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| **NQTL: Concurrent Review** | |
| **Classification(s):** | |
| **Step 1 – Identify the specific plan or coverage terms or other relevant terms regarding Concurrent Review and a description of all mental health or substance use disorder and medical or surgical benefits to which each such term applies in each respective benefits classification** | |
| ***Step 1(a): Define Concurrent Review***:  **Concurrent Review (CR) is defined as a technique for managing the appropriate utilization of healthcare services under which service claims are only eligible for coverage if provider obtains approval or re-approval from the Plan for Medical Necessity of the ongoing delivery of the service at the current level of care during a facility stay or course of treatment. Services subject to CR may or may not also be subject to Prior Authorization or Retrospective Review, but the definition of CR does not include Prior Authorization or Retrospective Review strategies.**  **In this definition and the following analysis, “service” means any healthcare treatment, service, prescription drug, product, or other benefit that is covered under the terms of the Plan.** | |
| ***Step 1(b): Identify the M/S benefits/services for which Concurrent Review is required***: | ***Step 1(b): Identify the MH/SUD benefits/services for which Concurrent Review is required***: |
| **Step 2 – Identify the factors used to determine that Concurrent Review will apply to mental health or substance use disorder benefits and medical or surgical benefits** | |
| **Medical/Surgical**: | **MH/SUD**: |
| **Step 3 – Identify the evidentiary standards used for the factors identified in Step 2, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply Concurrent Review to mental health or substance use disorder benefits and medical or surgical benefits.** | |
| **Medical/Surgical**: | **MH/SUD**: |
| **Step 4 – Provide the comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to mental health or substance use disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical or surgical benefits in the benefits classification** | |
| ***Step 4(a): For each M/S benefit subject to Concurrent Review, identify which of the factor(s) in Step 3 were met***: | ***Step 4(a): For each MH/SUD benefit subject to Concurrent Review, identify which of the factor(s) in Step 3 were met***: |
| ***Step 4(b): Briefly describe the processes by which Concurrent Review is applied to M/S benefits***:  *Timelines and deadlines, including the frequency with which re-authorizations are required*:  *Forms and/or other information required to be submitted by the provider*:  *Utilization management manuals and any other documentation of UM processes that are relied upon to make a determination*:  *In-operation processes in place to make a determination such as distinctions between first and second-level reviews or between administrative and clinical reviews, peer-to-peer reviews, and the use of medical discretion applied in lieu of or in the absence of written criteria and guidelines*:  *Minimum qualifications for reviewers*:  *Minimum standards to issue a denial (e.g. sign-off from a physician with relevant board certification)*: | ***Step 4(b): Briefly describe the processes by which Concurrent Review is applied to MH/SUD benefits***:  *Timelines and deadlines, including the frequency with which re-authorizations are required*:  *Forms and/or other information required to be submitted by the provider*:  *Utilization management manuals and any other documentation of UM processes that are relied upon to make a determination*:  *In-operation processes in place to make a determination such as distinctions between first and second-level reviews or between administrative and clinical reviews, peer-to-peer reviews, and the use of medical discretion applied in lieu of or in the absence of written criteria and guidelines*:  *Minimum qualifications for reviewers*:  *Minimum standards to issue a denial (e.g. sign-off from a physician with relevant board certification)*: |
| ***Step 4(c) : Identify and define the factors and processes that are used to monitor and evaluate the application of Concurrent Review for M/S benefits***: | ***Step 4(c) : Identify and define the factors and processes that are used to monitor and evaluate the application of Concurrent Review for MH/SUD benefits***: |
| **Step 5 – Provide the specific findings and conclusions reached by the group health plan or health insurance issuer with respect to the health insurance coverage, including any results that indicate that the plan or coverage is or is not in compliance with this section** | |
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| **NQTL: Retrospective Review** | |
| **Classification(s):** | |
| **Step 1 – Identify the specific plan or coverage terms or other relevant terms regarding Retrospective Review and a description of all mental health or substance use disorder and medical or surgical benefits to which each such term applies in each respective benefits classification** | |
| *Define Retrospective Review*:  **Retrospective Review (RR) is a technique for managing the appropriate utilization of healthcare services under which the Medical Necessity of a service is reviewed after the delivery of the service and the service is only eligible for coverage if the Plan determines that the sevice was Medically Necessary. Services subject to RR may or may not also be subject to Prior Authorization, Concurrent Review, or Outlier Management, but the definition of RR does not include Prior Authorization, Concurrent Review, or Outlier Management strategies.**  **In this definition and the following analysis, “service” means any healthcare treatment, service, prescription drug, product, or other benefit that is covered under the terms of the Plan.** | |
