

Instructions for Medical Necessity

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. This 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 a description of the materials relied upon to determine medical necessity for benefits. This does not need to be a detailed inventory of each and every different guideline, criterion, medical policy, level of care placement document, etc. For example, stating that the plan/issuer relies on clinical policy bulletins or corporate medical policies to determine the medical necessity/appropriateness of various items, services, procedures, or medications is sufficient rather than listing each one from A to Z (examples of clinical policy bulletins/corporate medical policies [here](#) and [here](#)). The purpose of this step is to outline the general types of criteria, guidelines, policies, etc. relied upon without listing specific criteria, guidelines, or policies. For example, stating that there are internally-developed clinical policy bulletins governing the coverage of some benefits is sufficient rather than listing each one, such as a policy regarding [applied behavior analysis](#), among others.

This step should be relatively brief.

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

Guidance: N/A. Given that all items, services, procedures, and medications must be medically necessary there could not be any factors that determine whether medical necessity applies. It is understood that it always applies.

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: Given that there are no factors to provide evidentiary standards for, this NQTL the emphasis should be on "evidence relied upon design and apply the NQTL". It is understood that delving into each piece of evidence relied upon is an impossible task (the linked applied behavior analysis medical policy above has over 70 citations alone). The goal should be to provide a general inventory of the different types of evidence relied upon and their sources. Similar to step 1, this step should be relatively brief.

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: For this NQTL, the as-written component is the only aspect of interest for analysis. While guidelines, criteria, medical policies, level of care placement tools etc. certainly are operationalized, that occurs during prior authorization, concurrent review, and retrospective review and should be captured as an in-operation process during those utilization review NQTL analyses.

The goal in this step is for the plan/issuer to provide clear and thorough analysis that explains how and why the plan/issuer has concluded that materials relied upon to guide decisions on medical necessity for MH/SUD benefits are comparable to and no more stringent than those in use for medical/surgical benefits.

This should focus on the finished products that are actually used by utilization review staff when making determinations about the medical necessity of a benefit. That means the plan/issuer is expected to take inventory of its criteria, guidelines, medical policies, level of care placement tools, etc. and demonstrate that those used for MH/SUD medical necessity determinations are not more stringent than those used for medical/surgical determinations.

This need not entail an exhaustive review of everything that exists. Rather, the plan/issuer could ensure that it has examined all of the criteria, guidelines, medical policies, level of care placement tools, etc. for MH/SUD and found and demonstrated that the most stringent elements are also present in various medical/surgical criteria, guidelines, medical policies, etc. For example, a plan/issuer might identify its approval criteria for applied behavior analysis, transcranial magnetic stimulation, and ECT as being relatively stringent and more so than other MH/SUD criteria in the outpatient classification of benefits. If it then demonstrates how various medical/surgical criteria in the outpatient classification of benefits are just as or more stringent, that would be a good way to show no more stringent application. The plan/issuer is not required to take that approach, but it may be an efficient method to pursue. Regardless, in this step the plan/issuer must be able to explain how and why it has concluded that the MH/SUD criteria, guidelines, medical policies, level of care placement tools, etc. are comparable to and no more stringent than those used for medical/surgical medical necessity determinations.

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, 3, and 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.