such without further commentary is sufficient.

The plan/issuer's analysis should also account for how decisions rendered during concurrent review are categorized and monitored by the plan/issuer because they may relate to the in-operation analysis for both MH/SUD and medical/surgical services. That is, denial rates may have at least two categories- denials recorded as denials based on medical necessity and denials recorded as administrative which can be due to a variety of reasons, e.g., provider failed to provide information deemed essential to the coverage decision. There is a related question as to how coverage modifications are recorded (e.g., the provider submits for an inpatient service and the coverage approved is negotiated down to approval for partial hospitalization) and whether coverage modifications are counted as denials. The plan/issuer must demonstrate through an analysis that these are defined and recorded comparably between MH/SUD and medical/surgical services.

The as written analysis should specifically account for any differences where the plan/issuer has delegated review functions for MH/SUD services to a third-party vendor or when a separate unit within the plan/issuer is responsible for the MH/SUD NQTL. The plan/issuer documentation here should provide a clear, logical, and comprehensive analysis which illustrates comparability as to the written policies and procedures where the review function is conducted by separate parties.

In Operation: The plan/issuer must also demonstrate that the NQTL is being applied in a comparable and no more stringent manner. The required comparative analysis must account for what happens when concurrent review is operationalized.

Merely explaining that certain processes exist and that those processes are "the same" for MH/SUD and medical/surgical may demonstrate that there is comparability, but it does not demonstrate no more stringent application. For example, it may be the case that only a licensed physician or a medical director can make a determination that a request is not medically necessary when a first-level reviewer cannot approve it. This process may be exactly the same for MH/SUD and medical/surgical. However, further analysis is required to demonstrate that these identical, in-operation processes are applied no more stringently to MH/SUD than to medical/surgical.

Comparative analyses of coverage denial rates, if offered as evidence of no more stringent application, which resulted from the concurrent review should be specific and broken down by benefits classification.

Plan/issuer reporting on denial rates should not be provided on an aggregate basis across classifications of benefits. Moreover, denial rates by themselves are not a sufficient basis to demonstrate no more stringent application in operation (nor are they sufficient basis to demonstrate more stringent application, e.g. noncompliance). In other words, merely displaying denial rates as the entirety of an in-operation analysis is insufficient on its face.

Reporting on interrater reliability (IRR) as evidence that criteria are applied consistently and as the sole basis to demonstrate comparability and no more stringent application in operation is also not a sufficient basis to demonstrate in operation compliance. IRR results are derived from a testing situation and are not necessarily reflective of what happens when concurrent review is operationalized. In order to demonstrate no more stringent application of the operationalization of the processes, the comparative analysis should account for several other pertinent operational metrics. These may include matters such as the percentage of cases that are referred for second level (physician) review, the frequency of peer-to-peer reviews, and others. Comparative analyses offered to demonstrate compliance in operation should provide information beyond denial rates and IRR results to demonstrate that everything was comparable and applied no more stringently in operation. **Also, please note** that greater frequency of peer-to-peer reviews for MH/SUD is not necessarily problematic as it is understood that some plans/issuers offer peer-to-peer to MH/SUD providers upon an initial denial as a matter of routine whereas that may not be the case for medical/surgical. If this is the case, an explanation as such should alleviate any concerns that greater frequency is indicative of more stringent application. Keep in mind that reporting data that indicates greater frequency of any particular metric for MH/SUD when compared to medical/surgical is never by itself dispositive of noncompliance so long as the plan/issuer is able to provide a persuasive explanation as to why it is not indicative of noncompliance.

The plan/issuer should incorporate as part of its analysis, quality assurance oversight reports which include review of the concurrent review processes, including generalized audits. This includes the results of any internal audits involving the first-level review process, the physician review process, the peer-to-peer process, and consultations with expert review process (if applicable) excluding IRR testing reports.

Step 5: The specific findings and conclusions reached by the group health plan or health insurance issuer with respect to the health insurance coverage, including any results of the analyses described in this step that indicate that the plan or issuer is or is not in compliance with this section.

Guidance: The plan/issuer should provide a reasoned discussion of its findings and conclusions identified in Steps 1 through 4 within the affected classification, including any citations to specific evidence considered and results of analyses which demonstrate that the issuer is or is not in compliance with MHPAEA.

The required information in Step 5 is inclusive of a summary and conclusion. The summary should be a concise statement or account of the principal information and results of the analyses offered to demonstrate compliance. It should not introduce new information or analyses not presented in the foregoing Steps. The conclusion provided should not merely be a summary of the principal supporting information or a re-statement of the plan/issuer's analysis; it should be a synthesis of the basis from the above required information and analyses which definitively demonstrates compliance as written and in operation.

If the plan/issuer has decided that it is not in compliance, it should describe any plan it has for corrective action.