| **Step 2 – Identify the factors used to determine that Retrospective Review will apply to mental health or substance use disorder benefits and medical or surgical benefits** | |
| *Identify the factors used to determine which M/S claims are subject to Retrospective Review* | *Identify the factors used to determine which MH/SUD claims are subject to Retrospective Review* |
| **Step 3 – Identify the evidentiary standards used for the factors identified in Step 2, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply Retrospective Review to mental health or substance use disorder benefits and medical or surgical benefits.** | |
| *Identify the evidentiary standards and sources applied to the factors listed for M/S benefits in Step 2(b)* | *Identify the evidentiary standards and sources applied to the factors listed for MH/SUD benefits in Step 2(b)* |
| **Step 4 – Provide the comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to mental health or substance use disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply Retrospective Review to medical or surgical benefits in the benefits classification** | |
| ***Step 4(a) : Identify and define the factors and processes that are used to monitor and evaluate the application of Retrospective Review for M/S benefits***:  *Timelines and deadlines for completing the Medical Necessity review and adjudication of the claim:*  *Forms and/or other information required to be submitted by the provider*:  *Utilization management manuals and any other documentation of UM processes that are relied upon to make a determination*:  *In-operation processes in place to make a determination such as distinctions between first and second-level reviews or between administrative and clinical reviews, peer-to-peer reviews, and the use of medical discretion applied in lieu of or in the absence of written criteria and guidelines*:  *Minimum qualifications for reviewers*:  *Minimum standards to issue a denial (e.g. sign-off from a physician with relevant board certification)*: | ***Step 4(a) : Identify and define the factors and processes that are used to monitor and evaluate the application of Retrospective Review for MH/SUD benefits***:  *Timelines and deadlines for completing the Medical Necessity review and adjudication of the claim:*  *Forms and/or other information required to be submitted by the provider*:  *Utilization management manuals and any other documentation of UM processes that are relied upon to make a determination*:  *In-operation processes in place to make a determination such as distinctions between first and second-level reviews or between administrative and clinical reviews, peer-to-peer reviews, and the use of medical discretion applied in lieu of or in the absence of written criteria and guidelines*:  *Minimum qualifications for reviewers*:  *Minimum standards to issue a denial (e.g. sign-off from a physician with relevant board certification)*: |
| ***Step 4(b): Identify and define the factors and processes that are used to monitor and evaluate the application of Retrospective Review***: | ***Step 4(b): Identify and define the factors and processes that are used to monitor and evaluate the application of Retrospective Review***: |
| **Step 5 – Provide the specific findings and conclusions reached by the group health plan or health insurance issuer with respect to the health insurance coverage, including any results that indicate that the plan or coverage is or is not in compliance with this section** | |
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| **NQTL: Outlier Management** | |
| **Classification(s):** | |
| **Step 1 – Identify the specific plan or coverage terms or other relevant terms regarding Outlier Management and a description of all mental health or substance use disorder and medical or surgical benefits to which each such term applies in each respective benefits classification** | |
| ***Step 1(a): Define Outlier Management***:  **Outlier Management (OM) is defined as a process by which unusual patterns of service coding, charges, and/or other claims information are identified and analyzed to detect potential fraud, waste, or abuse. OM does not include Retrospective Review.**  **In this definition and the following analysis, “service” means any healthcare treatment, service, prescription drug, product, or other benefit that is covered under the terms of the Plan.** | |
| ***Step 1(b): Identify the M/S benefits/services for which Outlier Management is required***: | ***Step 1(b): Identify the MH/SUD benefits/services for which Outlier Management is required***: |
| **Step 2 – Identify the factors used to determine that Outlier Management will apply to mental health or substance use disorder benefits and medical or surgical benefits** | |
| ***Step 2: Identify the factors used to determine which M/S benefits are subject to Outlier Management*** | ***Step 2: Identify the factors used to determine which MH/SUD benefits are subject to Outlier Management*** |
| **Step 3 – Identify the evidentiary standards used for the factors identified in Step 2, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply Outlier Management to mental health or substance use disorder benefits and medical or surgical benefits.** | |
| ***Step 3: Identify the evidentiary standards and sources applied to the factors listed for M/S benefits in Step 2*** | ***Step 3: Identify the evidentiary standards and sources applied to the factors listed for MH/SUD benefits in Step 2*** |
| **Step 4 – Provide the comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to mental health or substance use disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply Outlier Management to medical or surgical benefits in the benefits classification** | |
| ***Step 4(a) : Identify and define the factors and processes that are used to monitor and evaluate the application of Outlier Management for M/S benefits***: | ***Step 4(a) : Identify and define the factors and processes that are used to monitor and evaluate the application of Outlier Management for MH/SUD benefits***: |
| ***Step 4(b): Identify and define the factors and processes that are used to monitor and evaluate the application of Outlier Management***: | ***Step 4(b): Identify and define the factors and processes that are used to monitor and evaluate the application of Outlier Management***: |
| **Step 5 – Provide the specific findings and conclusions reached by the group health plan or health insurance issuer with respect to the health insurance coverage, including any results that indicate that the plan or coverage is or is not in compliance with this section** | |
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| **NQTL: Failure to Complete** | |
| **Classification(s):** | |
| **Step 1 – Identify the specific plan or coverage terms or other relevant terms regarding the Failure to Complete NQTL and a description of all mental health or substance use disorder and medical or surgical benefits to which each such term applies in each respective benefits classification** | |
| ***Step 1(a): Define the Failure to Complete NQTL***:  **Failure to Complete (FTC) is an exclusion of coverage for further benefits for an identified service for a specified period of time when the patient fails to complete a course of treatment using that service. FTC does not include the use of Medical Necessity criteria that require consideration or trial of alternative treatments before authorizing a service, or that require consideration of the patient’s engagement in treatment, receipt of other related services, readiness to change, and/or related psychosocial or behavioral factors in determining the Medical Necessity of the service, whether pursuant to Step Therapy, Prior Authorization, Concurrent Review, or otherwise.**  **In this definition and the following analysis, “service” means any healthcare treatment, service, prescription drug, product, or other benefit that is covered under the terms of the Plan.** | |
| ***Step 1(b): Identify the M/S benefits/services for which the Failure to Complete NQTL is applied***: | ***Step 1(b): Identify the MH/SUD benefits/services for which the Failure to Complete NQTL is applied:*** |
| **Step 2 – Identify the factors used to determine that the Failure to Complete NQTL will apply to mental health or substance use disorder benefits and medical or surgical benefits** | |
| **Medical/Surgical**: | **MH/SUD**: |
| **Step 3 – Identify the evidentiary standards used for the factors identified in Step 2, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the Failure to Complete NQTL to mental health or substance use disorder benefits and medical or surgical benefits.** | |
| **Medical/Surgical**: | **MH/SUD**: |
| **Step 4 – Provide the comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the Failure to Complete NQTL to mental health or substance use disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical or surgical benefits in the benefits classification** | |
| ***Step 4(a): For each M/S benefit subject to the Failure to Complete NQTL, identify which of the factor(s) in Step 3 were met***: | ***Step 4(a): For each MH/SUD benefit subject to the Failure to Complete NQTL, identify which of the factor(s) in Step 3 were met***: |
| ***Step 4(b): Briefly describe the processes by which the Failure to Complete NQTL is applied to M/S benefits***:  *Timelines and deadlines*:  *Medical records and/or other information upon which the determination is based that the patient failed to complete the course of treatment*:  *Policies and procedures that are relied upon to make a determination to exclude further coverage*:  *Minimum qualifications for reviewers*: | ***Step 4(b): Briefly describe the processes by which the Failure to Complete NQTL is applied to MH/SUD benefits***:  *Timelines and deadlines:*  *Medical records and/or other information upon which the determination is based that the patient failed to complete the course of treatment:*  *Policies and procedures that are relied upon to make a determination to exclude further coverage:*  *Minimum qualifications for reviewers:* |
| ***Step 4(c) : Identify and define the factors and processes that are used to monitor and evaluate the application of Failure to Complete for M/S benefits***: | ***Step 4(c) : Identify and define the factors and processes that are used to monitor and evaluate the application of Failure to Complete for MH/SUD benefits***: |
| **Step 5 – Provide the specific findings and conclusions reached by the group health plan or health insurance issuer with respect to the health insurance coverage, including any results that indicate that the plan or coverage is or is not in compliance with this section** | |
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